**PROJECT: YOUTH ACTION BRIDGE**

# Comparative Governance Toolkit: Maternal Health Transparency – Croatia & Ethiopia

## Outline



## Executive Summary


Achieving **Sustainable Development Goal 3.1**—reducing the global maternal mortality ratio (MMR) to fewer than **70 deaths per 100 000 live births** by 2030—requires more than technical

health interventions. Good governance, characterised by transparency, accountability and participation, is equally important. This toolkit provides a comparative framework for assessing and improving governance in maternal health programmes in **Croatia** and **Ethiopia**. Croatia is an EU member with one of the world's lowest MMRs (about **3 deaths per 100 000 live births** Ethiopia, an African Union member, has reduced its MMR from **871 per 100 000 live births in 2000** to **267 in 2020** largely through community health initiatives. Both countries still face governance challenges—Croatia with limited public participation and infrequent release of disaggregated data, Ethiopia with weak policy enforcement, limited regional autonomy and non-institutionalised citizen participation. The toolkit proposes a five-indicator assessment (budget transparency, data quality and timeliness, policy enforcement, institutional autonomy and citizen participation) and offers recommendations for reform.

## Key Terms

| Term | Definition |
|---|---|
| **MMR** | Maternal mortality ratio: maternal deaths per 100 000 live births in a specified period. |
| **Institutional transparency** | Openness in decision-making, budgeting and reporting that allows public scrutiny. |
| **Institutional autonomy** | Capacity of regional or local health bodies to make operational and financial decisions. |
| **HEP** | Health Extension Programme, Ethiopia's community-based primary health service platform. |
| **Maputo Plan of Action** | AU strategy (2016–2030) for reproductive, maternal and neonatal health. |

# 1 Introduction

## 1.1 Global context

Around **287 000 women** died from pregnancy-related causes in 2020, with 94 % of deaths occurring in low- and middle-income countries (WHO, 2023). Postpartum haemorrhage, infection, hypertensive disorders and unsafe abortion are the leading causes, all largely preventable with timely care. **SDG 3.1** and initiatives such as the **Global Strategy for Women's, Children's and Adolescents' Health** and the **Maputo Plan of Action** call for equitable access, community participation and transparent monitoring.

## 1.2 Country profiles

**Croatia** has universal skilled birth attendance and high antenatal coverage. Its MMR is extremely low (about **3 per 100 000 live births**【425881988276196†L246-L256】). However, rural and marginalised communities still face barriers to quality care, and public engagement in policymaking is limited. Data on maternal health are published infrequently and seldom broken down by region or socioeconomic group.

**Ethiopia** has reduced its MMR from **871 per 100 000 live births in 2000** to **267 in 2020**. The **Health Extension Programme** employs thousands of community health workers who provide basic health services and referrals. Despite this progress, enforcement of maternal health policies is uneven, regional health bureaus have limited decision-making authority, and mechanisms for citizen participation in policy formulation are weak.

## 1.3 Governance and health outcomes

Transparent budgets ensure maternal health funds reach intended services; timely, disaggregated data allow for informed decision-making; robust enforcement mechanisms hold providers accountable; decentralised authority empowers local solutions; and citizen participation builds trust and improves programme design. Weak governance can undermine even well-designed interventions, leading to persistent inequalities and preventable deaths.

## 2 Methodology

The toolkit uses a mixed-methods approach. Document analysis covers international norms (SDG 3.1, WHO guidelines), regional frameworks (EU health directives and the Maputo Plan), national strategies (Croatia's **National Health Development Strategy**, Ethiopia's **Health Sector Development Plans**) and empirical data from sources such as WHO and UNFPA. Semi-structured interviews with policymakers, health workers and community representatives complement document review. Where feasible, digital tools such as web scraping and text analysis are employed to monitor budget publications and data releases.

### 2.1 Governance dimensions

1. **Budget transparency** – Are maternal health allocations publicly available and broken down by programme and region?
2. **Data quality & timeliness** – Are maternal health indicators (e.g., MMR, service coverage) collected accurately, disaggregated and published promptly?
3. **Policy enforcement** – Are laws, plans and standards implemented and monitored? Are there sanctions or incentives when targets are missed?
4. **Institutional autonomy** – Do regional or local authorities have the authority to make decisions on resource allocation, procurement and staffing?
5. **Citizen participation** – Are there institutionalised mechanisms (public consultations, participatory budgeting) for communities and civil society to influence policies and budgets?

### 2.2 Scoring

Each dimension is scored from **0** (absent) to **5** (exemplary), with benchmarks detailed in Annex 1. For example, budget transparency scores range from 0 (no public data) to 5 (real-time, disaggregated spending dashboards). Qualitative explanations accompany scores to capture context and nuance.

## 3 Croatia: Governance Framework and Gaps

Croatia's health system has evolved from a centrally planned model to a social-insurance system aligned with EU standards. The **Ministry of Health** sets policy; the **Croatian Institute of**

**Public Health (HZJZ)** manages health data; and the **Croatian Health Insurance Fund (HZZO)** finances services through mandatory insurance. Key laws include the **Health Care Act**, which defines the health system's structure, and the **Reproductive Health Strategy**, which outlines maternal health priorities.

Despite high coverage and a very low MMR, Croatia faces governance challenges:

- **Limited participation** – Policy development is dominated by technical experts, with few formal channels for civil society and affected women to contribute. As a result, policies may not address local needs or inequities.
- **Data release** – HZJZ publishes annual reports, but data on maternal outcomes are often aggregated and released with a lag, hindering timely interventions. There is little disaggregation by region, ethnicity or socioeconomic status.

Opportunities for improvement include instituting mandatory public consultations on maternal health policies, publishing disaggregated data through online dashboards and introducing participatory budgeting for maternity-related investments. Croatia could also create community advisory boards to institutionalise patient voices in health governance.

## 4 Ethiopia: Governance Framework and Gaps

Ethiopia's health governance is shaped by the Federal Ministry of Health (FMOH), Regional Health Bureaus and community-based structures. Successive Health Sector Development Plans and the current Health Sector Transformation Plan II emphasise decentralisation and equity. The Health Extension Programme (HEP), launched in 2003, employs thousands of community health workers to deliver primary care, including maternal and child services. Legal frameworks (Constitution 1995, National Reproductive Health Strategy, Safe Motherhood Initiative) recognise health as a right.

Governance challenges remain:

- **Policy enforcement** – Maternal health strategies are comprehensive, but implementation is inconsistent. Budgets for maternal death surveillance and emergency obstetric care are often insufficient, and recommendations from review committees are not systematically adopted.

- **Limited autonomy** – Despite formal decentralisation, regional health bureaus require federal approval for major expenditures, including procurement of obstetric equipment and hiring of specialists. This slows responses to local needs.
- **Citizen participation** – Ethiopia's community engagement at service delivery level (through HEP and women's groups) is strong, but there are no formal mechanisms for communities to influence policy formulation or budgeting.

Reform opportunities include binding budget disbursements to maternal health performance, decentralising procurement and staffing decisions and institutionalising community participation through advisory councils and annual public hearings.

## 5 Comparative Analysis

Across the five governance dimensions, Croatia and Ethiopia display contrasting strengths and weaknesses:

| Dimension | Croatia | Ethiopia |
|---|---|---|
| **Budget transparency** | Health budgets are published, but maternal allocations are not clearly identified or disaggregated by programme or region. | Federal and regional budgets are public, yet maternal health spending is hidden within general health categories; off-budget donor funds are not consistently reported. |
| **Data quality & timeliness** | Euro-Peristat reporting ensures comparability, but domestic publication is annual and aggregated. | HMIS and digital platforms are improving data quality, but completeness and timeliness vary across regions and are seldom disaggregated. |
| **Policy enforcement** | Regulations exist, but enforcement of respectful maternity care is inconsistent; inspections lack follow-up. | Policy frameworks are ambitious, yet enforcement is weak; emergency obstetric care standards are not uniformly met. |

| Dimension | Croatia | Ethiopia |
|---|---|---|
| **Institutional autonomy** | Counties manage hospitals but have limited fiscal control; central approval is required for major investments. | Decentralisation exists on paper, but procurement and staffing remain centralised, constraining regional responsiveness. |
| **Citizen participation** | Civil society organisations have some influence but no formal role in budgeting; consultations are sporadic. | Community engagement through HEWs is strong at service level, but policy-level participation is ad hoc and not institutionalised. |

## 6 Operational Assessment Guidelines

To apply the toolkit, researchers should:

1. **Compile documents** – collect laws, budgets, strategic plans, audit reports and data releases relevant to maternal health.
2. **Interview stakeholders** – engage policymakers, healthcare providers, local officials and civil society organisations to triangulate document findings.
3. **Score indicators** – use the 0–5 benchmarks in Annex 1 to evaluate each governance dimension, providing qualitative justification for scores.
4. **Analyse trends** – consider how scores change over time; identify links between governance performance and maternal health outcomes.
5. **Communicate results** – share findings with government and civil society through reports, dashboards or public forums to foster dialogue and accountability.

Digital tools can support data collection and analysis. For example, natural language processing can identify maternal health allocations in budget documents, and web-scraping scripts can monitor whether data are published on time. Ethical considerations, such as data privacy and consent, must be observed.

# 7 Recommendations

## 7.1 Croatia

1. **Institutionalise participation** – Introduce mandatory public consultations and participatory budgeting for maternal health policies and resources.
2. **Disaggregate data** – Publish quarterly, user-friendly dashboards that disaggregate maternal health indicators by region, ethnicity and socioeconomic status.
3. **Community oversight** – Establish local health councils to provide feedback on maternity services and monitor budget execution.

## 7.2 Ethiopia

1. **Link funding to performance** – Allocate funds to regions based on progress toward maternal health targets and require implementation of recommendations from maternal death reviews.
2. **Decentralise procurement** – Grant regional bureaus conditional authority to procure equipment and hire personnel, with accountability mechanisms.
3. **Institutionalise participation** – Create community advisory councils and hold regular public hearings on maternal health plans and budgets.

## 7.3 Regional and global collaboration

1. **Develop a transparency index** – EU and AU bodies should co-develop a maternal health transparency index to benchmark progress and share best practices.
2. **Invest in digital innovation** – Support the deployment of electronic health information systems, mobile data collection and open-data platforms.
3. **Foster peer learning** – Facilitate exchanges between Croatian and Ethiopian professionals and civil society to share experiences on governance reforms.

# Conclusion

Maternal mortality is more than a clinical issue; it is a reflection of governance quality. Croatia and Ethiopia illustrate different stages of progress: Croatia's very low MMR hides governance gaps in participation and data transparency, while Ethiopia's significant decline masks challenges in policy enforcement, decentralisation and citizen engagement. By applying the five-indicator

assessment and implementing the recommended reforms, both countries can strengthen accountability, build trust and make further strides toward equitable maternal health outcomes. Lessons from this comparative toolkit can be adapted by other countries seeking to align their maternal health programmes with international commitments and human rights principles.

## Annex 1 – Scoring Benchmarks (Summary)

| Score | Budget transparency | Data quality & timeliness | Policy enforcement | Institutional autonomy | Citizen participation |
|---|---|---|---|---|---|
| **0** | No maternal health budgets published. | No maternal health indicators published. | No monitoring or enforcement. | Decisions fully centralised. | No mechanisms for public engagement. |
| **1** | Budget published but not disaggregated. | Sporadic data with long delays. | Policies exist but rarely implemented. | Local bodies have nominal responsibilities but no resources. | Informal consultations only. |
| **2** | Partial disaggregation | Annual data lacking | Some implementation but no sanctions. | Some financial decisions delegated; | Ad hoc forums with limited representation. |

| Score | Budget transparency | Data quality & timeliness | Policy enforcement | Institutional autonomy | Citizen participation |
|---|---|---|---|---|---|
| | ; irregular updates. | socioeconomic breakdown. | | approvals centralised. | |
| **3** | Annual disaggregated budget and expenditure reports. | Annual disaggregated data accessible. | Regular inspections; some recommendations implemented. | Shared authority with limited flexibility. | Annual public hearings; civil society invited. |
| **4** | Quarterly budgets with procurement details. | Quarterly updates and maternal death reviews. | Systematic audits with corrective actions. | Significant autonomy; accountability mechanisms in place. | Mandatory consultations and participatory budgeting pilots. |
| **5** | Real-time, disaggregated budgets and open data portals. | Real-time reporting disaggregated by region, age and socioeconomic status. | Robust enforcement; performance tied to budgets. | Full fiscal and operational autonomy with transparent reporting. | Institutionalised civic participation shaping policies and budgets. |