NATIONAL HEALTHCARE QUALITY AND SAFETY STRATEGY (NQSS)

2021-2025

(2013-2017 EFY)

TABLE OF CONTENTS

FOREWORD

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For the first time, Ethiopia developed and executed the National Health Quality Strategy (NQS) during the first period of the Health Sector Transformation Plan (HSTP-I) from 2015-16 to 2019-20. During this time, significant achievements were registered in improving the quality management system at all levels of the health system. The capacity building of healthcare professionals in quality improvement sciences and improvement initiatives and projects has resulted in significant improvement in patients' outcomes and experiences. National learning platforms and inter-facility learning, and collaborative endeavors have been established and promising results were noted.

Despite these gains, much work is still needed to institute a robust quality management system that guarantees continuous improvement. Upon the final year evaluation, it has been noted that inadequate collaborative implementation and insufficient integration of the interventions into the existing programs and projects were the major weaknesses in the execution of NQS. This new strategy, however, is designed building on the previous one and in such a way that it redresses the flaws. Besides, it is among other strategies that aim to operationalize the Health Sector's transformation plan (HSTP-II) Transformation agenda- Quality and Equity.

This strategy is co-designed by different stakeholders to establish a fertile ground for its collaborative implementation and integration with different programs. At every phase of the development, key stakeholders have been engaged, and their opinions and recommendations have been given serious attention. Evidence and guidance from the global quality and safety arena were tailored into the country context. World Health Organization's Guidance development for quality policy and strategy was followed.

The emergence of the Covid-19 pandemic has uncovered significant gaps in healthcare safety and put the care receivers, health workforce, and careers at an increased safety risk. Moreover, the magnitude and severity of healthcare-acquired infections and antimicrobial resistance call for a systematic response. As a result, this strategy puts in place certain interventions to strengthen evidence-based practice towards healthcare safety. Furthermore, The safety dimension of quality has gained global attention, for a great deal of evidence shows that it is much needed to address high-risk clinical conditions and the causes of harm. Hence this strategy is going to be known as the Ethiopian National Healthcare Quality and Safety Strategy (NHQSS).

The execution of this strategic plan demands a collaborative approach with high political commitment, active participation of the health workforce, and the contribution of all stakeholders. Extending my sincere appreciation to all who contributed to the development of

this strategy, it is with great hope that I would like to call upon all stakeholders, to continue all efforts that we have initiated previously and transform the quality and safety of our healthcare and achieve the ambitious targets set in the plan.

Looking forward to working with you all toward the successful implementation of the strategy.

Lia Tadesse, MD, MHA
Minister of Health
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List of acronyms

ALTS	Auditable Laboratory Transactions And Services
ANC	Antenatal Care
APTS	Auditable Pharmaceutical Transactions And Services
ART	Antiretroviral Therapy
CPD	Continuing Professional Development.
CRC	Compassionate And Respectful Care
CSC	Community Score Card
CSD	Clinical Service Directorate
CSOs	Civil Society Organizations
DM	Diabetes Mellitus
DHIS2	District Health Information System 2
DPCD	Disease Prevention And Control Directorate
ECCD	Emergency and Critical Care Directorate
EFMHACA	Ethiopian Food Medicine And Healthcare Regulation and Control Authority
EHAQ	Ethiopian Health Care Alliance For Quality
EHCRIG	Ethiopian Health Center Reform Implementation Guideline
EHSTG	Ethiopian Hospital Services Transformation Guideline
EPAQ	Ethiopian Primary Healthcare Alliance For Quality
EPHI	Ethiopian Public Health Institute
EPSA	Ethiopian Pharmaceutical Supply Agency
HEP	Health Extension Program
HEPHCD	Health Extension and Primary Health Care Directorate
HF	Health Facilities
HHRD	Health and Health-Related Regulation Directorate
HIS	Health Information System
HITD	Health Information And Technology Directorate
HMIS	Health Management Information System
HP	Health Post
HRDD	Human Resource Development Directorate
HRH	Human Resource For Health
HRIS	Human Resource Information System
HSTP	Health Sector Transformation Plan
HSTQ	Health Sector Transformation In Quality
IMCI	Integrated Management Of Childhood Illness
IPC	Infection Prevention And Control
LD	Legal Directorate
LQAS	Lots Quality Assurance System
MNCAH-N	Maternal, Newborn, Child, And Adolescent Health and Nutrition Directorate
M & E	Monitoring and Evaluation
MNH	Maternal and Newborn Health
NHIA	National Health Insurance Agency
NHQSS	National Healthcare Quality and Safety Strategy

NQS	National Quality Strategy
PMED	Policy Plan Monitoring and Evaluation Directorate
QHSD	Quality Health Service Directorate
RD	Reform Directorate
RDQA	Routine Data Quality Assessment
RHB	Regional Health Bureau
SARA	Services Availability and Readiness Assessment
TOT	Training Of Trainers
UHC	Universal Health Coverage
WoHO	Woreda Health Office
WHA	World Health Assembly
WHO	World Health Organization
QI	Quality Improvement
ZHD	Zonal Health Department

1 ACKNOWLEDGMENTS

Stakeholders at all levels of the healthcare system contributed to this National Healthcare Quality and Safety Strategy through various engagement modalities. The Ministry of Health is grateful for the writing team, national quality and safety technical working group members, and consultative workshop participants for their inputs and contributions. The Ministry also acknowledges the Institute for Healthcare Improvement (IHI) for its financial and technical support in the development of the strategy. A full list of collaborators can be found in annex 4.

2 EXECUTIVE SUMMARY

The National Healthcare Quality and Safety Strategy (2021-2025) is a continuation of the previous National Quality Strategy (2016-2020). The approach for preparing this strategy document was informed by the previous quality strategy implementation. Based on the lesson gathered from the previous National Quality Strategy evaluation, the current National Healthcare Quality and Safety Strategy document has established a transparent and participatory process of development involving the diffract directorates in the ministry of health and agencies, patient and professional associations, partners, and health facilities. The development process had three teams. The Writing Team, primarily responsible for the overall drafting of the strategic document; the Technical Team which consists of the three technical working groups; National quality working group, national healthcare safety working group, and Maternal and neonatal Health quality of care working group that provided technical inputs through consultative workshops and regular meetings; and the National Quality Steering Committee for guidance and approval in the overall preparation of the strategy.

Based on extensive consultations of both national and global documents on quality and safety, The Ethiopian high quality and safe care framework was formulated. Based on the framework, current state analysis (The state of quality and safety in Ethiopia, SWOT analysis, Stakeholder analysis) was done.

The goal of the strategy is to continually improve health outcomes and confidence in the system through the realization of the following five Objectives: improve evidence-based essential health care provision; improved People-Centered Care; reduce harm arising from the care delivery; improve efficiency in the health care delivery; and create a Quality culture through continuous learning and improvement. For all objectives, major activities and targets were prepared. A total of 60 major activities and 21 targets were included.

Implementation arrangement and detailed monitoring and evaluation plan—with simplified M and E framework—were prepared. In addition, a detailed operational plan was prepared which disclosed when who, and how the major activities could be tracked and measured. Budget for each strategic objective and major activities were prepared; a total of **4,243,263,848.4 ETB (92,211,084.7 USD)** is needed to execute the strategic plan.

Finally, integration of this strategic plan with other technical programs was suggested to facilitate the successful implementation and the national health care quality and safety strategy (2021-2025) was suggested.

3 INTRODUCTION

3.1 Background

Globally, for the very first time, healthcare quality and safety received attention at the 55th World Health Assembly in 2002. Since then, several initiatives to improve quality and safety have been launched. Following the WHA resolution, WHO initiated Clean Care is Safer Care (2005), to reduce healthcare-associated infection by focusing on improved hand hygiene; Safe Surgery Saves Lives (2008), dedicated to reducing risks associated with surgery; and Medication Without Harm (2017), to reduce the level of severe, avoidable harm related to medications globally by 50% over five years. However, low-quality and unsafe care continue to exist all over the world, and its burden is highest in the low- and middle-income countries.

In the Ethiopian health system, the 1993 health policy didn't directly address the quality and safety of healthcare. However, it mentioned that the "development of an equitable and acceptable standard of the health service system" was one of its policy directions, which could be related to the quality of care (1). Subsequently, four health sector development program plans (I-IV) were launched. The first two health sector development program plans were devoted to increasing access to health care by expanding primary health care facilities and initiating the health extension program. During the third and fourth health sector development programs, business process reengineering (BPR) was implemented as an intervention to improve the quality of care.

But it was in the era of Health Sector Development Program IV that quality and safety started to capture much of the attention of the Ministry of Health (MoH). One of the strategic pillars was "excellence in health service delivery and quality of care." One of the strategic objectives was to "improve quality of health services," dictating that health services should be delivered as per the prescribed quality standard. Despite the clear description of quality, however, there were no quality structures until the first Health Sector Transformation Plan (2). Ethiopian Food Medicine and Healthcare Regulation and Control Authority (EFMHACA) was established and oversaw the quality control of drugs, devices, health workforce and professional ethics, and facility health standard enforcements, especially in the private sector (3). The revised health policy of Ethiopia has given due emphasis to the improvement of quality, equity, and safety of healthcare as a policy issue.

Ethiopia during the second growth and implementation plan has implemented the Health Sector Transformation Plan (HSTP-I) (June 2015 – June 2020), in which transformation in quality and equity was on the agenda. To operationalize the sector-wide plan, the MoH developed and implemented the National Healthcare Quality Strategy (NQS) for the same period of HSTP-I.

The performance of the NQS has been reviewed through mid-term and end-term evaluations. These reviews show there have been notable achievements along with critical challenges. Among these achievements was the establishment of structures for quality management and clinical governance starting with the MoH and extending to the facilities. In the MoH-level Health Services Quality Directorate, the National Healthcare Quality Steering Committee, as

well as quality and safety technical working groups, was established. Quality structures at the regional, Zonal, Woreda, and facility levels were created. The Directorate organized the National Quality Summit, and it has been working on creating learning facilities. Also, the maternal and newborn health (MNH) learning district has been created in 14 districts and 48 facilities to facilitate collaborative learning within the district since 2018. However, the execution of this activity significantly varies among regions. Facilities (both hospitals and health centers) became successful in creating dedicated quality structures. At the community level, there are still no such quality structures except in some woredas currently supported by other partners.

A large group of providers and leaders were trained in QI methodology, especially at the federal and regional levels. Learning structures were initiated at hospitals, such as the Ethiopian Hospital Alliance for Quality, and health centers, such as members of the Ethiopian Primary Healthcare Alliance for Quality (EPAQ). Yet hurdles to structured peer learning and inadequacy of financial support were common challenges for these learning structures, especially for EPAQ.

3.2 Rationale

The NQS helped the country to leverage resources, establish the necessary quality structure at all levels, and create a pool of experts in the area of quality. But in the last five years, interest has been renewed at the global level in the quality and safety of healthcare. New interventions and concepts related to healthcare quality and safety have been shared on the global stage. Hence, Ethiopia needs to incorporate these new concepts and interventions, tailored to the contexts of the country.

Healthcare safety and high-quality universal health coverage are paramount. Especially in low- and middle-income countries, developing bodies of evidence show that problems of healthcare safety are prevalent. Healthcare-acquired infections, unsafe surgery, antimicrobial resistance, falls, and medication errors are some of the high-burden situations harming patients and healthcare workers. Therefore, addressing this problem systematically is mandatory. In this strategic document, we propose interventions for healthcare safety.

Moreover, the emergence of the global pandemic (COVID-19) has revealed the huge challenges and risks facing healthcare globally. The safety of healthcare workers and clients has been significantly impacted. This necessitates a concerted effort to ensure the safety of healthcare.

Building on the success of the first NQS and redressing the gaps by incorporating new interventions, the MoH aims to improve the outcomes and experience of care in the next five years.

3.3 Approach

The Health Services Quality Directorate, under the oversight of the National HealthCare Quality Steering Committee, was responsible for organizing and leading the process of developing the strategic plan preparation. Learning from the previous strategic plan development process, maximum engagement of all potential stakeholders was ensured using a

three-phase approach. Phase One consisted of situational analysis and goal setting; Phase Two covered intervention and priority areas; and Phase Three involved articulating implementation arrangements and a monitoring framework. Therefore, the preparation was based on a participatory and collaborative approach, ensuring the close engagement of potential stakeholders and partners.

The development process had three teams: the writing team, primarily responsible for the overall drafting of the strategic document; the technical team, which provided technical inputs through consultative workshops; and the National Healthcare Quality Steering Committee, which offered guidance and approval in the overall preparation of the strategy.

The development of the strategy was informed by WHO's "Handbook for National Quality Policy and Strategy" and followed the plan commission's guide to strategic plan preparation (Strategic Planning and Management) with slight modification. Other influences included an article in *Lancet Global Health*, "High-quality health systems in the Sustainable Development Goals era: time for a revolution"; the World Bank Report "Delivering Quality Health Services: A Global Imperative for Universal Health Coverage"; and a report from the National Academies of Sciences, Medicine, and Engineering, "Crossing the Global Quality Chasm: Improving Health Care Worldwide."

Besides, NHQSS development is largely based on HSTP-II objectives. The following table shows the link of HSTP-II with quality and safety.

Table 1: The link between the HSTP-II strategic objectives and quality and safety strategy

HSTP-II objectives	How is healthcare quality linked to these objectives?
1. Accelerate progress toward universal health coverage	The strategic objective emphasized the need for effective essential service coverage. It underscored that effective coverage has three components—needs of the consumer, utilization, and quality of healthcare intervention—and will be tracked as a measurement to realize UHC.
2. Protect people from health emergencies	Creating a resilient system—minimizing shock while providing routine health care—is one of the major features of providing safe care. One of the features of a high-reliability organization is "commitment to resilience." Also, a medical emergency is entertained here. A medical emergency is one of the high-risk care processes to which the current safety concepts and practices give due attention.
3. Contribute to the transformation of households	All recent pieces of evidence strongly affirm that high quality of healthcare must be co-produced between the health system and the service users.
	This objective laid down the foundation of creating people-centered healthcare.

HSTP-II objectives	How is healthcare quality linked to these objectives?
	This is one of the doorways to realizing a high-performing primary healthcare system, ensuring continuity of care—from primary to tertiary care—and comprehensive care (1).
4. Improve health system responsiveness	This objective is directly related to key attributes (dimensions) of quality of care: people-centeredness, timeliness, equity.

3.4 Framework, Elements, Definition, and Dimensions of High-Quality Healthcare

The Ethiopian quality and safety framework was developed in line with Ethiopia's health system framework of the HSTP-II and based on the Donabedian framework: input, process, and outcomes.

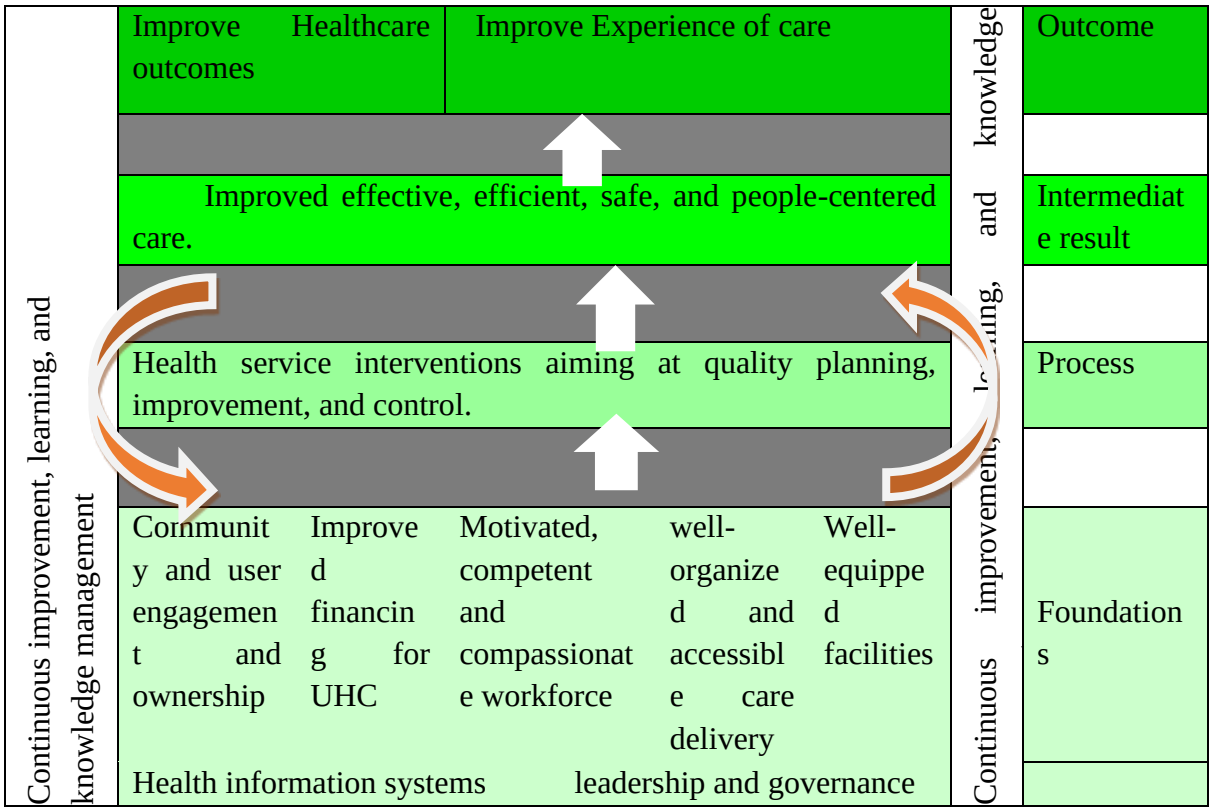

Figure 1. The Ethiopian quality and safe framework

Table 2. Description of the components of the framework

S.N	Components	Description
A. Outcomes of quality of care		
1	Healthcare outcomes	Reduced mortality and morbidity.
2	Experience of care	Satisfaction, willingness to recommend, trust (in health workers and care uptake), and retention.
B. Intermediate results		
3	Effective care (evidence-based care)	Care is based on the current knowledge and science and includes systematic patient assessments, accurate diagnoses, provision of appropriate treatments, and proper patient counseling.
4	Safe care	Absence of preventable harm.

S.N	Components	Description
5	People-centered care	People-centered care means that health systems ensure: (1) Continuity from illness prevention to palliation, between services and between levels of care (primary to speciality), throughout the life course; (2) Coordination across different care settings, in ways that meet the particular needs of the individuals and their carers; and (3) Comprehensiveness that broadens the portfolio of care—from health promotion through palliative care.
5	Efficient care	Reduce waste of time, resources, energy, and ideas.
C. Foundations		
7	Engagement and empowerment of users and community	Share information on quality and safety; support the users and community to improve their literacy; develop active users and community. Engage and empower community and users to make them not only beneficiaries but also enable them to hold the system accountable.
8	Leadership and governance	Leadership: political commitment, change management; policies: regulations, standards, norms, and policies for the public and private sector, institutions for accountability, supportive behavioral architecture, roads, transport, water and sanitation, electric grid, and higher education.
8	Healthcare financing	Financing: funding, fund pooling, insurance, purchasing, provider contracting, and payment.
9	Data and information systems for quality	Developing timely, accurate quality measures of health care services, users' experiences, and outcomes achieved. Institutions for evaluation, measurement, and improvement, learning communities, and trustworthy data; a culture of quality, use of data, supervision, and feedback.
10	Accessibility and organization of service delivery platforms	Number and distribution of facilities, public and private mix, service mix, and geographic access to facilities; care organization: roles and organization of primary, secondary, and tertiary care, and engagement of private providers; connective systems: emergency medical services, referral systems, and facilitation of community outreach.
11	Motivated, competent, and compassionate health workforce	Health workers, planners, managers: number and distribution, skills and skill mix, training in ethics and people-centered care, supportive environment, education (both pre-service and in-service), teamwork, and retention.
12	Well-equipped health facilities having adequate medicines,	The health facilities have adequate infrastructure, basic amenities (water, electricity, sanitation facilities), equipment, supplies, medicines, devices, and technologies.

S.N	Components	Description
	devices, and technologies	
D. Continuous improvement, learning, and knowledge management		
13	Every health system should strive to create a culture of learning and use it for the continuous improvement of the health care system. For this to happen, every health facility—or organization in the health system—should manage its learning needs based on the existing and identified gaps. Therefore, strong learning and knowledge management structures should be in place at all levels of the healthcare system.	

3.5 Core Elements of Quality Management

Leveraging all three core elements of quality management—quality planning, quality improvement, and quality control—holistically is one of the key foundations of this National Healthcare Quality and Safety Strategy.

3.5.1 Quality Planning

Quality Planning (QP) brings systems thinking to the highest levels of leadership and governance. It responds to the measured gap between what the population needs and what is currently being delivered in the health system. It then establishes the goals, policies, and strategy to close this gap, and ensures that the resources are allocated to do this effectively. Quality planning involves designing a structure that delivers the right care to patients at the right time, every time.

3.5.2 Quality Improvement

Quality improvement (QI) is a continuous process whereby organizations iteratively test and measure changes in work routines, set and achieve ambitious aims, shift whole-system performance, and spread best practices for rapid uptake at a larger scale to address a specific issue or suite of issues they have determined to improve.

3.5.3 Quality Control

Quality control (QC) is a normative process that includes quality assurance, wherein a system seeks to ensure that quality is maintained or improved, and errors are reduced or eliminated. Processes consist of both internal quality assurance and external quality assurance.

3.6 Definition and Dimensions of Quality

Quality and safety in Ethiopia are defined as:

3.6.1 Healthcare quality

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

3.6.2 Healthcare safety:

The absence of preventable harm from healthcare; and reduction of risk of unnecessary harm to an acceptable minimum. (Adapted from WHO)

3.6.3 Dimensions of Quality

Similarly, this strategy adopted WHO's dimensions of quality:

Figure 1: The Dimensions of Quality

Table: Descriptions of the dimensions of quality

S. N	Dimension	Description
1	Safety	Absence of preventable harm
2	Effective	Care is given as per current knowledge and recommendation
3	Efficiency	Reduction of waste
4	Equity	Care delivered uniformly without discrimination based on geography, gender, disability, ethnicity, or language
5	Timely	Reducing waits and sometimes harmful delays for both those who receive and those who give care
6	People-centered	Care respects and responds to individual and community preferences, needs, and values
7	Integration	Comprehensive care is provided in a coordinated way across the continuum of care

4 CURRENT STATE ANALYSIS

This section provides an assessment of the current state of quality and safety in Ethiopia. It examines quality and safety from the perspective of high-quality healthcare system dimensions. It also includes the SWOT (Strength, Weaknesses, Opportunity, and Threat) analysis and stakeholder analysis.

4.1 Healthcare outcomes

This refers to reduced mortality and morbidity, and positive health markers such as quality of life, function, and wellbeing, and absence of serious health-related suffering. The following table shows some selected indicators at the health institutions level (2):

Table 2.2: Health institution-level indicators

Indicators	Achievement (2011 EFY)
Institutional maternal mortality, per 100,000 births	44
Early institutional neonatal death rate (per 1000 births)	5.4
Stillbirth rate (per 1000 births)	13.9
Percentage of low-birth-weight (LBW) newborns	3.3
Inpatient mortality rate	2.4
Number of Women who reported ever experiencing symptoms of a fistula among those whose last birth was attended by a skilled provider per 1,000 (2007-2016.)	3.6

4.2 Experience of care:

This refers to satisfaction, willingness to recommend, trust (in health workers and care uptake), and retention. It is the result of the quality-of-care people receive from the healthcare system. Confidence (or trust) in the health care system affects people's preference for where to receive care. Due to a lack of confidence in the healthcare system, people are bypassing the lower level of care: 40% of people in a study in Ethiopia sought routine maternal and childcare (including antenatal care, family planning, and vaccinations) from hospitals (3). In addition to having an intrinsic value, this has an impact on retention in care and adherence to treatments, and these result in improving confidence in health systems (4). Patients' experience of the quality of health care is not seriously assessed by health facilities in Ethiopia; if at all it is assessed, it is not done so authentically.

Disrespect and abuse are common in childbirth and maternity services in Ethiopia. A systematic review and meta-analytic study revealed that half of the mothers (49.5%) experienced disrespect and abuse while they were giving birth in healthcare institutions. The prevalence of physical abuse, non-confidential care, abandonment care, and detention were 13.6%, 14.1%, 16.4%, and 3.2 % respectively (5).

4.3 Effective/evidence-based care

Evidence-based care starts at the time when a patient meets the treating health worker and encompasses systematic patient assessments, accurate diagnoses, provision of appropriate treatments, and proper patient counseling. Evidence-based guideline adherence in antenatal care, family planning, and sick child care was 47%, 34%, and 35 % respectively (3).

Incorrect diagnosis is common in Ethiopia. A clinical vignette administered for health workers revealed that the percentage of health workers who identified the following cases—malaria and anemia, neonatal asphyxia, postpartum hemorrhage, and tuberculosis—correctly were 11%, 45%, 58%, and 52% respectively (3).

Poor quality of care results in the underuse of proven interventions—or overuse of ineffective interventions (3, 6). Some proxy indicators in HIV and TB programs may provide information about the care people are receiving. The UN AIDS target of the second 90 and the third 90 achievements were 85% and 95% respectively (7).

4.4 Safe and timely care

A range of safety problems is more prevalent in health care settings. These include adverse drug events, healthcare-associated infections, injuries due to surgical and anesthesia errors (including wrong-site surgery), improper transfusion and injection practices, falls, burns, and pressure ulcers (8). Despite limited data on safety measurement at the system level, some institution-based studies show that the prevalence of surgical-site infection in Ethiopia was 12.3% (9); about half (47%) of health workers encountered adverse drug reactions (10). Acute blood transfusion reaction prevalence was 5.2% (11).

Delays in interventions for life-threatening illnesses such as labor complications, stroke, and trauma could cut short a life. Timeliness of care is at the heart of high-quality health systems. Cure in most cancers is possible if the treatment is given in a timely fashion; and early treatment prevents further damage and transmission in diseases such as diabetes, hypertension, and tuberculosis. Emergency triage of patients within 5 minutes of their arrival was 88%. One of the areas in which timeliness of care was severely compromised was cancer treatment—the median time to get curative radiotherapy was around 150 days (12). Nationally, the delay in elective surgical admissions was 51 days (13).

4.4.1 People-centered care

This implies continuity, coordination, and comprehensive care at all levels.

Continuity of care means continuity from illness prevention to palliation; between services (e.g., maternity and pediatrics); and between levels of care (e.g., primary to specialist care). Continuity of care has two important features: a health system's ability to retain people for care; and the ability of patients to get a treating health worker who is familiar with their medical history. Coordinated comprehensive care (integrated health services) (14) means health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course. These two

dimensions are very critical in the management of non-communicable diseases and chronic communicable diseases such as HIV. Such kinds of care require complex interplay among health workers—in a facility horizontally—and among platforms of care—from the community to tertiary platforms and beyond.

Examining the retention of care across services: Antenatal four coverage was 43%; three doses of pentavalent immunization was 61%; postnatal visit within two days of delivery was 34% (15). The tuberculosis treatment success rate was 95%.

Regarding the integration of care, all patients who come for one category of complaints should be examined for all potential other problems as well. For example, patients with tuberculosis should be tested for HIV; children under two years of age who come in for another complaint should be checked for growth and monitoring, etc. Around 87% of TB patients were tested for HIV in Ethiopia.

4.4.2 Foundations of high-quality health systems

These foundations should be in place to provide high-quality health care. The foundations, which include the six-plus building blocks of the health system, are: users and community engagement, quality governance and accountability, healthcare financing, data, and health information systems for quality, accessibility, organization of service delivery platforms, competent and empowered health workforce, and well-equipped health facilities with adequate medicines, devices, and technologies.

4.4.3 Continuous learning, improvement, and knowledge management

Creating a learning organization (learning system) could help to identify defects and strengths continuously, and based on its real-time assessment, provide remedial actions in real-time. Learning organizations are proactive, and they continuously identify defects and act on them. Components of the learning organization (learning system) include transparency, reliability, improvement, measurement, and continuous learning; leadership plays a critical role at the center (16). In the last five years, two improvement methods, Kaizen and the Model for Improvement have been used to bring improvement as an engine and vehicle for improvement respectively.

4.5 SWOT Analysis

Table 3: SWOT analysis is prepared based on the quality framework.

Dimensions	Strength	Weakness
Better health Confidence in the experience of care, effective coverage	- Trends in general morbidity and mortality in some priority areas are improving. - Experience of care/patient satisfaction is measured.	- Limited data on morbidity and mortality due to poor quality and/or non-utilization of care. - Limited/lack of data to gauge confidence/trust in the health system. - Confidence/trust in the health system is presumed to be low. - Experience of care is not linked to service improvement; unclarity on how to measure patient satisfaction. - Focus is on crude coverage rather than effective coverage.
Evidence-based care	- Presence of some clinical protocols and treatment guidelines; available audit tool (HSTQ).	- There is no designated system to continually avail, update, use and audit the clinical protocols. - The clinical audit tool (HSTQ) is too complex to use quarterly, and it is not updated on time. - Weak monitoring of evidence-based practice both at private and public facilities. - Weak compliance with evidence-based practice.
People-centered, safe, timely, and efficient care	- Awareness is increasing that care in Ethiopia is suboptimal (not timely, etc.). - National and subnational effort to improve continuity of care. - Well-delineated care delivery platforms. - Some efforts to improve efficiency and improve the processes of care.	- Data on the safe provision of care is very limited and not measured well. - The health service does not support open culture, transparency, or systems thinking. - Suboptimal integration and comprehensiveness across service components. - Missed opportunity for prevention and early detection in the health facilities is very high. - Waste due to poor clinical processes and/or unsafe care is not well-understood. - The efficiency of health care processes is not well-measured.

Dimensions	Strength	Weakness
Engagement of community and users	- Availability of platform to engage the community. - Presence of some initiatives to engage the community (community scorecard, town hall meeting, health facility boards).	- Lack of adequate effort on quality- and safety-related demand creation. - Lack of proper and measurable community engagement for quality and safety. - Absence of a clear community engagement mechanism and guidelines. - Minimal engagement of patients and their association in ensuring the quality of care. - Lack of simplified/easily understandable tools to improve quality and safety. - Patient and family literacy and engagement in their care are very low.
Accountable leadership and governance	- Quality is given due attention; structures have been created; the HSTPs identified quality as major agenda. - Health facilities established governing boards. - Capacity building of leaders at the federal and regional levels was initiated. - Presence of different directives and guidelines; some are tracked on DHIS2 (EHSTG, EHCRIG, health facility regulation standards, etc.).	- Previous NQS lacked a clear implementation plan. - Quality structures created are not working optimally: weak steering committee, quality directorate could not mainstream quality and was unable to create coordination and collaboration. - Lack of clear accountability mechanism for quality. - Unstable leadership: high turnover, lack of succession planning. - Lack of continuous practical training on leadership for quality. - Unclear scope and functions of quality structures at all levels. - Nonexistent quality and safety structures at private facilities. - Poor governance for quality audit tools and protocol implementation. - Improvement initiatives are driven by donors. - Accreditation is considered a luxury by top leadership. - Lack of mechanism for rewards and incentives. - Double standard in enforcing regulations between public and private health facilities. - Engagement of professional associations and patient associations is weak.

Dimensions	Strength	Weakness
		- Lack of clear structural distinction among service purchasers, regulators, and providers. - Public health facilities do not renew their license yearly.
Improved financing for UHC	- Increased budget allocation for health care at each level. - Presence of health care financing strategy. - Private-wing services in selected hospitals. - CBHI implementation for service improvement. - Performance-based financing schemes are in the pilot stage.	- Absence of budget line for improving quality in the health care system. - Lack of budget allocation at the program level for quality. - Non-proportional allocation of budget for the need for medical equipment and supplies. - Quality improvement initiatives do not get adequate finances. - Poor progress in health insurance coverage. - Blanket coverage on health insurance scheme rather than attaching to the quality of care. - Weak triangulation of health insurance with quality and safety. - Performance-based financing mechanisms for both health care facilities and health care providers are still not approved. - Lack of efficient, effective, and timely utilization of allocated budget. - Weak implementation of public-private partnership.
Strong data and health information (HIS) system for quality	- High leadership commitment to data and information. - The development and incorporation of key performance indicators (KPIs) for service monitoring in the existing HIS - The presence of the DHIS2 platform	- Weak monitoring and evaluation (M&E) framework of the previous NQS - Absence of quality-adjusted (effective coverage) measures - Poor data quality resulting from poor capturing, reporting, generation, and use at all levels. - Limited human resources capacity to generate, analyze and utilize data. - The adverse event reporting mechanism is almost nonexistent; safety and occupational data are very limited. - Weak local and external data quality assurance at all levels. - Weak information use culture, especially at the point of generation.

Dimensions	Strength	Weakness
		- No transparent and publicly reported measures for quality and safety. - Low effort to scale up electronic medical records.
Accessible and well-organized service delivery	- Improved physical access for service. - Increased public and private ambulance services. - Presence of approved comprehensive essential health service package.	- Despite increasing access, there are major quality and equity issues among regions and people. - Private health facilities are not well-linked with public ones. - People bypass the lower health care system and overcrowded referral hospitals. - Healthcare delivery is not yet aligned with the essential health service package (EHSP) - Some tertiary care services are not accessible to all people. - Limited capacity to provide coordinated emergency care services; referral system coordination is very limited.
Motivated, competent, and compassionate healthcare workforce	- Efforts to build the capacity of healthcare providers in quality and safety. - Initiation of an advanced level of quality improvement training. - Presence of national CPD strategy. - The engagement of health professional associations is increasing. - Multiple strategies and initiatives (HRH strategy, CRC strategy, HRIS)	- Trained staff turnover at all level. - Critical shortage of trained staff. - Lack of scope-based clinical practice for healthcare providers. - Implementation of CPD and CRC are weak. - Gap in monitoring the effectiveness and efficiency of in-service training. - Lack of effort in the integration of quality of care in the pre-service education. - Lack of well-equipped skill lab in the healthcare facilities. - Improving quality is not linked with the job description of health professionals. - Absence of a clear career path for quality officers at different levels. - Limited capacity of health professional associations in quality and safety.

Dimensions	Strength	Weakness
Well-equipped health facilities with adequate devices, medicines, and technologies	- Data on service provision and readiness is regularly available. - Efforts are being made to improve general service readiness of health facilities. - Introducing new diagnostic and treatment technologies.	- Health facility infrastructure and general service readiness inadequacy. - Purchasing system is not real-time. - Most public health facilities suffer from a shortage of drugs, supplies, reagents, and equipment; medicine and equipment are not state-of-the-art. - Lack of accessible and timely medical equipment, maintenance systems, and workshops at the national, regional, and zonal levels. - Inadequate capacity for medical equipment and supply quantification, monitoring of specification. - Lack of efficient use of resources at all levels.
Continuous learning and improvement	- Availability of structured learning platforms (EHAQ, EPAQ, quality summits).	- Poor knowledge management and translation practice/system in place. - Learning platforms are irregular, are not well-budgeted, and learning is not structured. - A system of quality audits is not well-instituted and is generally lacking. - Lack of documentation of lessons learned from QI initiatives. - Lack of a strong support system at woreda and zonal levels. - Lack of evidence of translation or scale-up. - System for institutional memory does not exist. - Lack of learning culture in the health facilities.

	Opportunity	Threat
	- Government commitment to quality of care. - The global evolving concept of quality of care. - Donor and development interest in the quality-of-care initiatives. - Increase in community demand for high-quality healthcare.	- Global pandemic (example: SARS-CoV-2). - Political instability and natural disaster. - The existing civil service law and the inal independent from it. - Health science education culture overlooks q in education, poor teamwork, and collaborat systems thinking). - The legal environment is not supportive of safety (example: punitive attitude).

	Opportunity	Threat
	- The willingness of some of the health colleges to integrate quality into pre-service education programs.	- Low quality of pre-service education - Basic infrastructure (water, electricity, and stress in trying to provide high-quality and s

4.6 Stakeholder Analysis

Stakeholders are key players in the health sector, and their analysis is crucial to ensure healthcare quality and safety in the sector and the success of the health program. During the planning process of the health interventions, it is important to consider the needs and interests of those who have a "stake" in the health sector. The following table shows the stakeholder analysis.

Table 4: Stakeholder analysis table

Stakeholders	Behaviors we desire	Their needs	Resistance issues	Institutional response
Community, patients, and their families	Participation, engagement, and ownership	Access to high-quality and safe health services, empowerment (informed, supported, competent)	-Dissatisfaction	-Community mobilization, ensure engagement and ownership
	High health literacy		-Opting for unsafe alternatives	-High-quality and safe service and providing information
	High health-seeking behavior		-Underutilization	
Health workforce	-Committed and competent in providing high-quality and safe care	-Conducive environment	-Dissatisfaction	-Motivation
	-Participation and engagement	-Transparency and responsiveness	-Unproductive	-Involvement
	-CPD	-Incentives	-Attrition	-Making them the real owner of their institution
		-Capacity building	-Sabotage	
All directorates, agencies, regional	-Ownership and engagement	-Access to state-of-the-art concepts, skills, and tools of	-Fails to mainstream the concepts of	-Engage in the national quality and safety governance

Stakeholders	Behaviors we desire	Their needs	Resistance issues	Institutional response
health bureaus (RHBs), zonal health departments, woreda health offices, and health institutions		quality and safety interventions	quality and safety	
	-Mainstreaming healthcare quality and safety in their plans and activities	-Capacity building, being informed and supported	-Fragmented move to ensure safety and quality	-Proper coordination, implementation of the quality intervention, and monitoring
	-Cascading the strategy, allocating enough resources and structures to ensure quality and safety		-Undermine the needs for quality and safety	
	-High quality and safety will be their motto			
Parliament, Prime Minister's Office, Council of Ministers, regional governments	Ratification of policies and proclamations	-Implementation of proclamations, policies, etc.	-Administrative measures	-Put in place a strong M&E system and comprehensive capacity building mechanisms
	-Resource allocation	-Delivering high-quality and safe care	-Influence on budget allocation	-Public reporting
		-Plans and reports		
Line Ministries (Education, Attorney General,	Work harmoniously to make the healthcare environment	Evidence-based plan and reports	-Fragmentation	-Collaboration
		-Engagement and being informed	-Low health literacy	-Transparency

Stakeholders	Behaviors we desire	Their needs	Resistance issues	Institutional response
Water, Finance, Labor, Women's and Youth Affairs)	conducive to high-quality and safe healthcare	-Technical support	-Considering health as a low priority	-Advocacy
Health professional training institutes	Knowledgeable, skilled, and ethical health professionals trained	Technical and policy support, guidance	Curriculum revision	Policy and leadership support
Development partners	-Harmonized and aligned	Develop accountable, transparent, and responsive quality and safety governance	-Fragmentation	-Government leadership
	-Participation	-Involved in planning, implementation, and M&E	-High transaction cost	-Transparency
	-More financing		-Inefficiencies	-Efficient resource use
	-Technical support			-Build financial management capacity
NGOs, CSOs, and professional associations	-Harmonization and alignment	Involvement in planning, implementation, and M&E	-Dissatisfaction	-Transparency, advocacy
	-Participation, resources, and Techncial assitance		-Fragmentation	-Capacity building
	-Participation in licensing and accreditation		-Scale down	-Financial support

Stakeholders	Behaviors we desire	Their needs	Resistance issues	Institutional response
	-Promote professionalism and engage in capacity building		-Withdrawal	
Private health sector	-Quality of care, client-oriented	-Enabling environment for their engagement	-Mistrust	-Transparency
	-Knowledge and technology transfer	-Avoiding double standard	-Low quality and unsafe care while seeking a high price for their service	-Accountability
		-Public-private partnership schemes		-Dialogue

5 STRATEGIC OBJECTIVES, KEY RESULTS AREA, AND STRATEGIC INITIATIVES

5.1 Vision, Mission, and Guiding principles

5.1.1 Vision:

To see a healthy, productive, and prosperous society.

5.1.2 Mission:

To promote the health and wellbeing of Ethiopians through systematic planning, improvement, and control of the quality of care.

5.1.3 Guiding principles

Table 4: Guiding Principles

Principles	Description
Accountability	The health system should hold people to account for their actions; those responsible must answer questions regarding decisions and/or actions.
Transparency	Making the healthcare system open to sharing data and information concerning the state of quality and safety. Patients, carers, families, the community, and health workers should be able to openly see what is happening in the healthcare system.
Collaboration	Understanding that that optimal quality and safety can only be achieved through teamwork and collaboration; and working in partnership with all key players including public, civic, and private actors.
Learning and Innovation	The organization learns continuously, identifies defects (non-optimal processes), and uses new methods to test ideas to rectify the defects and implement effective interventions sustainably at scale to garner the required results.
Equity	Address health care quality differences, that could be avoided or minimized, among individuals or groups of people defined by different factors: geographic, demographic, social, and economic. Main indicators and the state of the quality report described in the M and E section of this strategy will be disaggregated by major factors and appropriate actions will be taken in line with the national health equity strategic plan (2020/21-2024/25).

5.2 Goal, Objectives, Strategic Interventions, and Major Activities

5.2.1 Goal:

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

5.2.2 Strategic Objectives

1) Improve evidence-based healthcare provision
2) Improve people-centeredness of care
3) Reduce preventable harm arising from care delivery
4) Improve the efficiency of healthcare delivery

5) Create a culture of quality through continuous learning and improvement

5.2.3 Strategic Objective 1: Improve evidence-based healthcare provision

This objective describes the care that should be based on current knowledge and science. It includes systematic patient assessment, accurate diagnoses, provision of appropriate treatments, and proper patient counseling. Evidence-based care is one of the dimensions of quality—i.e., effectiveness. Current evidence is formulated and availed through different treatment guidelines, clinical protocols, and decision support tools. Many evidence-based guidelines are formulated by different bodies in Ethiopia, for different levels of care as well as for programmatic methods for treating diseases such as HIV, NCD, TB, and leprosy. Evidence-based care should be delivered in a timely fashion. To provide evidence-based care, the health system should have capable and motivated professionals; medicines, supplies, and equipment; care continuity and engagement of patients in self-care; and recording and data. Besides, regular clinical audits and learning systems must be in place to practice evidence-based care. This objective is measured by the effective coverage of key priority health conditions.

Strategic interventions and major activities:

A. Strengthen evidence-based healthcare delivery at all levels of the healthcare system.
1. Establish/strengthen a system to produce and regularly update evidence-based guidelines and protocols for all levels.
2. Establish/strengthen a clinical audit system that produces and regularly updates audits for all levels.
3. Implement scope-based practices for health professionals.
4. Incorporate compliance with evidence-based guidelines as a criterion for performance agreements with health insurance.

5.2.4 Strategic Objective 2: Improve people-centeredness of care

People-centered care is the provision of the right care, at the right time, in a coordinated way, responding to the service users' needs and preferences across the life span. It encompasses providing compassionate and respectful care; empowering and engaging communities in the design, service delivery, and assessment of the health services; and well-coordinated care at all levels. People-centered care goes beyond the dimension of quality; rather, it is a critical entry point to improve quality of care. Evidence shows that people-centered care is more effective, costs less, improves health literacy and patient engagement, and is better prepared to respond to health crises**.**

People-centered care means that health systems must ensure:

1) Continuity from illness prevention to palliation, between services and between levels of care (primary to specialty), throughout the life course;
2) Coordination across different care settings, in ways that meet the particular needs of the individuals and their carers; and
3) Comprehensiveness that broadens the portfolio of care—from health promotion through palliative care—that individuals and communities can use.

Five key strategic focus areas to ensure people-centered care are: empowering and engaging; coordinating service; reorienting the model of service delivery; strengthening governance and accountability; and creating an enabling environment.

This objective will be measured using indicators that show the integration of care, timeliness of care, and coordination and continuity of care.

It requires the whole health system to work for the patient coherently to provide care. Three elements of people-centered care delivery are:

1) continuity of care;

2) coordination of care; and

3) comprehensiveness of care.

Strategic interventions and major activities:

A. Ensure transparent engagement of patients, community, and civil society.

1. Advocate the importance of patient, family, and community engagement in health service design, delivery, and assessment.
2. Establish/strengthen health literacy units at health facilities.
3. Integrate quality improvement into existing community structures and programs.
4. Strengthen the engagement of patients and the community in facility management.
5. Develop/strengthen patient rights charter and grievance handling mechanism.
6. Engage professional societies in quality.

B. Create an enabling environment.

7. Establish/strengthen skill labs to impart clinical skills.
8. Link motivation and development of health workforce and leaders with evidence-based practice.
9. Incorporate healthcare quality and safety into all health professional undergraduate and postgraduate education curricula and broader professional development and training programs.
10. Incorporate healthcare quality and safety core competencies as part of regulatory requirements for all health professionals.

C. Ensure that well-coordinated services are available at all levels of the system.

11. Strengthen the referral system.
12. Establish a private health facility engagement platform to ensure quality and safety at all levels.

D. Redesign the service delivery system.

13. Redesign service delivery based on the essential health service package (EHSP).

E. Strengthen governance and accountability for quality and safety.

14. Develop an accountability framework for quality and safety.
15. Strengthen clinical governance systems at the health facility levels as an accountability framework.
16. Mainstream quality and safety at all levels including the health facilities.

17. Establish a national quality council to oversee and guide the quality and safety of services.
18. Support the implementation of performance-based financing schemes to incentivize the provision of safe and high-quality care.
19. Build leadership capacity in quality and safety.
20. Ensure that public facilities offer basic amenities and meet regulatory minimum standards.

5.2.5 Strategic Objective 3: Reduce preventable harm arising from care delivery

This objective is about reducing preventable harm arising from healthcare, especially in the treatment of high-risk clinical conditions, including surgical and anesthesia care, medications, blood transfusion, radiation, injection, infection prevention and control, and antimicrobial resistance. Reducing preventable harm means instituting interventions that boost teamwork, promote continuous improvement, and ultimately improve the culture of safety. Also, this objective focuses on establishing and improving the measurement of error and harm through an open and transparent reporting system. This means putting in place the legal foundations required to do so, and ultimately aspiring to create a just culture.

Strategic interventions and major activities

A. Ensure healthcare safety in the clinical processes.
   1. Establish and implement a national healthcare safety program that focuses on high-risk clinical conditions (medication errors, surgical and anesthesia care, and hospitals-acquired infections).
   2. Bring strong human factors (or ergonomics) perspective and input.
   3. Observe World Patient Safety Day every year.

B. Establish and strengthen healthcare safety policy frameworks.
   4. Redesign incident reporting system.
   5. Establish a healthcare safety legal framework.
   6. Create a patient and family advisory council that is focused on patient safety.

5.2.6 Strategic Objective 4: Improve the efficiency of healthcare delivery

Efficiency is one of the healthcare quality dimensions, related to avoiding waste—including waste of equipment, supplies, ideas, and energy. Healthcare waste includes the overuse of unnecessary care or ineffective approaches, medical errors, unsafe care, lack of care coordination, misuse (including inappropriate hospital admissions and bypassing), fraud, and abuse. Health system efficiency measurement deals with measuring and analyzing health system outputs in relation to inputs or vice versa. There are two kinds of efficiency: allocative and technical. We focus here on allocative efficiency. It examines whether limited resources are directed toward the correct mix of health care outputs, or whether the optimal mix of inputs is being used to produce its chosen outputs.

Strategic interventions and major activities:

A. Ensure efficient healthcare delivery
   1. Strengthen medical device management system.
   2. Expand the biomedical maintenance workshops.

3. Expand the APTS and LTS to all levels of facilities.
4. Standardize common supplies for common procedures.
5. Use demand-based human resources forecast and deployment.
6. Design economic measurement to compare the efficiency of hospitals.

5.2.7 Strategic Objective 5: Create a culture of quality through continuous learning and improvement

A learning healthcare system is "A system in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process, patients and families' active participants in all elements, and new knowledge captured as an integral by-product of the delivery experience." (Institute of Medicine 2013)

Healthcare is at the center of dramatic change. New technologies, new medications, and new approaches have changed the way we deliver care. Evidence shows that investing in the foundation of the system alone doesn't result in a good outcome unless the health system can adapt to new challenges. A culture of learning across the health system can lead to greater transparency and action, which in turn raise accountability. However, building a culture of continuous improvement is not a quick fix but a journey that never really ends, requiring commitment, investment, and persistence. Improvement requires the continuous production of relevant data, which measures performance and outcomes, and the translation of those data into action. Learning is the pillar for improvement, and measurement is at the heart of learning.

Thus, creating a quality culture and knowledge management in the healthcare system is of paramount importance to improve the quality and safety of healthcare sustainably.

Strategic interventions and major activities:

A. Strengthen continuous learning, improvement, and knowledge management systems.

1. Redesign the learning networks in such a way that they anchor district-level facilities.
2. Establish quality and safety hubs in geographically accessible areas to serve as benchmarking sites.
3. Standardize and support district-level quality coaching and mentoring systems for improvement.
4. Strengthen collaborative learning at all levels.

- Provide support to QI grants for learning.

5. Build the capacity of healthcare workers in quality and safety.
6. Establish a system for institutional mortality review for improvement.
7. Establish knowledge management and learning systems for healthcare quality and safety at all levels.
8. Organize regional and national quality summits.
9. Establish a system of voluntary health facility accreditation.
10. Support implementation and operational research on quality and safety.

B. Strengthen a high-quality data system for improvement.

11. Develop quality-adjusted indicators.
12. Develop dashboards for different administrative levels on selected priorities for reporting within the health sector.
13. Institute and scale-up electronic medical records in health facilities.
14. Strengthen health facilities to improve high-quality data capturing and translation into practice.
15. Ensure a two-way data feedback loop so that local facilities receive information to improve.
16. Regularly measure the experience of care at the facility level and use it for quality improvement initiatives.
17. Conduct quality assessments every two years.

5.3 Targets

1) Decrease institutional mortality rate from 2.2% to 1.5%.
2) Increase experience of care measure by 30%.
3) Decrease stillbirth rate (per 1000) from 15 to 14.
4) Decrease intensive care unit (ICU) mortality rate by one-fourth (25%).
5) Reduce preoperative mortality rate below 2%.
6) Increase treatment cure rate for management of severe acute malnutrition from 85% to 95%.
7) Increase the percentage of people receiving antiretroviral therapy with viral suppression by 4%.
8) Increase TB cure rate from 84% to 96%.
9) Increase the proportion of hypertensive adults whose blood pressure is controlled from 26% to 60%.
10) Increase the proportion of DM patients whose blood sugar level is controlled from 24% to 60%.
11) Increase the proportion of women 30-49 years screened for cervical cancer from 5% to 40%.
12) Reduce waiting time for surgery (delay for elective surgery) to 30 days.
13) Increase the availability of essential medicines at the health facility level from 79.2% to 90%.
14) Increase the proportion of health facilities implementing compulsory Ethiopian health facility standards from 53% to 80%.
15) Increase the proportion of primary healthcare facilities implementing Community Scorecard from 61% to 90%.
16) Increase the proportion of pregnant women who attend 4th ANC visits and get adequate care as per the national ANC guideline by one-third (From 47 % to 63%).
17) Increase the percentage of children under five diagnosed with pneumonia who are receiving appropriate treatment per national or IMCI guidelines by one-third.
18) Increase the proportion of children under five with diarrhea who are treated with ORS and Zinc from 44% to 67%.
19) Increase bed occupancy rate from 41.9% to 75%.
20) Reduce surgical-site infection rate to below 5%.
21) Increase appropriate referral rate (referral rate as per standard) by 30% from baseline.

6 IMPLEMENTATION ARRANGEMENT

6.1 Governance and Organization Arrangement

A well-functioning and accountable governance structure must be in place to implement this strategy. At the national level, the Health Care Quality Directorate will be reassigned in such a way that it reports to the Minister of Health directly. Its role will also be readjusted to guide, support, lead, and oversee the implementation of the NHQSS within the MoH. The directorate will select a few quality-adjusted indicators to track the quality of care of each program area. In addition, the National Healthcare Quality Council will be legally established. It will consist of other relevant sectors, professional associations, private sectors, patient society, and community representatives to oversee and advise the MoH on the state of quality, implementation, and monitoring of the strategy. Furthermore, to facilitate the coordination of actors in the area, a national accountability framework for quality will need to be signed by all stakeholders at the national and sub-national levels.

Subnational-level administrative structures will develop similar structures as per their specific context for the implementation of the strategy. The suggested structure and roles are described in detail in the table below.

Table 4.7: Summary of roles of entities

Level	Summarized roles and responsibilities
Ministry of Health	- Structure: Directorate - Reports to: to the Minister of Health - Staffed with multi-discipline senior physicians, public health professionals (researchers, statisticians), healthcare quality and safety experts, pharmacists, nurses, laboratory and healthcare data specialists, and monitoring and evaluation experts. - Roles: - Formulate policy, strategy, and operational plan to promote high-quality health service coverage across the country. - Support regional health bureaus for successful implementation of policies, strategies, and operation plans. - Monitor and evaluate progress toward high-quality health service coverage including the effectiveness of the health service delivery (tier) system, support mechanism, and funding options. - Lead the establishment of the National Quality and Safety Council. - Lead multisectoral collaboration with different actors for quality including the Ministry of Education, road and transport authority, electric utility, and water supply agency. - Mobilize external resources and negotiate with the Ministry of Finance for adequate allocation of budget and other resources to deliver high-quality health services. - Oversee the performance of the implementation of the NHQSS.

Level	Summarized roles and responsibilities
	- Strengthen leadership and ownership among stakeholders in the health system regarding healthcare quality and safety at all levels including the sub-national. - Ensure the integration of healthcare quality and safety intervention in all health areas across the health system. - Select and apply indicators and data requirements for monitoring the implementation of health service quality and safety strategy. - Ensure that all directorates, agencies, and institutes have incorporated quality of care activities across all agencies and program areas, both in activity and in finance.
Regional health bureaus (RHBs)	- Structure: Directorate - Reports to: the head of regional health bureau - Staffed with physicians, nurses, quality and safety experts, pharmacists, and laboratory professionals. - Ensures the good coordination and implementation of the NHQSS - Contextualize regional health service quality and safety strategy and formulate an operational plan to promote high-quality health service coverage across the region. - Support zonal health departments, hospitals, and woreda health officers for the successful implementation of regional strategies and operation plans. - Mobilize resources and negotiate with the regional cabinet to prioritize the allocation of funding for healthcare. - Monitor and evaluate progress towards high-quality health service coverage including the effectiveness of the health service delivery (tier) system, support mechanism, and funding options within their region. - Lead multisectoral collaboration, in their respective regions, with different actors for quality including education bureau, road, and transport bureau, electric utility, and water supply agency, etc.
Zonal and woreda health offices	- Structure: Unit - Reports to: to the head of zonal health department - Strengthen leadership and ownership among stakeholders on quality planning, quality assurance, and quality improvement in the region. - Identify and contextualize required standards and protocols and initiate the development process; disseminate them for zones, woredas, and healthcare institutions. - Day-to-day oversight of quality and safety across all departments, zonal health department, hospitals, and woreda health offices on behalf of the National Healthcare Quality Steering Committee and MoH. - Provide capacity building for other health departments, zonal health departments, healthcare institutions, and woreda health offices.

Level	Summarized roles and responsibilities
	- Lead and support district-based quality coaching activity in collaboration with the catchment primary/general hospital. - Lead the monitoring and evaluation of regional healthcare quality and safety strategy implementation.
Hospital	- The structures of hospitals may vary according to their level. - Structure: - Specialized/comprehensive specialized and university hospitals: Directorate - Reports to: the chief executive officer/chief executive director - General hospitals and primary hospitals: Unit - - Reports to the chief executive officer - Advocate the institutionalization of quality of care and patient safety culture within the hospital and among the health workforces. - Provide technical oversight for all departments in the hospital on quality improvement, planning, implementation, and assurance. - Establish hospital Healthcare Quality and Safety Committee which consists of representatives from all departments in the hospital that oversee and assist/support each department's QI team and overall quality and patient safety activities. - Ensure that healthcare quality and safety shall be one of the major objectives in the hospital's five-year strategic plan; cascade the quality and safety objectives in the hospital's annual, quarterly, and monthly plans. - Strengthen the network for a quality alliance with the catchment health facilities and within the network and provide the necessary technical support in cascading district-based quality coaching. - Ensure that QI projects are designed, implemented, and monitored using appropriate quality measures based on the quality gap assessment.
Health center	- Structure: quality and safety committee - Reports to: the health center director - The health center will establish a healthcare quality and safety committee—members will be from major departments of the health center. - The health center will have responsibility and accountability to oversee the health post's state of quality and safety implementation. - Advocate the institutionalization of quality of care and patient safety culture within the health center and health post among the health workforce. - Provide technical oversight for all departments/units on quality improvement, planning, implementation, and assurance.

Level	Summarized roles and responsibilities
	- Ensure that healthcare quality and safety shall be one of the major objectives in the health center's five-year strategic plan; cascade the quality and safety objectives in the health center's and health post's annual, quarterly, and monthly plans well. - Strengthen the network for a quality alliance with the catchment health facilities and within the network. - Ensure that QI projects are designed, implemented, and monitored using appropriate quality measures based on the quality gap assessment in the health center and health posts.
Community patients and their families	- Establish quality improvement teams at the community level. - Collaborate with other agencies, organizations, and relevant stakeholders in integrative planning and implementation of the NHQSS. - Actively engage in health facility community engagement frameworks and make facilities more accountable and responsible for what they do. - Create modalities for peer learning, patient advocacy groups, and other relevant platforms.

7 MONITORING AND EVALUATION

Measuring the quality of healthcare is a powerful tool to accelerate improvements in the delivery of effective, high-quality, and responsive care, to track the progress of the strategy implementation, and to increase transparency and accountability. In this section, a proposed set of quality indicators is outlined, using a framework that links back to the goal of continually improve health outcomes and confidence in the system through the realization of improved provision of evidence-based care, reducing harm, improving people-centered care, improving efficiency in care, and creating a quality culture through continuous learning for improvement.

7.1 Monitoring and evaluation framework plan

This monitoring and evaluation (indicator) framework will support the identification of important elements to track in the NQSS. This framework will help to guide the measurement of quality and safety in the Ethiopian context. It is adapted from the HSTP-II M & E framework—which is originally adapted from the WHO health-system strengthening M & E framework (17).

Fig 4: Monitoring and evaluation framework

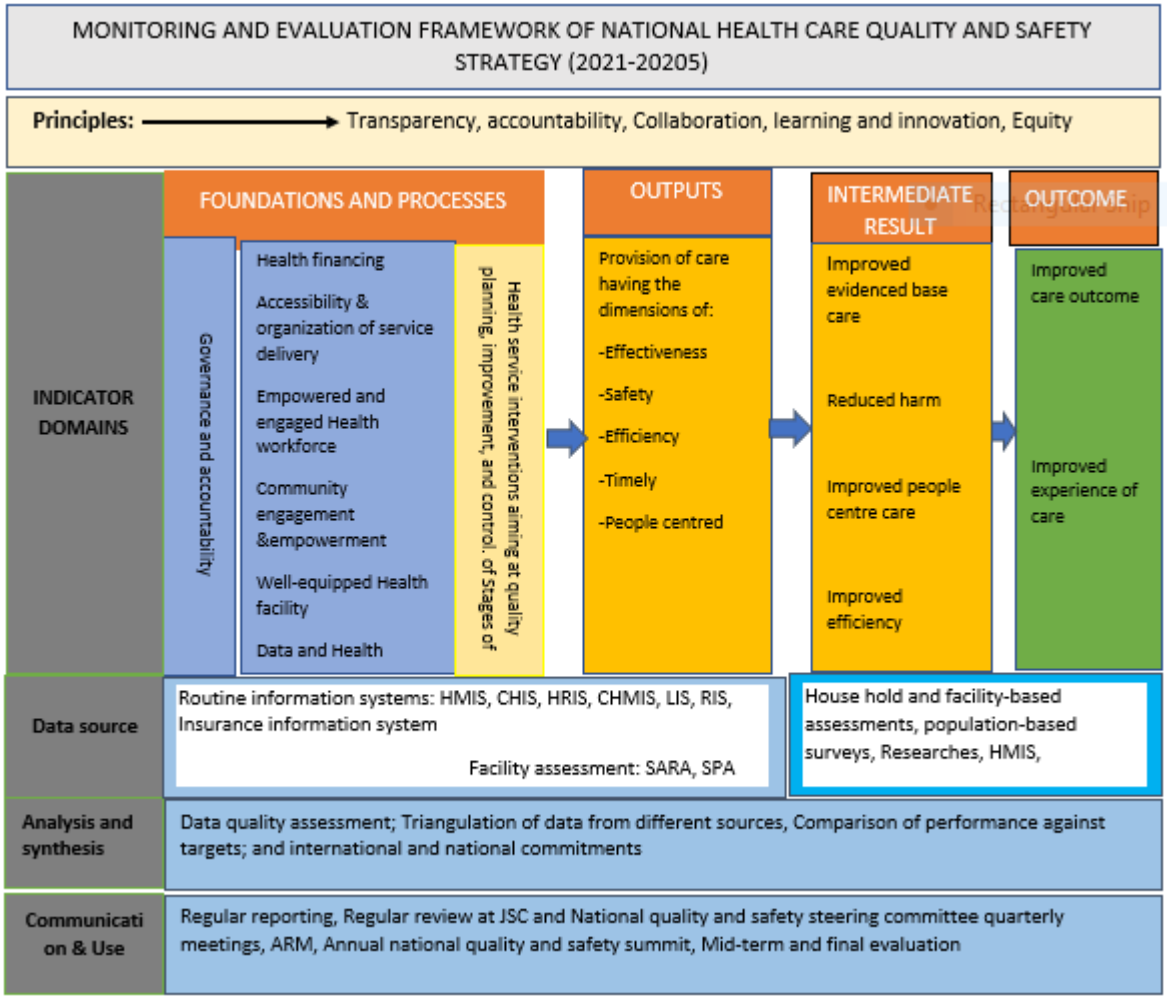

Table 8: Description of the healthcare quality and safety monitoring and evaluation framework

Indicator domains	Descriptions
Health system foundations, processes, and outputs	The health system foundations, processes, and outputs reflect **health system capacity**. Adequate health system inputs are the foundations of a high-quality health system. Interventions—envisioned to be implemented in this strategy plan—focus mainly on improving the delivery of health services by improving processes of care. Outputs are the result of the interventions done at the levels of the foundations and processes of care.
Outcomes	Outcomes (immediate and intermediate) are the results of investments and reflect **health systems performance**. The immediate outcomes we expect are Improvements in effective care (evidence-based care), improvements in people-centered care, improved efficiency, and reduced harm. As a result of people-centered, effective, evidence-based care, improved efficiency, and reduced harm, we expect better health care outcomes and improved user experience.

7.2 Quality Indicators and Core Measures

It is necessary, to avoid parallel reporting, to use the current data sources. The identified indicators are currently used to track the HSTP-II and will be used to track the performance of the NHQSS. Currently, there are 151 health indicators, comprising impact, outcome, output, and input indicators. But there will be a new set of indicators, which mainly show the performance of quality dimensions. All the quality indicators selected have gone through the following nine prioritization criteria:

1. **Health priority:** Does the indicator measure a specific health priority?
2. **Scope of impact:** What is the scope of impact in measuring this indicator (e.g., clinical outcomes)?
3. **Evidence base:** Is there sufficient, available, and credible evidence for this indicator to reach on consensus without any doubt?
4. **Feasibility:** What is feasible given the data that are already collected; how easy will this be to implement?
5. **Accuracy:** Are the data collected through this indicator accurate?
6. **Actionability:** Are clear actions and changes in individual, institutional, or system behaviors possible from looking at this indicator?
7. **Comparability:** Can this indicator be compared against a gold standard or with other countries or across regions?
8. **Credibility:** Is the indicator credible for those who need to take action and for those whose performance is being measured and compared?
9. **Clarity:** Is the indicator described in clear and unambiguous terms?

The indicators are selected from HSTP II indicators and some which are not available will be collected using surveys. Major suggested indicators are annexed in this document. Indicators required for quality improvement work at different levels of care and health administrative

units are not fully listed here. Therefore, further indicators will be needed to track quality and safety at different levels of care. Indicators will be suggested based on the M & E framework, to track quality and safety continuously at all levels of care.

7.3 Performance monitoring

Performance monitoring of the NHQSS will be coordinated by responsible offices and units at all administrative and health facility levels across the continuum.

7.3.1 Data quality and reporting

Data quality assurance will be done following the policy plan monitoring and evaluation directorate procedure. The Health Service Quality and Safety Directorate will focus on designing QI projects aimed at improving data quality, information use, and informed decision-making. These projects will be done in collaboration with the Policy, Plan, Monitoring and Evaluation Directorate (PMED).

More and more indicators will be utilized at lower levels such as districts and health facilities. Furthermore, these indicators will be analyzed along major contributing factors affecting equity of health care quality—geographic, demographic, social and economic factors—and appropriate interventions will be taken to redress the in equity.

All directorates, administrative structures (regions, zones, woredas), agencies, institutes, and health facilities will prepare quarterly quality and safety reports and send to the appropriate authority. During the time of the annual plan reporting, all quality and safety plans should be mainstreamed well on the yearly plans of directorates, agencies, institutes, administrative structures, and health facilities.

7.3.2 Performance review

A performance review will be held at all levels: federal, regional, zonal, and woreda. The performance review, at the Federal level, will be organized in collaboration with the Policy, Plan, Monitoring, and Evaluation Directorate (PMED); at the subnational level, the same approach will be followed.

7.3.3 Quality and safety dashboard

A dashboard with key indicators will be designed and used at all levels of the healthcare system to improve accountability and transparency. The dashboard summarizes major progress on the NHQSS implementation. It also serves to track progress at the national level over time and to inform strategic planning for improving quality.

7.4 The State of Healthcare Quality and Safety Assessment Report

The NHQSS introduces a comprehensive state of quality and safety assessment that gauges the implementation of the strategy. The format, the contents of the report—including what quality and safety core indicators should be reported—and other necessary components of the report will be determined in consultation with the stakeholders, including directorates, agencies, regions, partners, and the National Healthcare Quality Steering Committee.

7.5 Evaluation of the NHQSS

There will be two evaluations: mid-term and end-term. Evaluation will be undertaken at mid-term (2022/23) and end-term (2025). While the mid-term evaluation will assess progress toward results and generate lessons learned, the end-term evaluation will reveal whether the targets are met and inform the development of the subsequent strategic plan. The evaluation will be conducted by external evaluators to increase the trustworthiness and acceptability of the evaluation reports.

8 INTEGRATING THE NHQSS WITH TECHNICAL PROGRAMS

Any disease-specific or population-specific programs could be considered vertical or technical programs. Intentionally integrating/aligning these programs with the national health care quality and safety allow the MoH to leverage quality-related capability in the implementation of the NHQSS. In addition, the integration will curb duplication of efforts, and hence enhance effective and efficient use of the available resources.

A handful of vertical/technical programs exist in Ethiopia, focusing on both chronic communicable diseases and non-communicable diseases in maternal, neonatal, child, and adolescent populations. Stakeholders working on these programs are primarily focusing on the MoH's effort to improve in these areas. They are using the national plan and measurement platforms such as the health management information system (HMIS) and population and household surveys. Hence, we can conclude that the stakeholders' major programs are integrated with the national plan, and they are aiming to achieve the targets set by the country. In the previous quality strategy, stakeholders were using major tools and training materials authorized by the MoH. In addition, stakeholders do engage in the quality and safety technical working groups and the National Healthcare Quality Steering Committee; integration on quality has already started.

The previous quality and safety strategy engaged relevant implementing partners, multiple directorates and agencies, and professional associations from the very beginning until its completion; hence, the strategy garnered the contribution and technical know-how of these specific vertical programs.

Integration at the strategy level means that while these technical programs maintain their operational autonomy, they continue integrating the strategy to maintain operational efficiency and effectiveness. For this strategic-level integration, quality and safety structures at the federal and regional levels continuously mainstream the strategy plan and coordinate the performance of each major party. The quality and safety structures will continue to engage and educate about the importance of having one plan.

9 COSTING THE STRATEGY PLAN

The following table forecasts the necessary budget under each strategic objective.

Table 9: Summary of costs by strategic objectives,

Strategic objectives	Budget breakdown by years and total budgets					
	2020	2021	2022	2023	2024	Total budget
SO1: Improve evidence-based healthcare provision	2,033,600.0	21,790,257.8	14,458,728.3	12,957,600.0	13,991,616.5	65,231,802.5
SO2: Improve people-centeredness of care	1,561,939.7	133,988,962.3	196,857,121.8	252,892,043.4	268,661,530.7	853,961,597.9
SO3: Reduce preventable harm arising from care delivery	0	45,671,980.8	63,024,177.8	87,539,644.9	94,577,399.4	290,813,202.8
SO4: Improve the efficiency of healthcare delivery	0	7, 306, 266.44	10,594,741.84	15,210,781.5	8,929,000.6	42,040,790.3
SO5: Create a culture of quality through continuous learning and improvement	19458350	332,639,336.4	627,857,727.2	893,070,142.6	1,118,190,898.7	2,991,216,454.9

Total estimated budget	23,053,889.7	541,396,803.6	912,792,496.8	1,261,670,212.5	1,504,350,445.8	4,243,263,848.4

CHAPTER 7
OPERATIONAL PLAN

Table 9: Operational plan

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
SO1: Improve evidence-based healthcare provision								
A. Strengthen evidence-based health care delivery at all levels of the healthcare system								
1.1. Establish/strengthen a system to produce evidence-based guidelines for all levels.	Quality Health Service Directorate (QHSD)	56,864416.5		1				A dedicated Case team will be in place to oversee the evidence guidelines/protocol preparation and update (Yes=1; No=0)
1.1.1. Continually update and avail evidence-based guidelines and protocols.	Clinical Service Directorate (CSD)/Health Extension & Primary Health Care Directorate (HEPHCD), MNCAH-N Directorate, Diseases Prevention and Control Directorate (DPCD)				510	509		# Clinical conditions with developed clinical standards
1.1.2. Evaluate all guidelines and program documents introduced	QHSD			60%	70%	80 %	90%	% of program-based guidelines evaluated and updated

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
by all directorates and agencies into the system.								
1.2. Develop and update quality audit tools for health centers and hospitals (primary, general, and specialized).	QHSD	6,769, 350.2	2	3	4			# of quality audit tools for health institutions
1.2.1. Conduct regular facility-based audits.	Health facilities/ Woreda Health Offices (WoHO), Zonal Health Department (ZHD) Regional Health Bureaus (RHBs), National Health Insurance Agency (NHIA)		35 %	50%	60%	65 %	70%	% of health facilities conducting quarterly facility-based audits
1.3. Implement scope-based practices for health professionals.	Human Resource Development Directorate (HRDD), Health & Health-related Regulation Directorate (HHRD),			40%	70%	80 %	90%	% of health facilities enforcing scope-based practice for health professionals

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
	RHBs/WoHO/health facilities							
1.4. Incorporate compliance with evidence-based guidelines as a criterion for performance agreements with health insurance.	NHIA/CSD/HEPHCD/ RHBs/WoHO/ health facilities			1	1	1	1	Agreement incorporated and implemented (Yes=1; No=0)
					25%	50 %	75%	% Health facilities that have implemented the incorporated agreement
1.4.1. Design transparent quality and safety facility grades to promote evidence-based practice.	NHIA/CSD/HEPHCD/ RHBs/WoHO/health facilities	1,598, 35.8		1	1	1	1	Design transparent quality and safety facility grades (Yes=1; No=0)
								Incentivize facilities in line with their quality and safety "grades" (Yes=1; No=0)
SO2: Improve people-centeredness of care								
A. Ensure transparent engagement of patients, community, and civil society transparently in the care								
2.1. Advocate the importance of patients, family, and community engagement in health service design, delivery, and assessment.	HEPHCD/ all other directorates and agencies/ RHBs/WoHO/ health facilities	1,164376						# of printed materials distributed (e.g., banners, flyers, and posters)
		13,155,767.4			120 min	120 min	120 min	# of minutes per year television and radio events are streamed
		3,631,681.8			240 min	240 min	240 min	# of radio events streamed in five different languages
	QHSD/CSD/ HEPHCD/RHBs	41,260,913		100	400	700	1000	# of facilities that implement a network of patient advocates

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
2.2. Establish/strengthen health literacy units at health facilities.	CSD/HEPHCD/ RHBs/WoHO/ health facilities	199, 510, 015.5		200	300	400	500	# of hospitals that have established health literacy unit (under quality and safety unit)
					50%	80 %	90%	% of health facilities that have conducted patient health literacy assessments regarding their diseases
	HEPHCD/RHBs/ WoHO/ health facilities	8,737,652.2		40%	50%	80 %	90%	% of health facilities providing onsite training in basic clinical communication skills
	Health facilities			30%	50%	80 %	90%	% of health facilities that provide health education on safety reporting systems, right to access medical records, right to informed consent, right to emergency response
2.3. Integrate QI concepts into the existing community structures and programs and link them with improvement.	WoHO/health centers			1	1	1	1	Mainstreaming of quality planning, improvement, and control is done for health extension program (Yes=1; No=0)
	QHSD/RHBs	1,707,766.4		1				Simplified quality improvement training manuals for HEP & community(Yes=1; No=0)
					350	200		# of TOT training

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
	WoHO/health centers/Health Posts (HPs)	120,355,272.0			20%	40 %	70%	% of woredas with at least 50% of HEW workers trained in integrated quality improvement HEP
2.4. Strengthen the engagement of patients and the community in facility management.	CSD/HEPHCD/RHBs	1,198,526.9			1			Procedures and manuals for facility management are revised and implemented (Yes=1; No=0)
	Reform Directorate (RD)/RHBs/ WoHO/ health centers		65 %	70%	75%	80 %	90%	% of health centers that have implemented CSC
	CSD/HEPHCD/RHBs/WoHO/ health facilities	22,840,625.8	60 %	70%	80%	85 %	90%	% of hospitals that have conducted town hall meetings
				70%	80%	85 %	90%	% of health facilities engaging community representatives on their board
2.5. Develop/strengthen patient rights charter and grievance handling mechanism.	Reform Directorate (RD)/RHBs/WoHO/ health centers			65%	80%	85 %	90%	% of health facilities actively implementing patient charter
				200	300	400	500	# of hospitals implementing patient liaison services
2.6. Engage professional associations in quality and safety endeavors.	QHSD			1				They are on board and have identified areas of engagement (Yes=1; No=0)
				1				Based on the areas of engagement, the MoH through QHSD has signed MOU with them (1=Yes; 0=No)

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
				1	1	1	1	Performance of the associations is tracked as per the agreed plan (1=Yes, 0=No)
B. Create enabling environment								
2.7. Establish/strengthen skill labs to impart clinical skills.	HRDD/CSD/ HEPHCD/ MNCAH-N / DPCD	1,198,526.9		1				A revised skill lab establishment guide is available (Yes=1; No=0)
		327,860,164.8		10	10	10	10	# of general and primary hospitals equipped with skill labs
2.8. Link motivation and development of health workforce and leaders with evidence-based practice.	HRDD/QSD				1			Quality and safety performance are embedded in the health workforce and managers' appraisal system (Yes=1; No=0).
	HRDD/QSD				1			Motivation schemes are devised linking quality and safety performance of health workforce and leadership with incentives (Yes=1; No=0)
	CSD/HEPHCD/RHBs/WoHO/ health facilities				25%	50 %	70%	% of health facilities implementing the new motivation schemes

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
2.9. Incorporate healthcare quality and safety into all health professional undergraduate and postgraduate education curricula and broader professional development and training programs.	QSD/HRDD	1,294,169.3			1			Healthcare quality and safety are incorporated into health professionals' undergraduate and postgraduate curricula (Yes=1; No=0)
						1		Quality and safety competency tests are incorporated into health workers' licensure exam (Yes=1; No=0)
2.10. Incorporate healthcare quality and safety core competencies as part of regulatory requirements for all health professionals.	QSD/HRDD					1		Healthcare quality and safety core competencies are incorporated into the job descriptions of healthcare professionals (Yes=1; No=0)
C. Ensure that well-coordinated services are available at all levels of the system								
2.11. Strengthen the referral system.	Emergency and Critical Care Directorate (ECCD)/CSD/ HEPHCD/DPCD/ MNCAH-N/RHBs/ WoHOs/ health facilities	9,243,468.0		1				The current national referral directory is revised (Yes=1; No=0)
				20%	40%	60 %	70&	% of health facilities that have implemented the current referral directory
					1			The referral directory is digitalized (Yes=1; No=0) .

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
2.12. Establish a private health facility engagement platform to ensure quality and safety at all levels.	QHSD/ RHBs/WoHOs							Revised policy framework on public/private partnership is completed
			1	1	1	1	1	Private health facilities are represented in the quality and safety technical working groups(Yes=1; No=0)
D. Redesign service delivery system								
2.13. Redesign service delivery based on the essential health service package.	QSD/ all other directorates/RHBs/ NHIA	1,707,766.4		1				Service delivery is redesigned and aligned with the essential health service package
					1			The new redesigned health service delivery promotes early detection and prevention and integrated health care delivery (Yes=1; No=0)
		58,864, 538.0			01	01	01	# of large-scale/nationwide improvement initiatives conducted to improve efficiency, timeliness, safety, and effectiveness of care.
E. Strengthen governance and accountability for quality and safety								
2.14. Develop an accountability framework for quality and safety.	QHSD/RHBs/WoHO	5,992,634.4		1				Comprehensive quality and safety accountability frameworks are developed at the federal, regional, and woreda levels (Yes=1; No=0)

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
				1	1	1	1	Accountability framework implementation is tracked regularly (Yes=1; No=0)
2.15. Strengthen the clinical governance system at the health facility level as an HF accountability framework.	CSD/ECCD/ HEPHCD/CSD/ RHBs/WoHO/ health facilities	1,707,766.4		1				Clinical governance frameworks are prepared for health facilities (Yes=1; No=0)
				1	1	1	1	Clinical governance framework is implemented and tracked regularly (Yes=1; No=0)
2.16. Mainstream quality and safety at all levels including health facilities.	QHSD/CSD/ECCD/ HEPHCD/DPCD/ MNCAH-N/RHBs/ WoHO/ health facilities		1	1	1	1	1	Quality and safety plans are integrated into the annual health plans at all levels for health facilities and individual health professionals (Yes=1; No=0)
			1	1	1	1	1	Quality and safety performances are evaluated regularly at all levels for health facilities and individual professionals (Yes=1; No=0)
	QHSD/RHBs							# of directorates, agencies, RHBs, and woredas allocated at least 5% of their budget for quality and safety
				50%	70%	80 %	90%	% of health facilities retaining at least 20% of funds for quality planning, control, and improvement

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
2.17. Establish a National Quality Council.	QHSD	1,735, 982.9	1	1				Legal framework for National Quality Council is prepared (Yes=1; No=0)
				1				National Quality Council is established (Yes=1; No=0)
2.18. Support the implementation of performance-based financing schemes for the provision of safe and high-quality care.	QHSD/HRDD/ Legal Directorate/ RHBs				1			The legal framework is prepared to allow performance-based financing (Yes=1; No=0)
						1	1	A performance-based financing scheme is linked with the performance of health facilities and individual professionals (Yes=1; No=0)
2.19. Strengthen the healthcare leadership for quality and safety.	QSD/CSD/ECCD/ HEPHCD/RHBs/ WoHO/ health facilities	1,707,766.4		1				Brand-new quality and safety leadership training manual is developed (Yes=1; No=0)
		19,993,642.3			100	250	500	# of leaders trained using the brand-new training manual
					1			The merit-based appointment is included in the accountability framework (1/0)
2.20. Enforce basic regulatory minimum standards to ensure that public facilities meet them.	Health & Health-related Regulation Directorate (HHRD)/RHBs/			50%	50%	50 %	50%	% Of health facilities inspected at least once per year to ensure that minimum regulatory standards are met.

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
	WoHOs/ health facilities							
2.21. Strengthen public health facilities to ensure that they offer basic amenities.	Public infrastructure/ RD/RHBs/ WoHO/ health facilities		6%	12%	18% %	24 %%	31% %	% of health facilities supported to meet standards regarding the water supply.
			4%	9%	14%	19 %	24%	% of health facilities supported to meet standards regarding electricity
			6%	13%	20%	27 %	34%	% of health facilities supported to meet standard regarding waste management
			5%	10%	15%	20 %	25%	% of health facilities supported to meet standard regarding latrines
SO3: Reducing preventable harm arising from health care								
A. Ensure healthcare safety in the clinical processes								
3.1. Establish and implement National Healthcare Safety Program that focuses on high-risk clinical conditions.	CSD/HEPHD/ RHBs/WoHO/ health facilities			70%	80%	85 %	100 %	% of health facilities that have embedded safety activities in a quality unit
		175,253,333.2		1	2	3	3	# of nationwide safety improvement projects on high-risk clinical conditions
		75,660,38.0		70%	80%	85 %	90%	% of health facilities that have implemented medication management safety improvement program

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
				40%	80%	85 %	90%	% of health facilities fully in compliance with the national IPC standard
				50%	70%	80 %	85%	% of health facilities in compliance with the national rational drug use directive
3.2. Bring strong human factors (or ergonomics) perspective and input	QHSD/Health Infrastructure Directorate/Ethiopian Pharmaceutical Supply Agency(EPSA) RHBs/CSD/ health facilities	241,810.0			1			Gap assessment is conducted concerning human factors (Yes=1; No=0)
	QHSD/Health Infrastructure Directorate/EPSA/ RHBs/CSD/ health facilities	1,294,169.3			1			The guideline is developed on human factors which will help to mainstream ergonomics principles in the workplace (Yes=1; No=0)
	QHSD	16,238,404.2			200	1000	1000	# of people-oriented on human factors
	QHSD/Health Infrastructure Directorate/EPSA/ RHBs/CSD/				40%	60 %	80%	% of health facilities at which the human factors principles are mainstreamed into their licensing,

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
	health facilities							regulatory, and accreditation requirements
	QHSD				01	01	01	# of learnings translated from high-risk industries (e.g., aviation)
3.3. Observe World Patient Safety Day every year.	QHSD/CSD/ HEPHCD/MNCAH-N/DPCD/RHBs	2,473,760.1	1	1	1	1	1	Patient safety day is celebrated yearly (Yes=1; No=0)
B. Establish and strengthen healthcare policy frameworks								
3.4. Redesign the safety measurement and reporting (incident reporting, medical error, culture of safety) system	QHSD/ responsible directorates and RHBs	8, 555, 403.8		1				Redesigned safety measurement system to regularly track incident reports, medical error, and culture of safety (Yes=1; No=0)
	All directorates/ RHBs/ health facilities			50%	75%	80 %	90%	% of health facilities that have implemented the redesigned patient safety measurement system
3.5. Establish policy/legal/institutional frameworks that promote the principle of openness throughout healthcare, including patient safety incident disclosure to patients and families.	QHSD/Legal Directorate (LD) RHBs	1,735, 982.9		01				# of pieces of legislation promulgated to facilitate just safety culture
	QHSD	2,622,047.0			1			Institutional safety framework is developed and disseminated to all facilities (1=Yes; No=0)
	Health facilities at all levels				50%	60 %	80%	% of health facilities that have implemented the safety institutional framework

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
3.6. Create patient and family advisory councils focused on patient safety.	QHSD/CSD/ HEPHCD/MNCAH-N/ DPCC							Patient and family advisory councils are established at all levels
				1	1	1	1	All projects on safety are designed with the voices of patients and families incorporated(Yes=1; No=0).
3.7. Invite victims of harm or family representatives to be involved in designing action to reduce the likelihood of a recurrence.	QHSD/CSD/ HEPHCD/RHBs	1,198,526.9		1				Guidelines prepared for engaging victims of harm (Yes=1; No=0)
	CSD/HEPHCD/ RHBs/WoHO/ health facilities			100	400	800	1000	# of health facilities implementing guidelines for engaging victims of harm
								# of documents prepared and disseminated on harm related to unsafe care
SO4: Improve the efficiency of healthcare delivery								
A. Ensure efficient healthcare delivery system								
4.1. Strengthen medical device management system.	QHSD/Pharmaceutical and Medical Equipment Directorate/EPSA/CSD/HEPHCD	25, 220, 012.7		5	5	5	5	# of maintenance workshops supported or established
4.2. Expand the APTS and ALTS to all levels of facilities.	Pharmaceutical and Medical Equipment Directorate							

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
4.3. Standardize common supplies for common procedures.	QHSD/HIA/CSD/ RHBs/hospitals	5,697,997.3		5	10	20	30	# of procedures for which supplies and other inputs are standardized
					100	500	1000	# of health facilities that have implemented the standard procedures with standardized supplies.
4.4. Use demand-based human resources forecasting and deployment.	HRDD/CSD/ HEPHD/RHBs/ WoHO/ health facilities	1,850,076.5			1			Demand-based HR forecasting and deployment is piloted (Yes=1; No=0)
					1	1	1	Demand-based HR forecasting is adopted
					90	120	60	# of experts/officers trained to apply the tools
4.5. Design economic measurement to compare the efficiency of hospitals.	QHSD/NHIA/CSD/ RHBs/hospitals	9, 272,703.9			1			Economic measurement is devised and piloted to compare the efficiency of hospitals (Yes=1; No=0)
						1		Hospital efficiency comparison report has started to be published every two years (Yes=1; No=0)
5. Create a culture of quality through continuous learning and improvement								
A. Strengthen continuous learning, improvement, and knowledge management systems								
5.1. Redesign the learning networks in such a way that they anchor district-level facilities.								

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
5.1.1 Assess the effectiveness of learning networks (EPAQ/EHAQ).	QHSD/CSD/ HEPHCD	3,359,100.0		1				Assessments are done to review the performance of the two learning platforms (Yes=1; No=0)
5.2. Establish quality and safety hubs.	QHSD/CSD/ HEPHCD	261,865,432.1		5	10	15	20	# of geographically accessible quality and safety hubs
				20%	40%	50 %	60%	% improvement in key quality and safety indicators from the baseline of quality hubs
5.3. Standardize and support district-level quality coaching and mentoring system for improvement.	QHSD/RHBs	1,707,766.0		1				National guidance on district-based coaching and mentoring is prepared and implemented (Yes=1; No=0)
				1				Training material for coaching is developed
	RHBs/WoHO	201, 624, 106.4		20%	40%	60 %	70%	% of districts (woreda health offices and primary hospitals) that conducted coaching and mentoring on quality and safety as per the standard
		78, 959, 226.7		120	189	321	460	# of primary hospitals which received coaching and mentoring (from zones and general hospitals)

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
	QHSD/CSD/HEPHCD	4,294, 968.2		13	13	13	13	# of supportive supervisions conducted by Ministry of Health to regions
	RHBs/ZHD	27, 235, 795.5		20%	40%	60 %	70%	% of woredas which get supportive supervision from regions/zones twice annually
	WoHO/ZHD/RHBs	126, 015, 066.5		20%	40%	60 %	70%	% of health facilities which get supportive supervision from woredas/zones/regions on a quarterly basis
5.4. Conduct regular collaborative learning sessions to strengthen learning.	QHSD/all other directorates	13, 297, 503.9		2	2	2	2	# of learning collaborative sessions conducted at the federal level
	RHBs/ZHD/referral hospitals	6,393,777.6		2	2	2	2	# of learning collaborative sessions conducted at the regional level
	ZHD/general hospitals	3, 641, 769.8		2	2	2	2	# of learning collaborative sessions conducted at zonal levels
	WoHO/primary hospitals	859, 127, 561.8		20%	40%	60 %	70%	% of woredas that conducted quarterly collaborative learning sessions
5.4.1. Provide grants to support the institutionalization of QI at all levels.	QHSD/CSD/ HEPHCD/MNCAH-N/ DPCD	52, 373, 086.4		10	20	30	40	# QI grant awarded to health facilities

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
5.5. Build the capacity of healthcare workers in quality and safety.	QHSD/CSD/ HEPHCD/MNCAH-N/ DPCD/NHIA	31, 335, 538.2	100	400	400	400	400	# of total healthcare professionals trained in Quality improvement TOT
	CSD/HEPHCD/ MNCAH-N/DPCD/ NHIA/ RHBs	96, 994, 302.2	500	3000	3000	3000	1500	# of healthcare professionals trained in basic QI
	QHSD/CSD/ HEPHCD/MNCAH-N/ DPCD	31, 335, 538.2	100	400	400	400	4000	# of healthcare professionals trained in patient safety TOT
	CSD/HEPHD/ MNCAH-N/DPCD/ NHIA/RHBs	96, 994, 302.2	500	3000	3000	3000	1500	# of healthcare professionals trained in basic patient safety
	QHSD/CSD/ HEPHD/MNCAH-N/ DPCD/NHIA	35,646, 072.1		600	600	600	300	# of healthcare professionals trained in quality coaching TOT
	CSD/HEPHD/ MNCAH-N/DPCD/ NHIA/RHBs	68,797, 136.1		3000	3000	3000	1500	# of healthcare professionals trained in quality coaching
	QHSD/CSD/	799,017.9		1				Review guide developed (Yes=1; No=0)

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
5.6. Establish a system for institutional mortality review for improvement.	HEPHCD/MNCAH-N/ WoHO/health facilities			20	40	60	70	% of health facilities (hospitals and health centers) implementing mortality review
5.7. Establish knowledge management and learning units for healthcare quality and safety at all levels.	QHSD/HRDD/CSD/ HEPHCD/MNCAH-N/ WoHO/health facilities	1,198,526.9		1				SOP is developed for the establishment and guidance of knowledge management and learning units at all levels (Yes=1; No=0)
		3,359,100		1				Web-based knowledge management site developed (Yes=1; No=0)
				1	1			# of RHBs with knowledge management unit/center (Yes=1; No=0)
		10,087,028.9		13	13	26	26	# of bulletin/journal articles/policy briefs published and disseminated by MoH and RHBs
5.8. Organize national and regional quality summits.	QHSD/ all other directorates/RHBs	7,966,901.9	1	1	1	1	1	National Quality Summit conducted every year
	RHBs	32,865,015.9	4	5	8	12	12	# of regions that conducted subnational quality summit in their region
		3, 359,100	1	1				Roadmap is developed for voluntary accreditation system (Yes=1; No=0)

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
5.9. Establish a system of voluntary health facility accreditation.	QHSD	25,000,000		1				Designated a body and execute the whole accreditation system (Yes=1; No=0)
		30, 707, 766		01	01	01		# of facility accreditation standards developed (international and local for hospitals and health centers)
						01	01	# of health facilities internationally accredited
5.10. Support implementation and operational research on quality and safety.	QHSD/EPHI/all other directorates/RHBs/ health facilities	20, 271, 511.5			01	01	01	# of operational and implementation research studies conducted
B. Strengthen a high-quality data system for improvement								
5.11. Develop quality-adjusted indicators.	QHSD/PMED	1,198.526.9						# of quality-adjusted indicators developed
	QHSD/PMED/all other directorates/ RHBs/health facilities							# of quality-adjusted indicators tracked via different portals
5.12. Develop dashboards for different administrative levels on selected priorities for	QHSD/PMED/ health facilities			1				Indicators selected for dashboard visualization at all levels of the system (Yes=1; No=0)

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
reporting within the health sector.		595, 123, 436.9		20	40	60	70	% of health facilities that have started to use public dashboard visualization
	Woreda health offices	136, 272, 549.3		200	400	600	700	# of woredas that have started to use public dashboard visualization
	Zonal health department	16,170,575.6		30	70	100		# of zones that have started to use public dashboard visualization
	RHBs	1, 088, 621.6		2	12			# of RHBs that have started to use public dashboard visualization
5.13. Institute electronic medical records (EMRs) in health facilities.	HITD/QHSD/CSD/ ECCD/HEPHCD							# of health facilities that have instituted and started to use EMRs
5.14. Strengthen health care facilities to improve high-quality data capturing and translation into practice.	QHSD/PMED/ RHBs							% of health facilities conducting LQAS on monthly basis
								% of RHBs conducting the regular RDQA
5.15. Ensure a two-way data feedback loop so that local facilities receive information to improve.	RHBs/WoHO/ facility quality and safety units							# of formal feedback reports on quality and safety given to woredas by RHBs and ZHD
								# of formal feedback reports on quality and safety given to health centers and hospitals by woreda health offices

Major activities	Responsibility	Budget (in ETB)	Implementation year and target					Activity indicator
			Y1	Y2	Y3	Y4	Y5	
								# of formal feedback reports on quality and safety given to facility departments by facility quality and safety units
5.16. Regularly measure the experience of care at the facility level and use results for quality improvement initiatives.	Health facilities		40	50	60	80	100	# of health facilities measuring the experience of care
5.17. Conduct state-of-quality assessment every two years.	QHSD/PMED/ EPHI	104,750,724.8		1		1		State-of-quality assessment is conducted every two years (Yes=1; No=0)

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11 ANNEXURES

11.1 Annex 1 : Indicators and Targets

	Indicators	Type of Indicator	Level of data collect-ion	Data source	Frequency-cy of data	Base-line	Targets
1	Decrease institutional mortality rate from 2.2% to 1.5%.	Outcome	Facility	HMIS	Monthly	2.2%	Decrease by 30%
2	Improve experience of care.	Outcome	Population	Survey	Every 2 years	77	By 30%
3	Decrease stillbirth rate (per 1000).	Outcome	Facility	HMIS	Monthly	15	14
4	Decrease ICU mortality rate by one fourth.	Outcome	Facility	HMIS	Monthly		Reduce by 25%
5	Reduce Preoperative Mortality below 2%.	Outcome	Facility	HMIS	Monthly		Below 2%
6	Increase treatment outcomes (cure rate) for management of sever acute malnutrition.	Outcome	Facility	HMIS	Monthly	85%	95%
7	Increase the percentage of people receiving antiretroviral therapy with viral suppression.	Outcome	Facility	HMIS	Monthly	91%	Increase by 4% (95%)
8	Increase TB cure rate.	Outcome	Facility	HMIS	Monthly	84%	96%
9	Increase the proportion of hypertensive adults whose blood pressure is controlled.	Outcome	Facility	HMIS	Monthly	26%	60% (increase by 130%)
10	Increase the proportion of DM patients whose blood sugar level is controlled.	Outcome	Facility	HMIS	Monthly	24%	60% (increase by 150%)
11	Increase the proportion of women 30-49 years screened for cervical cancer from 5% to 40%.	Output	Facility	HMIS	Monthly	5%	40%

	Indicators	Type of Indicator	Level of data collect-ion	Data source	Frequency-cy of data	Base-line	Targets
12	Reduce waiting time for surgery (delay for elective surgery)	Output	Facility	KPI	Monthly		<30 days
13	Increase the availability of essential medicines at the health facility level.	Input	Facility	HMIS/ SARA	Monthly / Every 2 years	79.20 %	90%
14	Increase the proportion of health facilities implementing compulsory Ethiopian health facility standards.	Input	Facility	RIS	Annual	53%	80%
15	Increase the proportion of primary health care facilities implementing Community Scorecard.	Input	Facility	Admin Report	Annual	61%	90%
16	The proportion of pregnant women who attend the 4th ANC visit and get adequate care as per the national ANC guideline.	Output	Facility	Survey	Every 2 years	47%	63%
18	Increase the proportion of <5 children diagnosed with pneumonia receiving appropriate treatment per national or IMCI guidelines.	Output	Facility	HMIS	Monthly		Increase by one third
19	Increase the proportion of <5 children with diarrhea who are treated with ORS and Zinc.	Outcome	Facility	HMIS	Monthly	44%	Increase by one third (67%)
20	Increase bed occupancy rate.	Output	Facility	KPI	Monthly	41.9 %	75%
21	Reduce surgical-site infection rate.	Outcome	Facility	KPI	Monthly	-	Reduce to <5%

	Indicators	Type of Indicator	Level of data collect-ion	Data source	Frequency-cy of data	Base-line	Targets
22	Increase appropriate referral rate (referral rate as per standard).	Outcome	Facility	Survey	Every 2 years		TBD

11.2 Annex 2: Linkage Between HSTP-II Strategic Directions and Healthcare Quality

HSTP-II Strategic Directions	Description of the Strategy Directions (taken from HSTP-II)	How is health care quality linked to these strategic directions?

Enhance the provision of equitable and high-quality comprehensive health services.	- Providing comprehensive (promotive, preventive, curative, rehabilitative, and palliative) care both equitably and with the highest attainable quality.
	- Integrated primary health care approach will be ensured.
	- An essential health service package (EHSP) will be provided based on an integrated approach across all levels of health care delivery.
	- Health services will be provided fairly to all needy people without any systemic disparity.
	- All major promotive, preventive, curative, rehabilitative, and palliative programs will be implemented under this objective.
		- What is the highest attainable quality? It means that the care will be safe (without harm); timely (avoiding waiting); effective (based on best available evidence); efficient (optimal use of resources); equitable (distributed fairly to all needy people without any systematic disparity); people-centered (the needs, preferences, and values of people are at the center); and, finally, integrated (care coordination at all levels and throughout the life cycle)(18).
		- HSTP-II has described the quality of healthcare and equity as a major program/initiative.
		- HSTP-II has underscored that high-quality healthcare could be achieved through:
		  - A health system that ensures UHC and embeds quality of care into its foundation.
		  - Evidence-based care that is standardized for implementation.
		  - Demonstrating continuous improvement, learning, and knowledge management.
		  - Producing better health impacts.
		  - Reducing harm, waste, and resources.

		- Benchmarking best practices. - Ensuring patient and community engagement.
Improve public health emergency and disaster risk management.	- It focuses on effective and timely anticipation, prevention, early detection, rapid response, control, recovery, and mitigation of any crises. - The crisis could impact the health, social, economic, and political well-being of society. - The range of threats is diverse including infectious disease, food and water contamination, chemical and radiation contamination, war and other societal conflicts, etc. - During HSTP-II, emphasis will be given to strengthening the capacity for preparedness, detection, prevention, response to, and recovery from all health emergencies and disasters. - It needs a multisectoral response as the threat usually arises from outside of the realm of the health system. -	1. The crisis could impact the health of society. It may disrupt the existing healthcare system: either it overwhelms the existing system or people may flee for their lives to other places, where there are no health services, or they are already strained. If the system is disrupted, people may be exposed to unsafe and low-quality care. 2. If the nature of the threat is highly contagious, people may not come to the health facility seeking help for other health services, fearing that they may contract the diseases if they come to the facility. - The health system must be ready to contain such a threat: strengthen regular risk assessment, capacity building, and multisectoral collaboration. - Health facilities should always be anticipating these kinds of risks and make themselves ready to contain such a threat if it happens.
Enhance community engagement, empowerment, and ownership.	- Active participation, engagement, and empowerment of communities to have control over their lives; could be done by improving decision-making power and health literacy.	- The health system is all about improving the health and well-being of the population and meeting the needs and preferences of the population should be the main driving factors for the health system. People are key partners of the health system; they are not only the beneficiaries but should hold

	- Individuals, families, and the community will engage in the planning, implementing, monitoring, and evaluation of health systems.	the system accountable. For this, their engagement and ownership have paramount importance and make the system people-centered (1, 3, 14, 18).
Improve access to pharmaceuticals and medical devices and ensure their rational and proper use.	- This strategic direction focuses on: - Strengthening the pharmaceutical supply chain. - Strengthening the pharmacy service and device management system. - Availability of effective and affordable medicines and devices. - Rational and appropriate drug use. - Reducing pharmaceutical waste.	- One of the foundations for achieving high quality of care is the availability of drugs, medicines, supplies, and medical equipment (3,18).
Improve the regulatory system.	- Ensuring the safety, efficacy, and proper use of medicines, devices, and food items. - Regulate health institutions (both public and private), health professionals, and traditional medicine healers. - Regulate tobacco and alcohol.	- Legislation and regulation are one area—that could be implemented at the highest level of the health system—of quality interventions (18, 19).
Improve human resources development and management.	- The aim is to realize motivated, competent, compassionate, and committed health professionals in adequate numbers and skill mix.	To realize the high quality of health care, one of the foundations is having a competent and motivated health workforce. To have this, it is necessary to have quality pre-service competency-based clinical education, continuous learning of health workers in the clinical setting, training in ethics,

	- It focuses on the quality of pre-service education and CPD. - It gives due emphasis to the integration of ethics and professionalism both in pre-service and CPD training.	and favorable environment and working conditions.
- Enhance informed decision-making and innovation. - Enhance digital health technology.	- It is about promoting evidence-based decision-making at the individual, household, community, and all other levels of the health system by using data and data only. - The data is from institutions and the community, coming through different and appropriate channels. - Health innovation entails promoting a new way of doing things—to promote health and well-being—emanating from new or improved health policies, systems, products, technologies, and services. - Digitization is targeted to clients, health workers, health system managers, and health data services. - Digitization aims to tackle the existing challenges to realize high quality of care.	- At the heart of a high-quality healthcare system, there is a learning healthcare system—learning iteratively without ceasing. One of the components of the learning healthcare system is "science and informatics": real-time access to knowledge and digital capture of the real user experience (1).
Improve health financing.	- Provide adequate financing to achieve the universal health coverage UHC—through the integrated primary health care approach—and without any financial hardship for citizens.	- To realize high quality of care, adequate healthcare financing must be ensured, and disbursement of funds and purchasing of healthcare should be linked with high quality of care (3).

	- Aims to finance healthcare through domestic sources.	
Improve health infrastructure.	- Well-equipped and well-furnished health facilities to provide quality of care—both the existing and new facilities.	- This is one of the foundations of high quality of care: accessible and well-equipped health care facilities (18).
Improve traditional medicine.	- Aims to work on traditional medicines, practitioners, use, and research.	This is the informal health care from which many people get health services as an alternative to the formal sector.
Incorporate health into all policies. Enhance private sector engagement.	- Prevent and mitigate the harmful effects of other sectors' policies on population health. - Through multisectoral collaboration, help other sectors to see the effects of their policy on health determinants. Aims to improve the engagement of the private sector in improving access to and quality of health services.	- "Looking beyond the government health sector"—including other public sectors and other actors such as the private health sector—is one of the recommendations from the *Lancet* article on high-quality health systems in the sustainable development era (3).

11.3 Annex 3: Future State of Healthcare Quality and Safety in Ethiopia

Level of the health system	Future state
National	- The equity and efficiency of the health system interventions will be dimensions for planning; equity and efficiency will be measured and tracked, and improvement will be initiated. - Sound measurement will be in place in the health system and will be used for quality improvement. - Leadership will set realistic quality goals with appropriate quality-adjusted indicators at all levels of the health system. - There will be selected quality and safety indicators to be tracked by DHIS2. - The health system at all levels will be responsive to the needs of people. - Clinical protocols/guidelines will be available for all care given on all platforms; they will be continuously updated by a dedicated body for this purpose, compliance will be measured and tracked, and quality improvement projects will be designed to improve compliance. - Standards, directives, and accreditation guidelines focusing on improving quality and safety will be aligned and harmonized. - Strong and vibrant quality and safety governance will be in place at all levels of the health system, which will be responsive and accountable to people. - Quality and patient safety activities will be well-financed at all levels. - The health system will be well-funded by the government and innovative methods will be in place to diversify incomes for the health system; financing/refunding will be linked with quality and safety. - Leadership in the system shares common understanding, knowledge, and skill on quality and safety; the system will put in place a leadership succession program to impart continuity and institutional memory. - The purchaser, regulator, and provider of healthcare will have independent structures and coordinate their efforts to improve access and financial risk protection while linked with quality and safety. - The private health sector is uniformly treated just as the public sector and they will be integrated with the public system to provide efficient and consistent care. - Performance-based recognition and reward motivation scheme, linked with quality and safety, will be devised for the health workforce and leaders. - A culture of data-driven decision-making will be promoted. - Quality and safety concepts will be integrated into the pre-service curriculum. - The legal system, as well as the health system, will be improved to embody the concept of just culture.

Regional, zonal, and woreda	- Successful quality improvement programs will be scaled to cover facilities beyond hospitals nationwide. - District-based learning platforms will be strengthened. - Supportive supervision, coaching, and mentoring schemes will be redesigned again to improve the accountability and effectiveness of these initiatives. - Health service delivered by the three care platforms (primary, secondary, and tertiary) will be redesigned in line with the newly approved essential health service package; and referral and continuity of care will be strengthened and tracked. - A learning and accountable organizational culture will be instituted to promote knowledge and continuous learning at all levels.
Facility	- Clear accountability will be set and measured to enforce minimum standards on both public and private health facilities without the double standard. - Enough data will be captured at the facility level which focuses on processes and inputs and is linked with quality improvement activities. - Safety event reporting and other measurements of quality and safety will be in place and tracked to monitor the status of safety and quality at a health facility. - Health professionals will practice based on their newly identified scope to improve their confidence and accountability. - The engagement of senior professionals, in quality and safety, will be strengthened at the facility level. - A safe and conducive working environment will be created to motivate health professionals. - Quality and safety in the health facility plans will be linked with the job descriptions of health professionals. - Health facilities will have competent health workers with the skills, attitude, and knowledge to care for their clients respectfully and compassionately. - Teamwork and a culture of high reliability and just thinking will be embedded in all facilities to improve safety and quality. - Health workers will be very aware of people-centered care and will deliver such care in an integrated and timely manner. - Continual learning and renewal of health workers' licenses will be linked with CPD. - A public reporting platform will be initiated for hospitals based on some identified indicators.
Community, patient, and family	- People's voices, needs, and preferences will be honored; communities, patients, and families will have a strong platform to share perspectives on the quality and safety of health care. - Community engagement platforms will be strengthened/created to engage patients, their families, and patient associations to improve quality and patient safety.

	- A strong health literacy wing will be established at the health facility level and in the community to improve the demand for better care. - Patients and their families and the local community will be appropriately engaged in all facility boards. - Community scorecards, town hall meetings, and other creating initiatives will be in place to promote people-centered care.

11.4 Annex 4: List of Contributors, Reviewers, and Workshop Participants

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