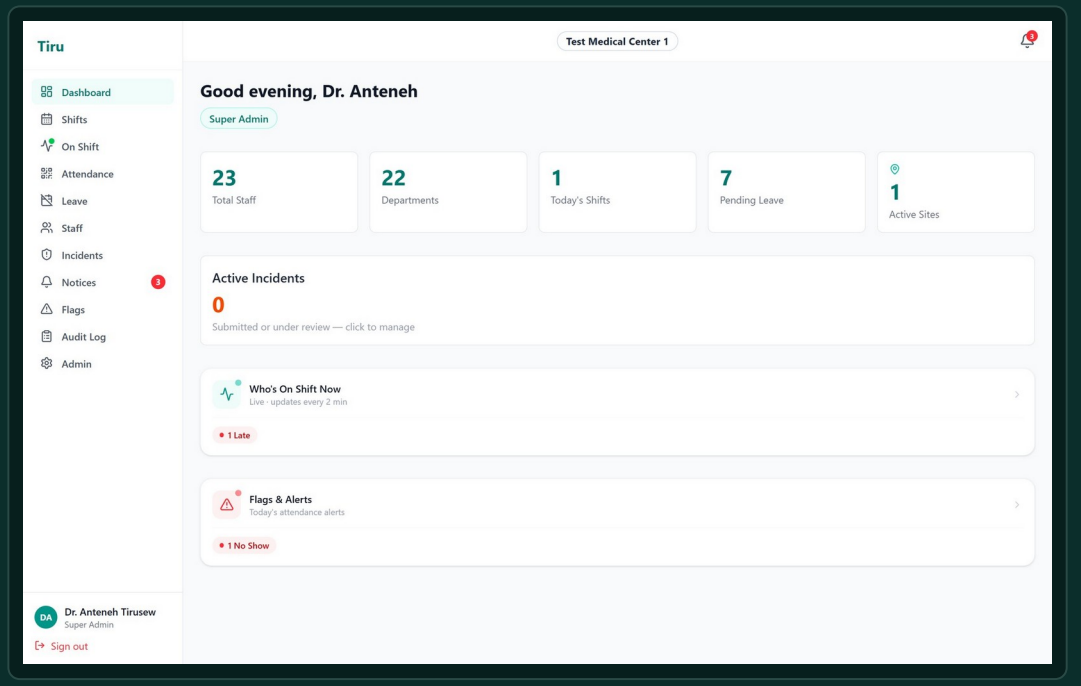
TIRU HEALTH · ADDIS ABABA

Tiru Ops

The operating system for what happens inside the hospital.

Attendance, coverage, communication and incidents — visible in real time, for the first time.

Dr. Anteneh Tirusew
General Practitioner & Digital Health Innovator · AHIF 2026 Fellow
Investor presentation · September 2026



LIVE LEADERSHIP DASHBOARD

"Tiru" means good in Amharic — our standard for the care, and for the operations, every facility should deliver.

THE PROBLEM

The unwatched engine room

Private healthcare races to digitise the patient-facing experience — while the operational core stays invisible, manual and unaccountable. These are not edge cases. They are daily events.

SPECIALIST LATENESS

The 8:00 AM specialist arrives at 10:00 — and nothing flags it.

A patient promised 8:00 waits two hours. The facility pays for hours not worked. No system raises an alert; leadership finds out only if the patient complains.

Cost: Payroll loss · reputation · patient safety risk

PATIENT SAFETY

Midnight seizure. The emergency shelf is empty.

A patient arrives in status epilepticus. The emergency anticonvulsant is out of stock — flagged two days earlier by a junior staff member with no reliable channel to escalate it.

Cost: Patient harm · liability · institutional trust

SERVICE FAILURE

Lab reagent outage. The patient already paid and waited.

A reagent or imaging system fails mid-morning. No one tells waiting patients. They find out at the window — after waiting, after paying.

Cost: Refunds · churn · reputational erosion

WHY THIS, WHY US

Built from inside

Not a software team imagining hospital problems — a physician who lived them across five years of clinical practice, in the departments and at the desk where they happen.

01

The conviction

Before a facility can serve the patient outside its walls, it must put its own house in order inside them. That is the sequence everyone is skipping.

02

The defensibility

These problems are invisible from outside the building — obvious only to someone who has stood at that desk.

03

The advantage

A physician-founder walks into any private facility and is trusted as a peer — not as a software vendor.

FOUNDER

Dr. Anteneh Tirusew

- General Practitioner, MD (University of Gondar)
- Former Assistant Medical Director, American Medical Center
- Former CPD Director & Medical Helpline Supervisor, HabariDOC
- 2026 Africa Healthcare Innovation Fellow

TARGET CUSTOMERS

Built for the people who run the building

Our buyer controls the budget and feels the pain most sharply — the owner, CEO or General Manager of a private health facility.

PRIMARY · NOW

Private clinic & hospital owners

109 private facilities already mapped in Addis Ababa. Single sites to small chains. Monthly ETB subscription, sold direct through the Tiru Health Medical Directory pipeline.

SCALE · NETWORKS

Multi-site healthcare networks

Groups running 3–20 facilities across a city or region. One agreement covers every site, on one dashboard, at network pricing.

HARD CURRENCY · USD

NGOs & international health partners

Donor-funded programmes that need verified attendance records for accountability reporting. USD-denominated MOUs.

ADJACENT

Corporate & institutional clients

Companies running on-site medical teams, occupational health units, or shift-based clinical staff.

THE SOLUTION

One platform. Every operational layer.

A single hybrid web-and-mobile platform, built to a working MVP — functional end to end across every module.

01
Verified-presence attendance
Contactless QR + GPS geofence

02
Live shift & coverage
Scheduled vs. present, in real time

03
Flags & alerts engine
Rules set by leadership, applied live

04
Internal communication
Targeted and broadcast notices

05
Incident reporting
Structured, anonymous-capable

06
Leave & approvals
Full digital lifecycle

07
Audit log
Tamper-evident record of every action

08
Equity-first kiosk
A full channel for every worker

11 roles across 4 permission tiers — from CEO and HR to department heads, clinicians and the kiosk — so every person sees exactly what their job needs.

The leadership picture, in real time

Total staff, departments, today's shifts, pending leave, active sites, open incidents — one screen, updated live.

Who is on shift now

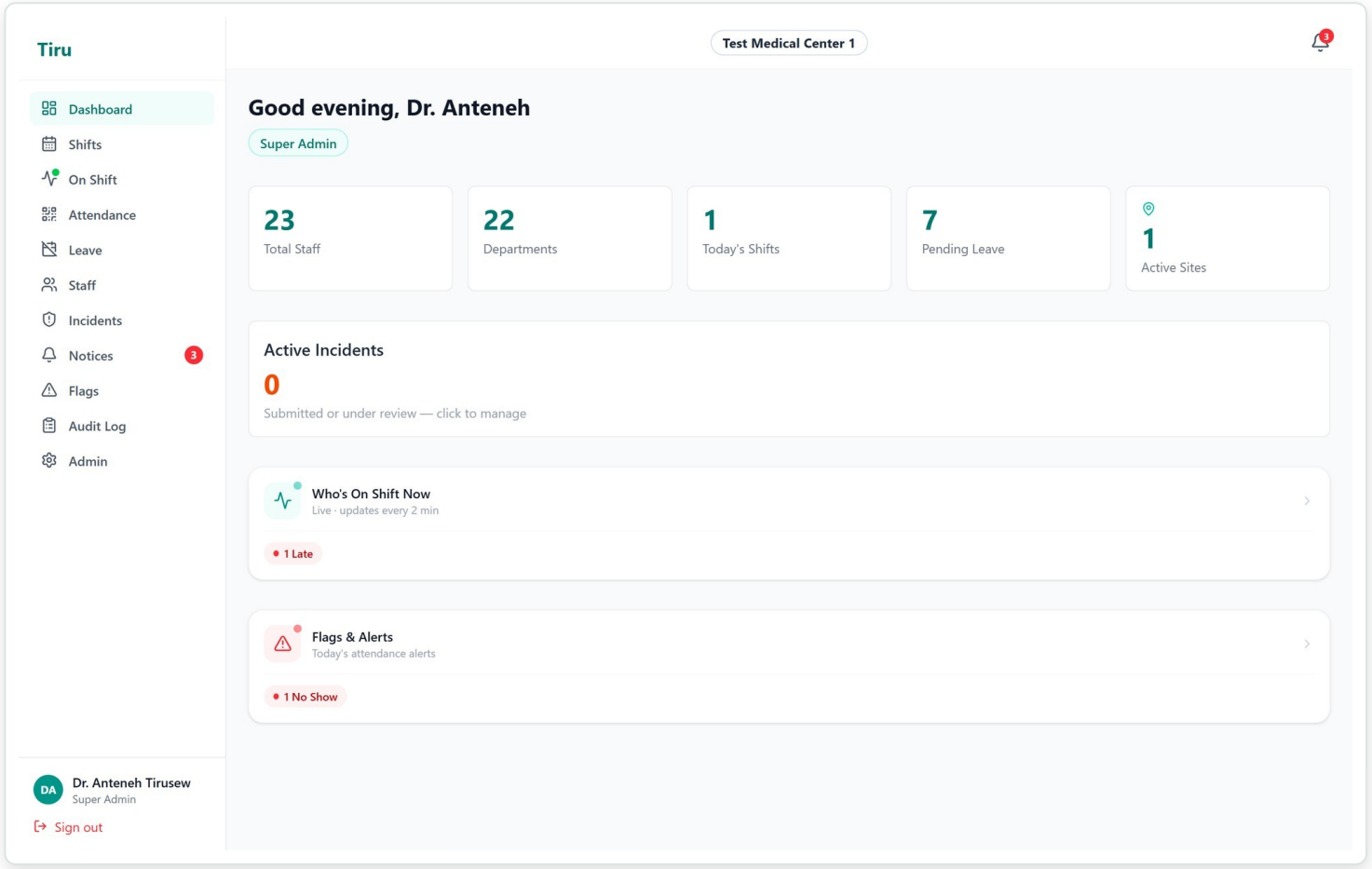
Present and late, updated every two minutes

Flags & alerts

Today's attendance issues, surfaced automatically

From anywhere

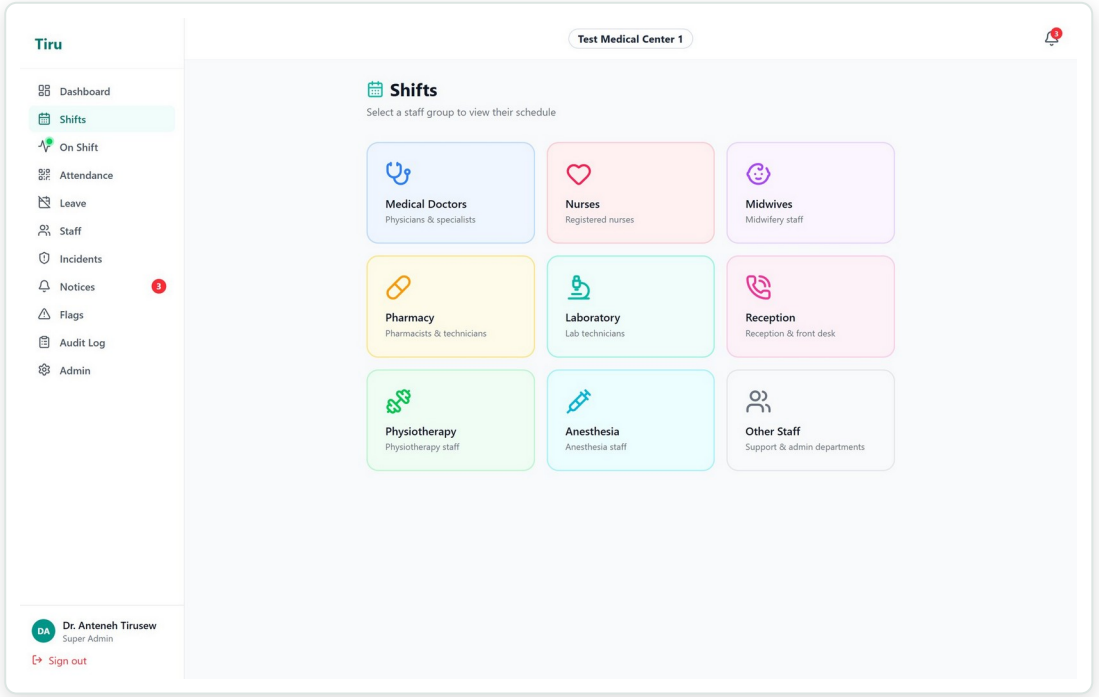
Leadership sees the building without being in it



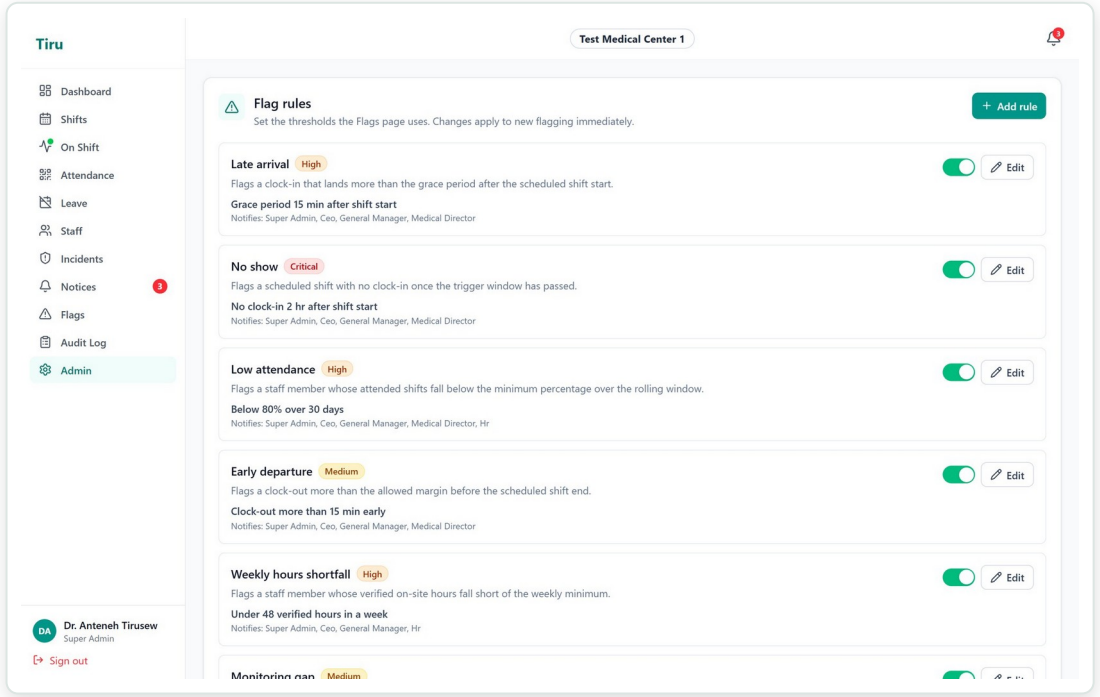
LEADERSHIP DASHBOARD — LIVE OPERATIONAL STATE

Every shift covered. Every rule yours.

Schedules for every department, cross-checked against actual clock-ins. Leadership sets the rules; the flags engine applies them live and alerts the right person.



SHIFTS — EVERY DEPARTMENT, ONE NAVIGATOR



FLAG RULES — THRESHOLDS SET BY LEADERSHIP

Flag rules set by leadership, applied live: no-shows · late arrivals · low attendance · monitoring gaps — each with its own threshold, severity and who gets notified.

Presence, verified — not asserted

Most systems ask “was a credential entered?” Tiru Ops answers a far harder question: “is this enrolled person, on their own device, physically inside right now?”

LAYER 1 — LIVE TODAY

Rotating single-use QR + server-side clock + GPS geofence. Off-site clock-ins are refused outright.

LAYER 2 — IN DEVELOPMENT

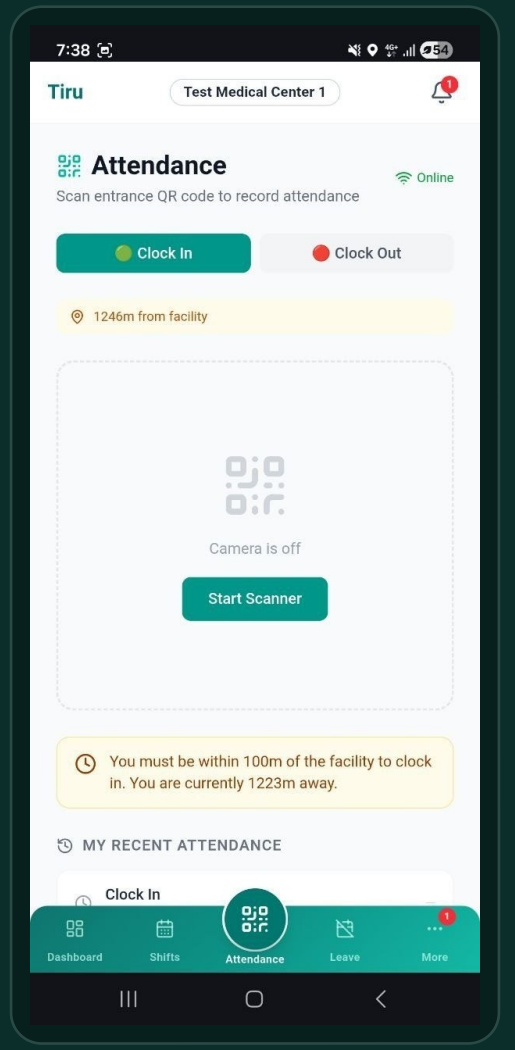
Device (hardware ID) + SIM (ICCID) binding. Single-device registry. Optional randomised 3×/week selfie match.

LAYER 3 — ON THE ROADMAP

AI face comparison + behavioural biometrics (PIN cadence) on the shared kiosk.

LAYER 4 — COMPLIANCE ENGINE

OS-level geofence events plus a 15-minute liveness heartbeat verify 8 cumulative hours on site per shift — anchored to Ethiopia's 48-hour labour mandate. Works fully offline.



CLOCK-IN REFUSED — 1,246 m FROM FACILITY

LABOUR LAW COMPLIANCE ENGINE

We prove you were there — all day

Ethiopia mandates 48 hours a week, eight hours a day on site. Almost no facility can prove it. Tiru Ops can — without draining the phone, and without needing a network.

EVENT-DRIVEN, NOT POLLING

Boundary registered once

At clock-in the facility perimeter is handed to the phone's operating system, which wakes the app only when the boundary is crossed.

15-minute liveness heartbeat

A low-cost check of battery, permissions and SIM — proving the device is alive while boundary events track movement.

Offline by default

GPS listens to satellites, not a network. A full shift can pass without signal; the record uploads on reconnection.

FAIR BY DESIGN

Breaks that respect people

Lunch is tapped out and closes automatically on re-entry. Capped at 60 minutes server-side, so a forgotten tap never invents free hours.

Monitoring gaps, told honestly

A flat battery is not absence. Under 30 minutes is forgiven; beyond that a remark is required at clock-out, routed to HR, fully auditable.

3–8% battery per shift

Against 15–30% for naive continuous polling. Staff never notice it — the difference between adopted and uninstalled.

A fingerprint tells you when someone arrived. **Tiru Ops tells you where they were all day.**

COMPLIANCE IN PRACTICE

A decision, not a data dump

Leadership never sees a GPS trail. They see a summary they can act on — per person, per shift, per week.

WHO SEES WHAT

01

Staff, at clock-out

Present 7h 43m · break 45m · outside 32m. Three seconds to read, no training needed.

02

Department head, daily

One line per person, shortest shift first.

03

HR, weekly and monthly

Verified hours against the 48-hour mandate, every shortfall broken down by cause — exportable for payroll.

04

The existing flags engine

Compliance feeds the alerting already running for attendance. Nothing new to learn.

DELIBERATELY PARKED

Motion signature

Detects a phone left on a desk inside the boundary. Held back: continuous sensor reads cost battery and privacy — and no fingerprint system detects this either.

Prayer break handling

Daily prayers and Friday Jumu'ah don't fit a single 60-minute lunch model. Deferred until pilot data shows the real pattern — a visible consideration no scanner offers.

We ship what we can defend.

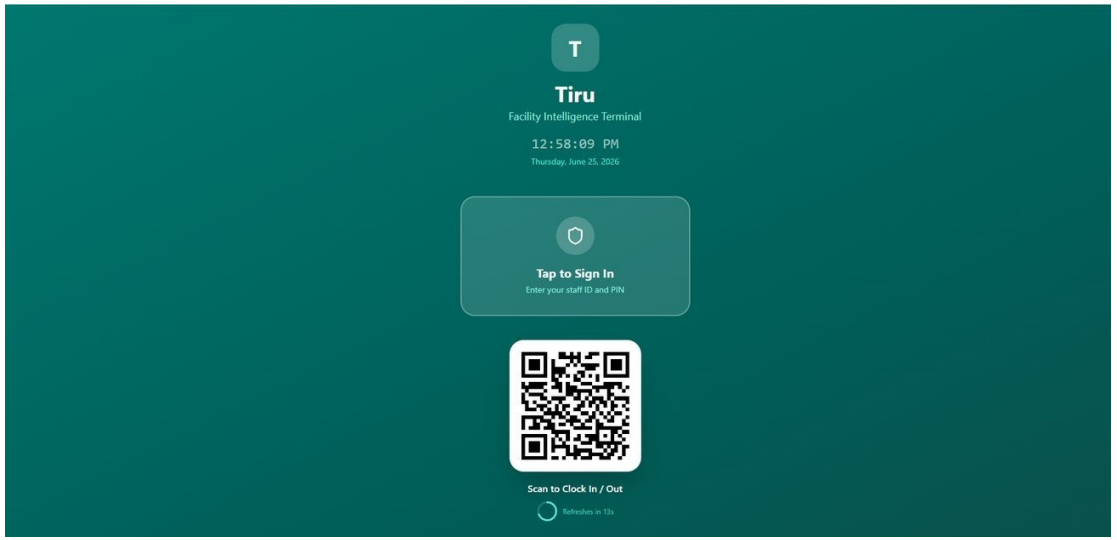
WHY NOT FINGERPRINT?

Built for the clinic. Not retrofitted to it.

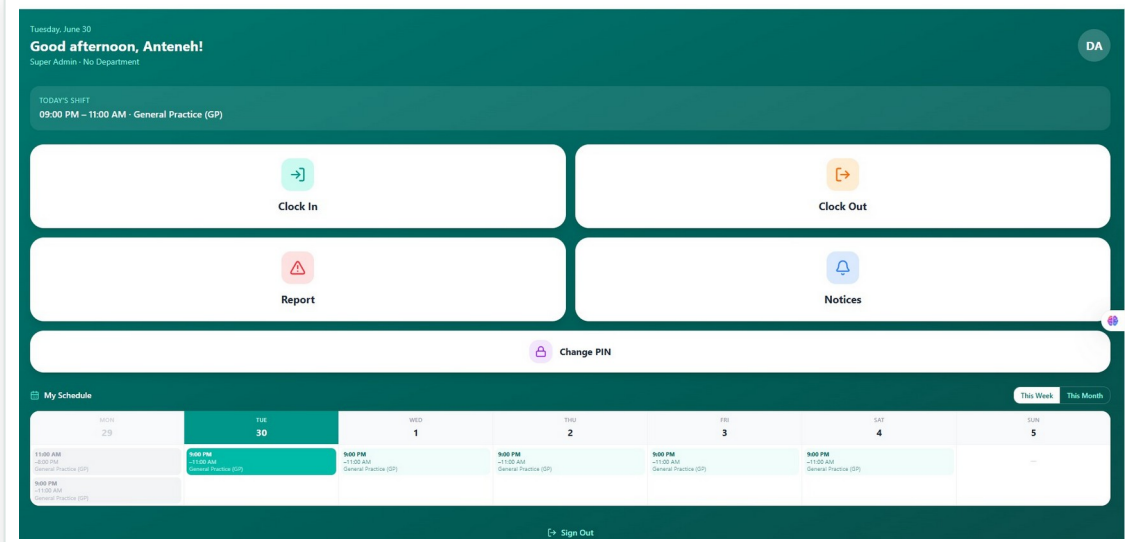
	Fingerprint biometric	Tiru Ops
Real-time visibility	None — data sits on a local device; leadership sees yesterday	**Live — who is present, late or missing, from anywhere**
Hygiene & infection risk	High — shared contact surface; suspended during COVID-19	**Zero-contact — a QR scan, no shared surface**
Cost per site	High — device purchase, installation, maintenance	**Near-zero — a new site is a configuration record**
Multi-site scale	Poor — every site is its own device and data silo	**Native — every site on one dashboard**
Interpretation & action	Manual — raw punch logs to export and reconcile	**Automated — flags escalated to the right person**
Remote management	Impossible without physical access	**Full — monitor, audit, communicate from any device**
Staff equity & access	Partial — one device, one point of failure	**Universal — app + kiosk; nobody excluded**
Identity assurance	Biometric at a single point only	**Layered — geofence, rotating QR, device & SIM binding**
Communication	None — attendance only	**Built in — CEO to every staff member, directly**
Between clock-in and clock-out	Records clock-in and clock-out only — no tracking in between	**Tracks presence all shift, offline, breaks excluded**

The kiosk is a full channel — not a fallback

Staff without a smartphone clock in, receive notices, report incidents and see their schedule on a shared terminal. A CEO can reach the security or janitorial team directly — no intermediary, no message lost.



FACILITY TERMINAL — STAFF ID + PIN, SELF-REFRESHING ENTRANCE QR



STAFF VIEW — CLOCK IN/OUT, REPORT, NOTICES, SCHEDULE

Nobody is excluded by design — including janitorial and security teams.

WHERE WE ARE

An MVP that already works

Clinical insight plus hands-on engineering — built, deployed and configured for a live pilot facility.

MVP

built & deployed

functional end to end, every module

109

private facilities mapped

on Tiru Health Medical Directory — our sister product and direct sales pipeline

2

co-founders

clinical (Dr. Anteneh Tirusew) + full-stack engineering (Yohana Mekuria)

AHIF

2026 Fellow

Africa Healthcare Innovation Fellowship — institutional validation

SHIPPED AND RUNNING

- ✓ QR + GPS geofenced attendance
- ✓ Kiosk with PIN self-service
- ✓ Configurable flag rules engine
- ✓ Live on-shift coverage
- ✓ Leave & approval workflows
- ✓ Incident reporting
- ✓ Broadcast & targeted notices
- ✓ Audit log & role-based access

BUSINESS MODEL

Per-staff SaaS. Zero per-site hardware.

A tiered subscription that scales with staff and facility count at near-zero marginal cost — the structural opposite of device-per-site biometrics.

DIRECT · ETB

Single facility

One clinic or hospital, onboarded and live in days.

SCALE · ETB

Healthcare network

A chain under one master agreement and a unified dashboard.

HARD CURRENCY · USD

NGO / international

Donor-accountability MOUs — the route to venture-scale revenue.

LATER PHASE

Government

A dedicated public-sector framework.

GO-TO-MARKET

Addis Ababa
private tier — 109 mapped

→

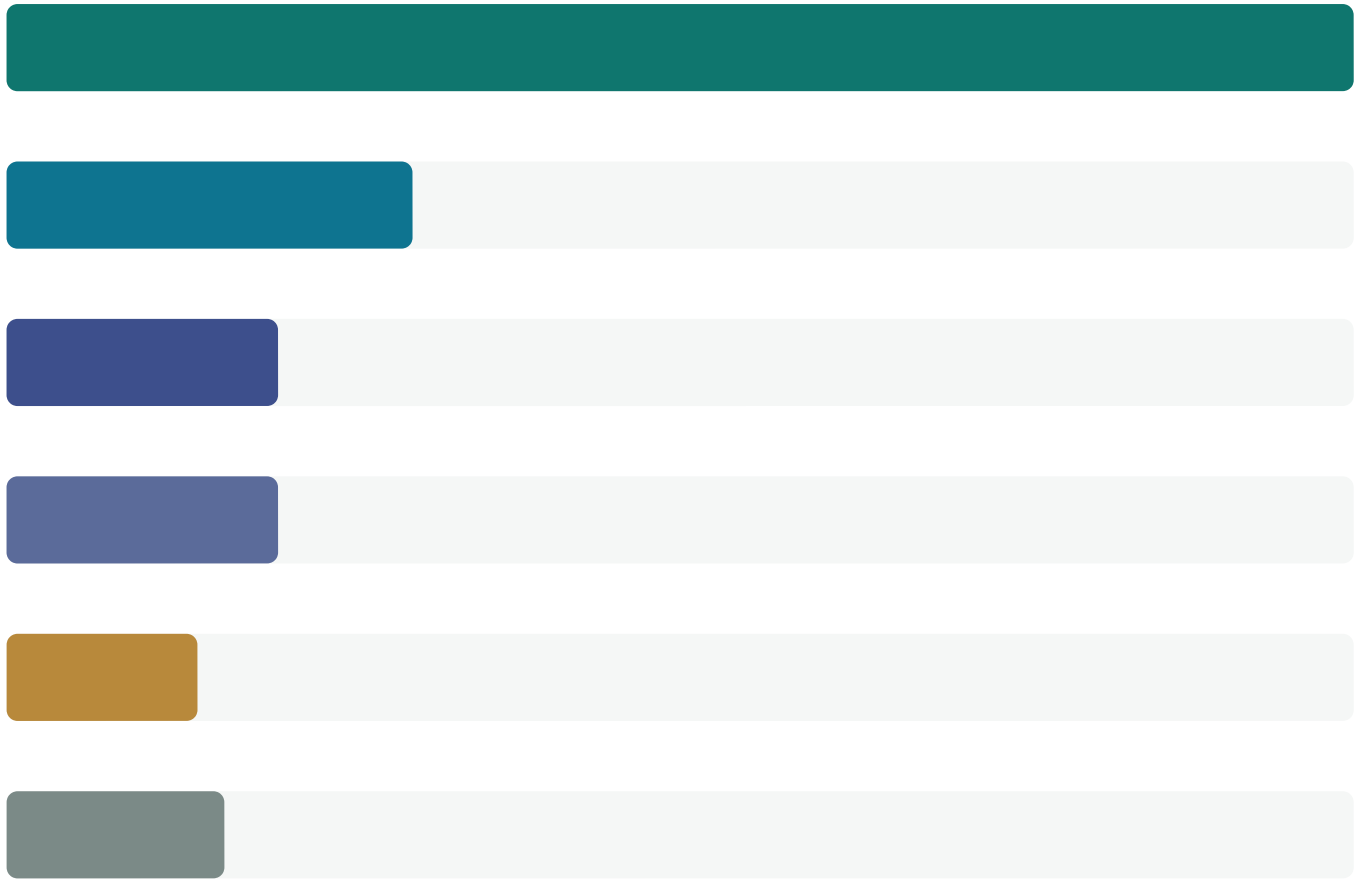
East Africa
same problem, same model

→

Any shift workforce
healthcare is the focused wedge

USE OF FUNDS

What the investment builds



Indicative allocation — to be finalised against the round size.

THE ASK

Every hospital in Africa will run on real-time operations data.

The only question is whose platform.

Tiru Ops begins where the problem is most acute and the proof is cleanest — and grows into the full operating system for healthcare delivery.

Investment

To take Tiru Ops from a working MVP to paying facilities — team, pilots and infrastructure.

Design partner facility

A private facility in Addis Ababa to run the first measured, baseline-to-impact deployment.

Partners & advisors

NGOs needing verified attendance, and advisors in labour law and scaling health SaaS in Africa.

Tiru Ops.

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