FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA
MINISTRY OF HEALTH

NATIONAL MNH QUALITY OF CARE ROADMAP (2017/18-2019/20)

JULY 2017

Foreword

In the last two decades, a historical track of progress was recorded in the Ethiopian health system through four successive phases of Health sector development plans (HSDP-I- to HSDP-IV). It marked a breakthrough development in the Ethiopian health sector in the face of a rapidly growing population to achieve a fast track in economic growth in the country. The country achieved the UN MDG 4 target three years ahead of the end of MDG, and under-five mortality was reduced by 67% from the 1990 baseline estimate.

Similarly, a good progress towards MDG5 target was made and maternal death was declined by nearly 72% (from 1,250/100,000 LBs to 353/100,000 LBs) between 1990 and 2015 though it failed short of meeting the MDG5 target of a three fourth decline. The neonatal mortality rate has been persistently high at 27/1000 LBs to the contrary. These unfinished MDG agenda signaled that in the SDG period the country should address further reduction in maternal and perinatal deaths and disability.

Building on the HSDP and aligning with the second growth & transformation plan of the country, the health sector transformation plan (HSTP-2016-2020) has flagged four transformation agenda. These are provision of quality health services in an equitable fashion, giving focus on district/woreda level transformation, strengthening health information systems or information revolution, and highlighting compassionate and respectful care. The quality and equity transformation agenda has put “Improving quality of Maternal and Neonatal care” at the top of its priorities.

In line with the government’s commitment to improve and strengthen the health system, the collaborative partnership with international governmental and non-governmental organizations will catalyze efforts to build a resilient and responsive health system. In this regard, a network for collaborative learning on the MNCH quality of care is established nationally and this network is further linked into the WHO led global alliance for quality, equity and dignity in health care of mothers and their children.

Hence, the Federal Ministry of Health has developed this strategic roadmap to guide the national leadership, action for improvement, learning and accountability for quality of care in maternal and newborn health. I believe this roadmap will serve as an excellent source document for an organized and enhanced effort of all actors in the country working for improved quality of care given to Ethiopian mothers and newborns.

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State Minister of Health

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Acknowledgment

The Federal ministry of health would also like to acknowledge with much appreciation the crucial role of experts and technical assistants from the several directorates in for their leading contribution in this roadmap finalization process. A special thanks goes to the core team who have invested their full effort in guiding the team in achieving the goal.

The federal ministry of health would also extend special gratitude to the World Health Organization for their leading role in the initiation and coordination of the MNH Quality of Care envisioned with halving the preventable maternal and neonatal death at national and global level network. I have to appreciate the guidance given by World Health Organization (WHO-HQ) MCH staffs and WHO Afro consultants and TAs that had assisted as in improving our commitment and engagement to join to the first wave countries for sharing and learning the multi-diverse and scope experiences throughout the path in achieving the targets sets within the timeframe.

Furthermore, the federal ministry of Health would like to express its appreciation to all partners namely **USAID, L10K, Packard, IHI, Ethiopian Midwife Association-EMA, CHAI, ICAP, save the children, MI, Pathfinder, UNFPA and UNICEF** involved and those who provided us their invaluable technical and financial support for the finalization of this national MNH quality of care roadmap.

Lastly but not least on the behalf of the federal ministry of health, I wish and envision our nations and our world at large celebrating to see healthy women and child leading joyful and quality life after the finishing line of the 2020 of this roadmap.

Daniel KEBEDE WORKU (MD)
STATE MINISTER

Daniel G/Michael Burssa (MD, MPH)
Chief of Staff, state Minister's office/ Programs/

Acronym

ANC	Antenatal care
CRCPO	Curative and rehabilitative core process owner
EHAQ	Ethiopian hospital alliance for Quality
EHIAQ	Ethiopian health institution alliance for Quality
EHRIG	Ethiopian health reform implementation guideline
EHSTG	Ethiopian health service transformation guideline
EPHCRIG	Ethiopian primary health care reform implementation guide
FMOH	Federal ministry of Health
FMHACA	Food, Medicine, health administration and control agency
GTP	Growth and transformation plan
HDA	Health development army
HMIS	Health management information system
HSQD	Health service quality Directorate
HSTP	Health sector transformation plan
IHI	Institute for health improvement
MDG	Millennium development goal
MI	Micronutrient initiatives
MMR	Maternal mortality ratio
MOH	Ministry of health
NCSS	National Child Survival Strategy
PPP	Public private partnership
QI	Quality improvement
QIT	Quality improvement team
RH	Reproductive health
RHB	Regional health bureau
RMNCAH	Reproductive, maternal, neonatal, child and adolescence health
SDG	Sustainable development goal
TWG	Technical working group
UNFPA	United nation fund for population
UNICEF	United nation children's' fund
USAID	United States aid for international development
WHO	World Health organization

Executive Summary

As a result of decades of relentless effort in health system strengthening and improved access to essential health services, Ethiopia has achieved remarkable gains in reducing maternal and child mortality. The MDG 4 target was achieved three years early when under-five mortality was reduced by 67% from the 1990 estimate. Good progress toward MDG5 was also made and the MMR had declined by nearly 75% from 1,250/100,000 LBs to 353/100,000 LBs between 1990 and 2015.

However persistent challenges still exist with inadequate utilization of health facilities particularly for delivery attended by skilled personnel. Lack of respectful care and poor quality of care contribute to women dropping out from the continuum of maternity care. There is significant regional variation in the performance of maternal health care. Weak collection and usage of data contribute to the ongoing challenge to improve MNH services.

The National Health Sector Transformation plan sets targets for equitable and quality health and calls for an improvement in the quality of MNCH care. Ethiopia has therefore engaged with the WHO led network to 'Improve Quality of Care for Mothers, Newborns and Children'. A preliminary step for members of this international network is to develop a country specific MNH quality of care Roadmap. Thus the Federal Ministry of Health with its development partners has developed this road map to improve the Quality of Care for MNH.

The MNH QoC strategic objectives are:

STRATEGIC OBJECTIVE 1: LEADERSHIP: Build and strengthen national institutions and mechanisms for improving quality of care in the health sector.

STRATEGIC OBJECTIVE 2: ACTION: Accelerate and sustain implementation of quality of care improvements for mothers and newborns

STRATEGIC OBJECTIVE 3: LEARNING: To facilitate learning, share knowledge and generate evidence on quality of care

STRATEGIC OBJECTIVE 4: ACCOUNTABILITY: To develop, strengthen and sustain institutions and mechanisms for accountability for quality of care

The Roadmap stipulates a goal of reducing institutional maternal and newborn deaths and stillbirths by 50% by 2020 and achieving a measureable improvement in user satisfaction with the care received.

The road map development is guided by a detailed situational analysis using the WHO MNH QOC analysis framework. Strengths and weaknesses along the four strategic objectives of the framework: leadership, action, learning and accountability are presented along with priority actions proposed for the identified gaps.

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The road map development is guided by a detailed situational analysis using the WHO MNH QOC analysis framework. Strengths and weaknesses along the four strategic objectives of the framework: leadership, action, learning and accountability are presented along with priority actions proposed for the identified gaps.

A work plan detailing activities for the major outputs of the strategic objective with the budget is included. There will be a country led dissemination of the roadmap to engage major stakeholders. The proposed actions from the roadmap will be incorporated into the annual operational plans of relevant directorates of the Federal Ministry of Health and Regional Health Bureaus. There will be widespread promotion of the roadmap and resource mobilization for its implementation.

The roadmap will be implemented from July 2017- June 2020 and a set of impact, outcome and process indicators are proposed for the purpose of monitoring and evaluating its implementation. Existing routine performance tracking mechanisms (supportive supervisions, review meetings) drawn from EHAQ experience in implementing quality initiatives will also be used for M and E.

Successful implementation of the roadmap is envisaged through continued political commitment, sustainable funding, strong partnership for health system strengthening and community engagement.

1. Introduction

The Sustainable Development Goals (SDGs) and the Global Strategy for Women's, Children's and Adolescents' Health set ambitious health-related targets for mothers, new-borns and children. Many women, their babies and children still die, or suffer from life-long disabilities, even after reaching a health facility due to poor care practices. Improving Quality of Care (QoC) and patient safety is critical to ending preventable maternal and newborn death and achieving the SDGs by 2030.

The health of mothers, newborns and children remain a priority agenda for the health sector. Owing to decades of relentless effort in health system strengthening and improved access to essential health services, Ethiopia has attained remarkable gains in health related MDGS.

One of the notable successes is Ethiopia's achievement of the MDG 4 target three years earlier by reducing under-five mortality by 67% from the 1990 estimate. Good progress in reducing maternal mortality was also recorded. According to estimates by the UN Inter-Agency Group (UN-IAG), substantial declines in maternal deaths have been documented over the last two decades. According to this estimate, the MMR had declined from 1,250 to 353 maternal deaths per 100,000 live births between 1990 and 2015. The absolute number of women who died during pregnancy or childbirth had also decreased nearly by 75%, from 31,000 in 1990 to around 11,000 in 2015. Therefore, Ethiopia is acknowledged as one of the countries in progress toward MDG5 MMR target of 267 maternal deaths per 100,000 live births.

However, there are persistent challenges with inadequate utilization of health institutions for delivery attended by skilled personnel and significant number of home deliveries; non-dignified maternity care; weak data collection and analysis of maternal health services; presence of regional disparities in the performance of maternal health care; poor quality of care along the continuum of care which has resulted in significant cascade loss of women attending maternity care (From 62% coverage for ANC 1 to a declining coverage in ANC4+ of 32%, SBA of 28% and lowest coverage for PNC of 17% according to EDHS 2016). Similarly, least progress was made in reducing neonatal mortality which stands at 29 deaths/1000 LBs in 2016.

Cognizant of this, the National health sector transformation plan (HSTP) 2016-2020, in line with the country second growth and transformation plan (GTPII), has set ambitious goals to improve equity, coverage and utilization of essential health services; improve quality of health care; and enhance the implementation capacity of the health sector at all levels of the system. In order to achieve the stretched targets in HSTP, four interrelated transformation agendas were identified. These are transformation of quality and equity of health care; woreda transformation; a movement towards compassionate, respectful, and caring health professionals; and information revolution.

The health system, over the last two decades, has been focused on improving coverage of essential health services and a lot remains to be done towards improving quality of care at each level of the health system. A focus in quality and equity required a shift in the status quo to drive improvements at national scale.

Hence, aligned with the National Health sector transformation plan and Ministry of Health's targets for equitable and quality health care service for all Ethiopians by the year 2020, the MOH has developed the

health sector quality strategy (HSQS) for 2016-2020. The health sector quality strategy aims 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.

An integrated approach to planning, improving, and controlling quality; activating key constituencies to advance quality; linking UHC strategy with quality and supporting strong data systems and feedback loops as the "backbone" of all improvement actions are the four strategic focus areas of the strategy. Maternal and child health is also one of the five public health priorities identified in the strategy.

For successful implementation of QI activities at all levels, FMOH has started putting in place the different organizational arrangements at various levels of the health system (MOH, RHBs, Zonal health desk, woreda health office, hospitals, health centers and community level).

At federal Ministry of Health level, a Health Service Quality Directorate (HSQD) supported by a National Health Care Quality Steering Committee is established. Progress is also being made in forming a Quality Unit (QU) led by CRCPO and supported by a Regional Health Care Quality Steering Committee at RHBs; assigning Quality focal person at zonal and woreda levels; quality unit at hospital and quality committee at health centers. The Health Development Army (HDA) will be working as Quality Improvement Team (QIT) at the community level.

Since putting the quality strategy in place, encouraging strides have been made in terms of putting the required structures, developing normative guidelines, tools and capacity building for effective implementation of quality improvement activities.

A learning collaborative has also been the fundamental approach of Ethiopia's experience in implementing quality. This was materialized through the Ethiopian Hospital Alliance for Quality (EHAQ) platform. EHAQ is a model of quality collaborative where hospitals form a network for systematic sharing of information, actively support each other in the replication of best practices, learn from alliance successes and establish a system of accountability in hospital services.

The EHAQ model is currently upgraded to Ethiopian health institutions alliance for quality (EHIAQ) by expanding and strengthening its networking with health centers. It will remain as the mainstay of learning collaborative in the country. It is the largest partnership network established among health institutions in Africa.

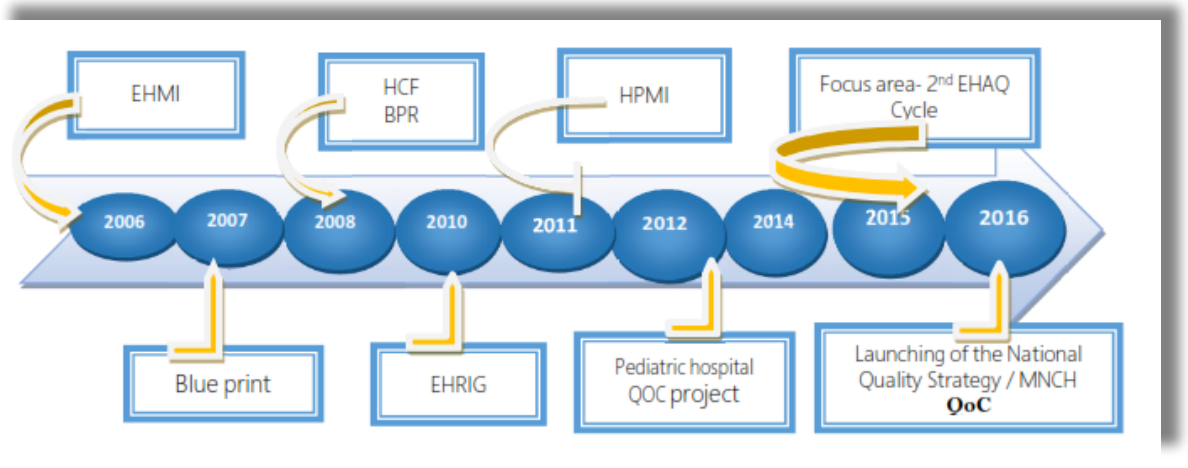
The WHO led Network to Improve Quality of Care for Mothers, Newborns and Children comes at a very important time in the country's effort to advance one of the health sector's transformation agendas, "transformation of quality and equity of health care". The Network is a broad-based partnership of committed governments, implementation partners and funding agencies, coordinated by the WHO to support efforts to improve maternal and newborn Quality of Care.

The network aims to deliver a vision of quality that is underpinned by the core values of quality, equity and dignity and targets to halve institutional maternal and newborn deaths in 5 years. It is Country led and builds on national structures for quality of care and domestic resources. A partnership for learning is built between first wave countries which can be rapidly drawn upon by other countries.

Ethiopia as one of the nine first wave countries in the network will optimally engage to learn from other countries in the network; share knowledge and generate evidence on quality of care to improve care for mothers, newborns and children especially around the time of birth and immediate postpartum period.

2. Evolutionary change of quality from initiative to strategic planning: Important milestones in the history of MNCH quality care in Ethiopia

The inception of organized and documented Quality improvement initiative in the health care institution of Ethiopian history goes back to 2006 when President Bill Clinton and Dr. Tedros Adhanom, former Ethiopian minister of health, agreed bilaterally to improve Ethiopian hospital service delivery through leading a masters' level hospital administration training with support from Clinton Health Access Initiative (CHAI) and Yale University. On 2007, the blue print hospital management initiative guideline was developed. In 2008, the application of Business process reengineering, a countrywide multi-sectorial reform in the health sector brought major changes in commitment for performance improvement from the national level to the lowest health care facility.



In 2010, the Ethiopian hospital reform implementation guidelines was launched and considered as flagship initiative within the first cycle of hospital alliance for Quality. Following the launch of EHRIG, the hospital performance measuring initiative to monitor the progress of performance of the EHRIG implementation and other quality of care initiatives through Key performance indicators (KPIs) was launched.

In April 2012, a 3 years' Russian Federation supported pediatric quality of care improvement project was introduced. This has been a very good opportunity to reposition the national effort to MNCH quality care. The implementation of this joint WHO/FMOH project not only paved the way to implement pediatric QoC but created an advocacy platform for orienting key stakeholders on Quality Improvement (QI) of maternal health. As of November 2013 and following stake holder orientation during the first year pediatrics QOC review meeting, the initiative to improving quality of maternal health was initiated and the pediatrics QoC activity was scaled up from 10 hospitals to 50 hospitals.

National coordination mechanism for Maternal QOC (TWG) was formed to embrace all partners working on maternal and new-born QI. The National Maternal and newborn health QoC assessment tool was then adapted from the WHO MNH assessment tool for hospitals and MCH QI indicators incorporated in to EHAQ validation/audit tool. Maternal QI has become the area of focus in Ethiopian hospital reform through Hospital alliance for quality since January 2014. The MCH QI implementation at facility level was one of the major components of EHAQ recognition and accreditation criteria for awards in the second round of EHAQ cycle.

During the second EHAQ cycle, capacity of lead hospitals in the alliance was built to apply the adapted WHO maternal, newborn and childcare quality improvement and self-assessment tool for hospitals. Lead hospitals assisted by MOH, partners and RHBs were able to assess baseline performance and implement quality improvement interventions. Further support through supportive supervision was given and final validation assessment which culminated in awards for the best performing hospitals in March 2016. Lead hospitals have also cascaded support to member hospitals in their clusters to improve MNCH care.

National MNCH QoC improvement effort through EHAQ initiatives

Notable improvements in 10 nationally defined QoC standard for MNCH care were made through the EHAQ across the whole continuum of care in obstetric, neonatal and child care from the baseline in 2014 to the final validation assessment in 2016

Through this national initiative, a number of success stories were registered at all levels. A strong sense of collaboration was created which resulted in sharing of best practices, a sense of positive competition and improvements in overall healthcare service delivery in hospitals. More specifically, from the baseline in 2014 to the final validation assessment in 2016, notable improvements in MNCH care were made for a total of 10 nationally defined quality of care standards across the whole continuum of care in obstetric, neonatal and child care (Table 1).

Table 2: Change among LEAD[1] hospitals in maternal and neonatal services measures from baseline to follow-up (N=18)

	Number of items per domain	Baseline score (SD)	Baseline percent of items met	Follow-up score (SD)	Follow-up percent of items met	p-value
Basic infrastructure score	8	5.50 (1.10)	68.8%	6.67 (1.14)	83.4%	0.043
Antenatal care facility assessment	9	6.62 (1.56)	73.6%	8.08 (0.74)	89.8%	0.010
Emergency obstetric care	33	21.77 (4.02)	66.0%	28.09 (5.29)	85.1%	<0.001
Caesarian delivery	16	10.33 (2.24)	64.6%	12.14 (2.80)	75.9%	0.064
Case management of post-partum hemorrhage and eclampsia	10	6.54 (1.63)	65.4%	7.77 (1.31)	77.7%	0.013
Pediatric care	12	6.33 (2.68)	52.8%	10.17 (2.09)	84.8%	<0.001
Laboratory service	5	3.67 (1.03)	73.4%	4.44 (0.73)	88.0%	0.014
Guidelines and auditing	7	3.72 (1.90)	53.1%	4.86 (1.75)	69.4%	0.044
Infection Protection and Patient Safety	10	6.22 (2.13)	62.2%	8.94 (1.47)	89.4%	<0.001
Total maternal and neonatal service score	110	65.57 (10.50)	59.6%	91.16 (12.42)	82.9%	<0.001

[1]LEAD hospitals were those selected by the Federal Ministry of Health (FMOH) based on their high performance relative to the Ethiopian Hospital Reform Implementation Guidelines (EHRIG) standards

In 2016, the national health care quality strategy was launched to bring about a strategic change from simple quality assurance process to institutionalizing the culture of continuous Quality improvement by health facilities.

MNCH is one of the priorities of the national quality strategy (2016-2020). It is included in the operational /annual plan of the health service quality directorate and implementation has started. To date the following achievements are made:

- Quality structures at different administrative and facility levels are being placed as stipulated in the strategy
- MNCH quality standards were developed based on the WHO standards and published in the Ethiopian Health sector transformation for quality guideline (HSTQ)
- Quality improvement and clinical audit tools were also prepared based on the WHO MNH quality standards
- The Ethiopian health services transformation guideline (EHSTG) which is a revised updated version of the Ethiopian hospital reform implementation guideline (EHRIG) was developed and MNCH Administrative standards included as one chapter
- The largest partnership network was established among Ethiopian health institutions which is meant to catalyse collaborative learning
- First round baseline infrastructure assessment was conducted in lead hospitals based on the quality of care audit tools
- The first health service quality bulletin was published where evidence in MNCH quality improvement among LEAD hospitals was included
- Orientation on Quality improvement methods, health service transformation for Quality (HSTQ) guideline and the Ethiopian health services transformation guideline (EHSTG) was provided for 2,500 participants from 244 hospitals (39 LEAD hospitals and 205 member hospitals)
- To institutionalize and sustain work on health service quality, a master's level Quality improvement course is under development
- 53 KPIs were developed among which MNCH QOC measures are included
- Health centre service management standards (EHCRIG) like that of EHSTG for hospitals, has already been published and distributed to health centres. Performance report is also sent quarterly
- QI training for health centres is also being given for Partner supported project Woreda
- The pre-existing manual outlining monitoring and evaluation of quality service in hospitals, "Hospital Performance Monitoring and Improvement Manual" is under revision to include the new KPIs
- The WHO draft core MNH indicators are also under consideration to be incorporated in the current HMIS revision

About Ethiopian Hospital Alliance for Quality-EHAQ

- The largest partnership network established in 2011 to improve the quality of care and catalyse collaborative learning among hospitals across the country
- **The third cycle of EHAQ run from 2014-2015 flagged the MNCH QoC initiative**
- MNCH Quality was one focus area for the third EHAQ cycle. It was concluded in March 2016 by awarding best performing hospitals

Much of the work since launching the national quality strategy was centered on putting in place the enabling environment in terms of norms, standards and guidelines as well as some capacity building. The monitoring and evaluation part is also being developed. Hence progress has to be heightened to especially initiate actual implementation of quality improvement activities in facilities based on the new guidance in the health service quality strategy.

3. MNH QOC analysis exercise in Ethiopia

As part of country engagement in the network to improve MNH QOC and prepare a roadmap, a situational analysis of quality of care implementation in MNCH was conducted using a QOC analysis frame work developed by WHO. The framework provides a step by step outline for governments, regional and district leaders and managers an opportunity to develop a more integrated approach to quality; harmonize multiple efforts and use a learning system to demonstrate, implement and scale up quality of care in the health system. The framework further assists in creating joint understanding of the network, agree on priority actions and get all stakeholders commitment.

The analysis was conducted at national, district and facility levels across all the strategic objectives of the network: Leadership, Action, Learning and Accountability. Information on strengths, weaknesses and remedial actions was generated for a number of out puts under each strategic objective.

Weaknesses were graded across levels of 1-4 to help identify priority/critical gaps to be addressed. As part of the framework, responsible government and development partner organizations were also assigned for the remedial actions and possible timelines to execute the actions outlined to cover a 3 years' period.

The process

- The network was introduced to MOH and development partners by WHO HQ mission to Ethiopia in September, 2016. At the time, the country quality of care landscape, government and partner commitment to join the MNH QoC network was assessed and information thus gathered was an input to the QOC analysis framework
- The QOC analysis framework was shared to all relevant partners for their understanding followed by a pre network launch workshop
- A national MNCH quality summit/ a pre network launch workshop was organized on 29th November-1st December 2016. One of the major objectives of the summit was to do the QOC analysis exercise
- Accordingly, the QOC analysis framework was introduced to the summit participants and completed through a group exercise. The summit was attended by a diverse group of stakeholders representing all lead hospitals including some university hospitals, all regional health bureaus, MOH and development partners. Groups were formed for each level (national, district and facility) and each of the four strategic objectives. So a total of 12 groups and 53 individuals participated in the exercise. (Annex IV)
- Through the exercise, strengths and weaknesses/gaps were identified; the gaps were given grades, actions proposed, responsible bodies and timelines assigned.
- For missing information, further review and refinement was done by MOH and WHO colleagues. And everything was compiled together.
- It was then shared to the HSQD director who has further reviewed and commented on the document.

- Further review was done by the country team, which went to Malawi for the Network launch meeting in February 2017 MOH, Save the children, UNICEF, UNFPA, USAID, IHI, WHO, Ethiopian Midwives Association. After Malawi, partner responsibilities were revisited and amended
- Final draft of the QOC analysis framework was produced and its priorities presented to the national QOC steering committee meeting chaired by Chief of staff, State Minister's Office Federal Ministry of Health on March 6, 2017, the national hospital quality review meeting held on March 7-10, 2017 and the national quality summit on 17th March, 2017
- The completed QOC analysis framework has gained MOH's approval and its priorities are here by incorporated as the road map document

National MNCH Quality Summit. A Pre Network Launch Workshop, 29 November - 1 December 2016

4. Goal

- **Reduce maternal and newborn mortality** –reduce institutional maternal and newborn deaths and stillbirths by 50% by 2020.
- **Improve clients' experience of care** – enable measureable improvement in user satisfaction with the care received.

The GOAL of the MNH QoC strategic roadmap:

- ***Reduce maternal and newborn mortality*** *– reduce institutional maternal and newborn deaths and stillbirths by 50% by 2020.*
- ***Improve clients' experience of care*** *– enable measureable improvement in user satisfaction with the care received.*

5. MNH QOC analysis result: Strategic objectives and priority actions

Results from the MNH QoC analysis framework are presented based on the four strategic objectives of leadership, action, learning and accountability and accompanying outputs. The general situation in terms of strengths, gaps and what needs to be done as priority action to strengthen systems for effective implementation of MNH quality of care is indicated to some detail.

5.1. STRATEGIC OBJECTIVE 1: LEADERSHIP

Build and strengthen national institutions and mechanisms for improving quality of care in the health sector.

Output 1: National and subnational governance structures for QoC are strengthened (or established) and functioning

A National Health Service quality directorate (HSQD)is established with in the federal ministry of health by end of 2015 and is responsible to play a leading role to operationalize all quality improvement works in the health sector. Under this directorate there are two case teams namely Quality Improvement and Hospital reform case teams. The Quality improvement case team works to institutionalize QI culture across the health sector and operationalize the implementation of quality strategy. This case team is also responsible to coordinate the national flagship initiatives such as Saving Lives through safe surgery (SaLTS) and Clean and Safe Health Facilities (CASH) initiative. The hospital reform case team is responsible for the development and revision of hospital reform and operationalizing the implementation of Ethiopian health services transformation guideline (EHSTG) which is developed in 20 chapters and its operational standards. A third case team, public private partnership (PPP) case team is under establishment to support QOC in private health facilities.

Quality improvement work in health centers and university hospitals is led by the clinical health services directorate of MOH.

These two directorates, HSQD and clinical service directorate are working on quality of care at different levels of health facilities with unclear coordination and linkages. There is a need to strengthen the HSQD which oversees and coordinates all the health system QI activities at all levels. This directorate should have the mandate to coordinate all the quality improvement activities under each directorate including MCH directorate.

HSQD led the revision process of hospital key performance quality indicators, and trainings to orient about quality improvement have been launched; with over 3,000 professionals (from RHBs, university and general hospitals) given quality orientation training through a train-the-trainer approach.

A separate agency, Food, Medicine and Healthcare Administration and Control Authority (FMHACA) is responsible for health and health related services and products quality regulation, which includes the practice, premises, professionals and products. The MCH directorate is also working on and introducing interventions to improve quality of care to mothers and newborns including the implementation of maternal, perinatal death surveillance and response system that explores the causes of death at facility and community level with continuous quality improvement interventions to avert further deaths.

However, there is limited understanding of the quality planning and improvement works that are being implemented by the different directorates. There is a perception that quality is only the job of the Quality Directorate – rather than other Directorates feeling ownership around quality. There is tremendous opportunity to build ownership on quality across the Ministry and identify large-scale results-based improvement initiatives where these directorates can play a key role in driving.

The engagement of other sector ministries in closely working with MOH is very weak for improving quality of care and reaching the standards. There is a need to engage all the concerned ministries to improve MNH quality of care with a multi sectoral approach.

National Health Care Quality Strategy, which is a subset of the Health sector transformation plan, was launched in December 2016. MNCH is one of the five priority health conditions in the strategy. Addressing the three core elements of quality (quality planning, quality improvement and quality control) in a holistic way is the key foundation of the Strategy.

A national health care quality steering committee is also in place following the HSQD establishment. It is chaired by the State Minister's office and comprised of members represented from relevant MOH directorates; MOH agencies like Pharmaceutical fund and supply agency (PFSA), Food, medicine, and health administration and control agency (FMHACA) and Insurance agency; development partners including UN agencies, implementing and funding agencies and professional societies.

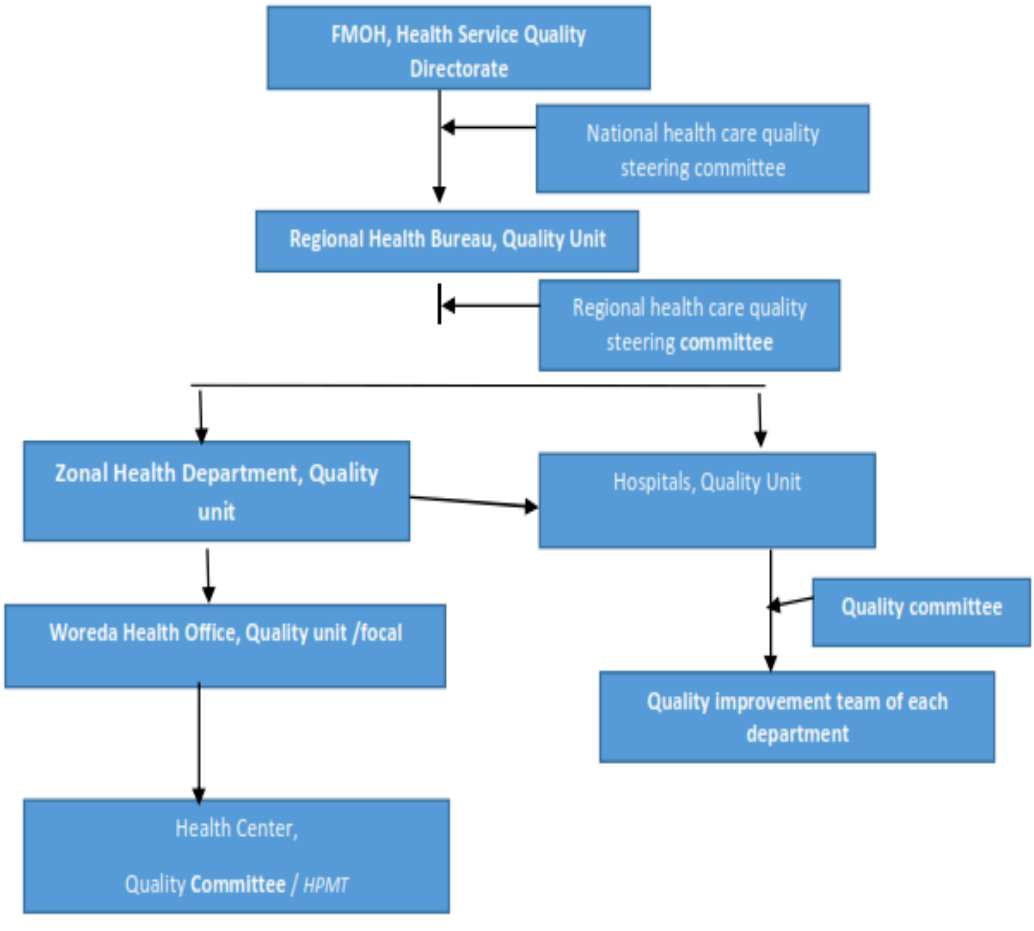
The *national health care quality steering committee establishment gave some opportunity in creating a common understanding on Quality improvement concepts and National quality strategy implementations among the relevant stakeholders.*

NOTABLE PROGRESS IN QUALITY STRUCTURE IN ETHIOPIA

- *National Health Care Quality Strategy, which is a subset of the Health sector transformation plan*
- *A National Health Service quality directorate (HSQD)is established with in the federal ministry of health*
- *A national health care quality steering committee is also in place following the HSQD establishment and chaired by State minister office*
- *National quality of care standards for MNH is adapted from the WHO standards, 2016 witin Health service transformation for Quality*

At subnational level, structures in the form of units, committees and teams at each administrative, facility and community level are approved by MOH as documented in the HSTQ guideline. Quality leads have been identified in some RHBs. In some hospitals, full-time quality officers of the quality unit have been selected and trained. In hospitals where HRH capacity is limited, officers have part-time quality roles. However, quality structures are not yet in place at zonal, woreda and at health centers of the country.

National Quality of Care Governance Structure



Priority Actions

- Strengthen National health quality steering committee:
  - Make it an inter-directorate platform to be chaired by the state minister or co-chaired by relevant directorates
  - Ensure active participation of members in meeting; require attendance and participation by all directorates focused on key health areas
  - Develop dashboard of prioritized quality metrics
  - Review and amend the TOR, its membership to include relevant MOH directorates, agencies, development partners including professional societies and consider establishment of a multi sectoral steering committees for quality of care at the national level

- Put the right structures (Quality units at region, zone and district offices including regional quality steering committee) with defined roles and responsibilities and plans
    - Revitalize technical working group (TWG) of MNCH through amendment of TOR and membership and make QOC a standing and regular agenda
- Put the right structures at facilities with defined roles and responsibilities and plans
    - Quality unit, quality committee and QI teams at hospital level
    - Quality committee at health centers
    - Establish quality improvement team at the community level (led by level I & II certified women development army members)
- Capacity building on QoC at all levels (national, regional, zonal and woreda levels)
- Demand creation on QoC of the community through the Women Development army level I & II certification program. This will be a good opportunity to improve the health literacy and quality of perception of the community.
- Develop regional and woreda MNH improvement plan with budget line item and time-bound aims.

Output 2: Operational plan for improving quality of care in MNH services is developed, funded, monitored and regularly reviewed

Targets for MMR, neonatal and under five child mortality are well articulated in national plans and strategies of the Health Sector transformation plan (HSTP), 2016-2020; National Child Survival Strategy (NCSS), 2015/16-2019/20, Reproductive Health Strategy (2016-2020) and Adolescent and Youth health strategy. Quality and equity of health care is one of the four transformation agendas of the HSTP and well integrated with in the National RH strategy, 2016-2020 and NCSS, (2015/16-2019/20). The HSTP target for MMR is to reduce from 420/100000 LBs to 199/100000 LBs corresponding to the network goal of reducing institutional maternal mortality by halve.

To accelerate progress towards improved outcomes, a national operational plan for MNH quality improvement is developed by the quality improvement case team of the HSQD. The MCH directorate operational/annual plan also includes several quality activities. Both operational plans are costed. Resource allocation in terms of finance and technical assistance is done through dialogue and discussion with partners represented in the national quality steering committee. Coordination and alignment of annual plans is also done with regions and other directorates of the MOH. Regular reviews of progress against targets (quarterly, semiannually and annually) are conducted through an internal MOH mechanism and a participatory process of engaging stakeholders. And the national plan is adjusted as required.

MNCH-N mapping by MCH directorate is finalized recently which has shown clearly which partner organizations are working where and on which MNH interventions. This mapping exercise will be a good opportunity to improve geographic distribution and quality of care for better MNH outcomes, allowing MOH to allocate resources and work closely with partners in addressing the most at need regions and woredas with poor MNH indicators.

As the quality structure establishment is going on, there is a need to create an ear marked budget line for quality of care including for MNH at subnational level.

Priority Actions

- Revitalize/Establish technical working groups (TWG) for MNCH represented by concerned directorates/processes, agencies and development partners including professional societies for regular monitoring of quality of care implementation at all levels.
- Strengthen resource mobilization with ear marked budget for MNCH QoC by reviewing existing annual investments from the FMOH and subnational annual plans, resource mobilization spreadsheet and MCH directorates spreadsheet
- Finalize stakeholder mapping (agreeing on roles, responsibilities and commitments) at national and subnational levels
- Harmonize QOC initiatives by different MOH directorates & partners during annual planning at national and sub-national levels
- Identify and work closely with key technical partners, define roles, commitments and responsibilities in support of the woreda and facility plan for improved MNCH care

Output 3: Advocacy and mobilization strategy for quality of care is developed and implemented at all levels

National and subnational level will and support for MNH QOC initiative is demonstrated through various ways. There is a regular system to identify and recognize champions on quality through the EHIAQ initiative. Nationally, best performing hospitals are awarded as lead hospitals and during the second EHAQ cycle, the focus area for the award was performance on MNCH QOC. The awarding ceremony is a high level meeting attended by the deputy prime minister of the country, government officials and key stakeholders.

MOH's commitment to the initiative and public updates on quality are also expressed through Ministerial website, EHIAQ Facebook page, quality bulletin and TV program of MOH. However, the HSQD doesn't have its own website and the existing website for the MCH directorate is not regularly updated. A national annual quality summit is organized where MNCH QOC is a priority agenda and support to the initiative mobilized.

Review of progress and course corrections is done through the health sector annual review meeting, annual review meeting on RMNCAH by MCH directorate and on quality by the then medical service directorate and the current HSQD. These forums are also used to maintain and build will and support by all concerned.

Mobilizing stakeholders to express and build will and support to MNH QOC is not strong at subnational levels and there is limitation in mapping and aligning stakeholder engagement/commitment in general.

Priority Actions

- Develop advocacy and mobilization strategy on MNCH QoC
- Establish quality directorate website/use the official MOH website and regularly update it for advocacy
- Activate/strengthen engagement of region/woreda in the EHIAQ regular (quarterly) meetings with stakeholders to build will and support
- Display key process and outcome data (Indicators) prominently in public places at facilities
- Disseminate information through different mass media outlets to advocate on MNCH QoC including the rights of clients
- Use public opportunities (e.g. waiting rooms, pregnant mother conference, HDA meetings) to publicize QoC efforts for maternal and newborn health

5.2. STRATEGIC OBJECTIVE 2: ACTION

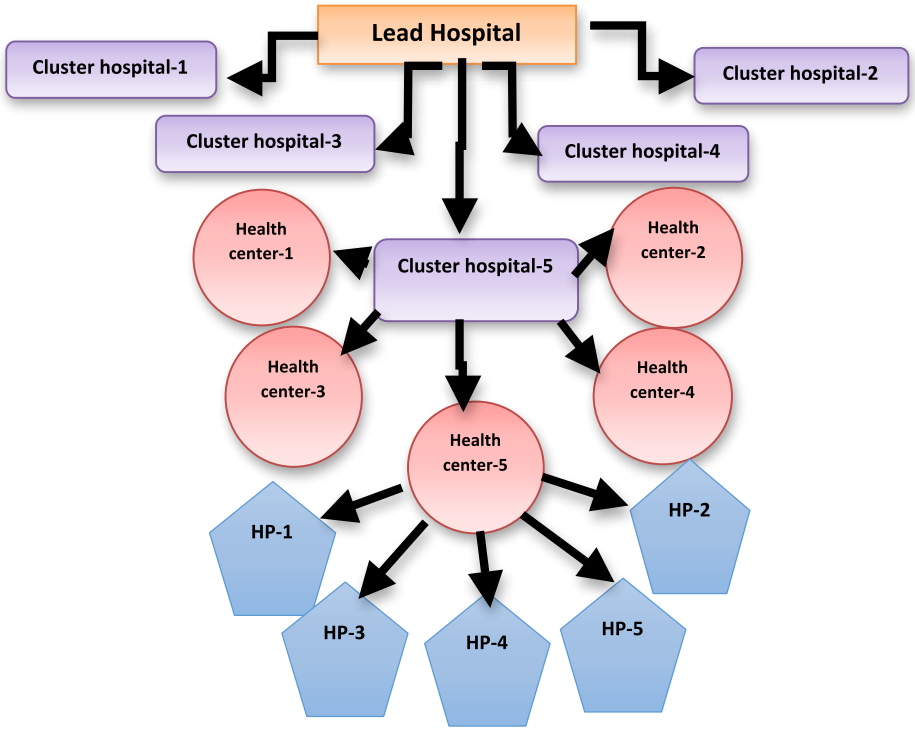
Accelerate and sustain implementation of quality of care improvements for mothers and newborns

Output 1: National package of country adapted QoC standards, best practices and implementation interventions is compiled, incorporated into the operational plan and disseminated.

National quality of care standards for MNH is adapted from the WHO standards, 2016. Obstetric management protocol for hospitals (2010) and health centers (2014) were developed and disseminated to facilities. A guideline for quality improvement and clinical audit is also developed (HSTQ). TWG is responsible for reviewing and updating QoC standards and guidelines. All Training Institutions/university hospitals have become part of the EHIAQ platform as Co-leads and are involved in the dissemination and uptake of the standards, management protocols and guidelines.

Ethiopian model of Learning District Network for MNCH QoC

There was some effort to use the EHIAQ platform as a vehicle to capture, assemble, and improve national package of improvement best practices for some flagship initiatives such as CASH, SaLTS and MNCH. Accordingly, the TWG reviewed QoC activities in lead hospitals within EHAQ initiative and best practices were incorporated in operational plans.



Adaptation of QOC standards and audit tools for health centers has yet to be undertaken. There is gap in inclusiveness of relevant partners in the EHAIQ platform and in the synthesis and sharing of best practices for implementation at scale. The system to capture successful QI interventions in cluster/member hospitals, health centers and at community level through the EHIAQ platform is in general not strong.

Priority Actions

- Finalize adaptation of QoC standards and audit tools for PHCUs (HCs and HPs)
- Involve all relevant technical partners in the EHIAQ platform and enhance their engagement in documentation and sharing of best practices
- Establish a systematic way of capturing and assembling a national package of improvement best practices by TWG to inform program delivery and next phase of scale up
- Build capacity of region/woreda/facility staff on QI, MNH standards and audit tools (HSTQ guideline, EHSTG, EPHCRIG)
- Build capacity of woreda on how to assess baseline performance, clinical and QI skills of facilities
- Build capacity of region/woreda/facility staff on how to review global/national change package for local adaptation
- Avail national MNH standards, audit tools, guidelines (HSTQ guideline, EHSTG, EHCRIG)

Output 2: Establish readiness for implementation of the MN initiative

The national MNH audit tool that was developed based on the WHO MNH standards has a set of key system input and process measures that reflect the performance of the MNH delivery system. 53 KPIs are developed based on composite scores of the measures in the audit tool including other outcome measures. The hospital performance monitoring and improvement manual detailing the monitoring and evaluation of quality service in hospitals is under revision. Hospitals keep reporting on KPIs but have not yet started reporting on the new ones. Key performance indicators (KPIs) development for health centers have been underway. A process is initiated for HMIS revision and incorporation of the WHO draft list of common core MNH quality indicators.

Baseline assessment on MNH QOC was conducted in hospitals in December 2014, then a follow-up supportive supervision conducted in July of 2015 and a final validation assessment to award best performing hospitals in February 2016. All assessments were done using an adapted version of the WHO MNH quality self-assessment tool for hospitals.

However since the launch of the current National Health Service quality strategy, 2016-2020, a comprehensive baseline performance assessment of facilities using the recently developed audit tools is not done. Only baseline infrastructure assessment of hospitals has been conducted. Some partners like IHI and MI have done baseline assessment of demonstration and scale up districts; and started to address resource gaps.

Priority Actions

- Prioritize and allocate the resources required to support the MNH QOC initiative
- Finalize identification and incorporation of core indicators in the DHIS2
- Test a set of measurable health indicators in the learning districts/sites. Take the experience to support inclusion in the next revision/iteration of the DHIS2
- Build capacity of facilities on how to assess baseline performance
- conduct baseline assessment at Woreda level on performance, clinical and QI skills of facilities and identify priority gaps

- Woreda should mobilize resources and technical assistance from MOH, regions and partners to fill gaps identified by the baseline assessment
- Facilities design and implement improvement plans in collaboration with DMT and SMT of facilities

Output 3: Initiate district-based phased implementation of MN QoC

In the Ethiopian context, implementation of QOC is full scale at a time and follows a facility based approach through the EHIAQ platform. Regions and woredas support facilities through this alliance. However, partners like IHI and MI are implementing district/woreda based phased implementation approach. For example, IHI is currently working in three demonstration woredas which will soon be expanding to a fourth woreda and is at the prototype phase in all woredas. MI and Emory University have finalized the demonstration phase in six woredas of Afar. Taking this experience as well as lessons from other demonstration projects in four woredas of Amhara and Oromia regions by Emory University, JSI, URC and other partners, MI has scaled up QI implementation to 900 PHCUs in 185 woredas. In these partners supported districts, base line assessment is conducted; resources and technical inputs are in the process of being provided and learning collaborative is established.

Formation of the learning collaborative between lead and member hospitals is well matured through the existing EHAQ experience. The process of upgrading the EHAQ to EHIAQ is at its very early stage. The process of selecting lead health centers and forming the networking among health centers and with hospitals has yet to be done.

Regarding selection of learning districts for the network, discussions are ongoing with MOH and partners and there is a recommendation to consider one of IHI's woreda as well one of best performing federal hospitals in the capital, Addis Ababa. So baseline assessment of learning districts and provision of resource and technical inputs has yet to be done after deciding on the selection and mobilizing resources/funding. Establishing learning collaborative in learning districts will follow the ongoing national effort of EHIAQ integrated with the partners' approach of district wide learning.

Priority Actions

- Finalize identification of learning districts using agreed criteria
- Conduct baseline assessment of learning districts
- Provide resources and technical support for priority gaps (training, mentoring, SS) for the learning districts
- Materialize the transition from EHAQ to EHIAQ, form EPAQ clusters
- Establish and strengthen the district level learning collaborative as per national guidance (using EHIAQ cluster review meetings, SS, mentoring)
- Engage Woreda in ongoing mentoring of facilities (prioritizing key process strengths and weaknesses, process mapping, fishbone, 5 Whys, etc. to plan and test ideas for improvement)
- Woreda leads/participates in establishing EHIAQ clusters for primary health care units
- Actively engage Woredas in facility learning sessions
- Strengthen TA to QI teams in facilities by district supervisors and partners (regular mentoring and coaching)

- Strengthen the EHIAQ lead cluster network as learning collaborative. Adapt the DMT-health facility learning collaborative approach within the EHAIQ context after reviewing the IHI or MI practice
- Strengthen participation of HCs in the EHIAQ quarterly learning session (cluster meetings)
- Scale up experience of learning districts to 11 districts, one from each region

5.3. STRATEGIC OBJECTIVE 3: LEARNING

To facilitate learning, share knowledge and generate evidence on quality of care

Output 1: Develop and strengthen data systems for quality of care improvement

There are two data systems reporting on quality indicators. One is the HMIS which has outcome level indicators focusing on coverage. In general, the HMIS doesn't have satisfactory indicators on quality. So work is initiated to identify key process/quality indicators and the WHO draft list of common core indicators on MNH QOC are considered for integration with the DHIS 2system.

The second data system collects KPIs from hospitals. The previous Medical Health Services Directorate and currently the HSQD are collecting KPIs for tracking change in hospital performance. KPIs from hospitals are reported to RHBs every month and from RHBs to HSQD/MOH quarterly. Like the HMIS indicators, the KPIs are also focused on volume of service and don't satisfactorily address quality. Hence revision of KPIs is well underway to address quality measurement across the whole continuum of the MNH care. ***Another important limitation with the KPI system is it doesn't exist at health centers.***

Guidance and tools to standardize data collection, synthesis and reporting of KPIs exists through the Hospital Performance Monitoring and Improvement (HPMI) manual as well as HMIS technical standards. In line with work on KPIs, the HPMI manual has been under revision.

This is an opportunity to use maternal death reviews to demonstrate good practice in terms of response. Moreover, there is an experience whereby EHAQ joint supportive supervisions conducted by the MOH and partners were used as a system for collecting and synthesizing best practices from hospitals and submitting it to the MOH. The National MDSR Annual report includes examples of good practice in response to individual Maternal Deaths and aggregated data. Partners also document their QI project experiences. Nevertheless, there is limited dissemination of best practices both by partners and MOH.

Review meetings on quality and national quality summit are also used for sharing of good QI project experiences. Recently started initiatives like use of HSQD face book, MOH web site and quality bulletin are also used as a way of dissemination.

In general, there is poor data utilization culture for prioritization, intervention and planning at different levels. Gaps in data quality also affect data use for decision.

Priority Actions

- Incorporate core MNH QOC indicators in to DHIS2
- Finalize revision of KPIs for hospital dash board
- Finalize the health center KPIs development process.

- Amend the existing data dashboard of hospitals based on the revised KPIs and improve capability to do analysis and generate information for action at facility level
- Prioritize MNH measures for regional/woreda QoC dashboard and design the data dashboard
- Design a national data dashboard for reporting at national (quarterly), regional (quarterly), district (monthly) and facility (monthly) levels
- Develop and implement community score cards
- Finalize performance monitoring and improvement manual for hospitals and develop one for health centers
- Review/develop district and facility maternal and perinatal registers and primary patient records based on new MNH QOC indicators in KPI and DHIS 2
- Support (mentor) facilities to initiate collection of input, process and output indicators of MNH standards (QI measures) through audit tools
- Develop a system for collecting and reporting case histories, stories from the field and testimonials for dissemination at facility, woreda and regional level
- Orientation and mentoring on data quality assurance standards and audit tool to all health facilities
- Adapt the DMT-health facility learning collaborative approach of partners and integrate it with the EHAIQ learning collaborative approach (existing lead-cluster network)
- Strengthen capacity of facility data processors on data analysis and use
- Strengthen capacity of facility leadership for understanding of data variation and use for planning

Output 2: Establish a virtual national and district learning system to share knowledge and link to global learning platform

There is no web based learning system interlinking district and national levels or national to global level. However, there are existing mechanisms of learning through regular performance review of all programs including MCH on quarter, semiannual and annual basis at all levels of the health system. Besides, performance of hospitals on quality is regularly reviewed through the EHAIQ quarterly cluster review meetings, regional and national biannual review meetings. However, learning from these reviews is not systematically synthesized by the TWG and widely shared.

District management so far was not involved in reviewing progress of QOC activities in facilities except the experience of some partners, which are implementing district based quality projects. However as per the current strategic guidance, districts will monitor QOC activities and receive monthly reports of facilities. There is no practice of feeding learning from districts to national learning system.

Knowledge products and tools are uploaded for wide dissemination in MOH website. However, the HSQD doesn't have its own web page and what is shared is limited to national guidelines.

Priority Actions

- Establish a national learning system (anchored in a MN improvement website) that is a resource for improving MN QoC for the country and links to the global learning platform

- Build capacity to feed learnings from woreda/region (summaries, overviews, manuals) into the national learning system
- Build capacity of health providers and facilities to track progress, feed learning and participate in learning through the national learning platform
- Establish the HSQD learning website
- Continue to use the existing directorate face book for learning

Output 3: Establish a face to face national and district learning system to share knowledge and link to global learning platform.

Regarding participation in global learning, partners' as well as national experience in QOC was disseminated through different global and regional forums and there is continued commitment to sharing knowledge and learn from others through cross-country visits and attendance at global convening.

In the Ethiopian Context District-Regional/National collaboration for learning is realized through biannual hospital (EHAQ) review meeting at national level where lead hospitals, RHBs and MOH participate. Within and between districts collaboration somehow happens through EHAQ where lead hospitals are networked with member hospitals within the same or another district. EHAQ has been an oldest and largest alliance since 2010 for bringing together facilities, leaders and managers. However the collaboration has been between lead and cluster hospitals and regions. It didn't include districts and health centers. Accordingly, only RHB and zonal focal persons participated in baseline audit process, follow-up supportive supervision and then validation assessment of hospitals but district supervisors and managers were not involved in these processes.

This network between lead and cluster hospitals (EHAQ platform) is used as a means of face to face learning between facilities whereby mentors from the lead hospitals visit and support cluster hospitals every month. There is also quarterly review meeting between lead and cluster hospitals where MOH and regional staff participate.

Currently the alliance is upgraded to include health centers and renamed as Ethiopian Health Institution Alliance for Quality. Districts are also expected to be actively engaged in facility QOC activities and play a coordination, monitoring and capacity building role.

Regarding district-community collaboration, MNH is a priority agenda which is advocated by district managers. Community wing meetings are conducted at quarterly base between the management of hospital and community where by complaints are heard and responded to. Patient satisfaction scores are reported as one KPI from hospitals to RHBs and MOH every quarter. Community satisfaction is not yet measured. KPIs to measure client satisfaction at health center and lower levels are not available. Existing community forums are not well utilized to discuss quality and satisfaction.

Priority Actions

- Strengthen participation of district/regional and national representatives in existing learning collaborative: EHIAQ cluster meetings, Mentorship of facilities, SS
- Hold regular review meetings on MNH QOC at regional, zonal and woreda levels (a learning opportunity between facilities within a woreda and between woreda with in a zone or region). A key agenda item at such meetings should be cases and data from the MDSR system.
- Hold regular national review meeting and quality summit
- Improve facilities' especially health centers' QI team participation in district wide gatherings to foster learning between facility teams
- Strengthen Hospital/facility leadership effort in establishing a culture of improvement and encouragement in facilities
- QI teams at hospitals should cascade the QI basic training to other staff (on core QI processes data analysis, root cause analysis, PDSA). Health centers and district health office quality officers should be included
- Use and strengthen existing HDA platform and community forums like the pregnant mother conference to disseminate better practices within the community, and to collect information on patient and community satisfaction
- Standardize the role of CBDDM (community based data for decision making) and HDA support for identification of danger signs as an element of QoC

Output 4: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up

There used to be a system to collect best practices through the EHAQ platform (when hospitals are being supervised jointly by MOH, RHB and partners). In addition, QOC best practices are published and shared on quality summits, health sector annual review meetings and quality bulletin. However, there is no established system for regularly collecting best practices and there is not as such any experience of testing change ideas, compiling as a change package and use for scale up. There was only one experience of using best practices to prepare a Labor and Delivery Change Package for Ethiopian Hospitals.

On the other hand, many partners document program learning and best practices from implementation of projects which are not systematically disseminated, tested and used for scale up. In general, the approach of district based phased implementation (from demonstration to scale up) doesn't exist except with the experience of some partners as indicated under the action strategic objective. Rather the lead hospitals in the EHIAQ clusters can be considered as demonstration/learning districts or sites.

Priority Actions

- Establish a systematic way to collect change ideas (through the TWG and in liaison with the MDSR system), to test, to compile as a change package and use for scale up.

- Plan and advocate for documentation and publicizing best practices for scale-up
- Work on publishing organized case reports
- Plan and advocate for documentation and publicizing best practices for scale-up
- Mentor facilities to:

- Adopt national best practices (tested change ideas), collect information (annotated run charts and stories) on the performance of those ideas and practices in the local facility context, and share with other facilities
- Continue to test new ideas for improvement if targets are not reached. Incorporate local successful tests (PDSAs) into new protocols for standard work at the facility and share with District
  - Advocacy for ongoing scale up of initiative, publicizing results by facility leadership

5.4. STRATEGIC OBJECTIVE 4: ACCOUNTABILITY

To develop, strengthen and sustain institutions and mechanisms for accountability for quality of care

Output 1: National framework and mechanisms for accountability for QoC are established and functioning

Progress towards achieving process and outcome targets is regularly reported to MOH through HMIS and there is a review mechanism of these data throughout the administrative levels of the health sector every quarter, semiannually and annually. Specific to quality, KPIs are also reported from hospitals to regions every month and to MOH every quarter. KPI data specifically goes to the medical services directorate of the MOH in the past and now to the health service quality directorate. KPIs are taken as one criterion whereby hospitals are transparently evaluated and recognized through awards.
Progress is also presented to and reviewed by the National Quality Steering Committee comprised of important stake holders.

However, there is limitation in the review process; it is not focused on identifying problems, designing solutions and monitoring follow up actions to remedy bottlenecks. Moreover, sensitive matters of political concern like maternal death are not reported transparently. Since woreda managers are held accountable for a maternal death, they tend to underreport. Human resource, finance and supplies are not regularly tracked and reported.

Different mechanisms exist to capture and report patient experience of care data and ensure public accountability. Community score cards are implemented in HCs and HPs of some pilot districts of major regions. Through this mechanism, communities evaluate the facilities using their own criteria, providers also self-assess themselves and finally they come together to discuss. Public wings and town hall meetings (between hospitals with community) also exist to hear client complaints but there are gaps in planning and monitoring follow up actions to address problems.

Ethics committees are established at facility, region and national level. Clients' satisfaction is one KPI which is monitored on quarterly base and reported from hospitals to regional and national level. Specific to MNH, mom satisfaction survey is conducted quarterly in hospitals and reported to MOH. However, these data are not publicly available.

Priority Actions

- Monitor transparent reporting of HMIS data through regular RDQA at all levels
- Develop health metrics dashboard which will be used by the National Healthcare Quality steering committee
- Implement MNCH score cards at national, regional and district levels
- Design a data base linking regional, woreda and facility levels in such a way that all levels including facilities report and able to view/monitor progress regularly (Resolve data transparency issues)
- Conduct public wing meetings, quarterly at all levels, and strengthen participation of HSQD and MCH
- Develop clear action points from community forums and public wing meetings, monitor follow up actions and report in subsequent meetings
- Conduct multi stakeholder dialogue to review progress and remedy bottlenecks at different levels
- Create links to Ethiopian social accountability program (ESAP)
- Report Maternal and newborn outcome data including MDSR data , patient experience of care data transparently and publicly
    - Strengthen patient/mom satisfaction survey and reporting at facilities
    - Strengthen/establish client councils
    - Implement patient charter
    - Implement community score cards
    - Establish Partnership defined Quality models that give the opportunity to the members of the community represented by either the HDA network or KCP have a say on the Quality of services in the facility.
- Display commitment to quality, experience of care data and run charts prominently in public places at facilities
- Strengthen LMIS at all levels
    - Make facility supply chain and management of resources a management priority
    - Identify and remedy bottlenecks (internal and external) contributing to interrupted supply of drugs and equipment
    - Build capacity of pharmacy and other relevant staff on regular and timely tracking/ reporting of stock outs of equipment and drugs
    - Strengthen DTC at each level of facility
    - Conduct SS and mentoring on LMIS
    - Avail necessary formats (internal facility report and requisition form, bin cards, RRF forms)
    - Implement pharmaceutical and warehouse initiative as per EHCRIG
- Regularly monitor functionality of ethics committees in hospitals through regulatory audit

- Design client grievance handling mechanisms at district levels through toll free telephone lines
- Establish the national and regional client grievance handling mechanisms through toll free telephone lines
- Create awareness of the toll free service at all levels
- Strengthen MDSR and introduce PDSR at all levels

Output 2: Institutionalize system improvement capability for country-led scale-up and sustainability

In terms of efforts to improve MoH Quality Directorate/teams capability to scale up and sustain MN improvements, Quality improvement leadership and management (QILM) training had been provided to champions from lead hospitals and staffs of health service quality directorate by partners. And the directorate staff have cascaded the training to FMHACA staffs and other hospitals. Capacity building training on kaizen managerial and administrative methods and approach is also planned for leaders and managers. There is limited follow up and mentorship program to sustain the capacity building activities. Several in service trainings in MNCH somehow also address quality of care, women friendly and respectful maternity care.

Routine knowledge sharing and learning exists in MoH through a 1-5 network of officers called the civil service health development army. The 1-5 network conducts daily meetings for sharing experience, knowledge and skill through monitoring of daily planning and performance. Through this system, documents on quality structure, tools and protocols are developed and published as health service transformation for Quality guideline. There is lack of uniformity and consistency in among the 1-5 networks during implementations. As a way of building capability of train future staff to use systems improvement methods to lead, manage and implement change, the Human Resource directorate and HSQD are working on a masters' level QI and patient safety course curriculum to be provided for physicians and health facility managers. There is no standard/systematic way of training current or new staff in the HSQD as well as established methodology of training future staff to use systems improvement for the time being.

Above all, sustainable funding or ear marked budget allocation for MNH QOC and clearly defining roles of different directorates and partners working on MNH QOC will strengthen institutionalization and sustainability of system improvement capability.

Priority Actions

- Allocate adequate budget for Quality planning, improvement and control activities at all levels
- Build capacity to use data for decision making at all levels
- Develop interface document to clearly define and align roles of different MOH directorates in QOC
- Strengthen 1-5 network to ensure quality issues are prioritized, discussed and action taken accordingly at all levels
- Highlight quality improvement work in quarterly health bulletin of MOH
- Publish Quality times and distribute widely

- Develop and disseminate policy briefs on quality of care Include quality domains in ARM experience sharing (e.g. CASH)
- Design CPD to train future MOH staff to use systems improvement methods to lead, manage and implement change
- Develop a master's level QI and patient safety course curriculum and initiate training
- Conduct experience sharing to areas with best practice at all levels
- Integrate QI concepts in pre-service curricula

5. Monitoring and Evaluation

Successful implementation of the roadmap relies on a clear monitoring and evaluation plan. A set of impact, outcome and process indicators will be used to monitor level of implementation of interventions in the roadmap and inform achievement of targets. M and E also improves institution of timely corrective actions on implementation challenges; optimal use of resources and accountability at all levels of the health system.

DHIS2

The main sources of data for monitoring and evaluation are the DHIS2 and the existing hospital performance monitoring system through KPIs. Indicators which can't be captured through the DHIS2or KPIs will be collected from routine data sources such as facility registers and/or patient records through small scale surveys.

MOM satisfaction survey, quality audits

The existing quarterly mom satisfaction survey in hospitals will be strengthened to regularly come up with reliable experience of care data and scaled up to health centers. As per recommendation of HSTQ, facilities will conduct a regular MNH service quality audit which will help them to identify the quality gaps and plan accordingly.

A number of other measures will be monitored by QI teams in facilities for a finite period of time while the team works to improve a specific process of care (e.g. improve management of newborn asphyxia.). These measures can be designed in alignment with the national MNH QOC standards (HSTQ).

Supportive supervision

Quarterly EHIAQ, EPAQ supportive supervisions will be conducted from lead hospital and health center to member hospitals and health centers respectively. The RHB, zonal and woreda health departments will participate in the SS.

SS will be conducted to lead hospitals by MOH. The respective RHB will participate in the SS.

Review meetings

- Quarterly EHIAQ/EPAC cluster review meetings will be held at lead hospital and lead health center levels. These review meetings will be attended by RHB, zonal health department and woreda health office
- Regional level review meetings will be conducted twice a year to review performance in hospitals and health centers. A separate hospital review meeting will be conducted twice a year at regional level
- National level review meetings will be conducted twice a year

MONITORING AND EVALUATION FRAMEWORK

HMIS

KPI

DHIS-2

The main sources of data for monitoring and evaluation are the DHIS2 and the existing hospital performance monitoring system through KPIs.

ANNEX I: INDICATIVE WORK PLAN WITH COST

STRATGEIC OBJECTIVE -1: LEADERSHIP							
LEADERSHIP: Build and strengthen national institutions and mechanisms for improving quality of care in the health sector.							
Ser. no	**Activities**	**Responsible Government**	**Responsible NGO**	**Budget**			
				July 2017-June 2018	**July 2018-June 2019**	**July 2019-June 2020**	**Total budget**
Output 1: National leadership and governance structures for QoC are strengthened (or established) and functioning							
1	Review and amend the TOR including the membership to include relevant MOH directorates, agencies, development partners including professional societies to be chaired by the state minister of program	MOH (SMO, MCH, HSQD)	WHO,USAID,DFID,EMORY,UNICEF,MI,IHI, SCI, ESOG, EMwA, EPS,CHAI,UNFPA	X			0
2	Prepare a generic TOR for regions to guide the establishment of a regional quality steering committee	MOH (MCH, HSQD, CSD)	WHO,USAID,DFID,EMORY,UNICEF,MI,IHI, SCI, ESOG, EMwA, EPS, UNFPA ,CHAI	X			0
3	Develop and use checklist to assess the presence and functionality of the QI governance structures at national and regional levels 1. establish working group 2. draft the checklist 3. workshop to build consensus 4. finalize and disseminate the checklist 5. utilize the checklist during ISS	MOH (MCH, HSQD, CSD)	WHO,USAID,DFID,EMORY,UNICEF,MI,IHI, SCI, ESOG, EmWa, EPS, UNFPA,CHAI	163,500.00			163,500.00
4	Leadership training on MNH QoC at national level(TOT)	MOH (MCH, HSQD, CSD)	WHO,EMROY,IHI	250,000.00			250,000.00
SUBTOTAL				413,500.00	0	0	413,500.00
Out put 2: National operational plan for improving quality of care in MNCH services is developed, funded, monitored and regularly reviewed							
1	Revitalize technical working group (TWG) of MNCH through amendment of TOR and membership and make QoC a standing and regular agenda	MOH- MCHD, HSQD, CSD	WHO,USAID,DFID,UNFPA,UNICEF,BMGF,J&J,Packardfoundation,CHAI,SC,MI,JSI,ESOG, EMwA,PATHFINDER,AMREF, JSI/L10K, AAU, EPHA,EPS,EMORY.	X			0
2	Strengthen internal resource mobilization with ear marked budget for MNCH QoC. 1.Annual partner mapping 2.Review existing annual investments from the FMOH annual plan, resource mobilization spreadsheet and MCH directorates spreadsheet 3. Advocate to increase resource allocation for quality of care	MOH (HSQD, MCH, CSD,FRM),	WHO, USAID, DFID, UNFPA, UNICEF, BMGF, J&J, Packard foundation, CHAI ,SC,MI,JSI ,ESOG, EMwA, PATHFINDER,AMREF,EPS	X	X	X	0
3	Utilize GIS mapping to ensure geographic equity for the initiative. Link with existing initiatives outside of HSQD or MCH: UHC/CBHI	MOH- HSQD, MCHD, CSD, HIT, PPD	The Michel's group, Tulane, social impact	X	X	X	0

Ser. no	Activities	Responsible Government	Responsible NGO	Budget			
				July 2017-June 2018	July 2017-June 2018	July 2017-June 2018	July 2017-June 2018
4	Harmonize QOC initiatives by different MOH directorates & partners during annual planning at national and sub-national levels.	MOH	WHO ,USAID ,DFID, UNFPA, UNICEF ,BMGF, J&J, Packard foundation, CHAI ,SC, MI, JSI, ESOG, EMwA, PATHFINDER,AMREF,EPS	X	X	X	0
SUBTOTAL				0	0	0	0
Output 3: National advocacy and mobilization agenda for quality of care is developed and implemented							
1	Develop advocacy and mobilization strategy on MNCH QoC 1. establish working group 2. draft the strategy 3. workshop to build consensus 4. finalize and disseminate the strategy	MOH- HSQD, MCHD, PCRD	PATHHFINDER, ABT, WHO, UNICEF, JHU/SBCC	163,500.00	0	0	163,500.00
2	Disseminate information through different mass media outlets to advocate on MNCH QoC including the rights of clients 1. establish working group 2. draft the message 3. Identify the outlet 4. disseminate the message	MOH- HSQD, MCHD, PCRD, HIT	WHO, UNICEF, UNFPA, JHU/SBCC	X	X	X	0
3	Establish quality directorate website/use the official MOH website and regularly update it for advocacy	MOH- HSQD, MCHD, PCRD, HIT	WHO, UNICEF, UNFPA, JHU/SBCC	70,000	X	X	70,000
SUBTOTAL				233,500	0	0	233,500
Out put 1: Regional leadership and governance structures for QoC are strengthened (or established) and functioning							
1	Establish Regional health Quality unit /process	RHB mgt team/ CRCP	To be determined by respective regions	X			0
2	Establish Regional quality steering committee including relevant RHB processes, regional PFSA, regional EPHI, regional FMHACA,development partners including professional societies and relevant other sector bureaus chaired by the RHB head	RHB mgmt. team/ CRCP	To be determined by respective regions	X			0
3	Develop/adapt TOR for the regional quality steering committee	RHB mgmt. team/ CRCP	To be determined by respective regions	X			0
4	Develop/adapt checklist to assess the presence and functionality of the QI governance structures at regional , zonal and district levels	RHB QU	To be determined by respective regions	450,000			450,000
5	Leadership training on MNH QoC at regional level to zones/woreda (where there is no zonal structure)	RHB mgmt. team/ CRCP	To be determined by respective regions	800,000	X		800,000
SUBTOTAL				1,250,000	0	0	1,250,000

Ser. no	Activities	Responsible Government	Responsible NGO	Budget			
				July 2017-June 2018	July 2017-June 2018	July 2017-June 2018	July 2017-June 2018
Output 2: Regional operational plan for improving quality of care in MNCH services is developed, funded, monitored and regularly reviewed							
1	Revitalize technical working group (TWG) of MNCH through amendment of TOR and membership and make QoC a standing and regular agenda	RHB HPDP (MCH), QU	To be determined by respective regions	X			0
2	Strengthen resource mobilization with ear marked budget for MNCH QoC. 1.Annual partner mapping 2.Review existing annual investments from the RHB annual plan, resource mobilization spreadsheet and health promotion and disease prevention core process spreadsheet 3. Advocate to increase resource allocation for quality of care 4. Allocate ear marking budget to zones for quality of care	RHB mgt team/ CRCP	To be determined by respective regions	X	X	X	0
SUBTOTAL				0	0	0	0
Output 3: Regional advocacy and mobilization agenda for quality of care is developed and implemented							
1	Adapt and use advocacy and mobilization strategy on MNCH QoC	RHB QU, PR	To be determined by respective regions	X	X	X	
2	Disseminate information through different mass media outlets to advocate on MNCH QoC including the rights of clients	RHB QU, PR	To be determined by respective regions	X	X	X	
3	use the official RHB website and regularly update it for advocacy	RHB QU, PR	To be determined by respective regions	110,000	X	X	110,000
SUBTOTAL				110,000	0	0	110,000
Output 1: Zonal leadership and governance structures for QoC are strengthened (or established) and functioning							
1	Assign Health Quality focal person	ZHD	To be determined by respective regions	X			0
2	Establish Zonal steering committee including relevant ZHD processes and other sector offices	ZHD	To be determined by respective regions	X			0
3	Develop/adapt TOR for the zonal quality steering committee	ZHD	To be determined by respective regions	X			0
4	Adapt checklist to assess the presence and functionality of the QI governance structures at zonal, district and facility levels.	ZHD	To be determined by respective regions	X			0
5	Leadership training on MNH QoC to districts			1,750,000	2,625,000	2,625,000.00	7,000,000
SUBTOTAL				1,750,000	2,625,000	2,625,000.00	7,000,000
Output 2: Zonal plan for improving quality of care in MNCH services is developed, funded, monitored and regularly reviewed							
1	Strengthen resource mobilization with ear marked budget for MNCH QoC. 1.Review existing annual investments from the woreda annual plan for resource mobilization 2. Advocate to increase resource allocation for quality of care	ZHD	To be determined by respective regions	X	X	X	
SUBTOTAL				0	0	0	0

Ser. no	Activities	Responsible Government	Responsible NGO	Budget			
				July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total budget
Out put 3: Zonal advocacy and mobilization agenda for quality of care is developed and implemented							
1	Adapt and use advocacy and mobilization strategy on MNCH QoC	ZHD	To be determined by respective regions	X	X	X	0
2	Disseminate information through different mass media outlets to advocate on MNCH QoC including the rights of clients	ZHD	To be determined by respective regions	X	X	X	0
3	use the official RHB website and regularly update it for advocacy	ZHD	To be determined by respective regions	X	X	X	0
SUBTOTAL				0	0	0	0
Output 1: Woreda leadership and governance structures for QoC are strengthened (or established) and functioning							
1	Assign Health Quality focal person	woreda health office	To be determined by respective regions, zone and woreda	X			0
2	Establish District steering committee including relevant district processes and relevant other sector offices	woreda health office	To be determined by respective regions, zone and woreda	X			0
3	Develop/adapt TOR for the district quality steering committee	woreda health office	To be determined by respective regions, zone and woreda	X			0
4	Adapt and use checklist to assess the presence and functionality of the QI governance structures at district and facility levels.	woreda health office	To be determined by respective regions, zone and woreda	X			0
SUBTOTAL				0	0	0	0
Output 2: Woreda operational plan for improving quality of care in MNCH services is developed, funded, monitored and regularly reviewed							
1	Strengthen resource mobilization with ear marked budget for MNCH QoC. 1.Review existing annual investments from the woreda annual plan for resource mobilization 2. Advocate to increase resource allocation for quality of care		To be determined by respective regions, zone and woreda	X			0
2	Develop district MNCH Quality improvement plan with budget line item and time bound aims		To be determined by respective regions, zone and woreda	X			0
SUBTOTAL				0	0	0	0
Output 3: Woreda advocacy and mobilization agenda for quality of care is developed and implemented							
1	use advocacy and mobilization strategy on MNCH QoC	woreda health office	To be determined by respective regions, zone and woreda	X	X	X	0
2	Disseminate information through different mass media outlets to advocate on MNCH QoC including the rights of clients	woreda health office	To be determined by respective regions, zone and woreda	X	X	X	0
3	use the official RHB website for sharing information ,and for advocacy purpose	woreda health office	To be determined by respective regions, zone and	X	X	X	0

			woreda				
SUBTOTAL				0	0	0	0
Output 1:Facility leadership and governance structures for QoC are strengthened (or established) and functioning							
1	Put the right structures at facilities with defined roles and responsibilities and plans o Quality Unit, quality committee and QI teams at hospital level as per EHSTG o Quality committee at health centers as per EHCRIG	Hospital/health center	Partners supporting the facility	X			0
Output 2:Facility operational plan for improving quality of care in MNCH services is developed, financed, monitored and regularly reviewed							
1	Strengthen resource mobilization with ear marked budget for MNCH QoC. 1.Review existing annual investments from the facility annual plan for resource mobilization 2. Advocate to increase resource allocation for quality of care	Hospital/health center	Partners supporting the facility	X			0
2	Review regularly the implementation of MNCH QoC work plan	Hospital/health center	Partners supporting the facility	X	X	X	0
Output 3:Facility advocacy and mobilization agenda for quality of care is developed and implemented							
1	Use public opportunities (e.g. waiting rooms, pregnant mother conference, HDA meetings) to publicize QoC efforts for maternal and newborn health	Hospital SMT/HMIS unit, PHCU, HEP, HAD	Partners supporting the facility	X	X	X	0
2	Display key process and outcome data (Indicators) prominently in public places at facilities	Hospital SMT/HMIS unit, PHCU, HEP, HAD	Partners supporting the facility	4,800,000.00	7,200,000.00	7,200,000.00	19,200,000.00
SUBTOTAL				4,800,000.00	7,200,000.00	7,200,000.00	19,200,000.00
TOTAL				**8,557,000.00**	**9,825,000.00**	**9,825,000.00**	**28,207,000.00**

STRATEGIC OBJECTIVE -2 ACTION

Accelerate and sustain implementation of quality of care improvements for mothers and newborns

LEVEL	Ser. No	ACTIVITIES	Responsible Government	Relevant Partners	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
NATIONAL	**1. National package of country adapted QoC standards, best practices and implementation interventions is compiled, incorporated into the operational plan and disseminated**							
	1	Adapt national MNCH QoC standard tools and guidelines to fit to the health center standard and revise the audit tools (Prepare a self-guide MNCH QoC standard assessment audit tool and print to be distributed to the learning district)	MOH (HSQD, CSD, HEP),	ESOG, EPS, EMwA, WHO, JSI, ICAP	844000	200000	200000	**1244000**
	2	Conduct launching and orientation workshop on MNCH QoC standards for heads of QU and MCH focal of lead hospitals , HCs and CRCP owners from all region (4 round) along with (HSTQ guideline, EHSTG, EHCRIG guideline)	MOH (HSQD, CSD, HEP),	ESOG, EPS, EMwA, WHO, JSI, ICAP	726000	0	0	**726000**
	3	Evidence generation for implementation through testing and collecting respectful, compassionate and caring initiative in maternity unit in those selected learning woredas/ districts	MOH (HSQD, CSD, HEP),	ESOG, EPS, EMwA, WHO, JSI, ICAP	250000	250000	250000	**750000**
	4	Incorporate the national intervention package into the national operational plan , align with different directorate and levels of structure through conducting a workshop with stakeholder and TWG	MOH (HSQD, MCH, HEP)	Professional society, WHO	118000	118000	118000	**354000**
	SUBTOTAL				**1938000**	**568000**	**568000**	**3074000**

	Ser. No	ACTIVITIES	Responsible Government	Relevant Partners	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
	2. Establish readiness for implementation of the MNH initiative							
	5	Identify learning districts in consultation with MOH using agreed criteria.	MOH (HSQD, MCH, PPD)	IHI, ICAP, WHO…	0	0	0	**0**
	6	Conduct a baseline assessment for basic infrastructure availability standard in 2 of nationally selected learning districts. To also fill gaps for learning and scale up districts (2 learning district)	MOH (HSQD, MCH, PPD)	IHI, ICAP, SAVE, WHO…	4218076	2000000	2000000	**8218076**
	7	Conduct baseline assessment on the rest of standards other than infrastructure and essential resource availability of MNCH QoC through MNCHC QoC audit tool. Identify list of quality gaps. (2 learning district)	HSQD,MCH, CSD,RHB's	Partners working in the selected learning district/site	205200	200000	200000	**605200**
	SUBTOTAL				**4423276**	**2200000**	**2200000**	**8823276**
	3. Initiate district-based phased implementation of MN QoC							
	8	Conduct a basic QI training for a total of 5 days on Quality improvement management and leadership (QIML) for a total of 25 participants CEO, HEAD of HC, Woreda focal (from 2 learning district)	HSQD,MCH, CSD,HEP, RHB's	Partners working in the selected learning district/site	200000	100000	0	300000
	9	Conduct a basic QI training for a total of 5 days for 90 participants in 2 sessions.	HSQD,MCH, CSD,HEP, RHB's	Partners working in the selected learning district/site	421807	200000	0	621807
	SUBTOTAL				**621807**	**300000**	**0**	**921807**
	1. Establish readiness for implementation of the MNH initiative							
REGIONAL	10	Identify scale up learning districts in consultation with RHB using agreed criteria 1 per region	MOH/HSQD, HEP, MCH, PPD	WHO, IHI, ICAP, MI, PATH, and JSI	0	0	0	**0**
	11	Conduct a baseline assessment for basic infrastructure availability standard in 11 regional scale up districts	MOH/HSQD, HEP, MCH, PPD	WHO, IHI, ICAP, MI, PATH, and JSI	0	2.2E+07	0	**22000000**
	12	Conduct baseline assessment on the rest of standards (other than infrastructure and essential resource availability) of MNCH QoC through MNCHC QoC audit tool identify list of quality gap for 11 of the scale up districts	MOH/HSQD, HEP, MCH, PPD	WHO, IHI, ICAP, MI, PATH, and JSI	0	2052000	0	**2052000**
	13	Integrate the learning district learning collaborative with EHIAQ through developing Health center to hospital integration manual	MOH/HSQD, HEP, MCH, PPD	WHO, IHI, ICAP, MI, PATH, and JSI	500000	0	0	500000
	14	Support the integration of EPAQ to EHIAQ through conducting the HC-Hospital cluster review meeting and collaborative learning session at district level	MOH/HSQD, MCH, PPD	WHO, IHI, ICAP, MI, PATH, and JSI	180000	1800000	1800000	3780000
	SUBTOTAL				**680000**	**2.6E+07**	**1800000**	**28332000**
	2. Institutionalize system improvement capability for country-led scale-up and sustainability							
	15	Develop a certificate advanced QI and patient safety course in the established CPD through the HR CPD program	MOH (MCH, HSQD, HR…)	IHI, ICAP, WHO	160000	160000	160000	**480000**
	16	Sponsor for enrollment of quality improvement and patients safety training for 2 officers from MOH and 2 focal from each of the learning district and MOH focal person	MOH (MCH, HSQD, HR…)	IHI, ICAP, WHO	0	300000	0	**300000**
	SUBTOTAL				**160000**	**460000**	**160000**	**780000**

	Ser. No	ACTIVITIES	Responsible Government	Relevant Partners	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
DISTRICT	**1. District adopts National package of country adapted QoC standards, best practices and implementation interventions**							
	17	Conduct a basic QI training for a total of 5 days on Quality improvement management and leadership (QIML) for a total of 50 participants from 11 scale up woredas/district managers and 11 RHB CRCP and 11 PHCU lead hospital CEO and special support directorates	MOH (HSQD, MCH, CSD, HEP)	WHO,USAID,EMORY,UNICEF,MI, IHI, L10K, ICAP, etc	0	400000	200000	**600000**
	SUBTOTAL					**400000**	**200000**	**600000**
	2. Initiate district-based phased implementation of MN QoC							
	18	Provide coaching and mentoring for district focal on MNCH QI monitoring and supervision skill	MOH (HSQD, MCH, CSD, HEP)	WHO,USAID,EMORY,UNICEF,MI, IHI, L10K, ICAP, etc.	409600	0	0	**409600**
	SUBTOTAL				**409600**	**0**	**0**	**409600**
FACILITY	**1. Facility adopts National package of country adapted QoC standards, best practices and implementation interventions**							
	19	Develop SOPs on capturing and implementation of best practices and intervention/change package at facility level	HSQD, HSCD, PHCU, Facilities, District QU supervisors, RHB &HSQD	Partners supporting the facility including IHI,CHAI, ICAP ,save the children	150000	0	0	**150000**
	20	Conduct inter facilities mentoring with in the cluster of each learning district	HSQD, HSCD, PHCU, Facilities, District QU supervisors, RHB &HSQD	Partners supporting the facility including IHI,CHAI, ICAP ,save the children	14000	140000	1400000	**1554000**
	21	Conduct integrated supportive supervision within the learning district on quarterly base	Facility QI/CG unit, leadership as SMT,	IHI,CHAI, ICAP ,save the children	0	0	0	**0**
	SUBTOTAL				**164000**	**140000**	**1400000**	**1,704,000.00**
	2. Establish readiness for implementation of the MN initiative							
	22	Provide coaching and mentoring for Quality unit team of facilities of 11 scale up district of the regions on MNCH QI project	MOH HSQD, QI/CG unit of the Facility, and District health office	IHI,CHAI, ICAP ,save the children, UNFPA	0	2354000	0	2354000
	SUBTOTAL				**0**	**2354000**	**0**	**2354000**
	3. Initiate district-based phased implementation of MN QoC							
	25	Conduct a basic QI training for a total of 5 days training on basics of Quality improvement 500 participants from 11 scale up woredas/district (45 participants from each scale up district)	Facility QI-CG unit, MOH HSQD, RHB	IHI,CHAI, ICAP ,save the children, MI, UNFPA	0	2000000	1000000	**3000000**
	26	QI team calls facility meeting after each LS to disseminate learning from the LS	Facility QI-CG unit, MOH HSQD, RHB	IHI,CHAI, ICAP ,save the children, MI, UNFPA	200000	200000	200000	**600000**
	27	Provide a joint bi-monthly TA to facility QI teams with RHB and district supervisors and partners	Facility QI-CG unit, MOH HSQD, RHB	IHI,CHAI, ICAP ,save the children, MI, UNFPA	200000	200000	200000	**600000**
	SUBTOTAL				**400000**	**2400000**	**1400000**	**4200000**
	TOTAL				**8,796,683**	**32,320,000**	**7,728,000**	**48,844,683**

STRATEGIC OJECTIVES- 3: LEARNING								
To facilitate learning, share knowledge and generate evidence on quality of care								
LEVEL	Ser. No	Activities	Responsible Government	Partner	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
NATIONAL	**Output 1: Develop and strengthen data systems for quality of care improvement**							
	1	Identify indicators for different levels and develop indicators definition and data management system guideline for national implementation framework	HSQD/MCH, PPD, MCHD	WHO, UNICEF, Yale University	**45000**	**100000**	**0**	**145000**
	2	Develop and install MNH QOC database software for RHB, Zone and districts.	HSQD/MCH, MCHND	WHO	**960000**	**0**	**0**	**960000**
	3	Provide induction orientation on the data management system of MNH QI for all levels.	HSQD/MCH, MCHD	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**148150**	**0**	**0**	**148150**
	4	Conduct refreshment training on the basic and updated electronic data management system.	HSQD/MCH, MCHD	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**148150**	**148150**	**148150**	**296300**
	5	Provide onsite support on database use for MNH QI application for action.	HSQD/MCH, MCHND	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**20799**	**0**	**0**	
	6	**Develop/adapt template** that guide documentation and reporting of best practice, case studies, lessons learned.	HSQD/MCH, MCHND,	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**7600**	**3800**	**0**	**11400**
	7	**Provide equipment for documenting and reporting of training on skill** to document and report best practice, case studies, lessons learned.	HSQD/MCH, MCHND,	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**29475**	**0**	**0**	**29475**
	8	**Implement motivational schemes** to encourage reporting of best practices, case studies from the field and testimonials -	HSQD/MCH, MCHND,	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**30000**	**40000**	**30000**	**100000**
	SUBTOTAL				**1389174**	**291950**	**178150**	**1690325**
	Output 2: Establish a virtual national and district learning system to share knowledge and link to global learning platform.							
	9	**Link webpage** developed from LD for MNH QoC to FMoH website to be linked to the global website for MNH QoC .(Communicate with PR of the MOH)	PR, HSQD/MCH, MCHND,		**0**	**0**	**0**	**0**
	10	Create Facebook account for MNH QoC that will be administered by the HSQD/MOH	HSQD/MCH		**0**	**0**	**0**	**0**
	11	Use of national and local mass media (Radio, TV, bulletin, newspaper, newsletter) to enable community to demand Quality MNH services and **promote components of MHN care.**	PR, HSQD/MCH, MCHND,	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATHFinder &JSI	**24000**	**48000**	**36000**	**108000**
	12	Use mobile Short Message Service (texts) to deliver key MNH QoC messages.	PR, HSQD/MCH, MCHND,		**160000**	**80000**	**80000**	**320000**
	SUBTOTAL				**184000**	**128000**	**116000**	**428000**

Ser. No	Activities	Responsible Government	Partner	Budget			
				July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	TOTAL
Output 3: Establish a face-to-face national and district learning system to share knowledge and link to global learning platform.							
13	Participate in the global collaborative learning sharing initiatives platforms	PR, HSQD/MCH, MCHND,	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	250000	250000	250000	750000
14	Assign national focal point to facilitate and coordinate MNH QI learning collaborative activities with countries in the network	HSQD		0	0	0	0
15	MNH QI learning collaborative activities will be included in the FMoH annual health plan.	HSQD/MCH, MCHND,		25000	25000	25000	75000
16	Organize national quality summit for MNH QI learning.	HSQD/MCH, MCHND, MNH QoC TWG	WHO, NI, IHI	85000	85000	85000	255000
17	Organize MNH QI learning platforms at national (EHIAQ, EPAQ, RMHCHN review meeting).	HSQD/MCH, MCHND, MNH QoC TWG		0	517000	517000	1034000
18	Organize international learning and sharing (exchange) visits. Select participant from the quality and MCH directorate participate in the international face to face learning Platform	HSQD/MCH, MCHND, MNH QoC TWG	WHO, UNICEF,	150000	150000	0	300000
19	Organize national learning and sharing (exchange) visits. Annual learning and sharing meeting in selected learning district by the woreda unit (site visit)	HSQD/MCH, MCHND, MNH QoC TWG	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	0	107000	107000	214000
SUBTOTAL				510000	1134000	984000	2628000
Output 4: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up							
20	**Establish MNH QoC TWG and QI review committee** at FMoH to identify and package scalable change ideas on MNH QoC.	HSQD/MCH,	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**25506**	**25506**	**51012**	**102025**
21	MNH QoC TWG identifies scalable change ideas from the field.	MNH QoC TWG	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**168000**	**0**	**0**	**336000**
22	QI review committee document identified and scalable change ideas from the sites/field	QI Review committee	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**0**	**0**	**0**	**0**
23	Disseminate scalable change package to **key stakeholders** - Partners, PPD, RHBs. (Conduct in-depth assessment and prepare contextual scalable package into the context to be tested)	HSQD/MCH, PPD	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**96800**	**96800**	**0**	**193600**
24	Publish scalable MNH QoC package using quality bulletin, peer reviewed journals,	HSQD/MCH, PPD	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**0**	**0**	**0**	**0**
25	Incorporate scalable MNH QoC to annual health plan	HSQD/MCH, PPD	UN agencies, NI, JSI, SCI, EU, L10K, IHI, T PHCU, PATH Finder &JSI	**0**	**0**	**0**	**0**
SUBTOTAL				**290306**	**122306**	**51012**	**631625**

	Ser. No	Activities	Responsible Government	Partner	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	TOTAL
REGIONAL	**Output 1: Develop and strengthen data systems for quality of care improvement**							
	26	Adapt indicators for zonal, district and facility level and develop data management system (including community scorecard) of MNH QI that outlines : the indicators definition, the source, methods and frequency of data collection,	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**		**0**	**0**
	27	Provide onsite support on database use for MNH QI application for action	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**20800**		**0**	**20800**
	28	Provide onsite support on database use for MNH QI application for learning sharing	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**		**0**	**20800**
	29	Provide training on skill to document and report best practice, case studies, lessons learned	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**29475**		**0**	**29475**
	SUBTOTAL				**50275**		**0**	**71075**
	Output 2: Establish a virtual national and district learning system to share knowledge and link to global learning platform.							
	30	Develop webpage for MNH QoC learning in the RHB websites to be linked to the FMoH website	RHB quality unit/PR	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	31	Use of regional and local mass media (Radio, TV, bulletin,, newsletter) to enable community to demand Quality MNH services and promote components of MHN care	RHB quality unit/PR	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	32	Use Short Message Service (texts) to delivery key MNH QoC messages	RHB quality unit/PR	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	SUBTOTAL				**0**	**0**	**0**	**0**
	Output 3: Establish a face to face national and district learning system to share knowledge and link to global learning platform.							
	33	Participate in the global collaborative learning sharing initiatives platforms - including the WHO led network	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	34	MNH QoC learning collaborative activities will be included in the RHB annual health plan	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	35	Participate in MNH QI learning platforms at regional /zonal levels (EHIAQ, EPAQ, RMNCHN review meeting)	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	36	Organize regional/zonal/woreda learning and sharing (exchange) visits	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**77000**	**77000**	**144000**
	SUBTOTAL				**0**	**77000**	**77000**	**144000**
	Output 4: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up							
	37	Establish QI review committee to identify implemented change ideas on MNH QoC in multiple setting (Urban/rural, agrarian/pastoralist…)	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	38	The regional MNH QOC TWG will document and identify the scalable change ideas from the sites/field	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	

	Ser. No	Activities	Responsible Government	Partner	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	TOTAL
	39	The QI review committee/RAC will do the documentation, scientific writing, design change packages and develop scalable package/evidence based learning	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	0	0	0	0
	40	Disseminate the scalable package for key stakeholders and publish using quality bulletin, peer reviewed journals,	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	0	48000	48000	96000
	41	Incorporate scalable MNH QoC to RHB annual health plan	RHB quality unit/PPD	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	0	0	0	0
	SUBTOTAL				**0**	**48000**	**48000**	**96000**
ZONAL LEVEL	**Output 1: Develop and strengthen data systems for quality of care improvement**							
	42	Adapt indicators for districts and facilities and develop data management system (including community scorecard) of MNH QI that outlines - the indicator definition, the source, methods and frequency of data collection,	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	0	0	0	0
	43	Provide orientation on the data management system of MNH QI for districts and facilities under the zone	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	9050	0	0	9050
	44	Provide onsite support on database use for MNH QI application for action for districts and facilities under the zone	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	0	9050	0	9050
	45	Provide onsite support on database use for MNH QI application for learning sharing for the districts and facilities under the zone	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	0	0	9050	9050
	SUBTOTAL				**9050**	**9050**	**9050**	**27150**
	Output 2: Establish a virtual national and district learning system to share knowledge and link to global learning platform.							
	46	Use of local mass media (Radio, TV, bulletin, newsletter) to enable community to demand Quality MNH services and promote components of MHN care	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	0	0	0	0
	SUBTOTAL				**0**	**0**	**0**	**0**
	Output 3: Establish a face to face national and district learning system to share knowledge and link to global learning platform.							
	47	MNH QI learning collaborative activities will be included in the government annual health plan at all levels	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Path finder &JSI	0	0	0	0
	48	participate in MNH QI learning platforms at national and regional /zonal levels (EHIAQ, EPAQ, RMHCHN review meeting)	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	77000			
	49	Organize woreda learning and sharing (exchange) visits for the districts and facilities	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	77000			
	SUBTOTAL				**154000**			

	Ser. No	Activities	Responsible Government	Partner	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	TOTAL
	Output 4: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up							
	50	Establish QI review committee to identify implemented change ideas on MNH QoC in the zone	ZHD Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	SUBTOTAL				**0**	**0**	**0**	**0**
DISTRCIT LEVEL	**Output 1: Develop and strengthen data systems for quality of care improvement**							
	51	use MNH QOC indicators and develop data management system (including community scorecard) of MNH QI that outlines - the indicator definition, the source, methods and frequency of data collection at a district level	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	52	Provide orientation to facilities on the data management system of MNH QI	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**9050**	**9050**	**9050**	**27150**
	53	Provide support to facilities on application of MNH QI database for action	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**9050**	**9050**	**9050**	**27150**
	54	Provide support to facilities on application of MNH QI database for learning sharing	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**9050**	**9050**	**9050**	**27150**
	55	Do regular data quality assessment on MNH QOC indicators in the facilities	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**14000**	**14000**	**14000**	**42000**
	SUBTOTAL				**41150**	**41150**	**41150**	**123450**
	Output 3: Establish a face to face national and district learning system to share knowledge and link to global learning platform.							
	56	MNH QI learning collaborative activities will be included in the woreda base plan	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	57	use existing district level review meetings as platform to share and learn QI practices and best practices among facilities	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	58	Organize district learning and sharing (exchange) visits	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**15750**	**15750**	**15750**	**47250**
	59	using community platforms such as Pregnant Women Conference, WDA meetings, public forum … to discuss and address issues of MNH QoC (including use of community score card)	worHO Quality Unit,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	SUBTOTAL				**15750**	**15750**	**15750**	**47250**
FAILITY LEVEL	**Output 1: Develop and strengthen data systems for quality of care improvement**							
	60	Use QOC indicators dashboard to develop data management system (including community scorecard) of MNH QI that outlines (the indicator definition, the source, methods and frequency of data collection at the facility level)	facility QIT/PMT,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**
	61	use/update data management system for MNH QOC monthly.	facility QIT/PMT,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	**0**	**0**	**0**	**0**

Ser. No	Activities	Responsible Government	Partner	Budget			
				July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	TOTAL
62	Use database information for MNH QOC for continuous improvement (PDSA cycle).	facility QIT/PMT,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	0	0	0	0
63	Do regular data quality assessment (DQA) on MNH QOC indicators in the facility and use information to feed the improvement cycle.	facility QIT/PMT,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	22000	22000	22000	66000
SUBTOTA				22000	22000	22000	66000
Output 3: Establish a face to face national and district learning system to share knowledge and link to global learning platform.							
64	MNH QOC learning collaborative activities will be included in the facility annual plan.	facility QIT/PMT,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	10000	10000	10000	30000
65	Use existing facility performance review meetings as platform to share and learn QI practice among facilities on quarterly base.	facility QIT/PMT,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	160000	160000	160000	480000
66	Participate in national and international learning and sharing (exchange) visits.	facility QIT/PMT,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI		600000		600000
67	Use community platforms such as Pregnant Women Conference, WDA meetings, public forum … to discuss and address issues of MNH QoC (including use of community score card).	facility QIT/PMT,MCH	NI, JSI, SCI, EU, L10K, IHI, Pathfinder &JSI	488000	488000	488000	488000
SUBTOTAL				658000	1258000	658000	
TOTAL				3,323,705	3,301,206	2,518,356	9,143,267

STRATEGIC OBJECTIVE- 4: ACCOUNTABILITY								
To develop, strengthen and sustain institutions and mechanisms for accountability for quality of care								
Level	Ser.No	Activities	Responsible Government	Responsible NGO	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
	Output 1: National framework and mechanisms for accountability for QoC are established and functioning							
NATIONAL	1	Monitor transparent reporting of HMIS data through regular quarterly RDQA	HSQD, MCH, PPD, RHBs	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	115200	115200	115200	**345600**
	2	Design a data base linking regional, woreda and facility levels in such a way that all levels including facilities report and able to view/monitor progress regularly (DHIS 2)	PPD, HIT, Health infrastructure directorates	JSI/DUP, JSI/HMIS, NASTADPSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAPCDC, IFHP, FHI 360, USAID	X	X	X	**0**
	3	Identify and remedy bottlenecks (internal and external) contributing to interrupted supply of drugs and equipment	PFSA, PMED, HSQD, MCH	Global health supply chain –PSM, CHAI, UNFPA, AIDS free project (previous deliver USAID), Engender, Marie stopes, CIRTH, pathfinder	X	X	X	**0**
	4	Strengthen Report and Requisition Form (RRF) system 1) RRF revision, 2) National consultative meeting on the use of RRF	PFSA, PMED, HSQD, MCH	>>	404,818			**404818**
	5	Strengthen LMIS o Conduct SS and mentoring on LMIS to hospitals o Avail necessary formats (internal facility report and requisition form, bin cards, RRF forms)	PFSA, PMED, HSQD, MCH	>>	112920	112920	112920	**338760**
	6	Conduct public wing meetings 2X a year	MOH (MCH, HSQD, PPD, HR…)	Relevant partners, civil society organizations, professional associations	108000	108000	108000	**324000**
	7	Develop TOR to work with Ethiopian social accountability program (ESAP)	HSQD, Clinical services directorate, FMHACA		X			**0**
	8	Regularly monitor functionality of ethics committee in hospitals thru regulatory audit	FMHACA, MOH/HR	Jhpiego	16800	16800	16800	**50400**
	9	Create awareness of the national client grievance handling toll free service	FMHACA		20,000			**20000**
	10	Strengthen MDSR and introduce PDSR	MCH, PHEM	WHO, ESOG, EPS, SCI	X	X	X	**0**
	11	Conduct regular annual review and multistakeholder dialogue for remedying bottlenecks	MOH (MCH, HSQD, PPD, HR…)	All relevant partners	X	X	X	**0**
	SUBTOTAL				**777,738.00**	**352,920.00**	**352920**	**1483578**
	Output 2: Institutionalize system improvement capability for country-led scale-up and sustainability							
	1	Establish separate cost centers for quality improvement and set system to track progress of expenditure through NHA at all levels	PPD, FRM, EPHI		X	X	X	**0**
	2	Build capacity to use data for decision making at all levels	PPD, DPC, MCH, HEP, HSQD, clinical services directorate	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID ,.CDC, IFHP, FHI 360, USAID	X	X	X	**0**
	3	Develop interface document to harmonize MNH QOC responsibilities between directorates	MCH, HSQD, clinical directorate, HEP directorate		X			**0**

	Ser.No	Activities	Responsible Government	Responsible NGO	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
	4	Strengthen civil service 1-5 networks to ensure quality issues are prioritized, discussed and action taken accordingly at all levels	MCH, HSQD, clinical directorate, HEP directorate	WHO,USAID,EMORY,UNICEF,MI,IHI, L10K,UNFPA	X	X	X	0
	5	Highlight quality improvement work in quarterly health bulletin	HSQD, Clinical directorate, MCH, HEP, PPD	WHO,USAID,EMORY,UNICEF,MI,IHI, L10K,UNFPA	X	X	X	0
	6	Publish Quality bulletin (quality times) and distribute widely	HSQD, Clinical directorate, HEP, PPD	WHO,USAID,EMORY,UNICEF,MI,IHI, L10K,UNFPA	192000	192000	192000	576000
	7	Develop Policy briefs about quality of care (workshop and printing)	HSQD, Clinical directorate, MCH, HEP, PPD	WHO, RAC members	24,450	24,450	24,450	73350
	8	Include quality domains in ARM experience sharing (e.g CASH)	HSQD, Clinical directorate, MCH, HEP, PPD	All relevant partners	X	X	X	0
	9	Conduct experience sharing to areas with best practice	HSQD, Clinical directorate, MCH, HEP, HR	All relevant partners	226,215	226,215	226,215	678645
	10	Integrate QI concepts in preservice curricula (capacity building for university hospitals, 15 hospitals in 2018 and another 15 hospitals in 2019)	HSQD, Clinical directorate, MCH, HEP, HR	Jhpiego, UNFPA	416,250	416,250		832500
	11	Design CPD to train future MOH staff to use systems improvement methods to lead, manage and implement change (hire consultant to develop a training package. Organize a workshop to review and finalize training package)	MOH (MCH, HSQD, HR…)	IHI, ICAP, WHO	430800			430800
	12	Develop a masters level QI and patient safety course curriculum and initiate training (Organize a final curriculum writing workshop)	MOH (MCH, HSQD, HR…)	IHI, ICAP, WHO	171,288			171,288
	SUBTOTAL				1,461,003	858,915	442,665	2,762,583
REGIONAL	**Output 1: Regional framework and mechanisms for accountability for QoC are established and functioning**							
	1	Monitor transparent reporting of HMIS data through regular RDQA	HSQD, MCH, PPD, RHBs	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	X	X	X	0
	2	Implement MNCH score cards at regional level	PPD, HSQD, MCH, RHBs		X	X	X	0
	3	Design a data base linking regional, woreda and facility levels in such a way that all levels including facilities report and able to view/monitor progress regularly (DHIS 2) 1) Conduct regional TOT	PPD, HIT, Health infrastructure directorates, RHB	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	154560			154560
	4	Identify and remedy bottlenecks (internal and external) contributing to interrupted supply of drugs and equipment	PFSA, PMED, HSQD, MCH, RHB	Global health supply chain –PSM, CHAI, UNFPA, AIDS free project (previous deliver USAID), Engender, Marie stopes, CIRTH, pathfinder	X	X	X	0
	5	Strengthen LMIS: Conduct SS and mentoring on LMIS to HCs	PFSA, PMED, HSQD, MCH, RHB	Global health supply chain –PSM, CHAI, UNFPA, AIDS free project (previous deliver USAID), Engender, Marie stopes, CIRTH, pathfinder	144000	144000	144000	432000

	Ser.No	Activities	Responsible Government	Responsible NGO	Budget			
					July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
	6	Avail necessary formats (internal facility report and requisition form, bin cards, RRF forms)	PFSA, PMED, HSQD, MCH, RHB	Global health supply chain –PSM, CHAI, UNFPA, AIDS free project (previous deliver USAID), Engender, Marie stopes, CIRTH, pathfinder	X	X	X	**0**
	7	Support implementation of pharmaceutical and warehouse initiative in EHCRIG by HCs	Clinical services directorate		X	X	X	**0**
	8	Conduct multistakeholder dialogue to review the progress and remedy bottlenecks	MOH (HSQD, MCH, HEP, PPD), RHB, ZHD, WoHO	WHO,USAID,EMORY,UNICEF,MI,IHI, L10K,UNFPA	X	X	X	**0**
	9	Conduct public wing meetings twice a year	RHB and agencies; health facilities	Private sector, professional associations, civil society,	108000	108000	108000	**324000**
	10	Regularly monitor functionality of ethics committee at hospitals thru regulatory audit	FMHACA, MOH/ HR, RHB	Jhpiego	X	X	X	**0**
	11	Create awareness of the toll free client grievance handling service	FMHACA, RHB		20,000			**20000**
	12	Strengthen MDSR and introduce PDSR	MCH, PHEM, RHB	WHO, ESOG, EPS,	X	X	X	**0**
	SUBTOTAL				**426560**	**252000**	**252000**	**930560**
	Output 2: Institutionalize capability for region wide use of multi-faceted implementation interventions							
	1	Establish separate cost centers for quality improvement and set system to track progress of expenditure through NHA	PPD, FRM, EPHI, RHB		X	X	X	**0**
	2	Build capacity to use data for decision making	PPD, MCH, HEP, HSQD, RHB	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	173880	173880	173880	**521640**
	3	Strengthen civil service 1-5 networks to ensure quality issues are prioritized, discussed and action taken	RHB		X	X	X	**0**
	4	Conduct experience sharing to areas with best practice	RHBs, HSQD, Clinical services directorate, HEP directorate	All relevant partners	1407558	1407558	1407558	**4222674**
	SUBTOTAL				**1581438**	**1581438**	**1581438**	**4744314**
ZONAL	**Output 1: Zonal framework and mechanisms for accountability for QoC are established and functioning**							
	1	Monitor transparent reporting of HMIS data through regular RDQA	HSQD, MCH, PPD, RHBs	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	X	X	X	**0**
	2	Design a database linking regional, woreda and facility levels in such a way that all levels including facilities report and able to view/monitor progress regularly (DHIS 2). Participate in regional TOT	PPD, HIT, Health infrastructure directorates, RHB	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	X			**0**
	3	Identify and remedy bottlenecks (internal and external) contributing to interrupted supply of drugs and equipment	PFSA, PMED, HSQD, MCH, RHB	Global health supply chain –PSM, CHAI, UNFPA, AIDS free project (previous deliver USAID), Engender, Mariestopes, CIRTH, pathfinder	X	X	X	**0**
	4	Strengthen LMIS: Conduct SS and mentoring on LMIS to HCs	PFSA, PMED, HSQD, MCH, RHB	Global health supply chain –PSM, CHAI, UNFPA, AIDS free project (previous deliver USAID), Engender, Mariestopes, CIRTH, pathfinder	X	X	X	**0**

Ser.No	Activities	Responsible Government	Responsible NGO	Budget			
				July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
5	Avail necessary formats (internal facility report and requisition form, bin cards, RRF forms)	PFSA, PMED, HSQD, MCH, RHB	Global health supply chain –PSM, CHAI, UNFPA, AIDS free project (previous deliver USAID), Engender, Marie stopes, CIRTH, pathfinder	X	X	X	0
6	Support implementation of pharmaceutical and warehouse initiative in EHCRIG by HCs	Clinical services directorate		X	X	X	0
7	Conduct multistakeholder dialogue to review the progress and remedy bottlenecks	MOH (HSQD, MCH, HEP, PPD), RHB, ZHD, WoHO	WHO,USAID,EMORY,UNICEF,MI,IHI, L10K,UNFPA	X	X	X	0
8	Conduct public wing meetings twice a year	RHB and agencies; health facilities	Private sector, professional associations, civil society,	108000	108000	108000	324000
9	Regularly monitor functionality of ethics committee thru regulatory audit	FMHACA, MOH/ HR, RHB	Jhpiego	X	X	X	0
10	Create awareness of the toll free client grievance handling service	FMHACA, RHB		20,000.00			20000
11	Strengthen MDSR and introduce PDSR	MCH, PHEM, RHB	WHO, ESOG, EPS,	X	X	X	0
SUBTOTAL				**128000**	**108000**	**108000**	**344000**
Out Put 2: Institutionalize capability for zonal wide use of multi-faceted implementation interventions							
1	Establish separate cost centers for quality improvement and set system to track progress of expenditure through NHA	PPD, FRM, EPHI, RHB		X	X	X	0
2	Build capacity to use data for decision making	PPD, MCH, HEP, HSQD, RHB	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP	X	X	X	0
3	Strengthen civil service 1-5 networks to ensure quality issues are prioritized, discussed and action taken	zonal health department, RHB		X	X	X	0
4	Experience sharing to areas with best practice	RHBs, HSQD, Clinical services directorate, HEP directorate	All relevant partners	X	X	X	0
Out put 1: District framework and mechanisms for accountability for QoC are established and functioning							
1	Monitor transparent reporting of HMIS data through regular RDQA	PPD, HSQD, MCH, RHB, WHO	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	X	X	X	0
2	Implement MNCH score cards at district levels	PPD, HSQD, MCH, RHBs, WHO	JSI	X	X	X	0
3	Design a database linking regional, woreda and facility levels in such a way that all levels including facilities report and able to view/monitor progress regularly. 1) Cascade training for DHIS 2	PPD, HIT, Health infrastructure directorates, RHB, WHO	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	55100	55100	55100	165300
4	Identify and remedy bottlenecks (internal and external) contributing to interrupted supply of drugs and equipment	PFSA, PML directorate, HSQD, MCH, RHB, WHO	Global health supply chain –PSM, CHAI, UNFPA, AIDS free project, Engender, Marie stopes, CIRTH, pathfinder	X	X	X	0
5	Conduct SS and mentoring on LMIS	PFSA, PML directorate, HSQD, MCH, RHB, WHO	>>	X	X	X	0

Ser.No	Activities	Responsible Government	Responsible NGO	Budget			
				July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
6	Avail necessary formats (internal facility report and requisition form, bin cards, RRF forms)	PFSA, PML directorate, HSQD, MCH, RHB, WHO	>>	X	X	X	**0**
7	Support Implementation of pharmaceutical and warehouse initiative in EHCRIG	Clinical services directorate		X	X	X	**0**
8	Conduct multistakeholder dialogue to review the progress and remedy bottlenecks	MOH (HSQD, MCH, HEP, PPD), RHB, WoHO	WHO,USAID,EMORY,UNICEF,MI,IHI, L10K,UNFPA	X	X	X	**0**
9	Support facility reporting of Maternal and newborn outcome data, patient experience of care data transparently and publicly	DMT, district quality focal person	WHO,USAID,EMORY,UNICEF,MI,IHI, L10K, UNFPA	X	X	X	**0**
10	Conduct regular (twice a year) public wing meetings, identify key problems, plan and monitor follow up actions	MOH and agencies; WHO, health facilities	Private sector, professional associations, civil society,	34000	34000	34000	**102000**
11	Regularly monitor functionality of ethics committee thru regulatory audit	FMHACA, MOH/ HR, RHB, WHO	Jhpiego	X	X	X	**0**
12	Design client grievance handling mechanisms thru toll free telephone lines and create awareness of the service	FMHACA, RHB, WHO		X	X	X	**0**
13	Support scale up of community score card thru	HEP directorate, HSQD, MCH, FMHACA, RHBs, zonal health department, WHO, facilities	L10K, transform PHCU, Yale university, Path, SCI, FMHACA, WHO	262400	X	X	**262400**
	1) 3 days orientation for HCs at district level, and action plans						
14	Strengthen MDSR and introduce PDSR	MCH, PHEM, RHB, WHO	WHO, ESOG, EPS,	X	X	X	**0**
SUBTOTAL				**351500**	**89100**	**89100**	**529700**
Output 2: Institutionalize capability for district wide use of multi-faceted implementation interventions							
1	Establish separate cost centers for quality improvement and set system to track progress of expenditure through NHA	PPD, FRM, EPHI, WHO		X	X	X	**0**
2	Build capacity to use data for decision making	PPD, MCH, HEP, HSQD, RHB, WHO	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	X	X	X	**0**
3	Strengthen civil service 1-5 networks to ensure quality issues are prioritized, discussed and action taken	WHO, ZHD		X	X	X	**0**
4	experience sharing to areas with best practice			70378	70378	70378	**211134**
SUBTOTAL				**70378**	**70378**	**70378**	**211134**
Output 1: Mechanisms for accountability for QoC are established and functioning							
1	Establish an interlinked regional, woreda and facility database in such a way that all levels including facilities report and able to view/monitor progress regularly (Resolve data transparency issues)	MOH (HSQD, PPD, MCH), facility SMT, facility QI-CG unit, DMT	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	X	X	X	**0**
2	Monitor transparent reporting of HMIS data through regular RDQA	MOH (HSQD, PPD, MCH), facility SMT, facility QI-CG unit, DMT	JSI/DUP, JSI/HMIS, NASTAD, PSI, TIE, HISP, UNICEF, Pathfinder, Save the children, WHO, ICAP, CDC, IFHP, FHI 360, USAID	X	X	X	**0**

FACILITY

Ser.No	Activities	Responsible Government	Responsible NGO	Budget			
				July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	Total cost
3	Conduct regular multi-stakeholder performance review and remedy bottlenecks	MOH (HSQD, PPD, MCH), facility SMT, facility QI-CG unit, DMT	ICAP, SCI, WHO, IHI, JSI/L10K, Emory University, NI	X	X	X	**0**
4	Conduct regular town hall meetings, identify key problems, plan and monitor follow up actions	WHO, ZHD, facility SMT, facility QI-CG unit, DMT	Relevant partners, civil society organizations, professional associations	68000	68000	68000	**204000**
5	Display commitment to quality, experience of care data and run charts prominently in public places at facilities	MOH (HSQD, PPD, MCH), facility SMT, facility QI-CG unit, DMT	ICAP, SCI, WHO, IHI, JSI/L10K, Emory University, NI	X	X	X	**0**
6	Involve the community and Kebele command post through a Partnership defined quality approach for regular contribution to the services provided at the facilities	MOH (HSQD, PPD, MCH), facility SMT, facility QI-CG unit, DMT	ICAP, SCI, WHO, IHI, JSI/L10K, Emory University, NI	687,750.00	687,750.00	687,750.00	**2063250**
7	Conduct patient/mom satisfaction survey and reporting at facilities (printing of tool)	facility QI unit, committee, MCH QI team, SMT at facilities		13,440.00	13,440.00	13,440.00	**40320**
8	Implement patient charter (Print and distribute, orient health providers and display in public places)	facility QI unit, committee, MCH QI team, SMT at facilities		3450	3450	3450	**10350**
9	Scale up community score cards nationally 1) Recruit community members to develop common score card 2) Design criteria for provider self-assessment and community evaluation and implement score card			748,800	748,800	748,800	**2246400**
10	Make facility supply chain and management of resources a management priority	Facilities, PFSA, PME directorate, DMT	global health supply chain –PSM, CHAI, UNFPA, AIDS free project (previous deliver USAID), Engender, Mariestopes, CIRTH, pathfinder	X	X	X	**0**
11	Build capacity of pharmacy and other relevant staff on regular and timely tracking/ reporting of stock outs of equipment and drugs 1) Drug supply management training	Facilities, PFSA, PME directorate, DMT	>>	676200	676200	676200	**2028600**
12	Build capacity of pharmacy and other relevant staff on regular and timely tracking/ reporting of stock outs of equipment and drugs 2) Training on standard dispensing practice	Facilities, PFSA, PME directorate, DMT	>>	463400	463400	463400	**1390200**
13	Identify and remedy bottlenecks (internal and external) contributing to interrupted supply of drugs and equipment	Facilities, PFSA, PME directorate, DMT	>>	X	X	X	**0**
14	Implement pharmaceutical and warehouse initiative in EHCRIG	HSQD, clinical services directorate		X	X	X	**0**
15	Establish DTC at each level of facility and build capacity	Facilities, FMHACA, DMT	>>	X	X	X	**0**
16	Conduct SS and mentoring on LMIS	Facilities, PFSA, PME directorate, DMT	>>	X	X	X	**0**
17	Avail necessary formats for LMIS (internal facility report and requisition form, bin cards, RRF forms)	Facilities, PFSA, PME directorate, DMT	>>	X	X	X	**0**
SUBTOTAL				**2661040**	**2661040**	**2661040**	**7983120**
TOTAL				**7,457,657**	**5,973,791**	**5,557,541**	**18,988,989**

6. Annexes

ANNEX II: MONITORING AND EVALUATION MATRIX

S.NO	INDICATOR	TARGETS FOR 2019/2020	SOURCE	PERIODICITY	LEVEL OF DATA COLLECTION
1.	**IMPACT INDICATORS**				
	Institutional maternal mortality ratio (MMR) 38/100,000 LBs	19/100,000 LBs	HMIS	Routine	Facility
	Institutional neonatal mortality rate (NMR) 3/1000 LBs	3/1000 LBs	HMIS	Routine	Facility
	Institutional stillbirth rate 20/1000 births	10/1000 births	HMIS	Routine	Facility
	Maternal deaths by cause	TBD	MDSR report	Routine	Facility
2.	**OUTCOMEINDICATORS**				
	Maternal satisfaction score	50% of facilities >= 80%	Mom satisfaction survey	Routine/ Quarterly	Facility
	Maternity Services Audit Score	50% of facilities >= 80%	HPMI system	Quarterly	Facility
	Proportion of women Survived from PPH	TBD	HPMI system	Quarterly	Facility
3.	**PROCESS INDICATORS**				
	Proportion of neonates treated for asphyxia at health facility	TBD	HMIS	Routine/ Quarterly	Facility
	Proportion of women administered immediate post-partum uterotonic (i.e. active management of the third stage of labor)	TBD	Facility audit	yearly	Facility
	Proportion of maternal and perinatal deaths and near misses reviewed with standard audit tool	TBD	MDSR reports	routine	Facility
	Proportion of newborns breastfed within one hour of birth	TBD	Facility audit	5 years	Community
	Proportion of newborns under 2000 gms initiated on facility based kangaroo mother care (KMC)	TBD	HMIS	yearly	Facility
	Proportion of women who received pre-discharge counseling for mother and baby	TBD	Facility audit	Quarterly	Facility
	Proportion of newborns with documented birth weight	TBD	Facility audit	Quarterly	Facility
	The proportion of women who wanted and had a companion supporting them during labor and childbirth in the health facility	TBD	Facility audit	Quarterly	Facility
	The proportion of facilities with basic sanitation available for women during and after labour and childbirth (private toilet/latrine, bathing.)	TBD	Facility audit	Quarterly	Facility
LEADERSHIP					
1.	Number (%) of regions, zones, woredas and facilities with functional leadership and governance structures for MNH QOC	100%	Administrative	yearly	Regional, zonal, woreda and facility
2.	Number (%) of regions with functional coordination mechanism (steering committee) for QOC	100%	Administrative	yearly	Regional
3.	Number (%) of health managers and leaders at national, regional, zonal and woreda levels trained on QI		Administrative /HRIS	Routine	Regional, zonal and woreda
4.	Number (%) of regions and woredas with MNH improvement plans (including budget line item and time-bound aims)	100%	Administrative	yearly	Regional and woreda

INDICATOR		TARGETS FOR 2019/2020	SOURCE	PERIODICITY	LEVEL OF DATA COLLECTION
LEADERSHIP					
5.	Number (%) of MNH QOC annual plans at regional levels aligned with national level plan	100%	Administrative	yearly	Regional
6.	Number (%) of MNH QOC annual plans at woreda levels aligned with national level plan	75%	Administrative	yearly	Woreda
7.	TWG s for MNH QOC are established and functional at national level	100%	Administrative	Routine	National
8.	Number of advocacy events for MNH QOC implemented through any of the outlets: web site, bulletin or mass media at national and regional levels	30	Administrative	Routine	National and regional
ACTION					
9.	MNH QOC standards and audit tools for PHCUs (HCs and HPs) are adapted and in place	100%	Administrative	Routine	National
10.	Number of best practices on MNH QOC documented and published	10 per year	Administrative	Routine	National, regional
11.	Number of national package of improvement best practices available to inform program delivery and next phase of scale up	5 per year	Administrative	Routine	National
12.	Number of health providers trained on QI, MNH standards (HSTQ guideline, EHSTG, EPHCRIG) and audit tools	6000	Administrative/HRIS	Routine	National, regional
13.	Number (%) of facilities where MNH standards and guidelines (HSTQ guideline, EHSTG, EPHCRIG) are available	3800	Administrative	Routine	National, regional
14.	A set of core indicators for MNH QOC are incorporated and reported in the HMIS	100%	HMIS	Routine	National
15.	Number (%) of health facilities within a learning woreda which conducted baseline performance assessment on MNH QOC standards/audit and identified priority gaps	100%	Administrative	Routine	Facility, woreda
16.	Number (%) of health facilities within a learning woreda which design and implement improvement plans in collaboration with DMT and SMT of facilities	100%	Administrative	Routine	Facility, woreda
17.	Number (%) of Woredas which mobilized resources and technical assistance to fill gaps identified by the baseline assessment				
18.	Number of learning districts selected	At least 2	Administrative	Routine	Regional
19.	Number of learning districts which conducted baseline assessment	At least 2	Administrative	Routine	Regional, woreda
20.	Number of learning districts which mobilized resources and technical support for priority gaps	At least 2	Administrative	Routine	Regional, woreda
21.	Number of regions which established EHIAQ and EPHUAQ clusters networking all facilities	11	Administrative	Routine	Regional, woreda
22.	Number (%) of EHIAQ and EPHUAQ clusters which conducted regular learning collaborative sessions (Quarterly cluster review meetings)	750	Administrative	Routine	Regional, woreda, lead hospitals and lead health centers
23.	Number (%) of Woreda participating in EHIAQ, EPAQ clusters' learning collaborative sessions	100%	Administrative	Routine	Woreda, lead hospitals and lead health centers
24.	Number (%) of Woreda participating in facility learning collaborative sessions	100%	Administrative	Routine	Woreda
25.	Number (%) of Woreda engaged in joint capacity building of facilities (supportive supervision, mentoring, coaching)	100%	Administrative	Routine	Woreda

INDICATOR		TARGETS FOR 2019/2020	SOURCE	PERIODICITY	LEVEL OF DATA COLLECTION
LEARNING					
1.	Proportion of core indicators incorporated in the revised HMIS or KPIs, (11 core indicators set to be reported within the global network)	100%	combined source HMIS, KPI, SARA-but HSTQ	Annual	National
2.	Proportion of core indicators integrated in DHIS-2that ar routinely collected and reported from facility dash board	100%	HMIS ,KPI		National, regional
3.	Proportion of facilities within the learning district visited by the monitoring and evaluation team annually	100%	Administrative	Annually	National and regional
4.	Availability of tools for collecting and reporting case histories, stories from the field and testimonials for dissemination at facility, woreda and regional level	100%	Administrative	Quarterly	Woreda and facilities
5.	Proportion of facilities within the learning district visited/ mento red on timely basis for data quality assurance standards	100%	New	Quarterly	National and regional
6.	Proportion of health information technicians (HITs) in facilities or HMIS focal points trained on data analysis and use	100%	Administrative	Annually	National ,regional and facility
7.	Availability of national virtual learning system for improving MNH QOC that can be accessed and linked to the global learning platform	1	Administrative	Annually	National
8.	Proportion of learnings submitted from woreda/region as (summaries, overviews, manuals) to national learning system and disseminated	100%	New Quality indicator	Monthly	National, regional and district
9.	Proportion of facilities with assigned person to track progress, feed learning and participate in learning through the national learning platform	100%	Administrative	Quarterly	Facility
10.	Availability of functional HSQD website	1	Administrative	Annually	National
11.	Availability of social media as a learning means for MNCH QoC	1	Administrative	Quarterly	National
12.	Proportion (%) of facilities within district participated in existing learning collaborative: EHIAQ cluster meetings, Mentorship of facilities, SS	80 %	Administrative	Quarterly	Facility and regional
13.	Proportion of planned MNH QOC review meetings conducted at national , regional , zonal and woreda levels	80%	Administrative	Quarterly	Woreda, zonal , region and national
14.	Number of annual MNH QOC summit conducted at national level	1	Administrative	Annually	National
15.	Proportion of health facilities within each district attended the quality summit	50 %	Administrative	Annually	National district
16.	Proportion of district wide gatherings attended by facilities QI teams	50%	Administrative	Quarterly	District , Facilities
17.	Proportion of facility leadership participated in the facility regular QI meeting and addressedkey administrative issues	50%	Administrative	Quarterly	Facility
18.	Proportion of trainings on QI cascaded to facility staff (on core QI processes data analysis, root cause analysis, PDSA)	80%	Quality training profile/ Administrative	Quarterly	Facility, regional , National
19.	Proportion of facility QI teams attended a QI orientation by recently trained provider (on core QI processes data analysis, root cause analysis, PDSA)	50%	Quality training profile/ Admin	Quarterly	Facility, regional National

INDICATOR		TARGETS FOR 2019/2020	SOURCE	PERIODICITY	LEVEL OF DATA COLLECTION
LEARNING					
20	Proportion of HDA platforms in facilities which discussed about patient and community satisfaction	> 50%	Administrative	Monthly	District
21	Proportion of pregnant mother conferenceswhich discussed about patient and community satisfaction	>80%	Administrative	Quarterly	District
22	Availability of functional client councils per facility as per the defined role and responsibility	100%	Administrative	Annually	Facility
23	Proportion of health facilities that publicly post patient and provider's right and routinely informed to patients atinformation/reception desk	100%	Administrative	Quarterly	Facility
24	Proportion of health facilities within district implementing the community score cards to improve the MNCH QOC	>50%	Administrative	Quarterly	District , Facility
25	Proportion of facilities with timely reports on indicators that measure clients' satisfaction in the labor and delivery ward in health center and lower levels	>80%	KPI , HMIS	Quarterly	Facility
26	% change ideas collected systematically (through the TWG), to test, to compile as a change package and use for scale up	100%	Administrative	Quarterly	Facility, National
27	Proportion of collected change ideas compiled as a change package and publicized for scale-up by the national TWG	>80%	Quality indicator	Quarterly	Facility, district, region and National
28	Proportion of published case reports and successful quality improvement best practices	50%	Quality indicator	Annually	
29	Proportion of lead hospitals provided mentoring support to their cluster hospitals and HCs within learning district as per plan	80%	Administrative	Quarterly	Region, District, facility
30	Proportion of public advocacies conducted (in the review meeting, other gathering) by the facility leadership on the ongoing scale up of initiative	50%	Administrative	Quarterly	Facility
ACCOUNTABILITY					
1.	Number (%) of regions with regular RDQA conducted at all levels	11	Administrative	Routine	National. regional
2.	Number (%) of learning districts with data verification factor for core MNH QOC indicators=1	100%	Survey	yearly	National
3.	Number (%) of learning districts implementing DHIS2	100%	Administrative	Routine	National, regional, woreda
4.	Number of public wing meetings conducted at national, regional, zonal and district levels	2 meetings at each level per year (24)	Administrative	Routine	National, regional, zonal and woreda
5.	% of hospitals conducting regular quarterly mom satisfaction survey	75%	Administrative	Routine	Facility, regional, national
6.	% of health centers conducting regular quarterly mom satisfaction survey	25%	Administrative	Routine	Facility, regional, national
7.	% of hospitals implementing patient charter	100%	Administrative	Routine	Facility, regional
8.	% of health centers implementing patient charter	50%	Administrative	Routine	Facility, woreda
9.	% of health centers implementing community score cards	100%	Administrative	Routine	Facility, woreda, regional
10.	Number (%) of facilities in learning districts displaying commitment to quality, experience of care data and run charts prominently in public places	100%	Administrative	Routine	Facility, woreda

	INDICATOR	TARGETS FOR 2019/2020	SOURCE	PERIODICITY	LEVEL OF DATA COLLECTION
ACCOUNTABILITY					
11.	Number (%) of facilities in learning districts with providers trained on drug supply management and good dispensing practice	100%	Administrative	Routine	Facility, woreda
12.	Number (%) of facilities in learning districts with regular SS and mentoring conducted to strengthen LMIS	100%	Administrative	Routine	Facility, woreda
13.	Number (%) of health facilities with functional DTC	100%	FMHACA	Annual	National
14.	Number % of planned regulatory audits conducted in hospital ethics committees	100%	FMHACA	Annual	National
15.	Number (%) of woredas where toll free telephone service for client grievance handling are established	30%	FMHACA	Annual	National
16.	Number (%) of regions and wordas with separate cost centers for quality improvement	100%	Administrative	Routine	Region, woreda
17.	Number (%) of quarterly MOH health bulletins where quality improvement work is highlighted	12	Administrative	Routine	National
18.	Frequency of time Quality bulletin is published and distributed	12	Administrative	Routine	National
19.	Number of policy briefs produced on quality of care	6	Administrative	Routine	National
20.	ARM experience sharing visits which included quality domains	3	Administrative	Routine	National
21.	CPD material designed to train future MOH staff to use systems improvement methods to lead, manage and implement change	100%	Administrative	Routine	National
22.	A masters level QI and patient safety course curriculum developed and initiate training	100%	Administrative	Routine	National
23.	A masters level QI and patient safety training initiated	100%	Administrative	Routine	National
24.	Experience sharing to areas with best practice conducted at national regional and woreda levels	3 at each level (9)	Administrative	Routine	National

ANNEX III: COSTING SUMMARY (JULY 2017- JUNE 2020)

S.no	STRATEGIC OBJECTIVE	BUDGET (ETB)			
		July 2017-June 2018	July 2018-June 2019	July 2019-June 2020	TOTAL
1.	Leadership	**8,557,000**	**9,825,000**	**9,825,000**	**28,207,000**
2.	Action	**8,796,683**	**32,320,000**	**7,728,000**	**48,844,683**
3.	Learning	**3,323,705**	**3,301,206**	**2,518,356**	**9,143,267**
4.	Accountability	**7,457,657**	**5,973,791**	**5,557,541**	**18,988,989**
	Total	**28,135,045.00**	**51,419,997.00**	**25,628,897.00**	**105,183,939.00**

ANNEX IV: LIST OF CONTRIBUTORS

The Federal ministry of health would like to acknowledge the following individuals and organizations for their contribution at different stages of the roadmap development process.

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   - Lead hospital CEOs and other representatives:
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     - Axum Referral hospital
     - Bishoftu referral hospital
     - Borumeda General hospital
     - Debrebirhan referral hospital
     - Debremarkos referral hospital
     - Debretabor General hospital
     - Dembidolo referral hospital
     - Dilchora referral hospital
     - Dubti referral hospital
     - Hidar 11 General hospital
     - Kulito General hospital
     - Leku Primary hospital
     - Mekaneselam General hospital
     - Mekelle General hospital
     - Nedjo General hospital
     - Shashemene referral hospital
     - Tercha referral hospital
     - Woldiya General hospital
     - Yirgalem Referral hospital

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