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MINISTRY OF HEALTH - ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!

The 6th Ethiopian Annual Health care quality and safety summit

Summit Proceeding

People-Centered and Integrated Health Services: The Pathways for Better Clinical Outcomes and Confidence in the System

May 6- 7, 2020

Inter Luxury Hotel, Addis Ababa

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Introduction

The Ministry of health – Heath Service Quality Directorate in collaboration with Regional Health Bureaus and development partners has been working to implement the healthcare quality Agenda of the health sectors transformation plan. So far, remarkable achievement has been made to institutionalize the quality culture, establishing quality management structures (national and sub- National levels), creating a learning system and building capacity and capability of Healthcare providers. This was mainly aimed to address key quality challenges and accelerating the improvement activities in healthcare.

In line with this, National Healthcare Quality and Safety Summit is one of the main activities that the Ministry has planned to conduct once annually with the aim of advocating embedment of quality and safety concepts in the existing healthcare management system.

The National Health care quality and safety summit is the key milestone for Health sector that will be used as a key platform to discuss the current state of healthcare quality, determine priorities for improvement and identify future opportunities to achieve health sector goals.

This is a sixth summit since establishment (2007 E.C). Healthcare Quality Summit has been organized to engage and connect a wide range of healthcare leaders and professionals. The National Healthcare Quality and safety Summit is an event that draws healthcare leaders, Providers, and stakeholders from across Ethiopia and beyond to share their views and experiences on quality and safety for better outcome. The features of the summit include keynote speeches, panel discussions on the national priority agenda, and breakout sessions with opportunities to network for healthcare leaders, diversified open field poster presentations, dissemination of the annual national quality bulletin, and launch of other reports and guidance documents in quality.

This year marks the beginning of the HSTP II implementation as well as the NQSS (2021-2025) which is still under the finalization stage. Therefore, this summit has given the opportunity and platform to discuss and draw on lessons from the experience of HSTP I and NQS-I performance and shape the NQSS (2021-2025) through the participation of major stakeholders such as the regional health bureaus.

Theme:

The theme of this year's summit is "People centered and integrated health services: the pathway for better clinical outcomes and confidence in the system"

Objectives:

1. Advocate the institutionalization of healthcare quality and safety management in the existing health system.
2. Maximize lessons learning and experience sharing by bringing stakeholders and experts involved in healthcare in quality and safety management
3. Learn from QED districts MNH quality of care implementation
4. Introduce National healthcare quality and safety strategy

Proceedings:

Day one: May 06, 2021: Pre-summit session: Presentation and discussion on National Quality Strategy II (NQS II)

Session I: Welcoming session

This session was moderated by Dr.Desalegne Bekele, MOH QI team coordinator. He welcomed the participants of the summit and recalled that it was not possible to conduct the regular quality summit last year, 2020 because of COVID 19 and associated restrictions. He highlighted that the motto of the summit "People centered and integrated health services: the pathway for better clinical outcomes and confidence in the system" is a very important subject which has gained much attention globally. He then and invited Dr.Hassen Mohammed, director of the Health service Quality Directorate (HSQD) to open the first day of the summit.

Photo: Welcoming and introducing objectives, Dr.Hassen Mohammed and Dr.Desalegn Bekele,

Dr. Hassen, welcomed again participants and highlighted the objective of the summit in general terms as:

- To discuss the new draft National Health care quality and safety strategy, 2021-2025 which can be considered as one of the achievements of the past one year. He also expressed that the rationale behind developing this strategy was the first NQS ended in 2020 and the need to include new global developments and updates
- Learn from the different QI initiatives implemented in facilities and current concepts and knowledge in quality

Dr.Desalegne introduced the agenda of the two days summit (Annex 1) followed by introduction of participants. The first day participants comprised of mainly Regional Health Bureaus and MOH Directorates.

Photo: Day one summit participants

Session II: National Quality Strategy (NQS)-I Review Report

Dr.Fitsume Kibret, MOH technical advisor indicated that the report is not about evaluation of the outgoing strategy but an attempt made to review the lessons learnt during its implementation. He started the session by asking reflections from RHBs on the following points:

- The progress made on establishing structures for quality during the NQS-I period
- The progress on implementation of the 54 interventions in the NQS-I
- Major challenges faced during the NQS-I period
- What can be done differently during the next strategy

The following were the summary of the reflection forwarded from Regional Health Bureaus representatives;

Reflection from Dire Dawa City Administration Health Bureau

Dire Dawa has two hospitals and fifteen health centers. The health bureau has established a case team for quality which is strong and well-staffed. Emergency and woreda transformation are also addressed under the quality case team. And the case team is really playing a leading role in the essential health care of the city.

Challenges:

- Still struggling to improve service accessibility
- Referral to the available hospitals is huge as there are no hospitals surrounding the city
- Budget is not allocated taking into consideration the huge patient burden

Actions taken/Interventions:

- The health bureau has assigned enough HR/General practitioners at health centers
- All health centers made to have waiting areas

- All hospitals are implementing pharmaceutical logistics system
- OR block opened in one HC
- Created hospital health center cluster for support
- Also trying to fulfill equipment and supplies gaps
- Launched and implementing i-care program
- Allocated enough ambulances for hospitals

Reflection from Afar Regional Health Bureau

Challenges:

- The health bureau has established a case team for quality which is considered inadequate as compared to the number of facilities in Afar (96 health centers and 7 hospitals). Besides it is only staffed with three people.
- The RMNCAH program is placed under a different structure and the program also has the funds with it. So regarding quality of the RMNCAH program, coordination with the quality case team is weak
- There is serious shortage of HR in facilities which are overburdened as a result.

Reflection from Somali Regional Health Bureau

Have established quality case team under curative core process.

Challenges:

- The structure has a problem
- The RHB was focusing on improving access, was not really in a position to talk about quality
- There have been big gaps in access and infrastructure (electric power supply etc.) in facilities

Actions taken/interventions:

- Have 6 primary hospitals graduated
- Plan to have 6 more primary hospitals
- Have formed hospital HC cluster
- Just starting to implement the quality strategy and hope to do better with MOH support

Presentation of the NQS-I review report

The NQS-I review report was presented by Dr. Fitsume Kibret, technical advisor for the Ministry of Health, Health service Quality Directorate. He started his presentation by highlighting that quality work has existed even before the NQS-I and presented the evolution of quality work in Ethiopia depicted as below.

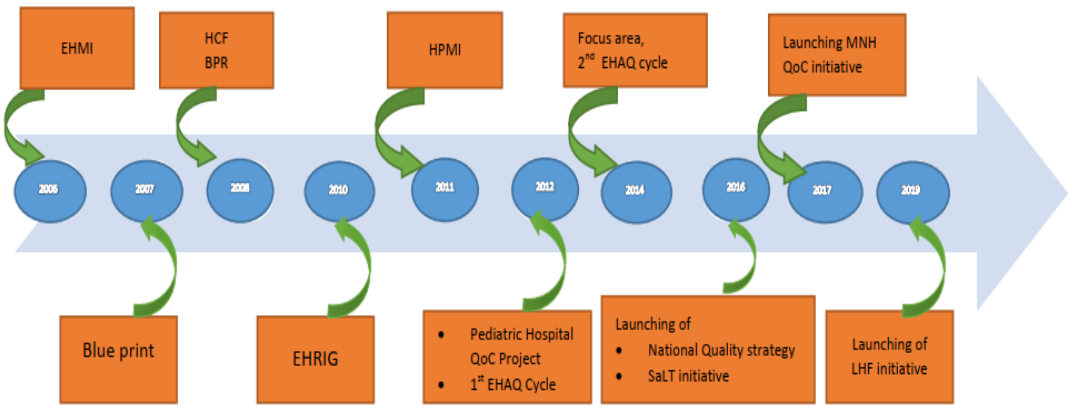


Figure 1. Journey of the National the Health care quality and safety efforts in Ethiopia.

The NQS-I was designed to materialize the Quality transformation agenda of Health Sector transformation Plan I (HSTP-I).

NQS-I commitments

- Establishing a structure for quality at MOH level as a directorate
- Creating champions in quality among the health leaders at MOH, its agencies; RHBs; professional associations
- Rolling out Quality structures and learning systems within every level of the system

The NQS-I had 4 SOs and 54 interventions

Rationale for the review of NQS-I

- Emerging global knowledge on quality (such as the 2018 WHO, World bank and OECD report)
- End of the NQS-I implementation period

Objectives of the review

- To assess the overall coordination and commitments of the government toward NQS implementation
- To asses implementation status of the 54 strategic interventions of NQS
- To formulate strategic recommendations based on the major gaps and opportunities identified during the NQS implementation

Methodology

- Quantitative and qualitative

Main findings of the review

- Familiarity with NQS-I
  - Good at big hospitals
  - Gaps in RHB's use of the NQS-I for planning
- High turnover of leadership at MOH, HSQD during the period, 4 directors in 5 years
- 77% of the interventions initiated
  - More interventions implemented under SO I and II
  - More implementation of interventions during the last two years of the strategy period
  - Large scale initiatives/efforts were underway

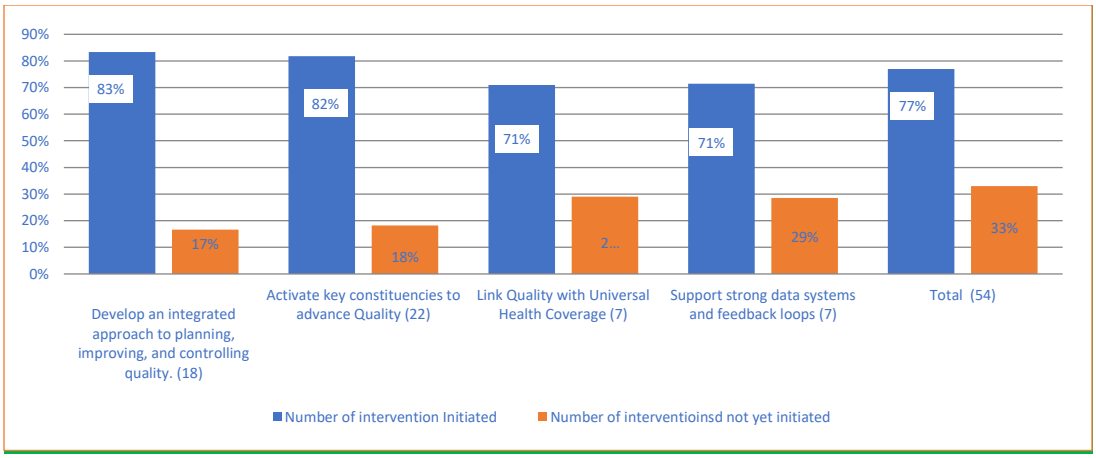


Fig. 2 Implementation status of NQS Priority interventions by strategic Objectives

- Improvement seen in foundations of quality
    - HR density (physician: population ratio) improved
    - Allocation of finance improved though not enough
    - Infrastructure (hospital: population ratio) also improved
- Service indicators such as ANC, SBA, PNC didn't show much improvement or stayed at the same level. Possible reasons being political instability and related problems

Qualitative findings

- "NQS content was not easy to understand, lacks clarity in priority interventions"
- "High turnover of in leadership at ministry and directorate level"
- "Absence of implementation guide, no budget for each interventions "
- 'Lack of sustained leadership commitment at all level"
- "ill-defined Roles and functions of quality structure "
- "Lack of clear coordination, integration, linkage/interface and accountability mechanism between the quality unit and other program structure across the health care system and HIA"

Conclusion/Major gaps

- NQS was not well understood and advocated
- Lack of consistency and integrity between NQS, HSTP and interventions
- Lack of clarity and incompleteness in interventions and their targets
- There was no adequate follow-up and accountability mechanisms
- Absence of implementation strategies and clear support mechanism
- Most Improvement focuses on service delivery point not systems based
- Lack of quality measures and utilization
- Lack of Monitoring plan
- Lack of data on actual national and regional investments on health care quality
- Inadequate Engagement and accountability of stakeholders

- Weak documentation and knowledge management system

Key recommendations forwarded?

- Leadership and Governance
- Leadership engagement in the development process
- Revisit the quality structure and redefine the scope and function at all level
- To clearly indicate the accountability, integration, linkage, and interface with in the sector and with key agencies
- System level intervention/thinking
- Learning and knowledge management system
- Emphasis for Interventional /operational research's at all level in the health care system
- Integration of learning system in the existing Review system
- Re-define quality adjusted measure focusing on effective coverage, provision of care, outcome of care and experience of care
    - Use of dashboard for selected key quality adjusted indicators
- Stakeholders Engagement for Quality:
- Health literacy Unit
- Private sector
- Patient society and community support group
- Health care Providers: Incentives, PBF, Recognition

Finally Dr.Desalegne expressed that the review was an independent one done through a consultant with UNICEF support and MOH's coordination

Session III: National Healthcare Quality and Safety Strategy-II (2021-2025)

The overview of the strategy: Development processes, Introduction, Situation Analysis was presented by Dr.Desalegne Bekele. As an introduction to the presentation, it was indicated that implementation of the strategy has already been initiated before endorsement. Some of the landmarks that gave emphasis to the quality agenda globally and nationally were mentioned: the 2002 world health assembly; the 1987 Ethiopian health policy; the current Ethiopian health policy which has quality as one strategic direction. Moreover, the HSTP II has allocated more than 50% of the budget taking into consideration the quality of essential health service package. Despite its limitations, the past NQS has also been successful in putting in place the quality structures; in producing quality and safety cadre; and inculcating the quality concept in people's minds.

The rationale for NQSS:

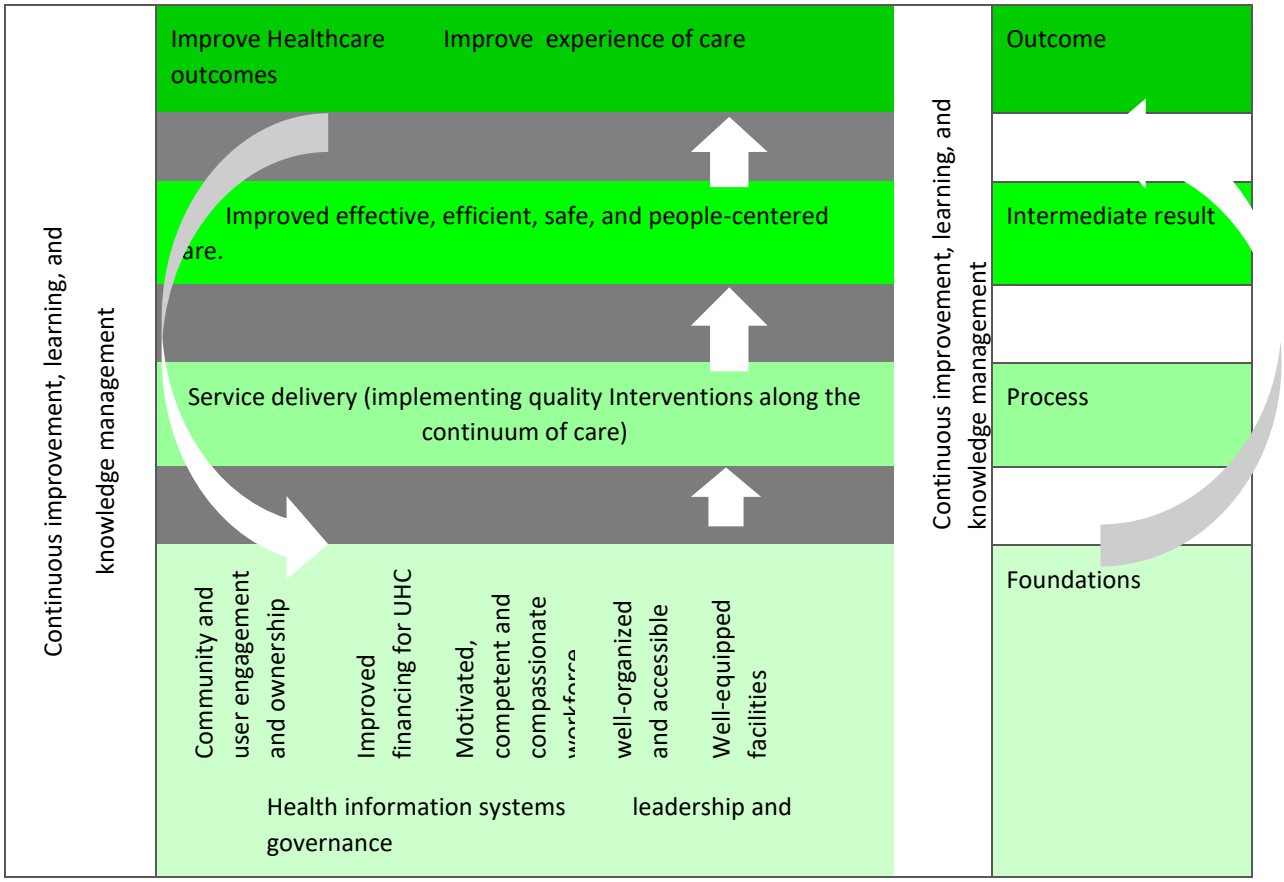
- Emerging new global evidence on quality, some of these landmark reports released in 2018 included Ethiopian case studies
- Safety as a dimension of quality started to gain attention especially related to antimicrobial resistance ad COVID 19

The development processes

- Was led through a steering committee which comprises of MOH directorates, agencies and donors

- The national quality TWG
- And a writing team which comprised of 4 MOH experts and a consultant
- A total of 100 experts participated in the development process

Fig. 3. The Ethiopian high quality and safe care framework



In the new NQSS integration was added as one important dimension of quality as health care in the country is fragmented

Situation analysis:

Key findings from assessment of the current state of quality and safety in Ethiopia across the six dimensions of quality was highlighted and the rich and detailed SWOT analysis presented directly from the draft NQSS.

Quality and safety in Ethiopia defined as:

"Comprehensive and integrated care that is measurably safe, effective, people-centered, and uniformly delivered in a timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently".

Vision: To see a healthy, productive, and prosperous society

Mission: To promote health and wellbeing of Ethiopians through systematic planning, improvement and control of quality-of-care delivery

Guiding Principles: Equity, Accountability, Transparency, Collaboration, Learning and Innovation

Goal:

The goal of the strategy is to continually improve health outcomes and confidence in the system.

In the strategy five strategic Objectives, 11 strategic interventions and 63 major activities identified,

All the SO's, intervention, major objectives and targets have been presented;

- SO 1: Improve evidence-based essential health care provision (1 intervention and 4 activities)
- SO 2: Improve People-Centered Care(5 intervention and 31 activities)
- SO 3: Reduce harm arising from the care delivery(2 intervention and 6 activities)
- SO 4: Improve efficiency in the health care delivery (1 intervention and 6 activities)
- SO 5: Create a Quality culture through continuous learning and improvement (2 intervention and 16 activities)

Targets identified: total of 28 in line with HSTP II

Implementation arrangement: defined with responsibilities at all quality structures

M&E plan: Based on defined framework with indicators for priority conditions, data sources , frequent of reporting and responsibility

Reflections from participants:

Oromia RHB

- Commented that the previous NQS was not even known by some regional leadership and owned by few people
- Informed that the current NQSS was admired during the IHI Africa forum which took place few days back
- Recommended that the current NQSS should be well disseminated and rolled out to lower level of the system especially the leadership
- Integration is very important as a dimension of quality to the country as resources are limited and it improves efficiency
- Also highlighted the importance of good planning to implement the broader agenda of quality and safety
- The definition of safety should be contextualized to our context and focus should be given to risk prevention and environmental safety

AA city administration health bureau

- Integration should be defined well.
- Networking with catchment facilities is very important and catchment facilities should be strengthened to avoid unnecessary referrals
- Quality should be every body's business and part of the job description
- Revisiting and adjusting the existing quality structures is important to bring about improvement in the system
- Sustainability of ongoing quality initiatives should be worked out
- Engagement of leadership of academic institutions as well as their governance structure (Integration of clinical and academic activities) should improve to address quality.
- Instead of short-term trainings CPD should be strengthened
- Efficient financing and equipment maintenance should also be given attention
- Integration of quality in preservice education

Dire Dawa city administration health bureau

Expressed their challenge:

- Lack of paramedics for ambulance service
- CBHI is causing a big decline in health facility funds which negatively affects provision of quality service. So financial allocation to regions should increase
- The existing infrastructural design needs revision as it can no longer accommodate the increasing population and demand
- Equipment maintenance should be given due attention as well as the quality of the biomed engineers training program at universities. The capacity of biomed engineers reported to be low
- Almost equal number of graduates are coming out of private training institutions as from the public ones. So due attention should be given to the quality of education in private training institutions
- Legal framework for accountability of HWs is needed with consideration of their rights

SNNPR

- Highlighted that MOH program directorates should have participated in the ongoing session of the quality summit, their role in quality is critical
- The vision of the NQSS as it was stated should align with that of HSTP II
- Horizontal integration (quality with programs) is important
- Regulation of public health facilities should be strengthened
- Some targets in the NQSS seem ambitious (those on ICU, vaccine wastage). Good to revisit

Additional Questions/Comments/Suggestions forwarded from participants:

1. The developed National Quality Strategy is very detailed and clear. However, in order to improve the Health system at the grass root level, attention should also be given to fulfil the gaps in unavailability of the necessary equipment, supplies and Human resource. Therefore equipping ambulances, availing

equipment including effective maintenance systems, building paramedic human resources in collaboration with local universities need to be prioritized.

2. As the CBHI enrollment increases, health facilities are flooded by increased flow of enrolled patients while the internal revenues remain almost the same resulting in budget shortage. Hence, additional budget support should be considered for compensating the health facilities otherwise the shortage of budget due to the increased service provision will result in challenging the health facilities regular quality service provision.
3. The current biomedical technician practices is not up to the expectation which result in gaps in equipment maintenance system. The MOH need to work with MOE/universities improved quality training system to ensure the development of well-trained biomedical technicians.
4. Health care quality of care improvement requires improved coordination and integration across all health programs, directorates, Regional Health Bureaus and other stakeholders. Therefore, their engagement in the development of quality strategy, including their participation in such annual Quality summit and other similar platforms is very critical to gain ownership and commitment towards the implementation of the strategy. Moreover, it will help to ensure the integration of the Quality improvement efforts into their respective health programs and projects including allocation of budgets for Quality of care.
5. Enforcement towards fulfillment of minimum standards should be strengthened and avoid the practices of double standard.
6. The targets set in some of the objectives of the National Quality strategy are different with other National documents such as HSTP II and also seems unrealistic, for example, ICU reduction by 50%, reduce the closed vaccine wastage rate to 0.5%.....that needs to be revisited?
7. Essential service availability target of 90% seems ambitious especially considering the currents availability status at woreda levels and Health centers budget of 50,000 ETB, which needs to be realistic & re-visited.
8. The meaning of the selected indicators/ targets included in the National Quality strategy to the HSQD needs to be clarified as the role of the quality structures towards the achievement of the targets requires other programs huge efforts including budget allocation that requires the major role of the respective health programs/directorates.
9. The target setting based on some of the routine indicators needs to consider the existing data quality issues, mainly those indicators with sever under reporting (such as surgical site infection rate, pressure ulcer incidence and Anesthetic adverse outcome). Accordingly, attention should also be given that, initial data quality improvement may result in an increasing of figures.
10. To address the current medical equipment and supply gaps, the strategy need to include interventions that promote local medical and equipment manufacturing for sustainable solutions.
11. The NQS includes comprehensive and key intervention, but the how part of the strategy should be identified and included in the strategy?
12. Why the accreditation program chooses voluntary participation of health facilities alone? Is that also feasible to implement accreditation in our context as the fulfillment of minimum standards remained to be difficult for public health facilities?
13. The NQS interventions mainly focused on national and administration levels and need to balance through providing emphasis for the health facility's level quality improving supports?
14. Why there is mix in the of implementation quality related initiatives/programs at national level among the MOH directorates? For example HSTQ and EHAQ programs are under the other directorates

outside the quality structures which create some confusion of roles among the different team at RHB level.

Responses/Comments from panelists:

15. The National Quality Strategy is alive document and open for inputs for enrichment. The HSQD will also circulate to all summit participants for more detail review, and forwarding inputs.
16. The National Quality and safety strategy II is the strategy of the Health sector at large and shouldn't be perceived as the strategy of the Health service quality Directorate alone. HSQD mainly focus on coordination of the implementation the strategy. In this regards, all the relevant stakeholders within MOH programs, partners and were engaged in the implementation process and MOH senior management were reviewing and providing input at key stages of the strategy development.
17. Regarding the implementation of the strategy, the HSQD as coordinating body, will ensure the successful implementation and monitoring of the strategy using the current & existing structures. Besides, there is also a plan to establish a National Quality council as reflected in HSTP II as well, who will be overseeing the national quality and safety agenda in the country.
18. The issues regarding the coordination of the strategy at National level, there is ongoing discussion with MOH senior leadership to ensure improved coordination through lifting the current parallel structure with program one step higher like PPMED.
19. Unlike the NQS I, the NQS II is costed and has a robust M&E evaluation framework with clear M&E plan, indicators, targets, and defined data sources which are vital components for successful implementation of the strategy. The selection of indicators was mainly designed to focus on results rather access or inputs.
20. The how part of the strategy is already identified and articulated well in the implementation arrangement of the strategy.
21. The HSQD is developing National accreditation roadmap which will serve as a guiding document for implementation of the accreditation program in the country. As the accreditation program focus on optimal standards, MOH will provide technical support to accredited few hospitals, which will become a benchmark for the remaining hospitals. Regarding the participation, once the insurance system is established, the accreditation will be linked to insurance system become mandatory.
22. The target of the strategy is aligned with the HSTP II indicator for the majority of the indicators. Hence new targets are not introduced in the NQS II. However, the ambitious nature of the targets need not to be considered as gap as it also keep us striving towards it.
23. There are interventions included in the strategy that focus on health facility quality improvement, to mention few, district based coaching supports, strengthening clinical audits, monitoring of practices and health outcomes.
24. The issues of current national quality improvement initiative, including the structure for quality need not be considered as a main focus area, we should rather focus on the strengthening the implementation of the initiatives or programs using the existing structures.

Day two: May 07, 2021: Summit sessions

The 2nd day of the summit is the actual summit day whereby key learning activities are organized on a number of quality and safety priority topics in the forms presentation, panel discussions, poster exhibition, and sharing of bulletins. Dr.Desalegn Bekele, HSQD QI coordinator, moderated the morning sessions. Dr. Desalegn welcomed her Excellency Dr.Liya Tadesse, Minster of MOH, donor representatives, MOH & RHB delegates and all the participants to the 6th National quality and safety summit. He highlighted the objectives and expected results of the National summit including the motto of the year: He then introduced the programs of the day and invited the partner representatives from UNICEF,WHO, USAID, and EMA to deliver their key message followed by opening speech of her excellency Dr.Liya Tadesse.

1st Key note address from UNICEF Ethiopia; Dr.Joyce Mphaya, UNCEF chief of Health

Representative of the UNICEF Ethiopia, Dr.Joyce Mphaya, delivered her key note address by congratulating the Ministry of Health for the good progress made over the years towards the achievement of universal health coverage. She also added, the success made in doubling health facility delivery since 2016 which contributed to the reduction of maternal mortality in the country. On the other hand, she also emphasized the stagnant progress in the reduction of neonatal mortality for the same period and the number of newborns dying during their early days of life remaining high. She further expressed, it is not access to the health services that may be the major issue but the quality of care these mothers and babies received in the health facilities indicating quality of care is critical in improving patient outcomes and confidence in the health care.

She further pointed out that, quality of care can be improved by simple steps mentioning evidence based service delivery, institutionalizing quality culture across the health system and building community confidence in the system as an example.

Moreover, she recognized the summit as essential part of learning to achieve quality of health care services for all people especially mothers and children's of Ethiopia.

Finally, she re- affirm UNICEF's continued commitment to support the health systems of Ethiopia in delivering quality health care to women, and children as part of UNICEF'S work towards giving every child a chance to survive and thrive and reduce neonatal and under five deaths.

2nd Key note address from USAID Ethiopia; Sinu Kurian USAID Deputy Health Office Director

Representative of the USAID Ethiopia, Ms. Sinu Kurian, delivered her key note address in which she reaffirms USAID's continued commitment to support the efforts of improving the quality of health

services, in particular to the reduction of maternal and child deaths in Ethiopia. She added, USAID is proud to support a healthy, productive, and prosperous Ethiopia. She also appreciated the Ministry of Health commitment in delivering quality health services to its citizens mentioning Quality, as well as equity, have been carried forward as priority agendas in the second Health Sector transformation Plan to accelerate progress towards universal health coverage.

Summary Ms. Sinu Kurian key note address;

- Emphasized healthy population is a critical building block for any country to achieve their economic development goals regardless of investments in a strong education system and a growing industrial sector. She added, that is why USAID has placed such a strong emphasis on supporting Ethiopia's public health programs.
- Ethiopia achievement of the Millennium Development Goals 4, 5 and 6, reducing child mortality by two-thirds, reducing maternal mortality by half, and achieving significant reductions in HIV and tuberculosis infections.
- Appreciated, how the Health Extension Program has been instrumental in bringing services closer to the communities that need them and recommended the need to build upon this to address the uneven service quality and in strengthening the efforts of improving the quality of health services.
- The current gaps in health service delivery; inequity in the regional differences in service access and quality, urban-rural disparities, and the stark inequities faced by the urban poor. And the effect of COVID-19 in impeding the provision of quality health services.
- USAID's flagship MCH and nutrition activities, Transform Primary Health Care, Transform Health in Developing Regions, and Growth through Nutrition, use quality improvement approaches to ensure the delivery of high quality reproductive, maternal, newborn, child adolescent and nutrition services at the primary health care.

Finally she again reaffirm USAID's commitment to support the Ministry's effort in delivering quality reproductive, maternal, newborn, child, and adolescent health and nutrition services. This includes strengthening woreda leadership, improving quality of care, empowering communities, support to the supply chain, health financing, and health workforce improvement.

3rd Keynote address from WHO Ethiopia country office; Dr.Paul mainuka

Representative of the WHO Ethiopia country office, Dr.Paul mainuka delivered his key note address on behalf the World Health Organization.

Summary Dr.Paul mainuka key note address;

- Emphasized the current global gaps in access to essential health services and poor quality hampered by poor coordination across providers and a lack of integration with other critical sectors such as social services. The predominance of curative care models based on hospitals, donor-driven vertical programmes and single diseases further compounds the problem, making service provision costly, inefficient and difficult to steer.
- Integrated people-centered health services (IPCHS) adopted by the World Health Assembly in May 2016 calling for a fundamental shift in the way health services are funded, managed and delivered. IPCHS are a key feature of robust and resilient health systems and are critical for progressing towards universal health coverage (UHC) and the Sustainable Developmental Goals (SDGs).
- IPCHS is also not only a dimension of quality but a critical entry point to improve quality of care. The use of "IPCHS" as a motto for the national quality summit is very timely to understand and recognize the role IPCHS will have for achieving the countries ambitious agenda of UHC and transformation in quality
- Community-based health extension program and use of community engagement platforms which Ethiopia has immense experience in this regard are key milestone to accelerate the progress towards UHC.
- The WHO led Network for Improving Quality Care for Maternal, Newborn and Child Health where Ethiopia at the forefront of the network is pathfinder for quality health care systems which aims to reduce maternal and newborn mortality in target districts by 50% over five years, and to halve childbirth-related stillbirths; and improve patients' experience of care.
- Ethiopia as one of the fore runner countries in the network has been working to achieve these objectives guided by the National Health Care Quality strategy and the four strategic directions of the network: Leadership, Action, Learning and Accountability.
- Ethiopia has gained valuable experience in implementing systems to sustain quality at national and sub national levels, in 14 learning districts and 48 facilities. So, it is believed that sharing the lessons that have emerged on how to build and institutionalize systems able to implement quality care will help other programs and localities identify critical levers of change that need to be considered in implementing quality care at scale.

Finally, Dr.Paul concludes his remarks by wishing a successful and fruitful summit.

4th Keynote address from Ethiopian Medical association (EMA); Dr.Tegbar Yigzaw)

Dr.Tegabr Yigza delivered his key note address by highlighting the current burden of poor quality of care and key recommendation based on scientific evidences including the lancet commission and World medical association. He also added, the EMA's commitment to collaborate with MOH and stakeholders to ensure improved quality of care.

Summary of the key note address;

- The Lancet global commission on high-quality health systems in the SDG era
    - Poor quality care is common and 60% of deaths from treatable conditions are due to poor quality care.
    - Health systems should focus on four values: they are for the people, they are efficient, equitable and resilient
    - Health systems should measure competent care, health outcomes, user experience and confidence
    - Countries will know their health systems are quality if health workers and policymakers choose to receive health care in their own institutions.
- Hippocratic Oath:
    - there is art to medicine as well as science, and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug
    - I will remember that I do not treat a fever chart, a cancerous growth but a sick human being
- World Med Association and Eth Med Association ethics manuals state that the best interests of patients should be the first consideration in medical care
- Patient-centered: to what extent do we consider and respond to interests, preferences and perceptions of patients in our health care? It is about listening to and communicating with the patient. It is about working collaboratively with other health workers.
- Patient outcomes: are we getting the best results? Do we consistently provide high quality care?
- Quality improvement: systems approach: standards, monitoring, leadership commitment, organizational culture, teamwork, communication, infrastructure, structure
- EMA is dedicated to promote the highest possible standards of medical care: safe, effective and people-centered care.
- We encourage physicians to lead quality improvement efforts as that is good for patients, providers and health systems.

Official opening, Her Excellency Dr. Lia Tadesse, Minister, Ministry of Health of Ethiopia.

Photo: Her Excellency Dr.Liya Tadesse delivering opening speech

The summit was officially opened by the speech delivered by her Excellency Dr.Liya Tadesse, Minister of Federal Democratic of Ethiopia, Ministry of Health. Her Excellency welcomed MOH, RHBs, development partners and all stakeholder's delegates to the 6th annual National quality and safety summit.

In her message, the minister highlighted the progress, successes, challenges and next priority areas of the health care quality and safety agenda in the country.

She noted why the Healthcare Quality and safety is timely agenda for MOH, justifying this was due to the concerns regarding the current healthcare quality and safety, clinical outcomes, and client experiences.

The following are the summary points of her Excellency messages which was delivered in her opening speech;

- Ethiopia's outstanding success in improving access to health services and improving the health outcomes during the successful implementation of the four phases of HSDP from 1997/98 – 2014/15.
- Highlighted the progress made in the last five years on major MCH programs with few statistics from the Ethiopian Demographic survey report;
    - percentage of live births delivered by a skilled provider increased from 28% in 2016 to 50% in 2019,
    - percentage of live births that occurred in a health facility, which increased from 26% in 2016 to 43% in 2019,
    - Pregnant women who had four or more visits increased from 32% in 2016 to 43% in 2019.
    - In addition under-5 mortality reduced from 67 to 55 per 1000 live births and infant mortality reduced from 48 to 43 per 1000 live births.
    - Conversely, Neonatal mortality has not shown a significant reduction over the years. Though there was a reduction from 39 deaths per 1000 live births in 2005 to 29 in 2016, it went up to 30 deaths per 1,000 live births in 2019.

- She added despite the gains made on those periods, there was still high rates of morbidity and mortality from preventable causes, and Quality of healthcare in terms of improving patient safety, effectiveness, and patient-centeredness, in both public and private facilities, is often inconsistent and unreliable.
- Healthcare quality, and equity were made one of the four Health sector transformation agenda in the sector's first transformation plan.
- National Healthcare Quality Strategy was developed in 2016 reflecting the countries commitment to safer, more effective, more accessible, and more equitable care for every Ethiopian.
- The strategy provided a roadmap for addressing key quality gaps and accelerating the improvement of healthcare quality nationwide on selected program and clinical areas.
- The 2nd national healthcare quality and safety strategy- II developed with ultimate aim to continually improve health outcomes and confidence in the system by realization of evidence-based essential healthcare provision, People-Centered Care; and efficiency in the healthcare delivery applying continuously learning system.

Finally, her Excellency call upon all stakeholders to collaborate and harmonize resources towards quality planning, control and improvement to realize the implementation of the national healthcare quality and safety strategy- II looking top-down and bottom-up approaches through system thinking In order to ease magnitude of healthcare quality and safety problems in our healthcare system.

The minister concluded the opening message by acknowledging the Medical service General Directorate(MSGD), the Health service Quality Directorate, supporting partners and all HSQD staffs for making the summit possible and extended her wish to have most successful and productive summit.

Session 1: QI Project Presentation: Reducing Wastage of Medical Supplies in Maternity Pharmacy, Nigist eleni memorial Hospital (NEMMH)

Presenter: Dr. Mihertab Ermias, General Practitioner/Lecturer, Coordinator, MCH Case Team, WCU NEMMH, Hosanna.

- The project were implemented in Nigist Elleni Mohammed Memorial Hospital located in Hosanna town of Hadiya Zone, SNNP Region.
- The problem identified for improvement were wastage of medical supplies and uncontrolled surplus in usage of items.
    - Though expense need to be directly proportional to delivery, there was unpredictable pattern of consumption- no relation with consumption.
    - 43% of our expenses is above our estimate

    - An extra 158,750 ETB is consumed each months (Annually 1.9 M ETB)
- The problem arise from four areas, Prescription and requesting, Dispensing supplies, Storage and shelving of supplies and use patterns.
- The aim statement was to reduce wastage of medical supplies.
- There were four designed and implemented interventions :
    - Create attitudinal changes,
    - Meetings and discussion with health professionals and selected individuals
    - Restricted access to our prescription request paper
    - Designated runner for labor ward to assist shelving and storage
    - Periodic restriction in requesting when items are abundant
- Results
    - In 2012 expense per mother was 361.12 ETB (23.3% decrease from 2011 EFY)
    - Difference between actual and calculated monthly expenses (53.3% decrease from 2011)
    - Difference between actual and calculated per mother expense
    - 60% decrease from 2011.
    - Calculated expense as percentage of TE (Increased from 57% to 80%).
- Recommendations
    - 20% of requested medical supplies are not used appropriately.
    - Scale up and spread to other dep't and catchment hospitals.
- Lessons
    - Efficiency is a big problem in our health care delivery.
    - Minimal efforts can bring a significant change- proved the pareto principles
    - Our change idea should focus on permanent changes.

Poster exhibition:

Poster presentation were organized in day 02 in the morning sessions and scheduled during break times and the rest of the time. A total of seven were set to be visited (Annexed).Besides, the each poster in included annual bulletin which was distributed during the annual Summit that participant can see the details of each poster.

Session II: Panel discussions

The panel discussions were facilitated by Professor Tsinuel Girma, Project Director and Lead for Evidence to Policy for the Fenot Project, Harvard T.H. Chan School of Public Health. He opened discussion through introducing the background of the panellists and presented panel topics to the audience.

Photo: Panelist discussion on progress including zoom session participants

The three panel topics were organized,

1. People-Cantered and Integrated Health Services
   Presenter: Dr.Ismaul shemsedin, Ishmael Shemsedin, MD, CEO from Alert Hospital,
2. Learning Health Systems Using Data to Drive Improvement
   Presenter: Dr.Abiyu kifle, from IHI
3. Roles of Healthcare Financing, accreditation for Healthcare Quali**ty**
   Presenter: Dr.Desalegn Tigabu, MD, Consultant, Institute for Healthcare Improvement**.**

Panel discussion topic one: Patient centered care: by Ishmael Shemsedin, MD, CEO, Alert Hospital, Addis Ababa, Ethiopia.

Main points presented:

- Health care delivery has three models: The **1st one is** Ethical/spiritual model classified as health care provider centred model mainly focuses on what is the rational thing to do under the certain circumstances, the 2nd as Product model categorized as custom centred model focusing on profit maximizing with market orientated approach and the 3rd as the Right model categorized as patient & family centred model which mainly focused on asking the questions on "**how can I help you** "through engaging person and family.
- Patient and family centred care defined: as a care where by respectful and responsive to Individual patient preferences, needs, values, and ensures that patient values guide all clinical decisions.
- Moreover, he added the finding from an article on patient-centred care elements by **Souraya Sidani & Mary Fox (2014**), he mentioned, comparing and contrasting the definitions and descriptions of PCC revealed three specific elements that were represented in these components: holistic, collaborative and responsive care.
- The organization set up for the health sector need to be designed in way that the role of the Health extension program will be enhanced that in turn improves the people centered care through highest skill and preparation of the team.
- The people centered care affects the outcome in the following ways,
  - Improved satisfaction scores among patients and their families.
  - Enhanced reputation of providers among health care consumers.
  - Better morale and productivity among clinicians and ancillary staff.

    - Improved resource allocation.
    - Reduced expenses and increased financial margins throughout the continuum of care.
- As a final conclusion, he added that, Person centered care goes beyond mere adjustment of the interaction between health care providers and care seekers. It requires change of perspective at all levels of the health care system.

Panel discussion topic two: Learning Health System in the era of health care transformation: by Dr.Abiyu Kifle, MD, Country Director, Institute for Healthcare Improvement.

Main points presented:

What is learning health systems (LHS)?

LHS is defined as healthcare systems in which knowledge generation processes are embedded in daily practice to produce continual improvement in care; Data as a by-product to generate knowledge and continuous improvement based on knowledge generated.

What are the Importance of establishing Learning Health systems?

- Large time gap between publication of evidences and application at the clinical practice level, mentioning that biomedical knowledge doubles every 73 days and it would also take 35 year for quality to double.
- System level improvement requires formation of interdisciplinary community to share ideas and learn from evolving scientific works

What system level requirements should be in place for high functioning Learning Health systems?

- An LHS trusted and valued by all stakeholders
- An economically sustainable and governable LHS
- An adaptable, self-improving, stable, certifiable, and responsive LHS
- An LHS capable of promoting a good cycle of health improvement

Potential learning platforms in Ethiopia context?

- Learning networks based on the administrative hierarchies: Woreda / Zonal level learning health system
- EHAQ / EPAQ, Hospitals or health centers collaborative
- Program specific learning process, MNH – QED, TB / HIV, Chronic disease, Surgical services …

Common challenges:

- Lack of clear aim/objective of learning, undefined timeline, deviating from the learning process, and data quality and data management issues are stated as the common challenges for LHS.

IHI Experiences:

The IHI Ethiopian experience of "Supporting a Woreda based learning health system" were also presented as an example of LHS practice in the country for sharing lessons. The following interventions were implemented,

- Creating coaching capacity at Zonal and Woreda levels
- Capacitating targeted health facilities
- Using set of indicators to guide improvement
- Conducting review meeting/learning Sessions

The success in implementation of learning system were also presented in terms of results in the reduction of maternal and newborn outcomes using run chart.

Key recommendations;

- Evaluate available learning platforms using "the requirements for high functioning learning health system" as a criteria of evaluation
- While attempting to establish/strengthen a learning system:
  - Set clear objectives of learning - agreed by all
  - Define scale-up mechanism and timeline
  - Outline clear data management plan
  - Consider the economy side of the learning process

Panel discussion topic three: Role of Healthcare Financing on health facility Accreditation: by Dr.Desalegn Tigabu, MD, Consultant, Institute for Healthcare Improvement.

What is universal Health coverage?

Universal health coverage (UHC) as giving all people access to quality health services according to need, and ensuring that the use of these services does not expose the user to financial hardship.

- Health financing in the UHC era need to be efficient and equitable, raising of sufficient revenues, pooling of resources and allocations to purchase quality health services.
- Purchasing of the purposes are categorized as **passive:** providers automatically receiving funds (budget allocations) or payment independent of performance and **strategic purchasing**: linking the transfer of funds to providers to information on aspects of their performance.

What is the UHC progress and status in Ethiopia?

- Per capita increased from US$ 7 in 2004/05 to US$ 33 in 2016/17, far below the required WHO estimate required to achieve the sustainable Development Goals by 2030 is $112.
- The UHC service coverage index of Ethiopia for 2019 was 39% and the WHO minimum threshold to achieve UHC by 2030 is an index of 80%.

According to WHO, health financing arrangements can influence quality in 4 four possible mechanisms.

- Selective contracting;

    - Provider payment systems;
    - Benefit package design
    - Investments in systems, patients and providers
- The three Models for external quality assurance are licensing, certification and accreditation
- According to International society of ISQua, accreditation is defined as a public recognition by a health care accreditation body of the achievement of accreditation standards by a health care organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards''

The benefits of accreditation, **according to Joint Commission International (JCI)?**

- Improve public trust that the organization is concerned for patient safety and quality of care,
- Provide a safe and efficient work environment that contributes to worker satisfaction
- Listen to patients and their families, respect their rights, and involve them in the care process as partners
- Create a culture that is open to learning from the timely reporting of adverse events and safety concerns
- Establish collaborative leadership that sets priorities for and continuous leadership for quality and patient safety level
- Prevent problems from occurring and provide ways to detect and correct errors and problems
- Maximize customer satisfaction

Finally, the following important lessons were shared with respect to overall establishment functional accreditation system,

- Design and implementation of full-blown accreditation system at one go in an LMIC context is challenging.
- Sensitizing stakeholders within the health sector and other sectors on the concept, methodology, benefits and expected outcomes of accreditation is critical
- Clear roadmap on accreditation is essential.
- inclusion of accreditation in the revised national quality and safety strategy and the next health sector strategic plan is commendable
- Engagement and collaboration with different actors of the health system, including the Ministry of Health, private health sector, and professional societies
- Continual dialogue and consensus on the governance of the accreditation body
- A participatory consultative process for local development of accreditation standards by involving the public, purchasers, and government sectors and professional bodies
- Incremental rather than 'big bang' approach
- Linking accreditation to performance-based financing programs or any other form of incentive
- Design a robust surveyor identification, training, engagement and retention mechanism

Questions/Comments/Suggestions from participants:

1. The learning health system types being implemented in our setup seems to be less productive; hence it needs to be evaluated to identify gaps and taking corrective actions accordingly.
2. A health system should be a learning health system to ensure safe and effective service delivery.
3. How can we implement performance based financing system in our set up taking in to account with the current limited budget allocation?
4. Performance based financing is one of the mechanism to improve quality of care. In Ethiopia, there are small scale implementation in some part of the country which showed promising results and lessons can be used to inform wider implementation.
5. Considering the learning health system, currently there are much lessons in many of the program areas such as MNCH. However, there is no defined system led by Ministry of Health to ensure the comprehensive use of the lesson through building intervention packages and scale up implementation.
6. As initial step for establishing payment system for health delivery system, the actual cost of each services need to determined and known. After identifying the exactly cost of the services, mode of payments and mechanisms need will be followed.
7. How can we enforce licensing as health facilities are not able to meet the standards mainly due to the higher minimum requirements?
8. Does person centered care improved with the current efforts of actors working on patient-provider interface only. Does it to focus on primary health care only?

Responses/Comments from panelists;

9. Health care financing showed improvement through time in terms of increased budget allocation, implementation CBHI and health facility size expansion. However, there is still much remain to be done. In this regard, much advocacy works need to done to ensure every citizen own his own health and invest in the health care, health should be considered as debating agenda for politicians especially at time of election and the discussion agenda need to focus on beyond access agenda, should focus on health care quality provision. Besides, building health citizen need to be considered foundation or pre-requisite for counties vision to attain the set ambitious economic development targets and government need to invest in the health sector.
   On the other hand, there is also inefficiency in the use of allocated minimum budget by the health facilities which needs to be corrected. This can be addressed through implementing performance based financing and splitting the purchaser, service provider and regulator
10. To ensure the less flow of patients in public health facilities, implementing performance based financing will address the problem.
11. Real licensing need to be developed so that it will implemented in public health facilities without instituting double standard implementation for private health facilities.
12. To strengthening person centered care three thing need to be exercised wel,

a. Building adequate stewardship, we need to develop communities who can ask for health care quality,
b. Political commitment and
c. Co-production i.e. Engage the public than focusing only government expectation only including Public private partnership.

13. It is said that coverage without quality can be harmful, therefore health care system delivery should be comprehensive and integrated. Therefore in order to ensure patient centered care, we need to build person centered system which requires policy, strategies and organization level interventions and partnership across the health system.
14. Within catchment integration and coordination is very key to ensure person centered care. This will ensure to avoid the current disconnect between tertiary care and primary health care.
15. We need to evaluate the current learning network itself to make sure the learning system function optimally and to move one step forward. Besides, we should address the common limitation such as not establishing defined objective with timeline.
16. Learning health system is very important to achieve the current objective of health care financing and person-centered care.

Finally Professor Tsinuel concluded the panel discussion through emphasizing the need to acknowledge the progress made so far with respect to health care financing, learning systems and patient centered care systems, and beyond and understand the incremental nature of change that will keep momentum.

Session: III: Maternal and Newborn quality of care lessons

Facilitator: Dr.Haimanot Ambelu, NPO-MPS ,WHO Ethiopia country office.

Presenters:

1. Dr.Desalegn Bekele, HSQD :Learnings from QED MNH Quality Improvement initiative
2. Ms. Aynalem Hailaemichael, Transform PHC: Organize and sustain implementation of onsite support systems (QI coaching, clinical mentoring) for MNHC improvement at the subnational level
3. Dr.Abiyu Kifle,IHI :Developing and sustaining a learning system to support the sharing of QoC knowledge within and across districts.

The objective is to share and discuss the Ethiopian lessons on MNH QoC network initiative which has been implemented since June 2010 E.C. (June 2018 G.C.) in selected 14 districts and 48 health facilities in the country.

Presentation 1: Learnings from QED MNH Quality Improvement initiative; Dr.Desalegn Bekele,HSQD

Main points presented:

Photo: MNH progress and lessons presentation, Dr.Desalegn Bekele

Why MNH QoC?

- Though under five mortality reduced significantly, the proportion of deaths occurs during the neonatal period were reduced at a slower rate and the current burden of maternal mortality with 412 maternal deaths per 100,000 live births and neonatal mortality with 29 neonatal deaths per 1000 live births is still higher. This is so regardless of the improved maternal health care/service coverage registered over the years.

- Improvement in maternal health care coverage needs to integrate health care quality to address the current persistent disparities and unmet need for maternal health care.
- Ministry of Health of Ethiopia has prioritized maternal and newborn quality of care and begun to design and implement several Quality improvement initiatives. One of the five priority areas for improvement reflected in NQS I.
- Developed and launched MNH QoC roadmap
    - Informed by gaps identified by the situational analysis conducted using the WHO MNH QOC analysis framework comprised of four strategic objectives of the framework: leadership, action, learning and accountability.
      Identified Goals:
    - reducing institutional maternal and newborn deaths and stillbirths by 50% by 2020 and
    - Achieving a measurable improvement in user satisfaction with the care received

How it is introduced?

- Ethiopia Joined the WHO led Global network to 'Improve Quality of Care for Mothers, Newborns and Children.
- The Network provides a platform for countries to ensure that quality of care becomes an integral part of health care delivery; it facilitates inter-country learning, knowledge sharing, and generation of local evidence and best practices.

What are the Implementation arrangement? Where and when?

- The HSQD in collaboration of development partners established district based learning collaborative network.
- Targeted 14 districts representing the agrarian, pastoralist and urban set ups (3 - 5 learning health facilities per district) in 8 regions and 1 city admin. One district comprising : Lead Hospital and/or Primary Hospital & 2-3 Health centers
- A total of 48 learning health facilities (8 referral & general hospitals, 12 primary hospitals, and 28 health centers.)
- Implemented since July 2018 (first months of 2011 EFY- July 2012)
    - 2010 EFY (July 2017-June 2018) considered as baseline year (Pre-implementation)

- 2011 EFY – 2013 EFY (starting July 2018) implementation year (Follow up years)

Progress made?

Leadership

- **Established quality structures;**
  - National : Establishment of HSQD , Steering committee and MNH QoC technical working groups
  - RHB Quality units established supported by the RHB Technical Working Groups (TWG)
  - At Zone/sub-citylevel, a quality case team established in most of them with two to four staff members
  - Woreda (District). one to two focal persons assigned for quality
  - One MNH QED focal in all the 14 districts
  - Public Hospital. A quality and clinical governance unit headed by a General Practitioner (GP)
  - Public Health Center. A quality committee with a focal person assigned from team members. Performance Monitoring Team (PMT) and a QIT that works to improve quality and performance
- Maternal and newborn quality of care network in the 14 districts become one of the flagship large scale QI initiatives, (Annual costed work plan aligned with RHBs and budget support for RHBs, Districts and HFs)
- Engaged key technical partners, define roles, commitments and responsibilities to support the implementation

Action:

- MNCH quality standards were developed based on the WHO standards included as one chapter in the Ethiopian Health sector transformation for quality guideline (HSTQ)
- Basic and advance QI trainings
- The National QI coaching guide was also developed and introduced in the MNH QoC learning sites
- 2 rounds of QI coaching training provided to the established pool of QI coaches from Districts and lead Hospitals
- In collaboration with supporting partners. (Transform PHC, Transform HDR, IHI, CHAI & WHO) on-site mentoring and coaching support provided to build clinical and QI skills of learning health facilities. (Annual from MOH level, 2 months-quarterly basis from District based teams)
- Maternal and Perinatal death surveillance and response system (MPDSR) strengthening (Trainings, tracking and feedback on maternal deaths)

Learning:

- WHO MNH QoC Monitoring and Evaluation framework were also adopted and implemented to track implementation of the program and results that includes fifteen common core indicators measuring provision of care, experience of care and WaSH.
- Additional Process and outcome measures from DHIS2/HMIS, and from HPMI/Hospital KPI to inform QI opportunities and track improvement at all levels
- Use of MPDSR data to inform QI efforts in the learning health facilities

- DHIS2 and data quality trainings including orientation on MNH QoC CCI measutres
- Integrating key MNH Quality measures in to routine HMIS systems underway
- Bi-annual National MNH QoC learning collaborative
- Annual Quality summit (MNH QoC as one of the priority and 14 districts actively participating)
- MNH QI work reflected in Annual Health care quality bulletins
- Support the design and implementation of QI projects, documentation and sharing of best practices and lesson learnt across the learning network

Accountability:

- MNH QoC measures including Maternal and newborn outcomes & patient experience as Key performance measures tracking and feedback provision,
- Strengthening MPDSR system implementation

Results:

Figure: 4: Run chart institution pre-discharge maternal mortality rate

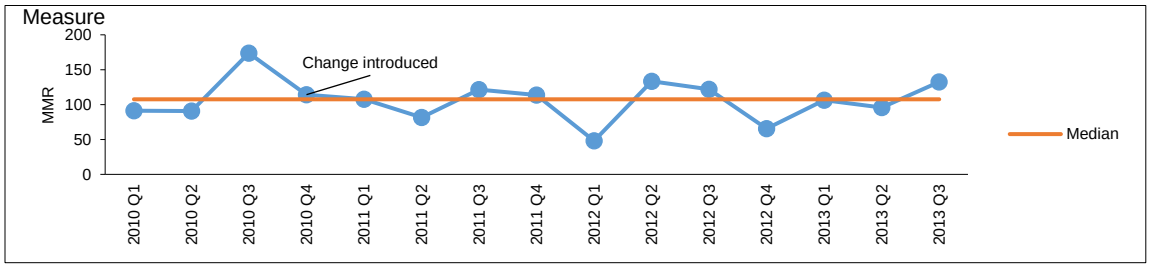


Figure: 5: Run chart institution pre-discharge neonatal mortality rate

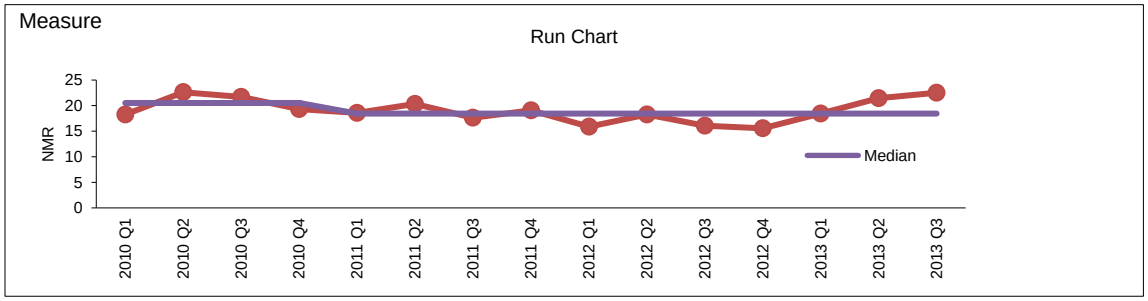
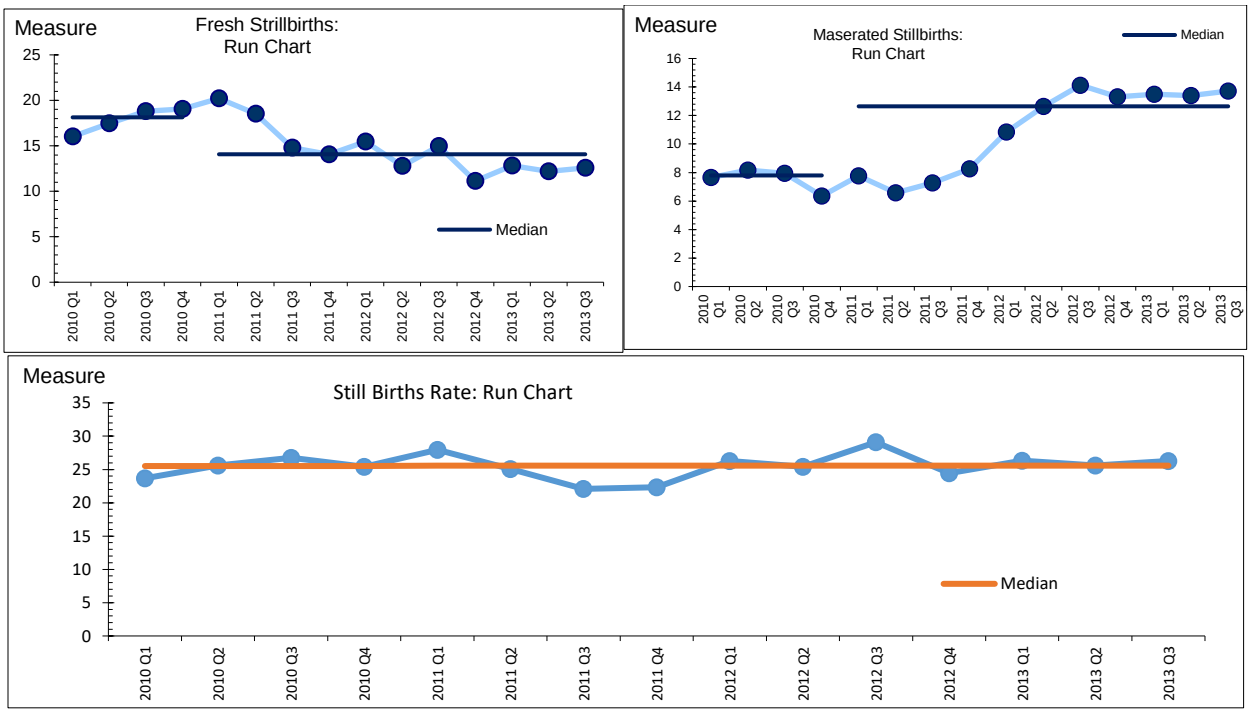


Figure: 5: Run chart institution Stillbirth rate (SBR), fresh Stillbirths, Macerated stillbirths



Lesson learnt:

- Building Leadership capacity and mechanisms for quality of care is vital for improved health care outcome.
- Building and strengthening district based coaching support in existing administration structures ensure sufficient expertise availability and help to sustain quality improvement
- Strengthening data system and feedbacks and using indicators tracking key prioritized improvement factors cornerstone for improvement.
- Linking quality improvement with Maternal and perinatal death surveillance is crucial for improving maternal and perinatal quality of care

Conclusion:

- Though the performance across the health facilities may be affected by the variation in the existing resource availability such as medical supplies, human resource and other structures, the early results of the MNH QoC network implementation has shown promising result with respect to reduction in institutional mortality outcomes
- Efforts for Improvement in quality of care guided by defined system wide approach strategy and improved stakeholder coordination and partnership.
- Continued and sustained implementation of the quality improvement efforts may also be required for long term and sustained results.

Presentation 2: Organize and sustain implementation of onsite support systems (QI coaching, clinical mentoring) for MNHC improvement at the subnational level: Aynalem Hailemichael

Main points presented

Why Clinical mentoring?

-To assist mentees to improve their knowledge, skill and attitude-To improves facilities' quality MNH care service

Purpose of QI coaching?

-To provide technical guide to the QI team to improve their performance and spread of QI knowledge.

How/ process clinical mentoring?

- National Training manual for Catchment Based Mentoring (CBM) was prepared
- TOT training was provided to the trainers: Midwives who are working in mentor hospital with good clinical experience and communication skill were trained in the mentorship program
- The training was cascaded to the ZHD, Woreda/district health office MNH officers and primary Hospital mentors
- Actual site level Clinical mentoring was conducted on monthly bases for six months, for a total of 30 sessions

How/process of QI coaching:

- National training manual &Coaching guide was prepared
- QI coaching Training was conducted for QI coaches and clinical mentors who had the basic QI training with real time experience with QI work then QI coaching training cascaded to Zone, woreda/district quality focal persons, HWs from Primary hospital
- Actual site level QI coaching: Monthly site level QI coaching, virtual QI coaching with telephone and telegram support for QAQI implementing health facilities

Result of clinical mentoring:

- More than 300 clinical mentors trained by USAID Transform Primary Health care activity, 43 woredas covered with catchment-based mentoring. Graduation criteria depends on the facility readiness and mentees skill and knowledge assessment result, which was assessed through baseline, midterm & end-line assessment that If facility provide adequate BEmONC service, and mentees skill and knowledge above 85% then there will be graduation
- Improvement observed so far: Mentees average skill practice and knowledge assessment has improved from 60%- 90% and facilities BEmONc service showed significant improvement through the CBM.

Results of QI coaching:

- More than 300 QI coaches trained by USAID Transform Primary Health Care activity, more than 156 woredas and 629 health facilities covered by QI coaching. Graduation criteria depends on maturity index of the QI team to able to work QI activities which is measured continuously by the coaches

Improvement observed so far

- There is regular site level and phone coaching support to QI implementing health facilities, facility QIT able to assess their gaps, monitor the QI project progress, review and assess data quality. Use of data for improvement has improved and Documentation of QI projects, Celebration of achievement and sharing experience has improved. Assignment of focal person who leads the improvement activities, presence of a functional QI team with different sub-teams (CASH, clinical audit, MPDSR etc.); and with regular QI team meetings to review the quality improvement work; most of the primary hospital and health centers has built a capacity to run QI activities.

Challenges:

- Quality improvement work is relatively new activity at woreda level, new staff were assigned to lead the QI activities, and more support is needed to these staff. Poor documentation, high Staff turn over both at the facilities and woreda level.

Way forward:

- Structure: strengthen the QI structure at all level, Integrating of QI coaching with catchment base mentoring, Integrating/linking the QI coaching and CBM with woreda level platform such as EHIAQ/EPAQ, review meeting (woreda based learning)
- Resource: resource allocation for catchment-based mentorship and QI coaching for its sustainability is critical

Questions/Comments/Suggestions from participants:

Dr.Hassen Mohammed invited the participants especially those from learning woreda/districtand facility to raise issues related to the implementation and lessons.

1. The direction of transitioning the MNH QoC initiative's implementation to the respective woredas will not be practical at this time. For example; the impact of COVID-19 pandemic that affects routine service delivery and the financial capacity of woredas to provide regular mentoring support to their catchment health facilities need to be considered as challenges for the transition. The decision of transitioning should be informed by conducting maturation assessment.
2. The approach of building the capacity of health facilities focusing on mentoring individual MNH experts and reaching the remaining staff through him/her is becoming less effective as it relies on individual staff who may be away from the facility for many reasons. Therefore, it is recommended to consider other approaches/mechanisms that targets department level support rather individual focused support.
3. The Regional Health Bureaus weak engagement in the MNH QoC initiatives has created gaps in spreading the lessons gained in the learning woredas to non-targeted districts within the region. Therefore, attention needs to be given to ensure RHB engagement in such district based learning

Photo: MNH lessons and General summit discussion with HSQD Director

initiatives that will be vital, especially in spreading learning across all health facilities within the region.

4. As presented by Dr.Desalegn, Stillbirth in the MNH QoC sites is not declining, this is mostly due to the existing skill gaps of professionals in the primary health care units. Is there any planned interventions from MOH to address this gap?
5. Can we say that there is a significant change in health outcomes in those implementing sites attributed to the MNH QoC intervention without triangulating/comparing the performance with non-targeted and similar set up sites?
6. The success or lessons gained in the health facilities is mainly the efforts of frontline staffs. Why we shouldn't recognize and motivate those frontline staff by bringing them in front in such forums?

Responses or comments from presenters and HSQD Director:

7. The MOH admits the minimal ownership and engagement of RHBs in the implementation of the MNH QoC initiative. The majority of the work was implemented by MOH and development partners. The limited culture of collaboration among health system structures especially in setting common aims can contribute to the limited engagement practices. However, the MOH has been supporting RHBs and Districts to improve engagement in many aspects that includes budget transfer and organizing regular biannual national learning collaborative sessions which bring together RHBs, MNH QOC learning woredas and health facilities.
8. Majority of the improvement activities were undertaken by the Health facilities, MOH support were mainly focusing on capacity building, organizing learning platforms and direct budget support for coaching. However RHBs engagement and support was not sufficient and varies across regions.
9. With respect to engagement all health facilities staffs, we usually work with assigned focal persons only as it is not practical to call all staffs in such forums/workshops. However, as team of experts undertake the design and implementation QI projects in the health facilities and the team members will get the opportunity to build their QI skill capacities in the entire process.
10. Considering the higher proportion of the population served at health facilities under woreda structures, woreda based improvement, coaching and learning is priority areas of support reflected in the NQS II. This will help to address quality gaps in primary health care unit level as well.
11. Quality improvement results usually monitored and tracked using a run chart to identify workable intervention and don't necessarily to follow sophisticated research procedures.

12. It will be important to arrange a separate forum to fully discuss all the issues and challenges related to the MNH QED implementation before the end of the current fiscal year. This will help to include all actors who contributed to the implementation of the initiatives and to have sufficient time for a comprehensive review of five year implementation and to design corrective actions that will be incorporated in the coming fiscal year period annual plan.

General reflections and discussion:

1. The summit was very fruitful as it is unique in terms including scientific presentation, integration of different stakeholders' views on key quality topics and discussion/review of the draft national Quality strategy. As a next step, we should ensure, the identified lessons and inputs gained in the summit will get implemented and monitored. Besides for next year annual summit, innovative QI projects addressing the key health system recurrent problems should be prioritized for learning.
2. The unavailability of uniform Quality structure across all levels is a challenge at RHB level. Separate Structures at National level are merged into one structure at RHB level. For example, in Gambella Region, Health system strengthening and Quality structures are merged as one directorate named as Health system strengthening and Quality Directorate, creating a work burden at RHB level as two different tasks are expected to be implemented by one directorate.
3. The Oromia region experience is worth to share in terms of the different efforts the region have accomplished to ensure health care quality in the region. Accordingly, RHB commitment was mentioned as key driver that helps to gain budget support and other necessary support for implementation of QI activities. Besides, mapping the different partners working in the region and conducting regular meeting and engaging them in the implementation, including mentoring, supervision and review meetings were also very critical.
4. The Oromia and Amhara regions' improved and continuous emphasis for health care quality to be considered as the regional priority is very critical and can be exemplary. This is demonstrated by establishing strong quality structures at RHB level and assigning of quality focal at zonal and district levels.
5. Establishing a Health care quality structure is important but we should also be fully aware that structure alone will not bring the expected results. Moreover, for the sake of efficiency, it is also preferred and expected in merging related functions as we go down to sub-national administration and the grass root levels. At most, the process of establishing a structure is also complex and require allocation of sufficient resources, Hence it is better to focus on reviewing our commitment for healthcare quality and to strengthening our team work towards improving quality of care.

Finally, Dr.Hassen Mohamed, acknowledged the HSQD team and MNH QOC TWG members who made the summit possible for their hard work and commitment. He also thanked all participants for attending the meeting and for their active participation and forwarding valuable inputs. Besides, he also appreciated the MOH leadership, her Excellency Dr. Liya Tadesse for her support to make the summit successful and productive.

Annex: 1: *Summit Program*

Day 1: ***6-May- 2021***

Time	Activity	Responsible Person	Moderator
08:30 - 09:30	Registration	Registration	Organizers
09:30 - 10:30	• Welcome and introduction of participants • Opening Remark • Admin. Issues • Summit Objectives	Dr. Hassen	Dr.Desalegn T.
10:30 - 10:45	Tea Break and Networking		
10:45 12:30	NQS-I Review Report	Dr. Fitsume K.	Dr.Desalegn T.
12:30 - 1:59	**Lunch Break**	Organizers	
2:00 - 3:45	*National Healthcare Quality and Safety Strategy-II (2021-2025): Overview* • Development processes, Introduction, Situation Analysis • Goal, Objectives, Targets, and Implementation plan	Dr.Desalegn/Dr. Fitsume	Dr. Hassen
3:45 - 4:00	Tea Break, Networking and Posters Visit	Organizers	
4:01 - 5:00	Discussion on the Quality Strategy	All	Yakob and Dr. Hassen
End			

Day 2: 7-May- 2021

Time	Activity	Responsible	Moderator
8:30 – 9:00	Registration	Organizers	Organizers
9:00 - 10:00	Keynotes Addresses	• WHO, EMA, USAID, UNICEF, and DFID	Yakob S
	Official Opening	• MOH - Minister	Yakob S
10:00 – 10:15	Improving Efficiency of Medical Supplies at Maternity Pharmacy	Dr. Mihret Ermias, Nigist Eleni Mohammed Hospital, Hosana	
10:15 – 10:45	Posters Visit	Organizers	Organizers
10:45 - 11:00	Tea Break and Networking	organizer	
11:00 – 12:30	**Panel Discussion** • People-Centered and Integrated Health Services • Learning Health System in the Era of Healthcare Transformation • Roles of Healthcare Financing**,** accreditation for Healthcare Quality	Presentations • MOH • IHI • EHIA	Prof. Tsinuel Girma
12:30 – 1:59	Lunch Break	organizers	organizer
2:00 – 2:40	Learnings from QED MNH Quality Improvement initiative: • Objectives, Interventions, Core Indicators, Results, Strategies to Hold the Gains and Spreading Improvement-(MOH)	Dr. Desalegn	Dr. Haimanot

2:40 – 3: 10	Learnings from QED MNH Quality Improvement initiative • Organize and sustain implementation of onsite support systems (QI coaching, clinical mentoring) for MNHC improvement at the subnational level (Transform) • Developing and sustaining a learning system to support the sharing of QoC knowledge within and across districts (IHI)	Implementing Partners • Transform-PHC • IHI	Dr. Haimanot
3:10 – 3:50	Discussion on lessons that have come out of MNH initiative implementation in Ethiopia	All	Dr.Hassen
3:50 – 4:20	Tea Break, Networking and Poster visit	organizers	
4:20- 5:30	General Discussion and Closing	MSGD/HSDQ	Yakob/Dr.Hassen
End			

Annex 2: List of participants

S.N	Name	Organization	Organization	Position	Phone #
1	Zenebu Yilma	Addis Ababa	Save the children	Nutrition Advisor	911678578
2	Dr.Meklet Getahun	Addis Ababa	Alert Hospital	Quality Director	911567934
3	Dr.Amsalu Tiblet	Addis Ababa	Alert Hospital	MSD	913028824
4	Dr.Bekele lemma	Addis Ababa	AHMC	Provost	910793836
5	Asnakech Tadesse	Addis Ababa	AA	midwife	911038632
6	Dr. Ismail Shemsedin	Addis Ababa	Alert Hospital	CEO	911457483
7	Dr Abdu Adem	Addis Ababa	SPMMC	Quality Director	986360107
8	Dr.Bezawit Tsegaye	Addis Ababa	Alert Hospital	CIQGD	913551417
9	Askal Haile Mikael	Addis Ababa		DPHPCP	913015069
10	Melesu Shibiru	Addis Ababa	MOH	Assistant	911953519
11	Dr.Berhane Redae	Addis Ababa	MOH	Technical assistant	911210543
12	Dan Mullgeta	Addis Ababa	MOH	Technical assistant	941226958
13	Ejigayehu Afework	Addis Ababa	National Blood bank service	Quality Head	912079650
14	Yabsra G/wold	Addis Ababa	MOH	Technical assistant	993930588
15	Aynalem Legasse	Addis Ababa	MOH	QI officer	911109314
16	Almaz Seid	Addis Ababa	MOH	QI officer	911455069
17	Dr.Haimanot Ambelu	Addis Ababa	WHO	NPO/MPS	917800339
18	Dr.Hassen Mohammed	Addis Ababa	MOH	HSQD Director	944336423
19	Aklilu Yeshitila	Addis Ababa	Transform HDR	QI Advisor	912099805
20	Aynalem Haile Mikael	Addis Ababa	Transform PHC	Program manager	911454563
21	Dr.Desaleg Bekele	Addis Ababa	MOH	QI team lead	943544307
22	Dr.Fitsum Kibret	Addis Ababa	MOH	Technical assistant	911556252
23	Dr.Yeneh Getachew	Addis Ababa	IHI	Advisor	923245151
24	Dr.Medihin Kassa	Addis Ababa	MOH	QI officer	9132237
25	Blen Tadesse	Addis Ababa	MOH	Office assistant	929132828
26	Ftalew Dagnaw	Addis Ababa	MOH	Technical assistant	911061646
27	Edmealem Mitiku	Addis Ababa	MOH	QI officer	945893421
28	Hayatu Mohammed	Afar	RHB	QI officer	912154904
29	Nur Humed	Afar	RHB	QI officer	921225041
30	Aderajew Tewolde	Amhara	Durbete Hc	CEO	918285280
31	Etsub Asrat	Amhara	Dur. Woreda	QI officer	918090588
32	Azimeraw Abera	Amhara	Lalibela HC	HC head	913386527
33	Dr.Abebe Assaye	Amhara	Tibebe Gion Hospital	Quality Director	918295667
34	Zemene Meseret	Amhara	Felege Hiwot Hospital	Nurse/MPH	971176937
35	Dr.Sewbesew Yitah	Amhara	Gondar teaching Hospital	Clinical Director	925304176
36	Dr.Ayale Abate	Amhara	Woldiya Hospital	Quality unit head	910444379
37	Nigatu yeshambel	Amhara	ARHB	QI officer	904343174
38	Dr.Merkina Awol	Benishangul G.	Assossa Hospital	Medical Director	910675746
39	Lemlem Bezabih	Dire Dawa	RHB	Head	937490286

S.N	Name	Organization	Organization	Position	Phone #
40	Fila Ahmed	Dire Dawa	RHB	CRCP	911395762
41	Gkambo Asua	Gambella	RHB	Quality Director	911364835
42	Ruot cathe	Gambella	RHB	Head	911501530
43	Omod John	Gambella	Gambela Hospital	CEO	924305928
44	Ibsa Ibrahim	Harar	RHB	Head of RHB	914947880
45	Dr.Bayisa Girma	Oromia	Chancho Hospital	Medical Director	913098631
46	Awol Hassen	Oromia	Shenen Gibie Hospital	QI officer	
47	Dereje Abdissa	Oromia	RHB	QI coordinator	926562128
48	Dr.Workneh Gebeyehu	Oromia	Tulu bolo Hospital	CEO	911810845
49	Dereje Mosisa	Oromia	Woreda HO	Head	920154801
50	Dr.Tesfaye Kebede	Oromia	RHB	Deputy Head	911956768
51	Mr.Mathewos Maja	Sidama	Kebado Primary Hospital	CEO	91074787
52	Habtama Belayneh	Sidama	Teferi Kela HC	PHCU Director	963945794
53	Dr.Negash Tagese	Sidama	Hawassa university Hospital	Clinical Director	916580324
54	Gudara Fente	Sidama	RHB	Quality Coordinator	925682630
55	Zerihun Gashaw	SNNPR	RHB		911942281
56	Jemal Shifa	SNNPR	Werabe Hospital	CEO	926353421
57	Dr.Miheretab Ermia	SNNPR	Nigist Eleni Hospital	MCH case team	911068554
58	Amsalu Obsa	SNNPR	Transform PHC	QI/QA program officer	911585192
59	Yitbarek Assefa	Tigray	RHB	QI officer	914820695
60	Dr.Getachew Mekonene	Tigray	RHB	Deputy Head	913436198