Quality, Equity, Dignity
A Network for Improving Quality of Care
for Maternal, Newborn and Child Health

Ethiopia

A. Background[1–6]

Core demographic data

Indicator	Value
Population size (thousands)	104,957
Total fertility rate (children per woman)	4.6
Maternal mortality ratio (MMR) (per 100,000 live births)	353
Neonatal mortality rate (NMR) (per 1,000 live births)	29
Child mortality rate (per 1,000 live births)	20
Stillbirth rate (per 1,000 live births)	18
Domestic general government health expenditure as percentage of gross domestic product (GDP) (%)	1.1
Domestic general government health expenditure per capita (in US$)	6.5

National coverage of key interventions

Intervention	%
Antenatal care (4 or more visits)	32
Skilled attendance during delivery	28
Institutional deliveries	26
Cesarean section rate	3
Initial breastfeeding (1 hour of birth)	73.3
Exclusive breastfeeding rate (of infants under age 6 months)	58
Postnatal visit for baby (within 2 days of birth, medically trained provider)	13
Postnatal care for mother (within 2 days of birth, medically trained provider)	17

B. Implementation milestones

completed · in progress · not started or incomplete · no data

Milestone	Status
National leadership for quality of care (QoC)	
Supportive governance policy and structures developed or established	completed
QoC for maternal and newborn health (MNH) roadmap developed and being implemented	completed
Learning districts and facilities selected and agreed upon	completed
QoC implementation package developed	completed
Adaptation of MNH QoC standards	completed
Action: Learning sites identified and prepared	
Orientation of learning districts and facilities	completed
District learning network established and functional (reports of visits)	in progress
QoC coaching manuals developed	completed
Quality improvement (QI) coaches trained	completed
On-site coaching visits occurring in learning districts	completed
Learning and accountability: QoC MNH measurement	
QoC for MNH baseline assessment completed	completed
Common set of MNH QoC indicators agreed upon for reporting from the learning districts	completed
Baseline data for MNH QoC common indicators collected	completed
Common indicator data collected, used in district learning meetings, and reported upwards	in progress
Identification and agreement with an academic or research Institution to facilitate documentation of lessons learned in the implementation of QoC activities	completed
Accountability and community engagement	
Mechanism for community participation integrated into QoC planning in learning districts	completed

C. Progress at the national level (2017–2018)

National overview of QoC for MNH

National quality policy or strategy

- The Ethiopian National Health Care Quality Strategy (2016-2020) includes maternal, newborn and child health (MNCH) as a priority area.

National aims

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National targets

- As reported in the Health Sector Transformation Plan (2016-2020) and the National Reproductive Health Strategy (2016-2020), national targets aim to:
  - Reduce the MMR from 420 to 199 per 100,000 live births by 2020
  - Reduce the NMR from 28 to 10 per 1,000 live births by 2020
  - Reduce stillbirth rate from 18 to 10 per 1000 births by 2020 include roadmap target

QoC technical working group (TWG)

- TWG membership includes the Health Service Quality Directorate, Maternal and Child Health (MCH) Directorate, Human Resource Directorate-CRC Initiative, Policy and Plan Directorate, implementing partners (i.e. WHO, IHI, Transform Primary Health Care-USAID, Transform Developmental Regional State-USAID, Ethiopian Midwives Association, Ethiopian Pediatric Society, Ethiopian Society of Obstetrician and Gynecologists, Clinton Health Access Initiative, UNFPA, UNICEF, AMREF, and Help-age), and the Regional Health Bureau QI unit coordinators of Addis Ababa and Oromiya region.
- The TWG follows the roles and responsibilities outlined in its terms of reference and met 10 times in 2018.

Joint products and activities by the QoC TWG

- Prepared terms of reference for MNH QoC TWG establishment, formally established the TWG and conducted regular monthly meetings (January 2018)
- Provided lead technical support in developing the National MNH QoC road map that was published (Oct 2017)
- Participated in plan alignment of the national annual operational plan for MNH QoC (2017/18 and 2018/19)
- Technically supported organization of annual national quality summits (March 2017, June 2018)
- Adapted the MNH QoC standards and introduced them to stakeholders
- Provided orientations/trainings on quality improvement (QI) basics, the MNH QoC initiative, MNH standards, tools and indicators to respective learning districts
- Selected learning districts (February 2018)
- Prepared a learning district MNH QoC implementation package (draft) (April-May 2018)
- Provided national-level orientation to regions and learning districts on the MNH QoC initiative, the national MNH QoC roadmap, the implementation package and monitoring framework; started regional adaptation/operationalization of the roadmap
- Technically assisted with the inclusion of core indicators in the recent health management information system (HMIS) revision and inclusion of a module on MNH standards, quality statements and key performance indicators (KPIs) in District Health Information System 2 (DHIS2)
- Adapted a monitoring technical guide/protocol for MNH QoC (draft) (November 2018)
- Technically guided the collection of baseline data on common core indicators and quality gap assessments in learning districts
- Drafted feedback to facilities based on baseline common indicator data analysis to guide specific QI interventions in learning facilities (November-December 2018)

Learning districts and facilities

- 17 learning districts (currently there is agreement to consider three of the hospitals in Addis Ababa as one learning site which makes the number of learning sites 14)
- 2-5 learning facilities per learning district
- 48 total learning facilities
- 3 learning facilities per learning district
- 113 learning facilities

District aims towards national strategy

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Clinical improvement aims

- Federal Ministry of Health selects aims by learning facility (3 aims per facility); these aims are selected based on data, but a commonality is prioritizing as much as possible care around the time of birth and immediate postpartum.
- National aims shared across facilities in certain districts

Quality interventions included in the national MNH QoC package*

Interventions to build a supportive environment

- Clinical in-service training (regional or district levels) based on gaps identified
- Modified approach to supervision to include QI in certain districts

Interventions to support change at facilities

- Training is now based on a more careful assessment of who needs it and when something is new. In-service trainings are provided on gaps identified (e.g. basic emergency obstetric and newborn care (BEmONC), IMNCI, SAM management, ETAT, NICU, newborn corner/ENC). There is integrated refresher training for health extension workers (HEWs).
- New focus on the safe childbirth checklist
- New self-assessment and improvement tool based on standards
- Increased focus on implementing maternal and perinatal death surveillance review; new annual plan identifies training needs, sees if committees are active and supports as necessary

*Interventions have started since the last update.

D. MNH QoC baseline data for learning facilities

Baseline common indicators

Challenges

- Delay in reporting and incompleteness of some indicators

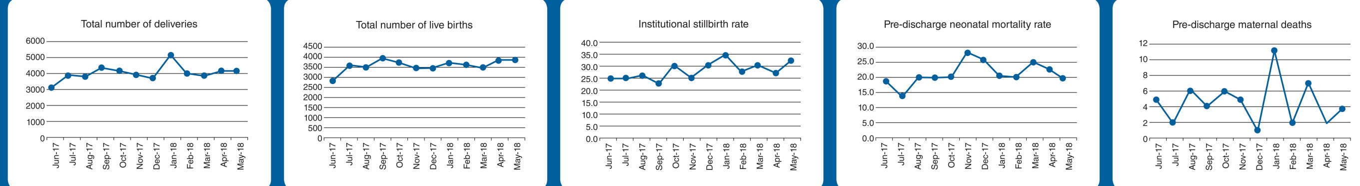
Opportunities and progress made

- Common indicator data collection and use guidance was developed and orientation was given to reporting health facility staff members

Planned activities

- Regular feedback and improved data use

Baseline monthly trends in key indicators for the June 2017 – May 2018 reporting period (monthly data are shown as national averages of 48 learning facilities)



E. Implementation progress in learning districts

On-site support for clinical skills and QI

Support for clinical skills

Who provides on-site support for clinical skills

- Mentors hired and deployed at the facility level. These mentors are senior midwives who are experienced instructors and have many years of experience. Staff mentors from larger facilities mentor staff at smaller facilities.
- Catchment-based mentorship uses woreda and zonal MCH officers, primary hospital midwives, and project cluster staff.
- Catchment-based mentorship is the Ministry's flagship initiative, whereby BSc-level midwives from hospitals with good performance on BEmONC and who received training on mentoring are selected to mentor one health centre for 6 months. The mentoring happens for one week every month.
- Mentorship offered by partners differs sometimes from the Ministry's guidance.

Challenges solved implementing on-site support for clinical skills

- There is family planning (FP) provider bias in some parts of the Amhara and SNNP regions. In Amhara region, health care providers didn't want to provide FP services due to misleading information. Continuous discussions with the health care providers improved this situation.
- To solve high turnover of trained and mentored staff members, we tried to include more mentees in the mentoring program and trained more staff from each facility.

Unresolved challenges implementing on-site support for clinical skills

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Support for QI

Who provides on-site QI coaching

- Joint on-site coaching by implementing partner staff (mostly midwives with MPH degrees) and the 3 district staff members (QI focal, MCH coordinator, and HMIS coordinator)
- Officials from the regional health bureau, woreda health office, and health workers from hospitals trained on QI are also involved in some districts in developing regional states
- At least once per month or every quarter (in districts with budget issues), coaches:
  - review facility level data and discuss with facility staff the progress of improvement projects
  - facilitate the use of QI tools
  - use this opportunity to retrieve data that are not part of the HMIS for the core indicators
  - support clinical duties as needed
  - visit the service units
  - discuss the arrangements and infection prevention procedures
  - support establishing QI teams and facilitate the initial QI team meetings
  - facilitate learning sessions at the woreda level
- In one of the learning districts, the lead hospital (a university specialized hospital) gives QI coaching and clinical skill building support to the other facilities in the network

Challenges solved implementing QI coaching

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Unresolved challenges implementing QI coaching

- Lack of clinical skill-building labs in hospitals
- District staff members who provide coaching are based at the woreda/district health office. It is not scalable for these 3 people to visit 11 sites every month, so this plan needs to be adapted.

Learning for QI

Tools for capturing learning from facilities

- We document change ideas that led to improvement as part of the change package for broader sharing and implementation. This information is captured using a QI project logbook.

Tools for sharing learning between facilities

- Learning sessions/review meetings are integrated into existing meetings for staff members, and this learning is recorded in the QI minute book/template.

Challenges solved implementing a learning system

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Unresolved challenges implementing a learning system

- Learning has not been synthesized systematically and integrated into the Ministry's annual plan for scale up and implementation at national level. The QoC TWG at the national level has yet to gather leanings from learning sites, identify effective and scalable interventions and come up with a change package.

Measurement system for QI

Patient-level common indicator data

- Common indicators plus indicators based on the specific QI aims
- All provision of care and water, sanitation and hygiene (WASH) core indicators are being reported from all learning sites to the national level.
- Reporting on common indicators for experience of care has not been initiated yet, though there is agreement to do so.

Programme-functioning data

- All districts will use a milestone-monitoring checklist.
- Implementing partners use specific checklists to monitor facility QI progress.
- A comprehensive reproductive, MNCH tool used by respective cluster coordinator every quarter and reported to QI advisor in regular basis in some districts

Availability of data system for measuring QoC

- Four common indicators are directly taken from the HMIS report. During the recent HMIS revision, efforts were made to include some of the late common indicators, for example on postpartum haemorrhage (PPH). But then the common indicator on PPH was dropped, and an indicator on kangaroo mother care was added. The DHIS2 has integrated a module on MNH standards and quality statements, though it is not yet functional.
- The following additional data sources are used:
  - HMIS registers
  - Interviews and observations (for experience of care and WASH)
  - Patient charts
- In the future, efforts will be made to integrate the core indicators in the DHIS2 by demonstrating the use of indicators for improvement.

Challenges solved implementing a measurement system

- Data quality was poor. Registration and systems for reporting activities performed at the facility level were very weak in some health facilities. To solve this, we included data quality management in the provision of mentoring.

Unresolved challenges implementing a measurement system

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Community and stakeholder engagement

Approaches for community/stakeholder engagement

- Community engagement approaches include the participant defined quality (PDQ) initiative that is linked with community action cycles, establishment of the client counsel, community score cards, town hall meetings, and community representatives on the health centre's governing board

Roles of community stakeholders or patient representatives

- Community stakeholders and patient representatives participate in the three phases of the PDQ process:
  1. Quality exploration (community and providers explore quality issues on MNH care separately)
  2. Bridging the gap (community and health care providers come together to discuss the gaps they identified, discuss the areas needing improvement, prioritize problems, and develop an action plan to work together)
  3. Working together on areas needing improvement
- Community representatives also participate in the quarterly review meeting.

Challenges solved engaging communities and stakeholders

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Unresolved challenges engaging communities and stakeholders

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Programme management

Programmatic responsibility

- Facility level:
  - Hospital: Quality Unit is responsible for QoC
    - Responsible for conducting quality audit
    - Gives feedback on the audit findings to the respective QI teams of the different unit/departments
    - Supports the QI teams to develop and implement QI plans
    - Monitors the implementation of the QI plans
  - Health Centre: Performance monitoring team on which the quality focal person is a member
- District level:
  - Quality focal person
    - Provides clinical mentoring and QI coaching support to facility QI teams
    - Facilitates learning collaborative sessions at woreda/district level
    - Conducts integrated supportive supervision to facilities on priority programs such as MCH
- Regional level:
  - Quality case team with 2-3 officers under the curative and rehabilitative core process
    - Operationalize national quality strategy and roadmap through regional adaptation
    - Coordinate and guide partners working on quality through regional steering committee and TWG
    - Build capacity and provide training on clinical and QI skills
    - Conduct SS and review meetings
    - Collect KPIs from facilities, give feedback and report to the national level
- National level:
  - Health service quality directorate
    - Sets national standards
    - Develops policies, strategies, guidelines, protocols and manuals
    - Coordinates a countrywide QI program
    - Mobilizes resources for QI
    - Strengthens quality structures
    - Identifies and strengthens infrastructural gaps
    - Coordinates and guides partners working on quality through national quality steering committee and TWG
    - Conducts national quality summits, review meetings and SS
    - Establishes quality resource centre

Challenges solved implementing program management

- To address poor infrastructure affecting program implementation (e.g. shortage of rooms, lack of electricity and water), we communicated with all responsible bodies at each level to solve these problems.

Unresolved challenges implementing program management

- Inter-directorate (MNCH and Quality) collaboration is not as expected at all levels. There is a low commitment to quality at different structural levels of the health system.
- Poor commitment of leadership and turnover at the facility and woreda levels are especially challenging. The government is changing regional leadership frequently and doesn't have a mechanism to hand over the activities being implemented at the zonal, woreda and health facility levels. This has directly hampered the programme's implementation.

References

1. Ethiopia Demographic and Health Survey: 2016 (2017).
2. UNICEF WHO Interagency SAB Database, data.unicef.org, 2018.
3. United Nations Children's Fund, Division of Data Research and Policy (2018). Global UNICEF Global Databases: Infant and Young Child Feeding, New York, May 2018.
4. Ethiopian Emergency Obstetric and Newborn Care (EmONC) Assessment 2016 (2017).
5. United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, DVD Edition.
6. WHO Global Health Observatory data repository. http://apps.who.int/gho, 2017.

All other data received from the relevant Ministry of Health and WHO Country Offices.

Acronyms

BEmONC	basic emergency obstetric and newborn care
DHIS2	District Health Information System 2
FP	family planning
GDP	gross domestic product
HEWs	health extension workers
HMIS	health management information system
KPIs	key performance indicators
MMR	maternal mortality ratio
MNCH	maternal, newborn, and child health
MNH	maternal and newborn health
NMR	neonatal mortality rate
PDQ	participant defined quality
PPH	postpartum hemorrhage
QI	quality improvement
QoC	quality of care
TWG	technical working group
WASH	water, sanitation and hygiene

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