Ethiopia

ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH - ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

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

Country context

POPULATION & MORTALITY RATES	2017	2020	2022
Population (in million)[1]	108.2	117.2	120.3
Maternal Mortality Ratio per 100,000 live births[2]	401	267	–
Neonatal Mortality Rate per 1,000 live births[3]	30	27	26
Stillbirth Rate per 1,000 births[3]	23	21	21

NATIONAL COVERAGE OF KEY INTERVENTIONS (2019)	%
Antenatal care (4 or more visits)[4]	43
Skilled birth attendance during delivery[5]	50
Institutional deliveries[6]	48
Post natal visit for baby (within 2 days of birth, medically trained provider)[6]	35
Postnatal care for mother (within 2 days of birth, medically trained provider)[6]	34
Caesarean section rate[7]	–
Family planning[8]	63
Initial breastfeeding (1 hour of birth)[9]	72
Exclusive breastfeeding rate (of infants under age of 6 months)[10]	59

1. United Nations, Department of Economic and Social Affairs, Population Division (2022). World Population Prospects 2022, Online Edition. https://population.un.org/wpp/Download/Standard/MostUsed/
2. World Health Organization. (2019). Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division: executive summary. World Health Organization. https://apps.who.int/iris/handle/10665/327596
   World Health Organization (2023). Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. https://apps.who.int/iris/handle/10665/366225
3. United Nations Inter-agency Group for Child Mortality Estimation (2023). https://childmortality.org/
4. WHO/SHR Global Database, Percentage of women aged 15–49 years attended at least four times during pregnancy by any provider, September 2022.
5. UNICEF/WHO joint database on SDG 3.1.2 Skilled Attendance at Birth. May 2022
6. United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring (2022). Global UNICEF Global Databases: Maternal and Newborn Health Coverage Database, New York, May 2022.
7. WHO Global Health Observatory. https://www.who.int/data/gho
8. United Nations, Department of Economic and Social Affairs, Population Division (2020). Estimates and Projections of Family Planning Indicators 2020. New York: United Nations.
9. United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring (2022). Global UNICEF Global Databases: Infant and Young Child Feeding: Ever breastfed, Early initiation of breastfeeding, Exclusively breastfed for the first two days after birth, New York, October 2022.
10. United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring (2022). Global UNICEF Global Databases: Infant and Young Child Feeding: Exclusive breastfeeding, New York, October 2022.

Milestone progress (2017-2022)

STRATEGIC OBJECTIVES	MILESTONE DELIVERABLES	2017	2020	2022
LEADERSHIP	Supportive governance policy and structures developed or established	On track	On track	On track
	Quality of care for maternal and newborn health roadmap developed and being implemented	On track	On track	On track
ACTION	On-site coaching visits occuring in learning districts	No information	On track	On track
	Quality improvement coaches trained	No information	On track	On track
	QoC coaching manuals developed	No information	On track	On track
	Learning districts and facilities selected and agreed upon	On track	On track	On track
	QoC implementation package developed	No information	On track	On track
	Adaptation of MNH QoC Standards	On track	On track	On track
	Orientation of learning districts and facilities	Not started	On track	On track
LEARNING AND ACCOUNTABILITY	Mechanism for community participation integrated into QoC planning in learning districts	Not started	Not started	On track
	A research institution to facilitate documentation of lessons learned identified and is active	Not started	Not started	In progress
	District learning network established and functional (reports of visits)	On track	On track	On track
	Common indicator data collected, used in district learning meetings, and reported upwards	Not started	On track	On track
	Baseline data for MNH QoC common indicators collected	Not started	On track	On track
	Common set of MNH QoC indicators agreed upon for reporting from the learning districts	Not started	On track	On track

Key: On track (achieved) · In progress (initiated but not completed) · Not started · No information

Ensuring MNH QoC core indicators are available in routine HMIS

DATA ELEMENTS	Integrated into HMIS	Collected	Reported	Used	Source
Pre-discharge maternal deaths	YES	YES	YES	YES	Reported in DHIS2 (Institutional maternal deaths & number of maternal deaths in the community)
Maternal deaths by cause	YES	YES	YES	YES	Reported through MPDSR system
Neonatal deaths by cause	YES	YES	YES	YES	Reported through MPDSR system
Facility stillbirth rate (disaggregated by fresh/ macerated when possible)	YES	YES	YES	YES	
Pre-discharge neonatal mortality rate	YES	YES	YES	YES	Reported in DHIS 2 (Institutional Neonatal Death Rate &number of Neonatal deaths in the community)
Obstetric case fatality rate (disaggregated by direct/indirect when possible)	YES	YES	YES	YES	Reported through MPDSR system
Pre-discharge counselling for mother and baby (woman-reported)	NO	NO	NO	NO	
Companion of Choice (woman-reported)	NO	NO	NO	NO	
Women who experienced physical or verbal abuse in labor or delivery (woman-reported)	NO	NO	NO	NO	
Breastfeeding within one hour	YES	YES	YES	YES	
Immediate postpartum prophylactic uterotonic for PPH prevention	YES	YES	YES	YES	
Birthweight documented	YES	YES	YES	YES	
Premature babies initiating KMC	YES	YES	YES	YES	
Basic Hygiene Provision	NO	NO	NO	NO	
Basic sanitation available to women and families	YES	YES	YES	YES	Periodic facility survey

Key: YES · NO · No information

Creating an enabling environment for sustainability and scaling up of MNH QoC

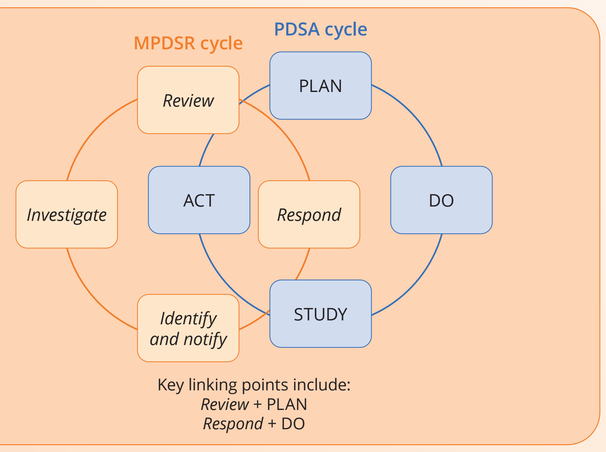
Aligning MNH QoC and maternal and perinatal death surveillance and response

MNH QoC operations and MPDSR have been integrated from the start in Ethiopia.

The Plan-Do-Study-Act (PDSA) cycle used by QoC teams as part of their QI cycles is a feature in both MPDSR and QoC processes. The first part of PDSA, the planning phase, draws upon problems identified by the MPDSR committees. The latter parts of PDSA, including the doing, studying, and acting phases, which belong to the *response* aspect, are carried out by QoC teams. MPDSR thus identifies the factors leading to death and informs the recommendations, which are then implemented and monitored by the QoC team.

MPDSR and QoC interface at all levels:

- At the **national level**, the emphasis is on leadership, coordination of linkages, and provision of guidance on how QI for QoC should function. Various directorates incorporate MPDSR and QI findings in their annual plans. The national level determines priorities based on data and designs strategies and roadmaps for QoC.
- At the **subnational level**, various technical working groups exist, some with national level representation. Experts from the maternal and neonatal QoC group work with the MPDSR working group. They use the information generated by MPDSR to inform QI priorities and action.
- At the **facility level**, MPDSR activities are led by the rapid response team (RRT). A dedicated quality unit led by a clinical officer (general practitioner) in hospitals and a performance monitoring team (PMT)/quality committee in health centers, oversee general QoC initiatives.
- There is interface between the MPDSR and QOC structures, so a member of the QI team or PMT joins the rapid response team (RRT) responsible for MPDSR during the development of response plan which will be linked to QI and supports its implementation.



Key linking points include:
Review + PLAN
Respond + DO

The political will of the FMoH to take ownership of maternal and perinatal health has facilitated the harmonization of implementation of MPSDR and QI cycles and supported the broader QoC efforts. These two processes have developed alongside one another and have benefited from each other's successes. The linkages between the broader QoC efforts and MPDSR have been strengthened by a number of factors.

- First, the well-established surveillance system and availability of surveillance data within MPDSR present clear evidence and inform recommendations for action.
- Second, health system governance emphasizes the alignment and development of linkages across different parts of the programmes as a means for improving efficiencies and achieving results.

Learning Health Systems

Across learning facility teams ongoing learning is documented and shared through regular national and district learning collaborative sessions, national and regional quality summits & annual quality bulletins, posters and oral presentations to allow consistent and continuous sharing of learning for rapid scale-up of improvement.

- A pool of QI coaches was established in learning districts with members from the hospital and district health office. QI coaches were trained on QI, MPDSR, data quality and common core Indicators. The coaches provide on-site support to QI teams in health centers.
- Learning facilities have been supported to establish QI units and teams and received basic QI trainings; Operational, technical, coaching and mentorship support is provided to the QI teams on how to identify gaps in care, prioritize areas for improvement and to develop, implement, and test change ideas that have the potential to bring about improvement following iterative PDSA cycles.
- QI teams & coaches receive regular technical support from the partners' improvement advisors to document improvement ideas and processes and share their successes.
- Collaborative learning sessions and forums/summits are organized for QI teams to share their improvement experiences and insights with colleagues which served as a primary mechanism for spreading best practices to other facilities teams.
- Based on the learning from implementation, an end term review of the national MNH QOC roadmap has been conducted in 2022 and a preliminary report was prepared to inform scale up.

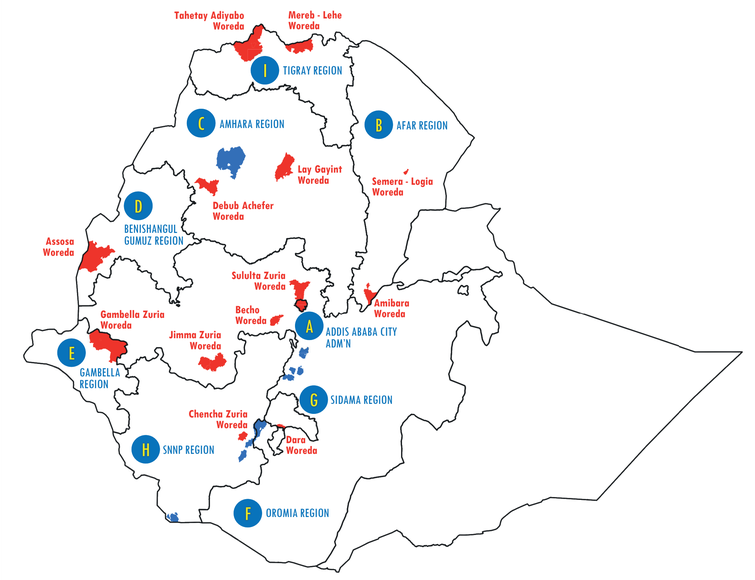
'A Collection of Tested Changes to Improve Maternal, Newborn, And Child Health (MNCH) Services in Health Facilities in Ethiopia'

- The change ideas represent a synthesis of the most robust and effective changes successfully implemented and tested in multiple health facilities (both referral & general hospital, primary hospitals and health centres).
- The *change package* is a compilation of the change ideas, the related strategies and specific actionable items that showed success in institutionalizing the culture of quality improvement to achieve improvement in MNCH QoC.
- The package aims to stimulate efforts to institutionalize QI and a data use culture. All ideas are consistent with national and global MNCH guidance, and are supported by data collected over time, which showed numerical improvement in quality MNH.

Process followed to develop the change package:

1. The package was developed by the National Technical Working Group for quality and in consultation with QI teams from all learning district facilities and respective Regional Health Bureau experts under the leadership of the HSQD.
2. A one-day harvesting meeting with the QI teams in July 2021 focused on reflection on the improvements registered in institutionalizing QI in health facilities. The harvesting meeting sessions was used as a platform to evaluate and score change ideas from different improvement projects using criteria including relative importance, simplicity and scalability.
3. This was followed by several rounds of face-to-face meeting with TWG members to review, refine and revise the Change Packages drafted from harvesting meeting and thereafter, a half-day virtual session during the regular meeting of the national MNCH quality improvement technical working group.
4. All change ideas were scored 0-3 by the participants. A score of 0 (zero) for example means no run chart rules met or suggestions for improvement. On the other hand, a score of 3 (three) means meeting at least 1 run chart rule sustained and easily scalable.

Map of the districts and learning facilities



A ADDIS ABABA CITY
Sp: AA RHB
Ghandi Memorial HO [Lead HO]
St. Peter Specialized HO [Lead HO]
Zewditu Memorial HO [Lead HO]

B AFAR REGION
Amibara Woreda
Sp: IHI
Awash Arba HC
Mohammed Akele Memorial HO [Lead HO]
Werer HC
Semera – Logia Woreda
Sp: Transform HDR
Chifra HC
Dubti Referal HC [Lead HO]
Megenta HC

C AMHARA REGION
Debub Achefer Woreda
Sp: Transform PHC
Ashuda HC
Durbete HO [Lead HO]
Durbete HC
Lalibela HC
Lay Gayint Woreda
Sp: CHAI
Gobgob HC
Nefas Mewecha HO [Lead HO]
Nefas Mewecha HC

D BENISHANGUL GUMUZ REGION
Assosa Woreda
Sp: Transform HDR
Assosa HO [Lead H]
Bambasi HC
Mender 16 HC

E GAMBELLA REGION
Gambella Zuria Woreda
Sp: Transform HDR
Gambella Referal HO [Lead HO]
Gambella HC
Itang HC
Pugnido Primary HO

F OROMIA REGION
Jimma Zuria Woreda
Sp: WHO
Ferenj Arada HC
Jimma University HO [Lead HO]
Serbo HC
Shenen Gibe HO
Becho Woreda
Sp: IHI
Tullu Bollo HO [Lead HO]
Tullu Bollo HC
Awash Bune HC

Sululta Woreda
Sp: Transform PHC
Chancho Primary HO
Chancho HC
Duber HC

G SIDAMA REGION
Dara Woreda
Sp: Transform PHC
Kebado Primary HO
Odola HC
Teferi Kela HC
Tolaricha HC

H SNNP REGION
Chencha Woreda
Sp: IHI
Arbaminch HO [Lead HO]
Chencha Primary HO
Dorze HC
Ezo HC

I TIGRAY REGION
Mereb – Lehe Woreda
Sp: CHAI
Ahetsia HC
Bireshewa Primary HO
Simret HC
Tahetay Adiyabo Woreda
Sp: Transform PHC
Adihageray HC
Adiwala HC
May Ayni Primary HO
Zeban - Gidan HC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Taking forward the unfinished and emerging agenda for quality MNCH

Key challenges faced during implementation of the QoC for MNCH initiative:

- The results, challenges and solutions captured from the end-term review of national MNH QoC roadmap is being used to inform programming and scale-up plans.
- Restructuring of the Federal MoH quality directorate along with reshuffling of staff that have been coordinating the MNH QoC is ongoing, and the HSQD is expected to have some major changes. This has particularly impacted the directorate's governance and coordination for smooth implementation of the initiative as their effectiveness is undermined when they are inadequately staffed, and their role and responsibilities are not clearly defined. This also affects government ownership including lack of funding to strengthen the implementation of the MNH QoC initiative and as well as scale up efforts beyond learning districts.
- Due to the ongoing humanitarian crisis, additional financial and technical support is required from implementing partners to reorient, restart and enhance coordination, QI planning, implementation, monitoring and knowledge sharing in the conflict-affected facilities and ensure scale up to further districts and facilities.
- On-site support and QI and clinical training are needed to build capacities of healthcare workers in the learning districts and facilities.