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MINISTRY OF HEALTH - ETHIOPIA
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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

# Review Report of the National Health Care Quality Strategy (2016 – 2020)

**September 2020**

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# Acknowledgments

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Finally, we thank UNICEF Ethiopia for the technical and financial support in the review and printing of the report.

# List of Acronyms

| | |
|---|---|
| **APTS** | Auditable Pharmacy Transaction and Services |
| **CASH** | Clean and Safe Hospital |
| **CBHI** | Community Based Health Insurance |
| **CG** | Clinical Governance |
| **CHS** | Community Based Services |
| **CPD** | Continuous Professional Development |
| **CRC** | Caring, Respectful and Compassionate |
| **EHAQ** | Ethiopian Hospitals Alliances in Quality |
| **EPAQ** | Ethiopian Primary Health Care Alliances in Quality |
| **FMHACA** | Food Medicine and Health Administration and Control Authority |
| **MOH** | Federal Ministry Of Health |
| **HDA** | Health Development Army |
| **HHRR** | Health and Health Related Regulatory |
| **HIA** | Health Insurance Agency |
| **HMIS** | Health Management Information System |
| **HPMI** | Hospital Performance Monitoring Indicators |
| **HSQD** | Health Service Quality Directorate |
| **HSTG** | Health Services Transformation Guide |
| **HSTP** | Health Sector Transformation Plan |
| **HSTQ** | Health Sector Transformation in Quality |
| **IA** | Improvement Advisor |
| **ICU** | Intensive Care Unit |
| **IHI** | Institute of Health Care Improvement |
| **KPI** | Key Performance Indicator |
| **MNH** | Maternal and Newborn Health |
| **NCD** | Non-Communicable Diseases |
| **NQS** | National Quality Strategy |
| **NICU** | Neonatal Intensive Care Unit |
| **OR** | Operating Room |
| **PHCU** | Primary Health Care Unit |
| **PHCD** | Primary Health Care Directorate |
| **PMT** | Performance Monitoring Team |
| **QA** | Quality Assurance |
| **QI** | Quality Improvement |
| **QIT** | Quality Improvement Team |
| **RHB** | Regional Health Bureau |
| **SaLTS** | Saving Lives Through Safe Surgery |
| **SARA** | Service Availability and Readiness Assessment |
| **UHC** | Universal Health Coverage |
| **WorHO** | Woreda Health Office |
| **ZHD** | Zonal Health Department |

# Forward

The National Healthcare Quality Strategy builds on the plan laid out in HSTP I to guide the implementation of one of the four transformation agenda of quality and equity in Health care. More importantly, the National Health Care Quality Strategy reflected Ethiopia's commitment to safer, more effective, more accessible, and more equitable care for every Ethiopian.

This review provides an assessment of the Ethiopian Health care quality system performance during the period covered by the Strategic Plan and an assessment of the utilization use of the strategic plan. It analyses lessons learned during the five years of implementation and draws on the insights of a variety of stakeholders towards the NQS I development and implementation. Thus, the review will contribute to the design of the next Strategic Plan and large-scale Quality improvement interventions.

The review indicated that the NQS helped define the 'how' part of HSTP and in raising awareness of quality across the Health care system although there was a limitation in the ease of understanding of the content of the NQS, which lacks clarity in its priority interventions, proposed quality structures, and responsibilities. The review also noted, most (75.9%) of the interventions under each strategic focus area were either initiated or completed and the proposed key activities under the three commitments have been accomplished. It also recognizes, the challenges of high turnover of leadership at the directorate level and lack of clear coordination, integration, linkage and interface, and accountability mechanisms between the quality unit and other program structures across the health care system.

The review recommends that the Ministry of Health strengthen the Integration and embedment of quality planning, improvement, and control in each program area across all levels of the health care system and restructure quality unit at a higher level, and defining the scope and the functions at all levels.

As the Health sector prepares to develop a new Strategic Plan, I hope this review will shed light on how MOH and its key stakeholders can further enhance the development of high-quality Health care system in the country.

Dr. Hassen Mohamed
Director of Health Services Quality
Ministry of Health

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# Executive Summary

The MOH developed a National Health Care Quality Strategy in 2016 (2016-2020). The goal of the NQS is to consistently improve the outcomes of clinical care, patient safety and patient centeredness, while increasing access and equity for all segments of the Ethiopian population by 2020. The NQS specified five priority areas and four strategic focus areas. Priority interventions are listed under each strategic focus area, with three commitments to be achieved in the short term laid out below.

In the past four years, the MOH and various stakeholders have been working on different interventions to improve health service quality in the country. The main purpose of the review is to determine the extent to which the NQS has achieved its desired strategic objectives, and to generate information and learning for the purposes of the 2021-2025 strategic plan. The evaluation involved both qualitative and quantitative methods. Data was mainly collected from interviews with key informants, focus group discussions and review of secondary data and all relevant international and national documents. The findings were compiled into predetermined thematic areas based on the qualitative and qualitative analysis guide.

### Key findings:

- Most (56%) of MOH staff, service providers in private facilities and professional associations are not fully aware of the contents of the NQS and in some cases have not seen or heard about the document at all.
- It has not been easy to understand the content of the NQS, which lacks clarity in its priority interventions, its proposed quality structures and its responsibilities.
- The three core elements (quality planning, improvement and control) described in the strategic document appears to be poorly understood and attention paid to each element varies at different levels.
- The NQS was helpful in defining the 'how' part of HSTP, and in raising awareness of quality. It is used as a reference or guide by some participants.
- Key activities under the three commitments have been accomplished: a quality planning system has been developed in most of the government structures, and a large group of providers and leaders are trained in QI. However, there are still regional disparities in the way this system is formed and operates.
- Most (75.9%) of the interventions under each strategic focus area are either initiated or completed. The effort to motivate providers and integrate training in QI skills in pre-service education is limited; most of the services are not responsive to the user's needs; very little is done in provision of patient-centered care, and linkage with the HIA is not yet happening.
- The introduction and implementation of different standards results in improved services and an increase in the proportion of facilities who meet standards for different chapters/areas.
- There are efforts to use data for improvement and decision-making, but overall practice needs more intervention in order to maximize and institutionalize these efforts.
- QI initiatives were planned and implemented in the areas of MNH, surgical care and HIV led by the HSQD.

- Although the EHAQ/EPAQ facilitate support for leaders of member facilities, structured peer learning and work on defined shared aims are missing from the network.

### Common challenges:

- High turnover of leadership at directorate level; absence of clear coordination mechanisms and plan alignment among different directorates within the MOH, other sectors and key partners; turnover of staff at facility level; limited or no budget allocated for QI activities; absence of implementation plan for interventions.
- Lack of clear coordination, integration, linkage and interface and accountability mechanisms between the quality unit and other programme structures across the health care system.
- Lack of basic health infrastructures and limited financial resources in the health sector, which affects proper planning and control of health service quality.
- Content, introduction and follow-up of facility requirements from regulatory bodies and other administrative and clinical standards introduced in recent years are a concern for facilities. The standards are not contextualized for local situations and for the facility level; approaches lacks clarity and uniformity.
- Limited involvement of clinicians, especially senior specialists; absence of scope-based practice of health professionals; lack of clear individual level performance measurement, well-organized support (coaching and mentoring) and incentive strategy reflected in low commitment of health workers.
- National large-scale improvement interventions/initiatives are limited to a few programme areas.
- Lack of quality-oriented indicators; emphasis for coverage not outcome indicators; poor data use culture and dashboard utilization; no properly designed quality measures for monitoring and feedback mechanisms for respective programme areas.
- Corruption of the health facility management and medical practices; false reports; intentional falsification of reports at different levels.

### Key recommendations:

- Focus on systems thinking; build on existing strategic objectives; expand the focus areas of NQS; develop budgeted implantation plan with source of funding; clearly define the responsible actors at all levels.
- Integrate and embed quality planning, improvement and control (three core elements) in each programme area across all levels of the health care system in order to ensure quality of care as the foundation of the system.
- Restructure quality unit at a higher level than the current structure and clearly define the scope and the functions at all levels, in order to facilitate coordination, integration and accountability; ensure that the structure is staffed with a multi-disciplinary team with both technical and improvement skills.

- Impose accountability mechanisms for quality of care which addresses wastage and inefficiency of supplies and equipment; reduce corruption in the healthcare system; introduce a strong and autonomous regulatory system; ensure performance-based appointment and financing.
- Re-define quality measures, focusing on effective coverage, provision of care, outcome of care and experience of care; regularly monitor using a dashboard and use for decision-making at all levels of the health care system.
- Re-design the service delivery system in a way that ensures most services are decentralized and PHCUs are autonomous for the health services provided in their context.
- Establish and strengthen learning structures and platforms within the health system that generate, analyze, compile and disseminate available evidence for further scale-up.
- Re-orient and integrate the collaborative learning system with the existing review meetings, aided by guidance on the content and approach at all levels of the health care system.
- Integrate quality training skills in pre-service education, both in undergraduate and postgraduate health education curriculum; initiate postgraduate level quality of care program to produce experts that will support and lead quality programs across all levels of the health care system.
- Work to improve commitment; introduce a system to retain health professionals; ensure that providers are performing at the appropriate level; improve productivity; recognize best performers.
- Encourage large-scale quality initiatives across all priority areas at national and subnational levels; encourage intervention research at all levels in the health care system.
- Develop and implement actionable strategic approaches to ensure engagement of professional associations, civil society, private sector, the community and other relevant stakeholders in planning, implementation, monitoring and evaluation of the health care quality portfolio.

# Introduction

The HSTP is the health chapter of Ethiopia's second Growth and Transformation Plan as well as the first phase of "envisioning Ethiopia's path towards UHC through PHC". The goals of the HSTP are twofold: (a) improve quality and equity of health care coverage and utilization of essential health services and (b) enhance the implementation capacity of the health sector at all levels of the health system. The second strategic theme – "Excellence in Quality Assurance" – refers to managing quality and safety. It also includes a strategic objective of "Improving Access to Quality Health Services". The four agendas in the health sector transformation are: (a) Woreda Transformation; (b) Caring, Respectful and Compassionate (CRC) health professionals; (c) Information Revolution; and (d) Ensuring Quality and Equity of Health Services. (1)

The MOH developed a national healthcare quality strategy in 2016 (2016-2020). The goal of the NQS is to consistently improve the outcomes of clinical care, patient safety and patient centeredness, while increasing access and equity for all segments of the Ethiopian population by 2020. The document defines "Quality" as "comprehensive care that is measurably safe, effective, patient-centered, and uniformly delivered in a timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently (2).

The strategy is framed by three core elements of quality: quality planning, QI and quality control. The model balances the planning efforts needed to ensure strong systems, the control efforts that must be in place to ensure accountability and safety, and the bold improvement efforts needed to rapidly shift and transform performance at scale. The NQS specified five priority areas of health, and four strategic focus areas.

The five priority health areas include: (a) maternal, neonatal, and child health, specifically reducing maternal and neonatal mortality; (b) malnutrition, especially the prevention and management of severe acute malnutrition; (c) communicable diseases, particularly malaria, HIV, and TB; (d) chronic diseases prevention and management, particularly diabetes, cancer, cardiovascular diseases, mental health, and chronic respiratory diseases; and (e) clinical and surgical services, focusing on timeliness of service provision.

The four strategic focus areas include: developing an integrated approach to planning, improving and controlling quality; activating key constituencies; driving improvement in quality by explicitly linking to UHC and supporting strong data systems with feedback loops as the "backbone" of all improvement efforts. Priority interventions are listed under each strategic focus area, a total of 54 strategic interventions are identified (18 for develop; 22 for activate; seven for drive; seven for support) to focus on within the five year period.

In order to implement the prioritized interventions, three commitments for the short-term were also laid out.

1. A Quality Structure with the status equivalent to a directorate will be developed which builds on existing structures within the MOH in order to set this agenda across Quality Planning, Quality Control and QI.

2. The capacity of directors, heads and case team leaders within each MOH Directorate, FMHACA, professional associations, the HIA and the core processes of RHBs will be strengthened with the goal of becoming champions for quality.

3. Structures and learning systems capable of delivering, improving and maintaining high levels of quality will be built at each level.

The MOH developed a guide to support implementation of health service QI activities in Ethiopian health facilities – the HSTQ. It has four sections: QI Guideline; Ethiopian Quality Structure; Clinical Audit Guideline; Health Service Quality Standards. The section on QI guideline describes the principles and steps in the process of QI, outlines two approaches recommended by the MOH's Kaizen Institute and suggests a model for improvement. The next section proposes structures at each level, from MOH to the community level. The roles, responsibilities and linkages of these structures are also outlined. The third section describes the purpose, stages and steps for conducting a clinical audit. The clinical audit covers all NQS priority health areas, except nutrition. The final section in the HSTQ includes the health service quality standards for 10 thematic areas, mainly for hospital set-up. Each quality standard is divided into quality statements which in turn are divided into quality measures (3).

The MOH, through the coordination of efforts by various stakeholders, has been investing its resources in implementation of the strategic plan. This effort includes establishing quality structures at every tier of the health system, developing a number of guiding documents, conducting workshops aimed at cultivating the culture of quality, supporting implementation of quality projects at facility level (including "learning facilities") and mentoring and coaching health care professionals in quality. Four years into the implementation of this strategy, the MOH believes that it is worth conducting a review of the implementation status in order to draw important lessons from the opportunities and challenges encountered, and to document best practices. This will provide an important opportunity for collecting evidence to inform the development of the next National Heath Care Quality Strategy (2021-2025).

# Objectives

The main purpose of the review is to carry out an assessment of the National Health Care Quality Strategy (2016-2020) in order to determine the extent to which it has achieved its desired strategic objectives and to generate information and learning for the purposes of the 2021-2025 strategic plan.

**Objectives:**

- To assess performances of government commitments on effective implementation of National Health Care Quality Strategy
- To assess the performances of strategic interventions identified in the National Health Care Quality Strategy
- To generate evidences for the formulations of strategic recommendation

# Methodology/Approach

The evaluation involves both qualitative and quantitative methods. Data was mainly collected from interviews with key informants, focus group discussions and site observations. In addition, a desk review was employed to analyse and triangulate relevant documents and reports, including secondary data and statistics.

### Key Informant Interview (KII)

Interviews conducted to better understand the types of intervention implemented; what worked well and what did not work well; results and successes; challenges and lessons; and what else could have been done for effective implementation of the NQS. The relevant information from KII were collected through one-to-one meetings. Different semi-structured interview guides ('questionnaires') was developed, tailored to specific subgroups (Annex 1, attached).

Interviewees were purposively selected from: relevant directorates of MOH and federal agencies; regional, zonal and woreda health offices; public and private health facilities; training institutions; associations and implementing partners. The team at the national level selected regions to represent: agrarian, pastoralist and city administrations; various phases in the introduction of the quality strategy, and to reflect the different efforts or initiatives across the country. In this process, two agrarian (Oromia and SNNPR), one pastoralist (Somalia) and one city administration (Addis Ababa) were selected for the review. In consultation with RBHs, the same criteria were used to select one zone, one woreda, one health center and one community from each region. The same number of public hospitals, private health facilities and training institutions were selected from each of the four regions.

The consultant took the responsibility for interviewing those from federal, Oromia regional and Addis Ababa city administrations. A team of two interviewers were identified, trained in the tools, and deployed to collect data from SNNP and Somalia regions, with one team for each region.

All the groups at federal level were approached, communicated with and scheduled for possible interviews. The team managed to interview most, (90%), except for a few from implementing partners and associations. The team was also able to travel to all selected regions and interview most of the candidates, except for a few at woreda and community level. The details[ of the number of interviews conducted in each category is shown in the table below (Table 1).

Table 1: Number of interviewees by office/institutions/departments

| No. | Offices/institutions/departments | Number | |
|---|---|---|---|
| | | Offices Plan (Achievement) | Interviewees Plan (Achievement) |
| 1 | Directorates from MOH and Agencies | 13 (15) | 18 (18) |
| 2 | Regional Health Bureau | 4 (4) | 8 (7) |
| 3 | Zonal Health Department | 4 (3) | 8 (6) |
| 4 | Woreda Health Offices | 4 (3) | 8 (4) |
| 5 | Public Hospitals (General and primary) | 8 (8) | 16 (15) |
| 6 | Referral Hospitals (Pre and in-service training) | 4 (4) | 8 (11) |
| 7 | Health Centers | 4 (4) | 8 (8) |
| 8 | Health Post (Communities) | 4 (2) | 8 (4) |
| 9 | Private facilities | 12 (12) | 12 (12) |
| 10 | Associations [Professional and patient] | 5 (3) | 5 (3) |
| 11 | Implementing partners/NGOs | 5 (2) | 5 (2) |
| **Total** | | | **104 (90)** |

### Site observations

As part of interviewing key staff at each level, 16 public health facilities (12 hospitals and four health centers), 12 private health facilities and two communities/health posts were visited on site. The team kept notes of observations and best practices and collected relevant data and related documents for possible review and analysis.

### Focus group discussion

Two focus group discussions were conducted. The first was with members of technical working groups and other key stakeholders, in order to understand: the process of introduction and implementation of NQS; how the directorate and steering committee handle/perform their expected key roles and responsibilities; how new initiatives, including facility network/collaborative, were introduced in the past four years; perceptions of whether quality of services has changed or not; lessons learned and recommendations for the next NQS. The second focus group discussion was with MSGD staff in order to learn more about whether the NQS is helpful; identify reasons for not implementing most of the priority interventions; discuss the challenges and what else should have been done for effective implementation of the NQS. A total of 11 and 10 participants attended the first and second sessions respectively.

## Document review

The documents reviewed for assessing the implementation status of each strategic intervention, and the progress and trends of core indicators include: national strategic and planning documents; performance/activity, and assessment/survey reports. The desk review also included a literature review (global documents) to collect evidence, new concepts, perspectives and opportunities for possible recommendations in the next NQS.

## Review of quantitative secondary data

The quantitative section of the evaluation aimed to complement the qualitative findings by exploring the progress in quality of care improvement over the last four years of NQS implementation from a statistical standpoint. To comprehensively assess the progress in quality of care improvement, the NQS monitoring and evaluation framework was used mainly as a basis for selecting quality metrics. Moreover, indicators related to NQS interventions and existing data sources were also used as additional criteria for selection. Target and baseline performance values from the HSTP were considered for those quality indicators used in the HSTP, in order to assess progress in performance. Routine HMIS reports including ARM reports and national assessment reports such as EDHS, SARA, EmONC were the main data sources used for reviewing performance.

The findings from interviews and focus group discussion were compiled in predetermined thematic areas of the interview/discussion guide. Findings of the quantitative review were then organized by the three areas of the health care system performance (inputs and outcomes), and by the five priority areas of the NQS as depicted in the NQS monitoring and evaluation framework. Descriptive narration, tables and graphs were used to present the findings.

# Document Review

The assessment report of NQS in September 2017 (4) and the midterm review of HSTP in 2018 (5) indicates some of the progress and challenges in implementation of quality, and forwards recommendations. The progress indicated in both reports includes: improved awareness and support for quality; higher quality; structures in place at the national level and some at the regional level (including at some RHBs, hospitals and health centres); developed/revised standards and guidelines; training of over 2900 HCW and mangers from all hospitals in QI and national hospital standard guidelines; introduced and implemented special initiatives and mechanisms to address certain aspects of quality of care: SaLTS, MNH quality of care framework and improving nursing services; changes such as improved patient flow, patient satisfaction and record keeping. Some of the common challenges listed in the reports include: lack of quality specific indicators; poor functionality and readiness of health facilities; fragmentation of QA/QI interventions by different directorates; limited scale of interventions. The recommendations forwarded in the reports includes: develop and implement detailed operational plan for NQS implementation which defines roles, activities, measurements, timeline, and budget across all levels of the health system; clarify various roles across directorates/agencies; encourage patient and community demand for quality; prioritize staff satisfaction in work at the facility level and conduct staff satisfaction surveys periodically.

The result from 2018 Ethiopia Service Availability and Readiness Assessment (SARA) showed little change in overall service readiness from similar assessment in 2016. Combining information from the five general service readiness domains (basic amenities, basic equipment, standard precautions, diagnostic testing and essential medicines), the general service readiness index at the national level was 55% – implying that 55% of all HFs, excluding HPs, were ready to provide general health services (the 2016 figure was 54%). The availability of services also showed a similar trend: only 75% of the hospitals provided CEmOC services (with all nine signal functions) in 2018 compared to 73% in 2016. Overall, 17% of facilities, excluding HPs, offer ARV prescription or ARV treatment follow-up services; this result is similar with SARA 2016 findings. The availability of services for diabetes diagnosis/management has shown improvement from the 22% in 2016 to 36% in 2018 (6).

The mini 2019 EDHS result showed almost the same figure as 2016 for NMR; a drop in under five mortality and malnutrition rate, and increase in service coverage for at least four ANC and facility deliveries (Figures 1-2). The percentage of women with postnatal checks during the first two days after birth is 33.8% (7).

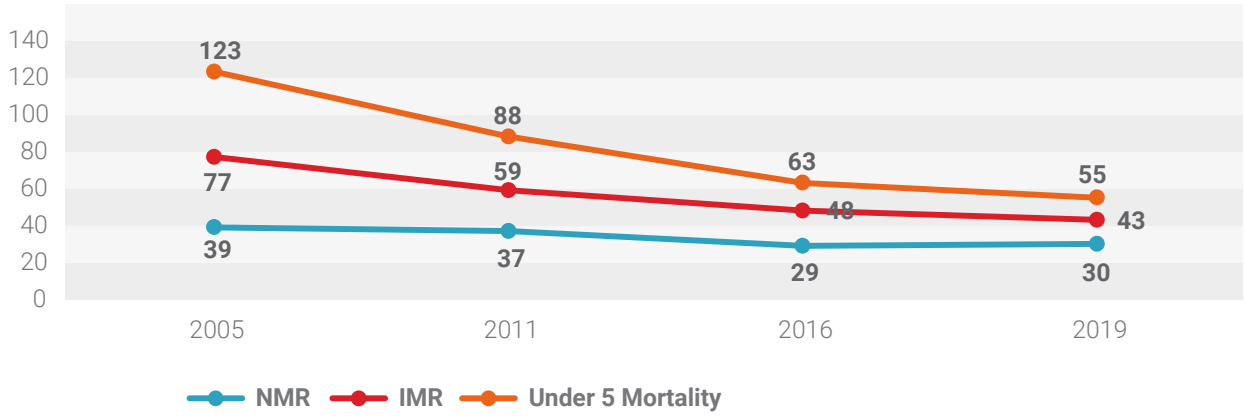


Figure 1: Progress in under five, infant and neonatal mortality rates, 2005-2019, EDHS

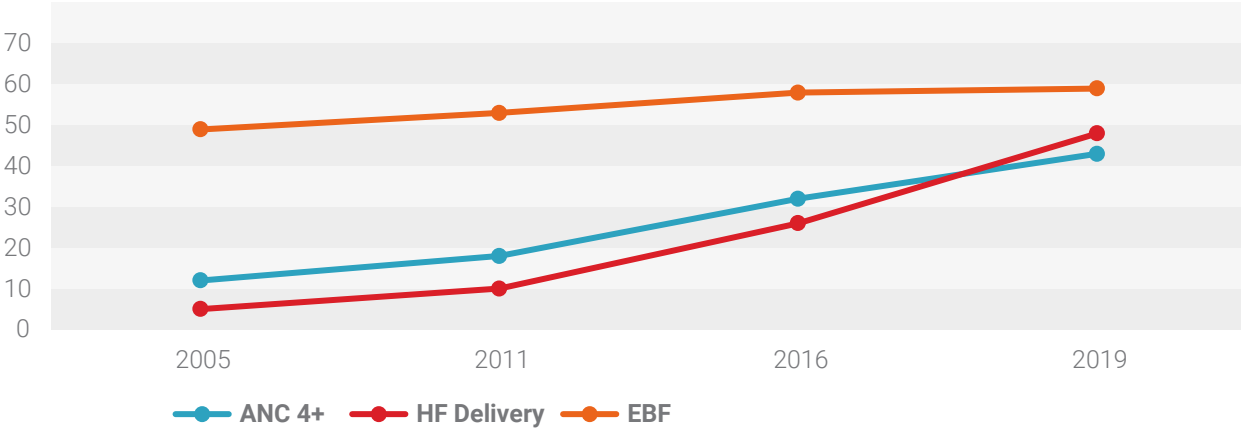


Figure 2: 4th ANC visit, skilled delivery and breast feeding practice, 2005-2019, EDHS

The concept of quality has evolved following three major global reports published in 2018. The first, "Crossing the global quality chasm: improving health care worldwide (8)", identified gaps in quality of health care globally using six quality dimensions and forwarded recommendations. The report indicated that between the availability and provision health care lies not just a gap but a chasm; and that most of the failures in the delivery of health care stems from how the system was designed and evolved. Some of the recommendations included promotion of a systems approach and a person-centered system, and suggested 13 design principles for a person-centered health system in order to: ensure accountability to health system users; improve the patient journey across the life course; build health literacy in the community; integrate and coordinate care; introduce/strengthen public private partnerships; learn and properly incorporate the informal care sector; address adverse impacts of corruption; create a culture of learning; use opportunities arising from the increase in availability of digital technologies and digital health technologies.

The second report, "Delivering high quality health services: a global imperative for UHC (9)", began by defining high quality health services and discussed the foundations for quality health care services and categories of interventions to improve them. High quality health services involve the right care at the right time; responding to the service users' needs and preferences, while minimizing harm and resource waste. The five foundational elements critical to delivering quality health care services are: health workers who are motivated and supported to provide quality care; accessible and well-equipped health care facilities; medicines, devices and other technologies which are safe in design and use; information systems which continuously monitor and drive better care; financing mechanisms that enable and encourage quality care. Seven categories of interventions stand out: changing the clinical practice of the frontline; setting standards; engaging and empowering patients, families and communities; information and education for health care workers, managers and policy-makers; use of Care Quality Improvement programmes and methods; establishing performance-based initiatives (financial and non-financial); legislation and regulation.

The third report, "Lancet High-Quality health systems in the service delivery (10)", focused on a systems approach to understanding and improving the quality of care. It defined a high-quality health system as "one that optimizes health care in a given context by consistently delivering care that improves or maintains health outcomes, by being valued and trusted by all people and responding to changing population needs". A high-quality health system is framed at three levels: impact, process of care and foundations. The quality impacts include: better health, confidence in system, and economic benefits. The process of care includes: competent care and system, and positive user experience. The foundations include: the population and their health needs and expectations; governance of health sector and partnership across sectors; platforms for care delivery; workforce numbers and skills; tools and resources, from medicine to data. The report also suggested three areas for improved measurement at the level of process of care and quality impacts: positive user experience, patient-centered outcomes and non-health effects of care. Some of the recommendations forwarded include: national investment in the foundation of high-quality health systems; health system responses based on health needs, knowledge and the preferences of people; moving beyond targeting the manifestation of poor quality towards a broader transformation of health systems.

# Findings – Qualitative

## I. Introduction and implementation of the NQS:

*[What do you think of the NQS? Are you familiar with it? How helpful was the NQS to guide and coordinate different efforts of addressing health service quality gap?)*

*Familiarity is defined/Operationalized as knowing the existence of the NQS; and used the strategy for planning and aligning purpose.*

The NQS was not communicated well within the MOH, even within the HSQD team. In regions there was no proper communication tool. The dissemination of the NQS was done mainly during the training sessions but a few regions such as SNNPR organized a launching workshop to familiarize stakeholders with the strategic document.

Over half (56%) of the interviewees from other directorates and agencies within the MOH are not familiar or of the NQS document nor familiar with NQS. Those who are aware of its existence or familiar with it are either part of the team involved in its development or attended launching or training sessions. The teams working/overseeing quality activities in almost all regional and zonal/sub-city health offices are familiar with NQS, but the level of familiarity is variable at woreda level. Woredas with partner support have a better know how than other woredas. Of the public facilities visited, most of the interviewees are familiar with the NQS but awareness differs by region and type of facility.

Of the private facilities, only those from the hospital and specialty clinics in Addis Ababa are familiar with the NQS; the average clinic in Addis and all private health facilities in the regions are not aware of the existence of NQS.

The team from professional associations is not familiar with the strategic document. The NGOs interviewed were part of the initial team in the development of the document and know the its details. Interviewees from NEP+ (HIV/AIDS association network) have information about the NQS from workshops and different consultative sessions but are not fully utilizing the document.

### Reflection

Some of the common reflections from interviewees and focus group participants include:

- The country used to have many QI initiatives, approaches and principles but most are fragmented and driven by implementing partners or donors. The NQS ensures uniformity and enables the government to lead the process.
- The NQS is inclusive of most concepts, reducing tension between different partners.
- Strategic focus, lists of priority areas, and problem solving approaches are all helpful.
- "Nothing is unnecessary but ambitious."
- The process for rolling out and implementing the strategy was not clearly articulated.
- The NQS lacks clear guidance on how to roll out quality at the community level; on approaches/strategies for learning systems, including guidance for collaborative platforms, and on how to include most of the key service/programme areas beyond the priority areas identified.
- In some areas, it is not easy to relate the categories/sub-categories of strategic focus areas with priority interventions, and with what is stated in the timeline and success indicators.

- The proposed owners for priority interventions were not properly identified or exhaustive; in some areas owners were not indicated while in a few cases owners not related to the area are included.
- The intent behind developing the HSTQ was not clear; different visions were expressed by different leaders and experts involved in the process. Most forgot the NQS and were more aware of the HSTQ.
- The scope is beyond one directorate: cross-cutting issues involving regulations, finance and day-to-day operations requires high-level coordination.
- Emphasis in recent years is more on hospital-level interventions than lower level facilities.

### Contribution

Some of the common contributions of the NQS mentioned by interviewees and focus group participants include:

- Defining the 'how' part of the HSTP; helps as a road map and framework.
- Raising awareness of, and support for, quality.
- Contributing to the establishment of quality structures across all levels.

*"Developed a mindset that quality requires a structure"*

- Providing a clear definition and concept; building capacity of staff; raising champions; developing a pool of quality advocates/ cadres.
- Advocating for data quality and use.
- Mobilizing resources and inviting key international players to the country.
- Most of those who are familiar with the document use it as a reference or guide, for example to prepare an incentive guide for data quality and use, an infection prevention guide for Tuberculosis programme, or a QI manual for Community Based Services (CHS).
- Guiding facility focus and providing concepts for the Terms of Reference of QI in Bishoftu Hospital, and a hospital quality strategy at Saint Peter.
- Helping design QI projects and facilitating networking among facilities.
- Use as communication tool with the international community, donors, regions and health facilities.

### Commitments

Commitment 1. A Quality Structure with status equivalent to a directorate will be developed which builds on existing structures within the MOH in order to set this agenda across Quality Planning, Quality Control and QI.

The focus of this commitment was the establishment of key structures at federal level and implementing five key activities.

- Establishment of Steering Committee, Technical Working Group and Quality Directorate.

Steering Committee. A steering committee was established in order to accelerate the achievement of system-wide transformational change in quality. The steering committee was comprised of representatives from key MOH directorates, regulatory bodies, and agencies established but lacks representation of key leaders from the private health sector and patient associations. In the first few years, the steering committee was strong and active, reviewing activities every six months and indicating the way forward. It discussed and decided on introduction of new initiatives;

provided overall guidance and decided on development of protocols. But in the last year the steering committee was not as strong or well functional as proposed and indicated in the document. It did not meet regularly or pass decisions. The assumption of the minster to the leadership of the committee did not happen.

> *"The steering committee functions are not also clear, competitive in few of the issues and leaving quality for HSQD".*

**Technical Working Group (TWG).** A functional health care quality TWG was organized at the national level and some of the regions had meetings on quarterly bases.

**Quality Directorate.** A Health Sector Quality Directorate (HSQD) was established with the objective of setting the quality agenda across Quality Planning, Quality Control and QI – and to drive it forward at the national level. The introduction of the quality concept, and of quality as agenda for discussion, has worked well. Quality is considered as a priority issue to receive a higher proportion of budget allocation among the directorates. However, aligning activities and communicating with other directorates proved difficult. Moreover, the HSQD has not worked well in interacting and coordinating with every directorate and relevant quality partner.

The HSQD, with support from the Steering Committee and TWG, was expected to implement the following five activities:

a. The Quality Directorate would refine the NQS through A collaborative process and develop a roadmap for change. This activity was not done. The working group – including the private sector, providers and patients – which was expected to support this process, was not established.
b. Quality Directorate will test, refine and finalize quality indicators across all levels of the health care system. Key performance indicators (KPI) have been developed and integrated after the launch of the NQS, and developed and incorporated into the DHIS2. However, the KPIs are only for hospitals and not for health centers.
c. Build learning systems for facilities to strengthen capacity and improve. A National Quality summit at has been regular over the past five years. In the past year the five largest regions (Oromia, SNNP, Tigray and Amhara) have also organized successful learning platforms publishing QI projects for experience sharing. In addition, the HSQD selected 28 health facilities (27 public hospitals and one army hospital) as learning health facilities in order to foster a quality culture. A framework/ guide was prepared, and five areas were identified to work in collaboration. In the past year, capacity building and financial support has been provided through biannual quality learning sessions. Quality oriented measures from HMIS/DHIS2 and KPI have been selected and regularly used for collaborative learning,. Similarly, a MNH learning district has been created in 14 districts and 48 facilities to facilitate collaborative learning within the district has been active since 2018.
d. Link quality with expansion of health coverage. There are efforts in the PHCD to incorporate quality along with service expansion. The directorate developed a quality training manual which can be used at the primary care level. Similarly, the HIA is in the process of developing a medical audit tool that can be used for reimbursement. Efforts have also been made to orient the HEP in the maximization program. However, still a lot remains in scaling and sustaining the quality concept at the community level to link with UHC.

e. Broadly engage with stakeholders focused on quality, e.g. Ethiopian Kaizen Institute and the National Accreditation Agency. There are efforts with the Kaizen institute in the development of the training manual however there are no document that showed engagement with ENAO. .

The establishment of similar structures at the regional level is planned, after considering the success of the HSQD at the national level, but to date no documentation of the success of the HSQD structure, or any testing at the regional level, has happened.

Commitment 2.The capacity of directors, heads and case team leaders within each MOH directorate, FMHACA, professional associations, the HIA and the core processes of RHBs will be strengthened, with the goal of becoming champions for quality.

The second commitment focuses on building quality expertise at the leadership level and creating quality champions.

- **Capacity building:** build quality expertise at leadership level
  - **Strengthening the capacity of directors, heads and case team leaders.** Only some of the directorates of the MOH, head of FMHACA and RHBs are trained. None of those from the HIA or professional associations have been trained. In recent years there have been efforts to build the capacity of those working in different directorates of the MOH but more must be done to reach staff in other directorates.
  - **Dedicated quality leads.** There are focal persons/leads for quality in most of the directorates, but few of the agencies like those for health insurance and pharmaceutical supply have a quality directorate. Some of the professional associations have a quality lead.
  - **Quarterly meeting of quality leads.** The expected quarterly meeting of quality leads to identify shared aims aligning with the NQS, share best practices and challenges did not happened as planned. However, biannual meetings with regional quality leads have occurred regularly.
- **Create quality champion**
  - In the past four years a successful effort was observed in developing quality champions and a pool of quality advocates/cadres – especially in health insurance and PFSA. But the role of quality champions in empowering others to train and work on quality was not especially visible.

Commitment 3. Quality structures and learning systems capable of delivering, improving and maintaining high levels of quality will be built at each level.

The main focus of this commitment is establishing quality structures at different levels.

*A quality directorate at the federal level and a quality unit at the regional level were established. In almost all zones, hospitals and city administrations, assignment of quality units is happening based on the approved structure. However, although the structure is approved in most woredas and HCs, assignment depends on the budget and HR availability. Except in those with a focused effort by the MOH and partners, most woredas and HCs began personnel assignment only recently.*

*"Wherever there is a structure, it is easy to rollout quality up to the lower level".*

- **Federal.** Established a HSQD with two case teams: SaLTS and QI. HSQD is reporting to the Medical Services General Directorate (MSGD).
  - The linkage, support and guidance of HSQD to federal level directorates and agencies is limited to the recent development of assessment tools, guidelines, standards and strategic documents. The overall reflection from the team across the directorates/ agencies is that communication with and guidance from HSQD is poor. Those under the same general directorates are in better position to share information, exchange ideas, plan and report together and discuss on budget allocation.

*"While working on TB infection prevention, the HSQD engaged as a member of working group".*

*"Input was expected from the HSQD in assessing health facilities and addressing issues identified but it was done without their engagement".*

*"The HIA was not invited to present its efforts at the quality summit; did not leverage the reach and structure of the HIA well. Communication of HIA with HSQD started only in the last few months".*

- Regions reflected a good working relationship with the HSQD in areas of training; provision of technical and financial support; conducting joint supervision, and participation in collaborative learning and experience sharing visits.
- Linkage of HSQD with professional associations and NGOs working on the QI project is limited. They are mainly working with respective programme directorates more than with the HSQD.
- **Regions.** Quality units were established at the regional level with current staffing ranging from three to six staff. The quality unit at regional level supported by the TWG is responsible for coordinating QI interventions by working closely with the respective team, in most cases leading QI activities. The regional team in Addis Ababa is mainly engaged in supporting hospital level QI activities.
- **Zone/sub-city.** A quality case team was established in most of the zones/sub-cities with two to four staff members.
- **Woreda.** Assignment of staff working on quality at woreda level is slow. In most of the regions one to two focal persons are assigned to work on quality at woreda level but there is no woreda level structure yet in Addis Ababa.
- **Public Hospital.** The structure differs from region to region and between level of hospitals. In Oromia, Somalia and SNNPR, most of the hospitals have a quality and clinical governance unit headed by a General Practitioner (GP) and with two to six staff, depending on hospital capacity (in most cases three). A similar structure is observed in three of the hospitals (St Peter, Yekatit 12 and Zewditu) visited in Addis Ababa. A Clinical Governance and Quality Directorate with 11 to 14 full time multidisciplinary staff. Most of the hospitals have a quality committee and department level QIT. In addition, hospitals in Addis Ababa have a Quality Council and a Quality Supervision and Mentoring Team.

- The hospital team regularly works on Health Services Transformation Guide (HSTG), HSTQ, Hospital Performance Monitoring Indicators (HPMI) and key KPIs; and also on other national QI initiatives.
- In most hospitals, the quality committee is responsible for clinical audits, gap identification and proposing a QI) project for specific QIT.
- The Quality Supervision and Mentoring Team (QSMT) in Addis Ababa hospitals oversee activities during the duty hours; address administrative issues; undertake duty attendances; assess incidents; regularly meet, list and solve problems. The QSMT prepares reports using a format designed for this purpose by the hospital and posted on a Telegram dashboard available for users/members of the hospital Telegram.

- **Public Health Center.** In almost all HCs a quality committee is formed with a focal person assigned from team members. The HCs have both a Performance Monitoring Team (PMT) and a QIT that works to improve quality and performance and, in most cases, the PMT functions as a QIT.

  *"Though the HC reform requires a committee to work on quality, in most cases it's not functional."*

- **Community.** Multiple activities have been performed to engage the community through the town hall meetings and implementation of community scorecard. However these strategies were well coordinated in those communities with partners support, community engagement in facility-level efforts is limited.

- **Private Health Facilities.** The structure varies by the level of the facility and by region. Almost all of the private hospitals have either a committee or unit working on quality of services in the facility. All the others, specialty and average clinics, do not have a formal structure responsible for quality. The manager – in most cases the owner – of the facility takes responsibility for ensuring standards are met and different guidelines/protocols of the facility are properly implemented.

## Strategic focus areas and priority interventions

**Strategic focus area 1:** Develop an integrated approach to planning, improving and controlling quality.

Overall, a lot remains to make quality planning, QI and quality control activities integral parts of all levels of the health care system.

**Prioritized interventions:**

1.1. Refine and institutionalize quality control mechanisms to ensure minimum standards of safety and quality are met.

- Enforcement of all set standards
  - Most of the gap analysis and action plan in relation to regulatory standards is done at the facility but not at the regional or national level.
  - No systematic support for facilities who fail accreditation/empanelment, or support for private facilities to improve quality.
  - Enforcement when facilities do not meet minimum guidelines and standards is present for private facilities, with almost none with the public facilities except with respect to adhering to protocols.
  -

- Monetary incentives for public facilities who exceed the minimum standard of those administration and clinical processes (HSTG and HSTQ), but not with regard to the regulatory standards.
- Some efforts observed in building a system of governance and accountability around meeting regulation standards.

- Development and execution of clinical standards for each type of service
  - No harmonization yet between MOH/MSGD and FMHACA standards, but efforts continue for developing and introducing different clinical protocols and guidelines and to ensure adherence by introducing clinical governance.

The standard requirements from regulatory bodies (FMHACA) indicate the minimum requirements of each level of health facilities, public and private, in terms of governance; patient rights and experience; HR management, services, and the physical quality of the facility. The service standard relates to practices, premises, professionals and products. The MOH/MSGD standards (HSTG and HSTQ) introduced in the last few years is mainly for public facilities at hospital level. The HSTG outlines the administrative processes for patients to access specific care in the facility departments and is being implemented in almost all hospitals in Ethiopia. Focusing on selected leadership and clinical functions, it sets a basis for quality management and guides the establishment of clinical governance and QI structures in the facilities. The HSTQ standards focus on clinical processes and the last sections include the health service quality standards for 10 thematic areas.

### 1.2. Launch nationwide results-focused QI initiatives focused on system transformation

- Build on EHAQ initiative
  - Capacity building/training was given to different groups of service providers at different levels but the participation of staff working in the laboratory and pharmacy was limited. Capacity building ranges from three days of basic training to attending an improvement advisor course. There was no adequate effort to improve the management skills of health care leaders, nor any systematic approach to improving the performance management system.
  - EHAQ/EPAQ facilitates support of lead facility to member facility. The number of clusters and hospitals participating in EHAQ increased and also includes HCs, but, in most cases, the goal of shared learning and working on defined shared aims was not observed. There was no proper coordination within the EHAQ to decide on the introduction of new and packaging and scaling up of existing improvement areas. Moreover, the learning platform has no guide to lead. Efforts to introduce new improvement areas in the EHAQ are limited. The experience has not yet expanded to establish a network of laboratory, pharmacy or private health facilities.

- Implement QI initiatives for priority health conditions and diseases
  - Implementation of QI initiatives in almost all of the priority areas either by MOH or partners. The use of a collaborative model between groups of facilities, for the purposes of peer learning, was implemented in a few of the priority areas. The national-level large-scale initiative includes the SaLT initiative and MNH QOC, and small-scale improvement initiatives included TB and HIV. However, in the area of non-communicable and nutrition

programme, improvement initiatives have been limited to partner project sites.
- There was no large-scale QI that focused on improving primary care, linked with health insurance at community or woreda level.
- Continuity of care with an improved referral system was observed at different levels of public facilities but not among private facilities or private to/from public facilities.

### 1.3. Strengthen quality planning throughout system to ensure adequate inputs for quality supplies and support planning more broadly

- Consistent quality planning
  - Not much in terms of developing process design or identifying clients' needs.
  - The causes of quality related issues were identified and analyzed in different ways, but capturing and integrating lessons learned with future plans was limited.
- Ensure availability
  - Different efforts exist to ensure availability of necessary and appropriate equipment, medicines and reagents.
- Improving capacity of equipment maintenance
  - Efforts includes: ensuring basic spare parts maintenance; maintenance workshop toolkit, at facility level; training maintenance professionals at degree level; outsourcing high tech, big equipment to relevant company; adapting a business model for 10 identified items.
- Use of data
  - Efforts/systems exist for using data to track supplies needed and mitigate against stock outs.

**Strategic focus area 2:** Activate key constituencies to advance quality

The different activities introduced to engage leaders and improve their knowledge and understanding work well. The effort to motivate providers and integrate training in QI skills in pre-service education is limited. There are different efforts underway to activate patient and community demand for quality services in sites using community scorecards, but very little has been done in provision of patient-centered care.

**Prioritized interventions:**

### 2.1. Develop, strength and motivate workforce towards continual achievement of safe and equitable care

- Motivate health professionals

There is no incentive strategy and the content of incentive packages in the NQS is limited. The incentive approach is geared more towards facility than provider, and there is not much in terms of aligning incentives and motivating staff. In most cases, providers are not satisfied with their job. The reasons could be related to: a lack of proper recognition and motivation, including financial; not using providers' knowledge and skill effectively; too much focus on CRC and quality without relating it to the wider social system; general change in the social value of the profession.

There is limited capacity within the professional association and limited effort to work for members/ providers rights. Most efforts are

project-based, and orientation or sharing information takes place at annual conferences. The Ethiopian Midwives Association is active in: reflecting providers' perspectives (midwives) in curriculum development; discussing/ lobbying for revision of standards for the number of midwives required in relation to the competency level; discussion and follow-up regarding the career structure of members attending different levels of education within the civil service commission.

- Pre-service and continuing medical education

Some of the professional associations and higher facilities include teaching in QI skills within their continued medical education, but the integration with pre-service education varies from institution to institution, from simple orientation/training of instructors to full integration. The training in QI skills is not yet linked to Continued Professional Development (CPD). The skill labs for building clinical skills are available in teaching facilities, and a few hospitals.

Among the visited hospitals with medical colleges, quality is integrated into postgraduate studies at Yekatit 12. There are efforts underway in Adama Hospital to integrate quality into the preservice medical education programm.

## 2.2. Build leadership which sees quality as a priority, across all levels of the health system

- Develop common understanding and vision among leaders
  - Efforts to develop common understanding and vision for quality among leadership is reflected in better support, putting it on the agenda for discussion and in the central allocation of resources.
  - Conducted successful annual quality summit. Annual quality summit facilitated sharing of local knowledge at the national level. This is replicated in some of the regions such as Amhara, Oromia, SNNP and Tigray.

- Increase knowledge of leaders
  - Training on quality has been provided to most leaders at federal and regional level, including training in "Leadership for Quality".
  - In most hospitals, clinical governance and QI are managed under one unit/ directorate at hospital level and are led by GP.

## 2.3. Activate patient and community demand for accessible and equitable quality services

- Engagement of Health Development Army (HDA)
  - Except in a few sites with partner support, engagement of HDAs in QI activities has not occurred.
  - Community scorecards at community level and at town hall meetings in hospital has been in use as part of community engagement for quality. There are also efforts in the health insurance scheme and partners programme to establish a forum at the health facility and within the administrative structure to discuss quality-related issues.

A community scorecard is a community-led governance tool which brings PHC facilities, local government structures and the community together to promote accountability and responsiveness to community needs. The implementation of community scorecards involves six steps and selected five indicators for scoring health facilities services. It is now being implemented in more than 600 woredas.

- Patient feedback
  - Most of the facilities, including private facilities, have a means to collect patient feedback but have not yet developed a uniform approach for acting on the feedback.

- Patient rights charter and grievance handling mechanism
  - Although it is part of the standards, only few facilities have implemented a patient rights charter or grievance handling mechanisms.

- Patients' access to information and clear communication with provider and facility
  - Except for few efforts within child health programmes, such as open house events at the HP level, there is no means for sharing information about service availability or proper communication mechanisms with provider and facility

- Community endorsement groups
  - Community forums are being conducted at all levels to assess areas that impact quality
  - Collaboration between community and facility with intention to build local pride in health care units is very limited
  - Except for a few facilities in which there is work underway with the community and patients in order to mobilize resources and build ownership of local health facilities, most of the work relates to community mobilization for education and outreach health services.

### 2.4. Hand-in-hand with encouraging patient demand for quality, provide patient-centered care across the health care system in order to be responsive of individual patient needs

- Chronic patient care
  - Chronic patient-centric care is not yet integrated across different level of facilities or among providers.
  - Except for a few corners of teaching hospitals and some of the private hospitals, no electronic medical recording system is used for patient care.

- Future health demands of individuals
  - There is no discussion around the future health demands of individuals or any established health literacy units in the facilities.

- Care of patients by team of individuals
  - Except the experience of few facilities, including in the private sector and among focused care (HIV/AIDS and victim of gender-based violence), experience of giving care to patients with a team of individuals in order to address different needs is non-existent.

**Strategic focus area 3:** Drive improvement in quality by explicitly linking UHC strategy with quality.

Linkage with HIA has not happened yet. The health insurance scheme needs to be linked to the quality of service provision.

*"Of the four strategic focus areas, very little is achieved/done in the third pillar".*

**Prioritized interventions:**

3.1. While expanding health insurance scheme coverage across all regions, link empanelment of facilities to quality

- Link quality with empanelment of facilities
  - No facility grading on quality or quality guidelines available to link with empanelment of facilities in the national health insurance scheme.

3.2. Develop performance agreements with facilities and the HIA which include quality and improvement

- Utilize funds for QI.
  - The HIA has performance agreements with facilities which include quality and improvement in anticipation for empanelment. Over 2,000 facilities are reported to have MOUs with the HIA. Except for a few gaps filling supplies and loans for drug purchases, there are no reports of utilizing funds for quality improvement.
  - As part of the initial effort in the health care financing strategy, facilities retain revenue within the facility and use it for different purposes, including QI activities.

3.3. Use Kaizen approaches to improve flow and efficiency in clinics and hospitals, decrease waiting times and improve hospital support services

- Use of flow principles
  - Use of Kaizen approaches and model for improvement is reported in only a few hospitals.
  - Improvement effort reported in some facilities in areas of decreasing outpatient waiting times (one of the indicators in the community scorecard), but not much sign of increasing inpatient loads except for the efforts in the SaLT initiative (surgery).
- Eliminate waste through lean approaches
  - Lean approaches are not used in the health system.
- Collaborative learning to improve flow.
  - Collaborative learning sessions have been organized for experience sharing within the EHAQ platform. Some hospitals have also been recognized not only for flow improvement but also for overall hospital performance assessed using EHSTG assessment tool.

3.4. Introduce financing strategies consisting of both incentives and penalties (including demand-side financing) as a complement to approaches described above

- Use of incentive and penalties financing strategies
  - No financing strategies introduced to incentivize or penalize facilities. However, there are effort by the HIA to cease reimbursing facilities which fail to meet minimum standards.

**Strategic focus area 4:** Support strong data systems and feedback loops as "backbone" of all improvement actions

Some efforts have been observed to expand the use of data for improvement and decisions informed by data, but these have not yet been institutionalized.

**Prioritized interventions:**

4.1. Develop a reliable and transparent reporting system for key indicators which continuously informs planners, providers and the public about the quality of the Ethiopian health care system

- Dashboards
  - No dashboard for different administrative levels of selected priorities has yet been developed. There are a few efforts in some facilities and partner supported areas, including at the national level.
- Quality indicators
  - KPIs have been developed and incorporated into the routine reporting system. However, most of these are hospital-level indicators and not sufficient for measuring programmes and the community quality of care. There are also too many for the facility to selectively use for QI.
- Use of data for decision-making
  - Efforts exist to use data for decision-making from the routine reporting introduced by different programmes, but overall intervention is needed to maximize the impact .

4.2. Utilize data to inform QI opportunities as health insurance coverage and increase access

- The HIA and different health programmes use data as opportunities for QI activities to improve coverage and access of services. Gaps are still observed in use of data for QI, and more work is needed on this.

4.3. Strengthen the capacity of health care facilities so they are capable of identifying and prioritizing local-level data use, including data generated from registers, patient chart audits and administrative data

- Efforts are underway in some of the facilities with the close follow-up of federal or regional offices, and those facilities participating in EHAQ/EHIAQ or partners supported programmes.

4.4. Ensure two-way data feedback loop so that local facilities receive information to improve; "supportive supervision" (e.g. benchmarking, regional/national trends, etc.)

- Feedback to respective facilities has improved, as part of strengthening the referral system and supportive supervision.

4.5. Incorporate principles of QI and data use within each priority programme area in order to achieve its aims

- Some weak efforts to incorporate principles of QI and data use in priority programme areas are underway.

Overall, 41 (75.9%) of the 54 priority interventions are either fully (16.7%) or partially (59.3%) implemented. The remaining 13 (24.1%) are not yet initiated or implemented. The least performed area is the third strategic focus area – linkage with HIA (Table 4).

Table 2: Implementation status of priority interventions by strategic objectives, 2020

| Strategic focus areas | # of interventions | # (%) of intervention with implementation status | | |
|---|---|---|---|---|
| | | Implemented | Initiated [partially implemented] | Not yet implemented |
| SO 1: Develop an integrated approach to planning, improving, and controlling quality | 18 | 4 (22.2%) | 11 (61.1%) | 3 (16.7%) |
| SO 2: Activate key constituencies to advance quality | 22 | 4(18%) | 14 (64%) | 4 (18%) |
| SO 3: Drive improvement in quality by explicitly linking UHC strategy with quality | 7 | 1(14.3%) | 2 (28.6%) | 4 (57.1%) |
| SO 4: Support strong data systems and feedback loops as "backbone" of all improvement actions | 7 | 0 | 5 (71.4%) | 2 (28.6%) |
| **Total** | **54** | **9 (16.6%)** | **32 (59.3%)** | **13 (24.1%)** |

**Reasons for low performance of some of the interventions:**

Common reasons for not implementing most of the priority interventions include:

- Difficult to understand NQS content; lacks clarity in priority interventions; not clear how to integrate or implement the intervention and the proposed quality structures and responsibilities.
- Not having implementation guide; no clear guidance in how to operationalize the interventions.
- Unclear how to rollout and implement the strategy properly.
- No sustained leadership commitment to ensure establishment of structures at different levels and to allocate budget in the early phases.
- Lack of quality culture: failure to address issues holistically, or by focusing on a system, inhibits efforts to create quality culture.

*"Interventions are not systematically implemented rather led by development of QI projects".*

- In recent years the steering committee was not strong or fully functional as proposed in the document. Initially it was chaired by the vice-minister but this was later interrupted.
- The scope of the HSQD and quality structures at different levels was not clearly defined; most do not know what to do.
- Problems staffing the HSQD: requirements for each position were not indicated; recruitment was done badly. Most did not have the potential or capacity for the assignment and no staff had experience of working on QI or leading QI projects. Incompetence in many QI skills among HSQD staffs, and limited capacity to coordinate the NQS, was also widespread.
- Weak coordination and collaboration with related directorates and agencies of the MOH.
- Change in leadership and high turnover of staff in the HSQD.

- Inappropriate working culture within the HSQD; mainly focused on routine activities rather than strategic issues.
- Problems with community-level interventions: NQS does not clearly show how to reach the community level, and the assumption that the regions would take the lead in this was wrong.
- Woreda-based planning was not harnessed properly, and team members were not clear or capable enough to integrate the NQS into the planning process.
- Absence of clear coordination mechanisms and plan alignment among different directorates within MOH, other sectors and partners.
- EHAQ and hospital reforms are under clinical directorates, whose platforms are difficult to use.
- The efforts of the HSQD and the HIA were not coordinated well. The initial focus of the HSQD was at the hospital level while the HIA focused on the PHCU level.
- The three core elements (quality planning, improvement and control) seem poorly understood and attention varies at different levels. The effort to develop and introduce standards, guidelines and tools took up most attention in the recent years.
- Initial training of too many participants in one session for three to five days was ineffective, tending more towards developing cadres than capable individuals.
- Transfer of responsibilities to regions was flawed: activities started at the hospital level without proper engagement of the regions from the outset.

*"Federal direct involvement at the hospital level at the beginning, and then trying to transfer the activities to RHBs was not easy, and had poor oversight. It could have gone through regions from the very beginning".*

- Limited capacity and contributions of most of the professional association to work for members/ providers' rights and influence related policies.
- Lack of proper monitoring mechanisms assess progress in NQS implementation.
- Scale-up and spread strategy was flawed: gaps were observed in documenting lessons/best practices, and in packaging and disseminating for wider use.

*"Though successes and best practices are observed at facility level, these efforts are not properly compiled and disseminated or scaled-up to others. Needs a web-based platform to collect these successes and to develop a change package for others to use it."*

## II. Efforts or new initiatives introduced to improve health services quality:

### Ensuring minimum facility requirements – standards

The Ethiopian Standard Agency develops standards related to product and services while the MOH works on health workers standard. One of the role of the Health and Health Related Regulatory (HHRR) Directorate in the MOH is health facility regulation of all categories at the national level. The directorate follows up on the level of standard for each category of health facility, and maintains the minimum level for health workers, health facilities, equipment and service delivery.

Private facilities collaborate with regulatory bodies at different level sfor assessment and for taking action on comments provided and gaps identified. They are visited by regulatory bodies, submit reports regularly and have good relations and healthy communications. They also participate in standard development but are not sure of whether their concerns are being heard.

*"The push from the regulatory bodies to close the previous structure encourages us to have a better facility and do a better job."*

- Development, introduction and implementation of standards, guidelines and indicators:
  - HSTG, HSTQ, HPMI and KPI for hospital level.

The hospital reform was supplemented by the introduction of KPIs for hospitals. Currently there are a total of 41 KPIs. The hospital performance monitoring and improvement manual (HPMI) includes 26 KPIs to oversee the hospital operations, while 15 KPIs are integrated into the revised HMIS indicators reference guide.

- Maternal and child health standard assessment tool for hospitals.
- HC reform implementation guide and KPI for HC level.

The purpose of the HC reform implementation guideline is to ensure: services provided by all public HCs are accessible, with equity and high quality; user satisfaction; sustainability; HCs perform well in terms of leadership and service delivery. The guideline is organized according to the 10 essential HC management agendas. The reform guide is now being implemented in most of the HCs. The KPI for health centers includes a list of 29 indicators. Of these, only 18 are included in the HC reform.

- Maternal and child health standard assessment tool for HCs.
- Ethiopian PHC Clinical Guidelines (EPHCG) and clinical record audit guideline for PHC facilities.

The EPHCG is a guide for the primary care of older children and adults. It is an integrated symptom-based algorithmic approach to address the common presenting symptoms and priority chronic conditions in the country. The guidelines provides basic management principles to deal with these diseases at HC level in an integrated user-friendly way to support health workers to provide care which is evidence-informed, compliant with local guidelines, comprehensive, compassionate and respectful. The guidelines are now being implemented in over 400 HCs.

- Development, introduction and implementation of programme/service focus quality strategy
  - National Maternal and Newborn Quality of Care Roadmap (2017/18-2019/20). A detailed roadmap indicating the goal, strategic objectives, activities and budget is developed for maternal and newborn quality of care.
  - Roadmap for Anesthesia Care in Ethiopia 2016/7-2020/1. The roadmap was prepared to guide efforts to ensure safe delivery of essential and emergency surgical and anesthesia services in the country.
  - Adopted the section from the NQS/HSTQ and developed, printed and distributed a pocket-size HIV/AIDS QI strategy.
  - A three-year QI and transition plan for iCCM/CBNC – iCMNCI
  - Revisited the national mental health strategy with a new concept of quality rights, using the WHO quality rights tool. The focus for service is not only quality but also on rights.
  - Prepared QI manual for Community-Based Services (CHS).

- Ongoing efforts in Maternal and Newborn Health
  - Maternal and perinatal death review.
  - Introduced catchment-based mentorship, where a trained mentor provides on-site mentorship for five days per month: tertiary to general hospitals; general to primary hospitals; all hospitals to their respective HCs; HCs to their catchment HPs. The focus is on improving the skills and knowledge of health workers.

- Efforts in HIV/AIDS and TB
  - The efforts on HIV/AIDS are organized around '3-90'. The first is case detection (90% of expected cases will have HIV test); the second is about treatment (of those tested and positive, 90% will be on care and treatment); the third is viral suppression (of those who started care and treatment, 90% will have viral suppression report below 1,000). Different initiatives and QI projects for gaps identified around each group are implemented.
  - TB and HIV collaborative testing: TB for HIV test and HIV for TB screening and prophylaxis.
  - TB laboratory. Established a network of 185 external quality assurance sites. AFB samples are collected every three months and tested, with results of 97% similarity.

- Efforts related to Non-Communicable Diseases (NCD), including mental health.
  - The NCD case team oversees programmes on: diabetes; hypertension; cancer (breast and cervical); COPD; RHD; chronic eye problems (cataract, glaucoma and refractive error).
  - Improve treatment access and quality of services at health centers and hospitals, especially for diabetes and hypertension. Improving quality of services through training and follow-up, and provide drugs with reasonable costs.
  - Increase access to facilities with cervical cancer screening and established cancer treatment centers in five teaching hospitals.

- Improve access to mental health services, expand the service – application of WHO programme
  - Devolve services to PHC level and mid-level professionals.
  - Phased introduction; first phase to 100 HCs.
  - Ensure continuity of care. Only 25% of hospitals are providing the service. Used a phased approach to enroll hospitals, introduce the interventions.
  - Integration with other programmes: HIV, TB and other NCD

- Improving clinical and surgical services
  - SaLTS - saving lives through safe surgery: increase productivity of surgery; reduce waiting list; introduction and use of WHO safe surgical checklist; improve OR function/efficiency; reducing surgical site infections; initiation of surgical services in primary hospitals.
  - Emergency and critical care: improving access and quality for emergency, burn, trauma and poisoning care.

- Efforts/initiatives to improve availability and quality of pharmaceutical and medical equipment:
  - Pharmaceutical and Medical Equipment's Directorate's efforts/ initiatives:

- Auditable Pharmacy Transaction and Services (APTS): locally developed initiative; started in a few facilities [1] and scaled up to a large number of facilities [150] in three years. Developed change packages by selecting facilities with areas where they show evidence of improvement. A training manual and guide is developed for others to use.
- Drug dispensing procedure for in-patient: purchasing whole prescription at the same time or on a daily bases to avoid wastage and financial loss by patient during change of management.
- Community pharmacy, within or outside the public facility, with limited distance. The purpose is to improve access and address the financial vulnerabilities of the patient.

- Efforts of Ethiopian Pharmaceutical Supply Agency (EPSA):
  - Introduce and implement quality management system according to the ISO standards (ISO 9001/2015).
  - Use WHO guide to tackle counterfeit drugs. Identified ten drugs and designed a strategy to assess their quality. Means to control quality include on-site inspection, collecting public complaints from a web site or free telephone call at 8772.
  - Customize WHO standard of good storage and distribution practice and periodically audit its proper implementation.
  - Business Process Transformation (BPT). Identify issues of redundancy in the process and work on improving the system.

- Improve data quality and management
  - Data quality assurance mechanisms, part of data quality guideline. Use RDQA/DQR, LQAS, and in-depth review of regions report.
  - Simplification – used to be multiple parallel systems, but with HMIS reform only key data elements and limited tools are included. The revision of indicators addressed issues of excess, lack of standardization and lack of definition.
  - Digitalization – improved some of the domains, including elements of data quality like timelines, backup, etc. Introduced in-built system to ensure quality like in DHIS2, checking the inconsistencies, validation and trend analysis.

Most of the national-level initiatives are implemented in the public health facilities, such as: CASH (clean and safe hospital initiative); patient safety – WHO patient safety approach; pain-free hospitals

- Pain-free initiative standard; nursing care services. Some of the specific initiatives observed in the public health facilities visited include: improved data management at Saint Peter, Yekatit 12 and Zewditu Hospitals; card room intervention at Yekatit 12 and Zewditu hospitals; work on inpatient medical record completeness and partograph utilization in Bishoftu General Hospital.

- Collaborative learning/networking
  - Ethiopian Hospital Alliance for Quality (EHAQ). Hospitals are participating either as lead or member hospitals in the EHAQ. The alliance works on different focus areas in three phases. The first phase focus on CASH; the second on maternal death, and the third on pain-free and SaLT. The number of clusters

increases over the different phases: for instance, in Oromia the number of clusters increased from three in the first phase to 16 in the third phase. Cluster-level meetings take place to present, share and discuss issues, but the approach and function of the alliances (e.g. lead versus member), appears different in Addis Ababa and other regions.

- The hospitals in Addis Ababa form a network and learn from improvement areas assigned from the EHAQ or individual facility-level QI projects. The hospitals alternatively host meetings and bench marking visit among the network. The network of six hospitals in Addis Ababa meet with the MOH every two weeks to discuss different issues.
- The EHAQ in regions other than Addis Ababa focus on on-site support of member hospitals by lead hospital. The support of lead to member hospital includes: assessing standards, identifying gaps and acting, including transfer of experience; on-job training; initiation of services, like surgery.

*"The EHAQ function better in rural areas where one is dependent on the other. It's difficult in Addis Ababa where most are focusing on their own issues".*

- A network for collaborative learning on the MNCH quality of care is established nationally and this network is further linked to the WHO-led global alliance for quality, equity and dignity in health care of mothers and their children. A total of 48 facilities are participating in the MNH quality of care collaborative. This district/woreda level collaborative on MNH seems to work well. It involves primary hospital, HCs and district health offices. If a lead hospital (general or referral) other than the primary hospital happens to be present in the selected learning district, it is also included in the network.

  Most of the partners are adapting a collaborative QI approach to work on different programme areas, mainly at the HC level. The programme areas include HIV/AIDS, MNH. NICU, child health, family planning and others. The collaborative platforms vary for different programmes. The gaps observed include not using the capacity built within the facility and the experience to expand and reach other programme/ service areas beyond the collaborative focus of the facility.

### III. Perception of Change/Result: (Change in quality of health services)

- Change in the introduction and implementation of new initiatives.

  *"Before the NQS, initiatives used to be all or none (covering most of the areas/ campaign) but after the NQS, there was more thought for learning, demonstration and testing of new interventions".*

- Better awareness, improved QI knowledge and skills observed. Observed better capacity, commitment and effort at the facility level, especially in those sites supported by partners.
- Improvement in performance of fulfilling standards at hospital and HC level.
- In facilities reached by the APTS initiative: improved efficiency, availability of commodities, transparency, workflow and client satisfaction reported.
- A clinical audit introduced and implemented in the CBHI scheme resulted in improvement of service quality in facilities where there is a responsible manager/leadership.

- Introduction and use of checklist (safe childbirth, safe surgical) improves the quality of services.
- Creating a clean environment following introduction and implementation of CASH initiative.
- Improved surgical services: ensuring surgical safety; addressing surgical site infections; backlog clearance of surgical patients.
- Improved pain assessment and management.
- Improve service access and use for NCD, as with hypertension and cervical cancer.
- The diagnostic quality and care for TB patients improved in recent years. The Gen xpert machine reached 313 facilities and expansion of TB culture from one to ten facilities
- Improvement also observed in facility structure and number of providers.

Improvement in data quality occurred, especially at higher levels, through better data management and accuracy/verification using RDQA/DQR. The data quality is still poor at lower levels, because of false reporting and limited/low capacity.

Overall, however, improvement is not yet observed in service delivery. A review of records from surveys showed: patient satisfaction remains poor; skill and competence of health workers is deteriorating; poor attitude of health workers is widespread; drugs are not easily available; lack of equipment; poor set-up of services.

## IV. Good Practices:

- Sharing and distributing responsibilities by departments among quality team members and working equally in the duty hours and reporting to the CEO/Provost in Addis Ababa hospitals.
- Different platforms created to introduce quality culture: Telegram to share information on status of reform, standard and quality; quiz to motivate staff to read at Saint Peter hospital.
- Learning from pilot HCs and scale up to others in order to improve access for psychiatry services and care for patients with NCD in Addis Ababa.
- Demonstration center organized in the delivery room of woreda 3 HC in Addis Ababa, in order to train newly employed staff by senior midwives, successfully improved and maintained quality of delivery services.
- Integrated one-stop center, clinical care services and support from justice and police for women victims of gender-based violence in SNNPR.
- Collaboration of HCs with hospitals in order to initiate and improve provision of minor surgery through on-job training of staff at hospital level, as part of EHIAQ.
- Use of checklist for home-to-home visits by health workers, mainly for screening and referral of TB. In a few sites, sputum is taken, stored and transported properly (with vaccine carrier) to HCs for diagnosis.
- Linking and working with private sector, Public Private Mix (PPM), on provision of services for TB patients. Working with 525 private health facilities in screening and diagnosis, and treatment and referral. The facilities are supported with training and supply of diagnostic, reagents and drugs.
- Introduce low-cost ultrasound services in some of the HCs in Addis Ababa through special arrangement with a radiologist to work on call and collect 30% of the earning and the remaining 70% as income for HC.
- Improve access to dialysis machine through Private-Public Partnerships in service provision in Somali region.

## V. Lessons:

- Organization and delivery of quality health services needs good leadership and support. Leadership support and commitment contributes to the success of QI projects.
- Active involvement of senior leadership can effect major change.
- Questions from clients about service quality encourages the facility to work harder and respond to their needs. Community engagement improves accountability of providers.
- Provider-level effort should be linked with input, addressing gaps in infrastructure and supplies. The health facilities need to have proper/appropriate structures, and there needs to be appropriate financing of the health sector.

*"Quality needs effort and resources. Service without quality is costly. Cheap is expensive. We need to invest, if we would like to have quality".*

- Improving internal processes is important; for instance, internal audits in the finance department.
- Redesigning processes and systems is key to faster and better performance.
- Simplified and elaborated guides and instructions facilitate its use. Simplification of indicators, manuals and systems is important for success.
- Incentive and disincentive mechanisms encourage facilities and providers to deliver quality services.
- Needs to have a champion to demonstrate result.
- Organizing strong coaching visits is important.
- People who are supported are more willing to improve.
- Experience sharing visits and learning sessions motivate staff to read, learn from others and become active members even without proper in-service training on basic QI.
- "Quality is a skill and needs to be developed through experience, not only by training".
- Preparation is important for effective collaboration: clearly define the objectives, practices, structures, etc. It also needs a dedicated person and governance structure.
- Establishing a quality structure can make a significant difference.

"Establishment of quality unit at department levels helps to gain more change than we estimate during the planning phase".

## VI. Next NQS:

### Existing NQS document

- Build on the existing NQS: continue with existing strategic focus; describe priority interventions/ activities in the operational document; differentiate between interventions implemented and those which have not; implement the remaining interventions.

### Process for next NQS

- Vision for long term, beyond five years.
- NQS development needs broad engagement and high-level leadership of the process. Participation will be limited if it is led by the HSQD, so should extend beyond it.
- Establish a strong technical team and ensure involvement of many stakeholders, including from the private sector, in order to work on the development of the next NQS.
- Create and ensure ownership of the NQS in the health sector by facilitating the participation of key directorates of high priority areas and representation of the right people.

- Conduct a thorough situational analysis and stakeholder mapping and engagement. Need to have a detailed/strong situational analysis that documents learning from the first phase of NQS; identifies lessons, limitations and strengths, and builds on pre-established initiatives. Consider also the experience of care in relation to the effort on CRC, linking quality with CRC.
- Start with public dialogue; identify and address public issues, and establish a culture to address the public issues of concern.
- Synthesize the lessons and the limitations of different learning platforms and develop/ adapt national guidance on the type, level, structure and management of collaborative learning.

**Content for next NQS**

- The existing NQS could be used as a guide or reference for content.
- Simplified content, which is easy to understand and communicate, and which reflects the local context; printed and distributed in a simple form.
- Adapt the national document to respective the directorates and for each level. Prepare a section in a form of module to share with different directorates and define a scope for each level, region to health facility.
- Improve the quality of services included in the Health Extension Programme; properly address the community element. Simple and precise community-level references.
- Align with other directorates efforts/ strategies; review other strategies; reflect it in the NQS or operational document.
- Link efforts to create model woredas, health centers and kebeles with quality.
- Strengthen link with HIA: ensure health expenditures are covered, decrease OP expenditure.
- Work on accountability by enforcing regulation and accreditation of public health facilities and relating them with health insurance.
- NQS should show a clear link between interventions and aspects of quality, and the operational document should incorporate this.
- Frame the input for proper function of different forms of care provided in the facility through the six WHO building blocks.
- Blend quality to pre-service education.
- Clarify the scope of health professionals with uniform and legally binding guidelines for all levels.
- Work to motivate staff; improve commitment; introduce a system to retain health professionals; ensure that providers are performing at their level of knowhow; recognize best performers.
- Expand the focus areas of the NQS to include promotive, all other clinical and palliative care.
- Clearly define the financial needs and sources; everything should be costed.
- Proper communication and ownership of NQS. Launching and advocacy should be properly planned and implemented, beginning at the national level before expanding to the regional level. Plan for proper dissemination so as to ensure buy-in and better understanding.
- Develop implementation strategy/guide.
- NQS could focus on the foundations rather than listing specific interventions/activities.

**Quality Structure**

- Establish a structure at a higher level than the current one to facilitate and ensure changes, and staff with a multi-disciplinary team, containing both technical and programme management skills. Expand the staffing and case teams to properly address the different needs.

- Revisit the role of the HSQD at the MOH: move away from follow-up of hospitals, focusing instead on fewer hospitals, and working on small projects in order to foster a comprehensive approach influencing the system; focus more on strategic issues like creating open communications and collaboration with the quality lead of directorates/agencies within the MOH and key partners; prepare operational plans, and mobilize and allocate resources.
- Revisit the structure at all levels and establish a quality structure which reflects the local capacity and services needed at that level. Requires a clear structure, with scope and roles addressing overlap at all levels. Structures need to be linked with BSC, link/ integrate with the JD.
- An ideal steering committee would be one in which guests are invited in addition to members, and which is highly active.
- Use the annual planning process, woreda-based planning, to reflect what is in the NQS.
- Introduce a multi-disciplinary team to work on quality and data.
- Delegate priority areas to the right directorate/ agency and focus on giving direction and mandate to others working on quality. Incorporate quality across services and different departments.
- Allocate adequate budget for quality activities.

**Data**

- Focus on outcome measures of quality; select a few key indicators in order to compare efforts across regions; working on data quality dimensions.
- Integrate quality with pre-service and in-service education and influence the quality of education.
- Work with pre-service education to integrate quality and ensure similar exposure and basic knowledge in key areas.

*"Need to consider recruitment/enrollment criteria: change the attitude to one of being easy to employ; should be inspired by serving, helping others".*

*"Look for how the health worker is working independently during the health facility assignment. Passing the examination does not necessarily mean that the person is capable".*

- Look for comprehensiveness of in-service training; training without follow-up is not enough.
- Create education/career opportunities for staff working in quality to improve retention and motivation.

While designing or planning for new standards/ legislation, consider the local context. Hospital standard needs to meet the level of the facility.

*"Some of the standards in selected chapters frustrate us; like the ICU in the primary hospital, focus on those that enable us to work."*

- Applicability of checklist should consider the regional situation, and should be modified according to the situation. Clinical audit tool should be smart and short.
- Before sending protocols and standards, discuss with health professional at the lower level as well.
- Focus on achievable and feasible measurements and indicators.

Ensure quality of drugs and equipment; strategically move for privatization of purchasing and distributions; introduce a system for possible equipment leasing.

**Other area of focus**

Collaboration

- Working/addressing inter-sectoral collaboration. Harmonize the directorate; establish council of experts.
    - Emphasis on coordination role of the HSQD: lead, guide and follow others. The HSQD needs to focus on oversight and making tools available, while the respective directorates take the lead in implementation.
    - Define clear roles and responsibilities at different levels. Assign quality focal within a case team and address the fragmentation of documents, like those for HC and hospitals.
    - Need a strong HIA that says no to poor or below standard services.
    - Improve efficiency of the MOH, including in purchase and distribution of equipment.
    - Differentiate provider, purchaser and regulator.

**Working with private sector**

- Ensure participation of the private sector; create a forum for the private sector/ associations. Address private engagement and look beyond thinking as competitors.
- Introduce a proper system of collaboration and communication among private health facilities, including collaboration in laboratory investigations. Create a common forum with private facilities, such as the inclusion of private hospitals in the EHAQ.

# Findings – Quantitative

The key findings from the SARA and EDHS reports were presented in the document review section above. This section also present findings from the HMIS data (available secondary data from the DHIS2 system) and other national assessment reports analyzed for selected priority areas and for the general health system performance over a five-year period, including the year before the introduction of the NQS (2015).

**Maternal and newborn care:**

The prioritized MCH issues in the NQS were mainly the reduction of maternal and neonatal mortality by improving the prevention and management of the main causes of maternal and neonatal death. Ensuring dignity and respect in maternity care is another prioritized area in order to improve the quality of care through focusing on the patient- and family-centeredness of care.

Increasing the number of facilities providing basic and comprehensive emergency obstetric and newborn care is one of the key lifesaving interventions for managing maternal and newborn complications targeted to reach 100% coverage at the end of 2020. However, 48% and 75% of health facilities are fully functioning BeMONC and CeMONC facilities respectively according to the SARA 2018 report.

Skilled care during pregnancy, childbirth and the postpartum period are important interventions in reducing maternal and neonatal morbidity and mortality. In this regard the routine HMIS report indicated that the proportion of deliveries attended by skilled health personnel, and women having at least four ANC visits from 2014/15 to 2018/19, were almost stable. Skilled birth attendance slightly increased from 61% in 2014/15 to 62% in 2018/19 and ANC four visits were 68% in 2014/15 and 70% in 2018/19. On the other hand, postnatal care coverage decreased from 90% to 78% in the same period. (Fig.3)

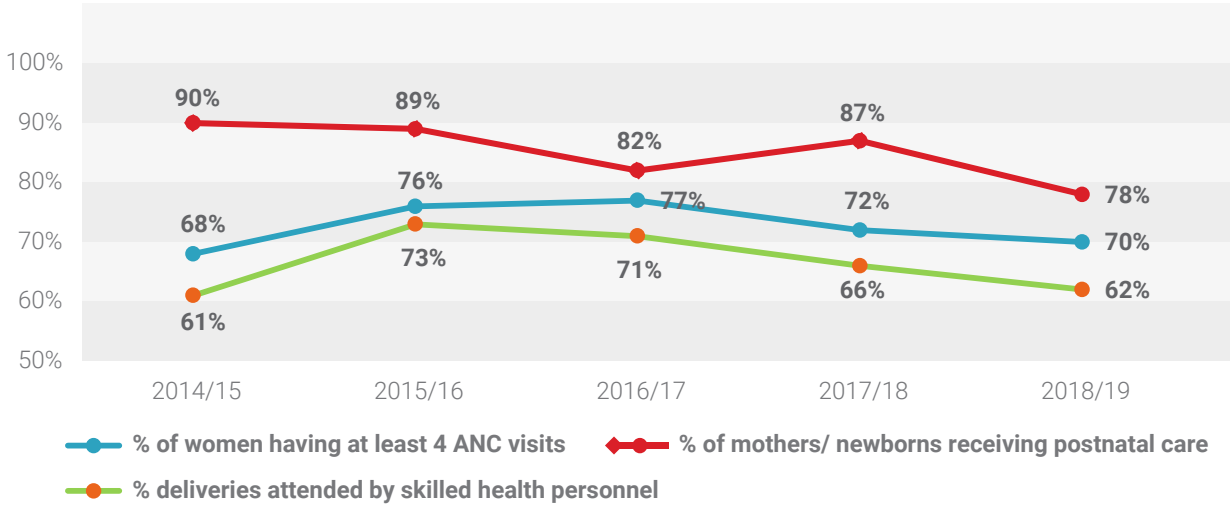


Figure 3 Women Having four ANC visit, skilled delivery and postnatal care; 2014/15-2018/19

Another way to look at the quality of care provision for pregnant women is timely and adequate care during ANC, such as a first visit within 13 weeks gestation, care provides protection from tetanus; repeated blood pressure measurements; screening for syphilis, HIV [as appropriate], and diabetes; counselling on risks, delivery planning and immediate breastfeeding. Screening for syphilis during pregnancy is one of the indicators to monitor the quality of antenatal care service. Pregnant women were tested for syphilis in 2014/15 is 32% to 2014/15, and showed increment to 1,814,497 (55%) in 2018/19 though it is still 30% below the 2019/20 target.

According to the 2019 Ethiopian mini EDHIS report, women who had a live birth in the two years before the survey were asked if they received a postnatal check-up within two days of delivery and only 33.8% reported that they had received the service. There is also regional disparity, with the lowest rate in Somali (10%), and the highest (74%) in Addis Ababa.

**Nutrition**

The NQS priority issue in the area of nutrition is the reduction of child mortality through the prevention and management of severe acute malnutrition. In this priority area, the NQS has not identified a sufficient number of indicators to monitor performance and there is also a limited number of indicators in the national HMIS, especially in the areas of management of acute malnutrition.

Biannual supplementation of Vitamin A for children aged six to 59 months is one of the nutritional interventions in Ethiopia. As per the routine HMIS report, performance of Vitamin A supplementation has shown a declining trend for the last four years, from 84% in 2014/15 to 75% in 2018/19. There is also a huge disparity across regions, with 0% in Somali to 100% in Addis Ababa.

Overall, the proportion of children under five years old with severe acute malnutrition that were recovered at discharge improved from 79% in 2016/17 to 81% in 2018/19.

**Communicable diseases**

The three priority areas within communicable disease are HIV/AIDS, malaria, and tuberculosis, with a focus on reducing the incidence of these diseases.

The focus areas for HIV are reduction in the incidence among targeted groups (MARPS and youth) and expansion of option B+ for elimination of mother to child transmission of HIV.

As indicated in Fig. 4, the number of pregnant mothers who received ARV prophylaxis (ART of Option B+) to prevent mother to child transmission of HIV has increased from 67% in 2014/15 to 81% in 2018/19. On the other hand, viral load suppression for ART patients at 12 months after initiation of ART is 77% in 2018/19, showing a decrease in performance compared to 2014/15 (78%).

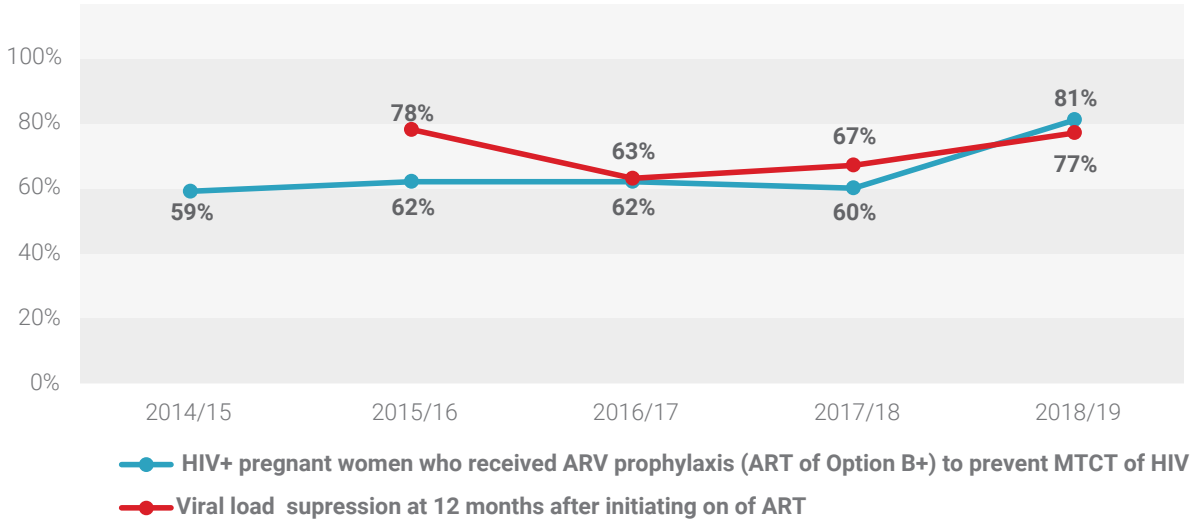


Figure 4 HIV Pregnant women who recived ARV prophylaxis and Viral supresion for ART patient 12 months after initiation of ART 2014/15- 2018/19

As indicated in Fig. 6 below, TB case detection has remained almost the same for years, about 68%, whereas the TB cure rate saw improvement from 78% in 2014/15 to 84% by 2018/19. The treatment success rate for TB is over 90% throughout the reporting period.

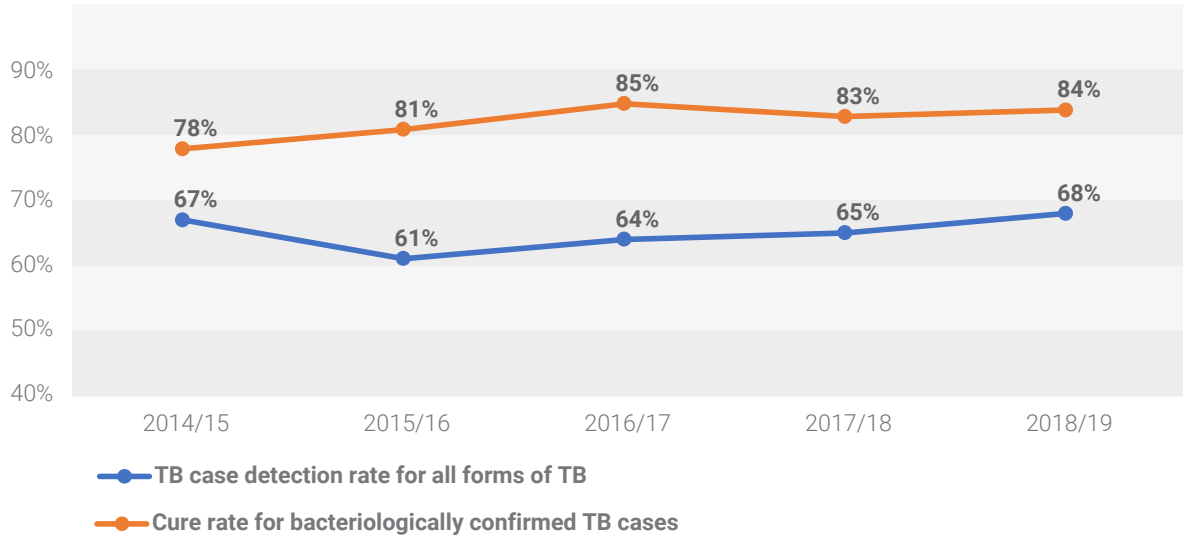


Figure 5: TB case detection and TB cure rate, 2014/15-2018/19

**Clinical and surgical services:**

The priority areas focused on improvements in emergency and clinical services at hospitals and health centers, particularly for surgical services.

Although there are no specific indicators identified under this priority area, selected hospital KPI measures with data available for the last two years provides some evidence on clinical and surgical service performance.

- Emergency room attendances with length of stay > 24 hours has decreased from 16.3% in 2017/18 to 8.2% in 2018/19.
- Surgical volume increased from 26,975 in 2017/18 to 187,249 in 2018/19.
- Proportion of women who survived from PPH increased from 48.0% in 2017/18 to 92.3% in 2018/19
- Rate of safe surgery checklist utilization slightly improved from 90.1% in 2017/18 to 91.1% in 2018/19.

Moreover, service-related indicators related to general service utilization and timeliness have also been included as additional aspects for performance monitoring by the NQS. These include outpatient visits, bed occupancy and ALOS. (Table 2). Outpatient per capital has improved from 0.48 in 2014/15 to 0.90 in 2018/19 but far below the HSTP 2020 target of 2. On the other hand, bed occupancy rate fell from 68% in 2014/15 to 42% in 2018/19, indicating inefficiency in utilization.

Table 3: Utilization and timeliness of care, OPD visit, bed occupancy rate and ALOS, 2014/15-2018/19

| S.N. | Indicators | Baseline | Implementation period | | | | |
|---|---|---|---|---|---|---|---|
| | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | HSTP Target |
| 1 | Outpatient attendance per capita | 0.5 | 0.6 | 0.8 | 0.6 | 0.9 | 2 |
| 2 | Admissions rate, per 1000 | 12 | 10.1 | 12.2 | 12.4 | 13.1 | |
| 3 | Bed occupancy rate | 68% | 37% | 38% | 42% | 42% | 85% |
| 4 | Average length of stay (in days) | 4.3 | 4.5 | 4 | 5 | 4.5 | 5 |

**Health system performance: outcome**

The outcome indicators provide information about whether healthcare services help people stay alive and healthy. Although there may be data quality issues with respect to mortality outcome measures, due to the under-reporting of deaths and changes in reporting performance, most of the outcome measures for the MNH priority areas show a declining trend for the last four years (institutional maternal mortality, neonatal death rate, stillbirth). On the other hand, there has been improvement in TB treatment success rate and malaria mortality reduction. (Table 3)

Table 4: Outcome measures progress, 2014/15-2018/19

| S.N. | Indicators | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|---|
| 1 | Institutional maternal mortality, per 100,000 births | 39 | 38 | 39 | 52 | 44 |
| 2 | Early Institutional Neonatal Death Rate | 2.9 | 2.8 | 3.2 | 4.6 | 5.4 |
| 3 | Still birth rate | 12.1 | 10.5 | 10.4 | 13.1 | 13.9 |
| 4 | Percentage of low birth weight (LBW) newborns | 2.7% | 2.6% | 3.1% | 3.5% | 3.3% |
| 5 | Survival on ART | 84.5% | 86.3% | 82.4% | 73.4% | - |
| 6 | TB treatment success | 91.1% | 92.6% | 94.4% | 94.1% | 94.1% |
| 7 | Malaria death rate per 100,000 population at risk | 1.1 | 0.9 | 0.6 | 0.2 | 0.3 |
| 8 | Inpatient mortality rate | 2.4 | 2.5 | 2.5 | 3.1 | 2.4 |

**Health system performance: input**

In general, input quality indicators are structural indicators related to the different dimensions of quality used to assess the setting of care or the foundation for providing quality health services. Accordingly, the NQS tried to identify indicators which include staffing ratio, the availability of essential medicines and technologies, and other related indicators.

Table 5: Human resource, infrastructure and budget allocation, 2014/15 and 2018/19.

| Category | Measure | 2014/15 | 2018/19 |
|---|---|---|---|
| Human resource | 1 Physician to population ratio | 17,160 | 10,734 |
| | 1 Nurse to population ratio | 1,873 | 1,657 |
| | 1 Pharmacy to population ratio | 9,814 | 9,275 |
| | 1 Medical lab to population ratio | 11,383 | 10,409 |
| | 1 Midwife to population ratio | 6,331 | 6,126 |
| | 1 Health officer to population ratio | 8,840 | 8,998 |
| Finance | Per capita health budget allocation, ETB | 122.78 | 295.83 |
| | Share of health budget from total allocated budget | 11.10% | 12.20% |
| Infrastructure | Health center to population ratio | 25,395 | 26,796 |
| | Hospital to population ratio | 476,593 | 313,873 |

# Findings – National large-scale quality improvement initiatives

**MNH QoC initiative:**

The NQS identified MNCH as one of the five priorities and sets targets for equitable and quality health and calls for an improvement in the quality of MNCH care. Therefore, the Ministry of Health with development partners has developed the National MNH QoC Road Map (2017/18-2019/20) to improve the quality of care for maternal and newborn health, and has joined the WHO-led global network to "Improve Quality of Care for Mothers, Newborns and Children" in order to learn and share successes and challenges through national and international learning collaborations.

The goal of the "Quality, Equity and Dignity for Maternal and Newborn Health Initiative" is:

- Reduce maternal and newborn mortality – reduce institutional maternal and newborn deaths and stillbirths in participating health facilities by 50% over a period of five years.
- Improve clients' experience of care – enable measurable improvement in user satisfaction with the care received over the period of five years.

The initiative has four strategic objectives named as LALA: Leadership, Action, Learning and Accountability.

- Leadership: Build and strengthen national institutions and mechanisms for improving quality of care in the health sector.
- Action: Accelerate and sustain implementation of quality of care improvements for mothers and newborns.
- Learning: Facilitate learning, share knowledge and generate evidence on quality of care.
- Accountability: Develop, strengthen and sustain institutions and mechanisms for accountability.

**Implementation arrangement:**

48 health facilities from 14 districts were selected for the implementation of the initiative, representing agrarian, pastoralist and urban parts of the country. There are three to four learning health facilities per district, and a total of five general hospitals, 14 primary hospitals, and 29 health centers were included. During the first year period from July 2017 – June 2018, site selection and other preparatory activities were implemented and considered as a baseline period, whereas actual implementation has been underway since July 2018.

**Implementation progress**

- National coordination mechanism for maternal & newborn health quality of care (technical working group) was formed to embrace all partners working on maternal and new-born QI.
- Regular monthly meetings have been conducted to guide the technical aspects of implementation, including monitoring of the initiative.
- Provided national-level orientation to regions and learning districts.
    - MNH QOC initiative; national MNH quality of care roadmap.
    - Implementation package.
    - Monitoring framework.

- National-level collaborative learning session organized where all 48 health facilities share experience among themselves.
- On-site support for building clinical skills and QI through regular mentoring and coaching in collaboration with supporting partners. (IHI, Transform PHC, Transform HDR, CHAI & WHO).
- Strengthening the implementation of maternal perinatal death surveillance and response system (MPDSR) through different capacity building activities, such as training, coaching and mentoring.

**Early Results:**

Progress has been made in the reduction of neonatal deaths and still births in the first year of implementation 2018 compared to the baseline period 2017. Neonatal mortality reduced by 6% from 20.4 to 18.9 per 1000 live births(Fig 5) and still births reduced by 5% from 25.3 to 24.1 per 1000 births (Fig.6).

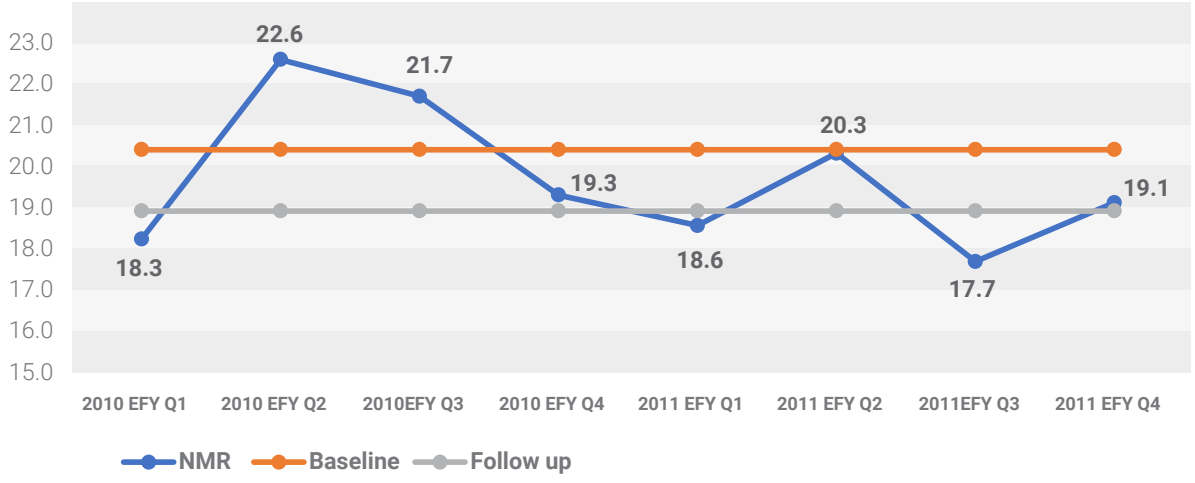


Figure 6: Neonatal mortality in 48 MNH QoC learning health facilities, 2017Q3-2019 Q2.

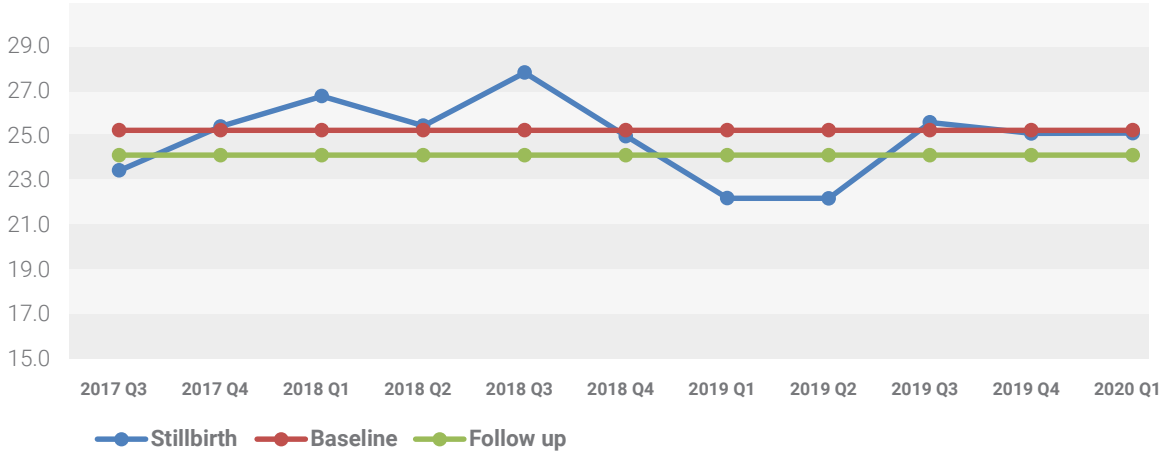


Figure 7 : Stillbirth in 48 MNH QoC learning health facility, 2017Q3-2020 Q1

### Saving Lives through Safe Surgery (SaLTS) initiative:

The goal of Saving Lives through Safe Surgery (SaLTS) flagship initiative is to make emergency and essential surgical and anesthesia care accessible and affordable as part of the universal health coverage. The SaLTS strategic plan focuses on making a package of essential and emergency surgical and anesthesia care available at all levels of the Ethiopian health care delivery system. The plan places special emphasis on strengthening primary care in order to provide essential surgical care.

Major achievements under this initiative include: National SaLTS Project team established under the HSQD; SaLTS plan prepared and being implemented; functional National SaLTS technical working group established; SaLTS leadership/advisory committee is being established at regional and hospital level; innovative oxygen production system has been implemented in some hospitals. In addition, construction of 410 OR blocks at HC-level, and renovation of major OR theatres, are underway in different regions; OR equipment (OR tables and Anesthesia machines, ICU equipment) is also under the procurement process for these facilities in order to increase access to safe surgery. Seven surgical indicators included in the national monitoring and evaluation tool and integrated into the DHIS2.

### Major achievements:

- Surgical volume in public hospitals improved from 26,975 in 2017/18 to 187,249 in 2018/19.
- Emergency room attendances with length of stay > 24 hours improved from 16.3 in 2017/18 to 8.2 in 2018/19.
- Peri-operative mortality decreased from 1.1 in 2017/18 to 0.8 in 2018/19.
- National Anesthesia Roadmap; list of national essential surgical procedures; national peri-operative guideline and monitoring and evaluation tools developed and approved. Surgery Check List (SSC) proven to decrease peri-operative complications, including SSI, adapted for the Ethiopian context and implemented nationally.
- 33 primary hospitals and 20 HCs supported with SaLT initiative to start safe surgical services in 2018/19.
- Reduced a national surgical backlog of 11,880 to 7299 (39% reduction) in the year 2018/19.

# Discussion

The introduction of the NQS lacks a clear communication plan at all levels. Most of the MOH staff are working in the offices, service providers in the facilities, while partners and professional associations are not fully aware of the content and in some cases have not seen or even heard about the document. The NQS was helpful in defining the 'how' part of HSTP, in raising awareness and support for quality, and is used as reference or guide by some. But it is not easy to understand its content and it lacks clarity in priority interventions, proposed quality structures and responsibilities. The strategy also lacks specific measures or estimated costs.

The key activities under the three commitments were accomplished: quality systems were developed in most of government structures except those at woreda and community level; a large group of leaders and providers, mainly from hospitals have been trained on QI; quality champions/advocates were developed. The linkage, support and guidance of the HSQD is better with RHBs than federal level directorates, NGOs and professional associations.

Most of the interventions under each strategic focus areas were initiated and a few were completed, but there are still gaps. Quality planning, QI and quality control are not yet integral parts of the routine system; the effort to motivate providers and integrate training in QI skills into pre-service education is limited; there are some efforts to encourage patient and community demand for quality services, but very little has been done in provision of patient-centered care; linkage with the HIA is not yet happening, and the expanded use of data for informing decisions is not yet institutionalized.

In this review, findings of improved awareness, QI knowledge and skills were similar to those reported in the HSTP midterm review and the NQS 2017 assessment report. The increase might be related to investment in training, coaching sessions conducted at different levels, facilitated benchmarking visits and learning sessions/reviews. A lot of effort has been observed in the introduction and implementation of different standards at hospital and HC level, and this is reflected in reports of progressive improvement in the proportion of facilities meeting standards for different chapters/areas. Other achievements related to project-focused efforts include: a clean environment following CASH initiatives; improved availability of commodities in sites reached with APTS; backlog clearance of surgical patients in sites covered with SaLTS initiatives; improved pain assessment and management. Although outcome level indicators are limited for comparing results over time, the overall reduction of facility level neonatal mortality by 7% in the MNH quality of care network is encouraging compared to similarly high figures for neonatal mortality reported in the mini DHS 2019 and EDHS 2016.

The quality definition adapted for Ethiopia focused on six quality dimensions. Efforts have been oriented more towards dimensions like effectiveness and timeliness of care, and ensuring care is addressing patients' needs and that the environment is safe for both patients and providers. Such efforts need to continue but it is also time for balancing the focus on technical content with improving overall process/systems in service delivery; addressing the needs of the foundations/ inputs for the health system, based on the six WHO building blocks, and creating a

competent health system which can adapt to social and technological changes, as well as to the different outcomes expected from patients.

The two approaches, Kaizen and the model for improvement, were introduced and applied on different scales in the health sector. The use of Kaizen is reported only in a few hospitals but use of the model for improvement is widely observed. The Kaizen is helpful in setting up and organizing services, and improving processes of service delivery. The model for improvement was used widely to develop, test and implement new ideas/solutions for problems identified at the facility or collaborative level. In most cases, the facilities experience problems which need to be fixed immediately by one or a few individuals. Both are good for improving processes and systems but there is a need for flexibility and to adapt approaches and tools which demonstrate effectiveness in planning and controlling quality in specific programme areas/services. Although the scale is different, there have been successful experiments in using different tools for the following: improving providers' performances; address providers' and patients' rights; reviewing/auditing the proper use of management protocols and complications/deaths; improving data quality; engaging communities.

The three core elements (quality planning, improvement and control) described in the strategic document and the priority interventions seem little understood and attention varies at different levels. Focus used to be more on QI than quality planning and control. Quality planning is a continuous process to ensure provision, design and re-design of services; QI is also a continuous process of addressing gaps and looking for a better way of delivering services. Quality control is a means to ensure proper and sustained implementation of what is planned and improved in the system.

The success in establishing quality structures at different levels was mentioned in almost all interviews and focus group discussions, and also in the previous assessment reports. Gaps were observed in: adapting the structure in different locations/regions; convincing the respective sector or civil service commission; understanding and performing according to the roles and responsibilities; integrating with pre-existing structures. Some confusion was also reported with regards to the role of temporary structures such as the steering committee and technical working groups with permanent quality structures.

A lot was invested in training providers and leaders at different levels. The MOH effort focused more at the hospital level while partners trained staff from the PHCU level. In most cases, a TOT approach was used to cascade and train providers and leaders in a short period, with limited post-training follow-up and minimal effort to reinforce the knowledge and skills gained during the training. This campaign type training could be helpful to raise awareness, build support and transfer basic knowledge but improved capacity needs practical experience, on-site support and continuous learning opportunities.

Some of the professional associations and higher facilities include teaching in QI skills in their continued medical education but integration with pre-service education varies from institution to institution, from simple training of instructors to full integration. Those institutions which reported integration started with postgraduate studies and specialization in the clinical fields. A few of the universities and some of the hospitals are functioning as In-Service Training sites. Training in QI skills is not yet linked with continued professional development. Skills labs to build clinical skills are available in teaching facilities, most of the hospitals and in a few HCs.

The efforts of HSQD and HIA were not well coordinated. The initial focus of the HSQD was at the hospital level, and then in support of facilities through RHBs. The limited efforts at woreda and PHCU level did not align with the HIA structure and its approach for reaching the lower units, linking with the woreda administration and focusing on the PHCU. Except for a few primary and general hospitals, hospitals are not included in the HIA. Some overlaps were also observed in the introduction of tools and in conducting audits at the level of the HCs.

Studies report inefficiency in the health sector: resources are not used properly; new, high value machines are not working for long periods; there is a lack of proper equipment maintenance; there are significant reports of expired drugs; trained staff are used ineffectively. Corruption of health facility management and medical practices, including intentional falsification of reports at different level, is worryingly on the rise. Like other new programmes, the QI are mainly supported by partners or by centrally funded projects, and do not raise or use much local resources. Too much investment and support in ensuring the availability of the right infrastructure without influencing the process may not be a sustainable or effective strategy.

In most cases, providers are not satisfied in their job. There is limited involvement of clinicians, especially senior specialists, in the system. There is also an absence of scope-based practices among health professionals, and a lack of clear individual-level performance measurement or well-organized support (coaching and mentoring) and incentive strategies. This is reflected in the low commitment of health workers. There is no organized effort to influence and advocate for policies related to providers' needs and rights.

The public health system needs more effort in order to fully implement patient-centered care. Most services are not responsive to users' needs. The results collected from patient feedback and patient satisfaction surveys may not reflect the actual quality of the services provided, since sometimes people report satisfaction with poor services. The effort to create patient and community demand for quality services and to boost community engagement in facility service delivery is not yet at the level required to influence health service delivery.

Interventions are poorly coordinated and are not systematically implemented. They are disease- or programme-specific, mostly partner-supported and some have not been integrated into the MOH system. Most national-level initiatives are implemented in the public health facilities, for example: CASH (clean and safe hospital initiative); patient safety – WHO patient safety approach; pain-free hospitals – pain free initiative standard; nursing care services.

Common efforts to improve health service quality revolve around adopting standards and technical guidelines for different services. The effort to develop and introduce such standards and guidelines, as well as audit tools to review/monitor their implementation, occupied most attention in recent years. Ensuring that minimum standards are met to deliver specific services is important, but it must be accompanied by additional efforts to improve the process and system of care provision.

Different department within the MOH, partners and professional and patient associations all have a variety of QI initiatives. Of the priority areas, considerably more focus and support are devoted to MNH than other areas. Some of the departments define quality in terms which are specific to their program; for instance, mental health incorporates rights concepts and community-based services including demand. Some of the programs have also adapted approaches from international experience, rather than sticking to what is in the NQS.

EHAQ/EPAQ facilitate the support given by lead facilities to member facilities, but structured peer-learning and collaborative working on defined shared goals are both missing from the network. There is no proper coordination within EHAQ in deciding on the introduction of new improvement areas, and on the packaging and scale-up of existing improvement areas. Rapid expansion of new improvement areas within EHAQ is limited. The experience has not yet expanded to establish networks of laboratories, pharmacies or private facilities. Most other collaborative learning is partner-supported and small-scale, covering only a few facilities/ woredas. In most cases, these collaborations demonstrated success in the project period, but they are rarely scaled up or disseminated to other areas.

# Major Challenges

- Difficult to understand NQS content: lacks clarity in priority interventions, proposed quality structures and responsibilities. The strategy was not inclusive of specific measures nor did it estimate cost and sources.
- NQS lacks simplicity: difficult to understand the NQS even at the HSQD team level; strategic interventions are not clearly articulated; unclear how to integrate or implement the interventions; document can be interpreted differently by different individuals.
- The proposed structure proposed is left to the community to decide, but a lack of basic details in the NQS leads to confusion and abuse. The scope of HSQD and quality structures at different levels is not clearly defined. There is confusion in the roll out of quality structures and activities from the national level to the regions and to the health facility level. The assumption that similar structures exist in the RHBs, ZHDs and WorHOs is wrong. Structures are not contextualized for the regions, with the misguided expectation that there are uniform structures across regions and levels. Gaps are also observed in the supervision/follow-up, and in supporting the establishment of governance structures at different levels by national teams.
- Difficult to get approval of quality structures from the civil service commission at lower levels. Requires easy communication and engagement with the civil service commission.
- Delays in establishing the appropriates structures down to the community level, and in development of some key tools.
- Lack of implementation guide and of clear guidance for how to operationalize the interventions.
- Lack of specific measure for assessing NQS implementation, and absence of key quality indicators in the NQS.
- Lack of proper monitoring mechanisms; no tracking mechanisms.
- NQS was not costed, nor were sources indicated.
- Leadership change both at ministerial and HSQD level affects implementation of NQS.
- Lack of sustained leadership commitment to ensuring establishment of structures at different levels and allocating budget in the early phases.
- Fragmentation of roles and responsibilities; parallel structures with other directorates limits coordination and collaboration.
- Lack of plan alignment: plans not based on the selected 54 interventions in the NQS; programme-level planning not oriented with a focus on quality; no alignment of different programmes within the MOH.

  *"Pushing against each other, as if to take each other's jobs, is observed even within the MSGD and other directorates".*

- Programme-focused approach of partners means their activities are not aligned with the government structure.
- High turnover of GPs heading the quality unit at hospital level due to transfer and postgraduate studies; no incentive or opportunity for career development for staff assigned to work on quality.
- No or limited budget allocated for QI activities.

- Quality of education in the pre-service is compromised: competency should extend beyond the technical skill of providers and incorporate the fundamentals of systems thinking; QI should include additional core competencies.
- Measuring knowledge only is not enough.

  *"Capacity is different from capability: we are producing health workers with capacity but without capability".*

- Lack of model health workers or institutions; lack of professionals who really care about and respect their patients.
- Challenge in reaching those working in the private sector and in remote sites with IST/CPD.

Content, introduction and follow-up of standard requirements from regulatory bodies (HHRR) is a concern for facilities, especially private ones. Standards are not contextualized for local situations; approaches lack clarity and uniformity with limited enforcement; narrow focus on administrative issues rather than looking holistically limits improvement beyond the required minimum.

*"Though we accepted the revised standard as the country's legislation to be adhered to; the standards are not Ethiopian. It's not contextualized for local situations and needs; it's too high. Requirements for some of the services may not be available in the market".*

*"The move from higher to specialty or medium clinics was not easy.... It affected the momentum of service delivery and relation with clients".*

- Standards are not uniform: same standards should be applied to public and private health facilities. Difficulty in enforcing findings of government health facilities means implementation is usually reversed.
- Common practice is simply to check the absence or presence of services, rather than considering their quality, the process of care, the knowledge or skill of providers and the scope of practices.

  *"There is too much pushing from regulatory bodies. Most are too fast and just fill the checklist and take actions, without patience or support. They are too dictatorial".*

The facilities also shared their concerns about other administrative and clinical standards introduced in recent years, especially at the hospital level. Some of the standards have excessively detailed criteria which are not contextualized for facilities, and which are not inclusive of all services such as mental health.

- Verification criteria for standards are too detailed; for instance, audits sometimes requires checking a lot of cards.
- Applying the same expectations, using the same standards, for teaching, tertiary and primary-level hospitals is difficult, as in the case of the HSTQ. It needs to be contextualized and shaped to the level of the health facility.
- No quality standard or quality measure available for mental health; rather, existing standards for general health services are

used.

Limited involvement of clinicians, especially senior specialists, in the system; absence of scope-based practice among health professionals; lack of clear individual-level performance measurement and well-organized support (coaching and mentoring) is reflected in the low commitment of health workers and the limited facilitation of patient transfer from one to the other.

Quality is underfunded and significant gaps are observed in quality control. These include: a lack of basic structures; below standard or nonfunctional health facilities; a lack of health workforces of the right size and mix; insufficient quality and availability of equipment; problems in drug availability and cost, especially for the NCD; poor distribution of supplies, especially to the private sector; low financial allocation to the health sector; lengthy procedures and difficult relations between the regulatory agency, purchasing institutions and the finance sector affect proper planning and control of health service quality.

- There is a need for the right infrastructure according to the standard set for public health facilities.
- The standard health workers for mental health has not yet been met in most facilities. Training in mental health takes place but with limited readiness of facilities to absorb trained professionals. There is a shortage of laboratory technicians in about a fifth of facilities, which affects access to TB diagnosis and hampers overall service quality.
- Equipment is not available or is expensive, e.g. for orthopedics care, and some does not last long due to poor quality. There are drug shortages and problems accessing drugs at reasonable cost for cases with NCD and mental health problems. Equipment and simple life-saving drugs are primarily distributed to government facilities, without equal consideration of private facilities.
- Financial problems, beginning with health facilities and requests out of their budget limit, and with a lack of on-time delivery of supplies. There is no clear relationship between the regulatory agency, the purchasing agency and Ministry of Finance. Health facilities are not financed, or at least not with respect to the concept of cost recovery.

Absence of comprehensive care; patient demand without proper knowledge; weak referral linkages and collaboration with the private sector, limiting the provision of high quality services to clients with better experience of care.

- Lack of comprehensive and holistic services for cases with HIV/AIDS, like treatment for opportunistic infections; psychosocial care is not at the level expected by the PLHIV, because of limited skills, knowledge and care provider experience.
- Patient requests for specific investigation and treatment only creates problems in providing proper care in the private sector.
- Lack of a proper referral system between private and public facilities; no system of collaboration or forum for positive competition among private facilities.

Developing, testing and implementing new ideas affected by lack of open environment at facility level; more than three projects managed

at the same time; work being done by only a few champions; no building upon established efforts; loss of institutional memory/history.

- Lack of an open environment for innovation at the facility level; performance management focuses on successfully accomplishing tasks planned as individuals or as a team; no room for failure; no encouragement of learning; no encouragement for developing and testing innovative ideas.
- Difficult to manage three to four projects at the same time; need to phase introduction and implementation.
- Work led by a few champions, only few of whom deliver change.
- Influenced by new partners (e.g. ISQA) rather than building upon established system/ efforts.
- Discussion without understanding the background means institutional memory is lost.

Corruption of the health facility management and medical practices, and false reporting at different levels, affects the provision of quality health services.

# Recommendations

The following recommendations are forwarded under selected thematic areas.

### Leadership and governance for quality

- The NQS should start from a detailed situational and stakeholder analysis. The interventions indicated in the strategy should have a detailed and costed implementation plan, with a clearly designated responsible actor.
- Re-establish a functional ideal steering committee which invites guests in addition to members, and expand members for the technical working group in order to improve ownership.
- Revisit the quality structure at all levels: position a national-level quality structure at a level higher than the current structure in order to facilitate, monitor, coordinate and lead the quality functions and ensure it is staffed with a multi-disciplinary team with both technical and improvement skills; similarly, revisit the quality structure at sub-national levels in order to reflect local capacity and the services needed at that level; assign a lead/focal person for programmes at case-team level in national, regional, zonal and woreda governments to work with the quality structure at each level.
- With the expansion of services and the increasing number of staff at the HC level, especially in urban areas, consider establishing a permanent team with a focal lead at department level; given the recent expansion of HEP structure, staff and services, consider assigning a focal person with a team of HP staff and community representatives (e.g. kebele command post members with representatives from informal care providers, health volunteers/HDAs, religious and influential leaders).
- Revisit the scope and function of the quality units at national and subnational level in order to: clearly indicate accountability, integration and linkages within the sector and with key agencies; provide proper guidance and coordination of different efforts; ensure quality planning, improvement and control (three core elements) for each programme area/service and level.
- The role of the MOH quality structure and HIA scheme at different levels needs to be clearly defined: introduce transparent mechanisms for cooperation; use the structures, experiences and capacities built by each wing to promote better quality of care overall.
- Shift towards a system approach by redefining quality in Ethiopia to include: a focus on the inputs to the health system; a process of delivering and receiving care; a notion of the health system's future evolution; outcomes expected from patients and other sectors.
- Restructure the functions of health service with an emphasis on provision, purchasing, and regulation as the three independent bodies critical to ensuring improved quality of care.
- Design and implement reward mechanisms for improving quality of care at all levels and promote the institutionalization of quality culture across the whole health care system.

### Measurement for Quality

- Re-define quality measures to focus on effective coverage, provision of care, outcome of care and experience of care so that they directly measure the quality of care for each priority areas, and include them in the routine health information system.
- Strengthen data use at the health care delivery point and by the leadership at all levels of the health care system.

- Use dashboards based on selected key quality indicators at all levels in the health care system, in order to facilitate decision-making and accountability.
- Establish and strengthen regular health care quality monitoring and feedback systems at national, regional, zonal, woreda, facility and community levels.

**Learning and knowledge management system**

- Reorient the EHAQ/EPAQ to align with the administrative structure which works to facilitate referral, linkages and technical support from higher to lower-level facilities.
- Develop and implement a national learning system guide that can be contextualized across the different regions and health care facilities.
- Integrate the collaborative learning system with the existing review system; re-orient some of the content and approaches, at all level of the health care system.
- Use a phase-based approach for the introduction and implementation of new evidence-based interventions. This means identifying the appropriate sites/level of implementation for those interventions intended for spread or scale-up.
- Establish and strengthen the learning structures and platforms within the health system which generate, analyze, compile and disseminate available evidence for further scale-up and for translating into action.
- Work on maintaining the improvements observed in facilities/districts following focused project support, and spread these lessons to other areas/services within the facility or district.
- Develop and implement guidelines for development, indicating key steps; who to involve and consult; reference to use, and the process of approval.
- Encourage large-scale quality initiatives at national and sub-national levels for priority health and health-related issues.
- Give due emphasis to intervention research at all levels in the health care system.

**Stakeholder engagement:**

- Establish a health literacy unit; build on existing efforts for using community scorecards; organize and support patient associations and community groups which will systematically review and provide regular feedback to facilities.
- Engage professional association and civil societies in quality of care improvement, in planning implementation and in monitoring and evaluation of health care quality.
- Create a platform which can facilitate the engagement of the private sector; establish a common forum with private health facilities for collaborative learning and other QI interventions.

**Accountability**

- Address inappropriate waste of equipment and drugs, by revisiting procurement procedures for purchase of high quality supplies; expand the quality control efforts of the PSA and build upon the increasing availability of commodities of APTS initiatives; build maintenance capacity at all levels.
- Identify the type and extent of corruption

in the health sector and introduce focused efforts to develop a fully transparent system and collaborate with the relevant sectors working in this area.

- Establish a control system with autonomous regulatory institutions which ensure minimum requirements for both public and private health facilities and with clear authority for enforcement.
- Clearly define the accountability mechanisms to ensure quality of care is directly linked with provision of care and outcome of care at all levels of the health care system.

**Health workforce:**

- Efforts to continuously build QI capacity need to be prioritized: integrate QI skills training in pre-service education, both in under and postgraduate studies; develop quality experts with postgraduate qualifications who will support a system-wide effort and will lead a team from federal to zonal to facility level; consider in-service training to transfer new knowledge and skills; link with efforts of different departments within and outside the health sector, including professional associations, in order to motivate providers, improve their satisfaction, ensure a healthy working environment and guarantee their rights.
- Work to improve commitment: introduce a system to retain health professionals; ensure providers are performing at the level appropriate to their knowledge and skills; improve productivity; recognize best performers.

**Redesigning service delivery system**

- Simplify approach to the development, content and use of standards and tools; except in a few areas, empower local health facilities and offices to adapt and use standards and tools.
- Devolve some health services currently provided at the secondary and tertiary level to primary health care levels.
- Re-design all existing QI initiatives to integrate improvement for all services provided at health facilities, and to include all health sector priority areas in a phased approach.

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# Review Report of the National Health Care Quality Strategy
(2016 – 2020)

**September 2020**

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MINISTRY OF HEALTH - ETHIOPIA

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