Federal Ministry of Health

Medical Service General Directorate

Health Service Quality Directorate

Learning Health Facility Initiative Guide

Introduction

In Ethiopia, numerous activities have been undertaking by different stakeholders to provide high quality health services to clients. Federal ministry of Health in Health Sector Transformation Plan has made health care quality one of four transformation agendas. At different levels of the country's health system, leadership and service delivering points the quality issues are being flagged. A detailed National Quality Strategy has been formulated making maternal and child health, nutrition, communicable disease, chronic disease and clinical and surgical services strategic focus areas.

In our health system there have been different ways of learning from other facilities practices. Informally, health care facilities adopt best practices from best performing facilities. There have been also formal ways of presenting and sharing good practices that were believed to be helpful for other facilities at times of review meeting. However, learning is a continuous process that needs formal platform to share knowledge, practices and well-functioning methods.

Learning health system with quality data, energetic and engaging staff, and adequate government support is very great ingredient in provision of high quality health care delivery. Learning process contains assembling and analyzing data, interpreting the findings, feeding the findings back to the system, changing the practice and scaling up the best practice to institutional, national and international level.

By considering the real situation on the ground Learning Health Facility initiative is set in Health Service Quality Directorate inorder to facilitate development of programs and reforms based on the best available evidence (global, regional, or local) and best practices. Facilities in this initiative are going to learn from their performance, work on quality improvement projects and share others the results they have got from their efforts. It also identifies best performers and determines the basis for their success. This set of intentional processes for actively learning and improving the health system is a goal that should be articulated and demonstrated first by the actions of senior leadership and subsequently echoed by middle management and the front-line staff.

Rationale

Too often, quality is perceived as a luxury that only high-income countries with best infrastructure can deliver. This is a fallacy! Building quality health services requires a culture of transparency, engagement, and openness about results along with leadership commitment, which are possible in all health facilities.

This is time to strengthen our healthcare system and show that it's possible to deliver high quality of care. So far, after the launch of National healthcare quality strategy; there have been several notable quality improvement efforts and initiatives to improve service quality.

There is a quality structure in FMOH, RHB till Woreda and in facilities. Trainings in quality improvement have been developed and many HCP have taken the training. EHAQ achieved lots of things with CASH and other initiatives. CRC has become an important agenda for facilities and many advocacy events and training have been provided.

But poor quality of care is still very common. Many studies have found that effective interventions are underutilized and unnecessary interventions, like antibiotics for viral illnesses, are over utilized. Mistreatment of patients and poor communication are prevalent. Resources are used inefficiently.

The health care provider has poor skill and also does not perform even when the knowledge and skill exist. There is a high turnover of management and HCP.

The midterm review found that there is fragmentation of quality improvement initiatives and there are gaps in HF functionality (HRH, infrastructure, commodities systems) and readiness (e.g., available water, electricity, sanitation facilities) — compromising the effort of "quality transformation. The review suggested devising system for monitoring care effectiveness,adherence to care standards, care process, including infection prevention and care outcomes. Strengthen availability, quality and use of evidence on equity and quality of care.

Despite these problems, some hospitals achieved tremendous progress. These facilities have strong health facilities quality management system and are doing continuous improvement of the organization's processes, provide healthcare services in a better degree of quality, increase patient satisfaction and be a learning site for others.

This shows it is possible to transform hospitals with the right interventions, by aligning resources if there is a leadership that is committed to improve quality of care. These facilities then learn from each other helping them provide better care.

Goal andObjectives

Goal

- To establish quality culture in selected health facilities to improve their health outcome and serve as a benchmark to other facilities.

Objectives

- To define quality and quality improvement for hospitals.
- To help facilities have a QI and clinical governance unit that has appropriate number of professional with different professional mix who have skill in improvement science.
- To create high quality hospitals with learning system that continuously produces relevant data, measures performance and outcomes, and translates those data into action.
- To improve efficiency of hospitals enabling them to provide care for more patients and save resources.
- To help facilities create demand for high quality care.
- Create a motivated health workforce that is part of the QI.
- To make the selected health facilities benchmarking site for others.
- To make them implementation site for initiatives (CRC incubation site, SaLTS, emergency care and information revolution)
- To support facilities in developing mechanisms for accountability for quality of care

Definition of Health Care Quality in Ethiopia

In Ethiopia, as highlighted in the HSTP, quality and equity are defined together, believing that the two must go hand-in-hand. The national quality strategy through various consultative processes, have prioritized the following domains of health care: safe, effective, patient centered, efficient, accessible, comprehensive, affordable, and timely. With these prioritized domains, quality in Ethiopia is defined to be:

> *"Comprehensive care that is measurably safe, effective, patient centered, and uniformly delivered in a timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently."*

There are six generally accepted dimensions, or aims, of quality, as laid out by the Institute of Medicine.

Safe: avoiding injuries to patients from the care that is intended to help them; the WHO defines "patient safety" as the prevention of errors and adverse effects to patients associated with healthcare

Effective: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

Timely: reducing waits and sometimes harmful delays for both those who receive and those who give care

Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy

Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

The strategy identifies the three Core Elements of Quality, namely quality planning, quality improvement, and quality control. Leveraging all three pillars in a holistic way is one of the key foundations of this National Health Care Quality Strategy.

Quality planning 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.

Quality control (QC), is a normative process that includes quality assurance, where a system seeks to ensure that quality is maintained or improved, and errors are reduced or eliminated. QC programs evaluate current health care quality, identify problem areas, create a method to overcome issues, and monitor the method taken to improve quality.

Processes consist of both internal quality assurance and external quality assurance. For instance, these monitoring and improvement activities may be internally motivated (problems are identified and addressed from within a health care facility by a facility based QI team) or externally required (standards are set, and problems are identified through inspection by government agencies (woreda, zone, region, federal

Defining quality improvement

The NQS defines quality improvement as *"…the combined and unceasing efforts of everyone—health care professionals, patients and their families, researchers, payers, planners, and educators—to make the changes that will lead to*

- *better patient outcomes*

- *better experience of care*
- *continued development and supporting of staff in delivering quality care*

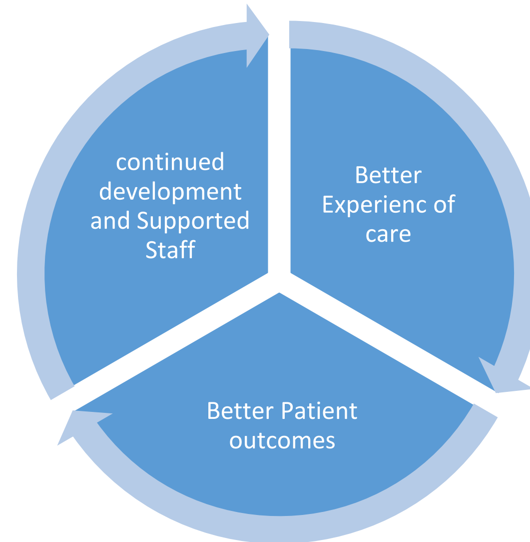
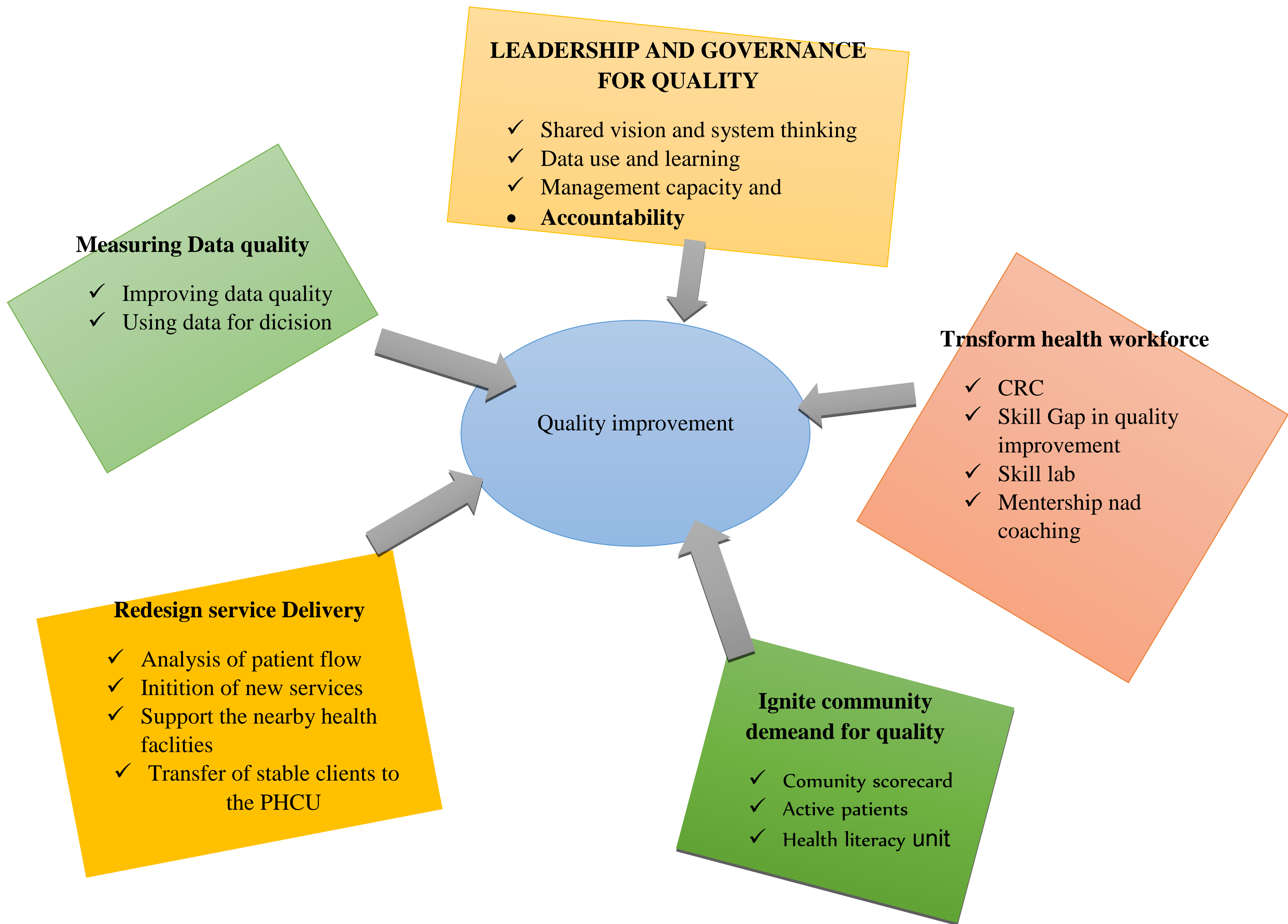


Figure 1. Defining Quality Improvement (adapted from Batalden, davidoff QualSafHealth Care 2007)

Quality improvement begins with an identification of a clear aim statement or charter, to answer the question: "What are we trying to accomplish?" Several overlapping and complementary QI models exist, which all stem from the "Science of Improvement" that starts with an aim and develops tests towards improvement. These include Lean, Six Sigma, Kaizen, and the Model for Improvement. In Ethiopia, Kaizen is thought of as the engine driving improvement, while the Model for Improvement can be seen as the "vehicle" that provides structure for

improvement. Specifically, Kaizen focuses on improving efficiency and lowering cost, through a methodology that can be integrated with other complementary quality improvement tools and approaches, such as the Model for Improvement. At the heart of both methodologies are small rapid tests of change that lead to sustained improvement.

Conceptual Framework for Quality Improvement


LEADERSHIP AND GOVERNANCE FOR QUALITY
Shared vision and system thinking
Data use and learning
Management capacity and
Accountability
Measuring Data quality
Improving data quality
Using data for dicision
Quality improvement
Trnsform health workforce
CRC
Skill Gap in quality improvement
Skill lab
Mentership nad coaching
Redesign service Delivery
Analysis of patient flow
Initition of new services
Support the nearby health faclities
Transfer of stable clients to the PHCU
Ignite community demeand for quality
Comunity scorecard
Active patients
Health literacy unit

Purpose of the QI frame work- in order to foster a culture of quality in Ethiopian hospitals that continuously seeks to provide safe, effective, person centered care. Building such a culture is paramount to ensure long term progress to improve quality of care.

The framework for Improving Quality is developed to help and guide our thinking, planning and delivery of care in our services. It is firmly orientated towards quality, safety and to improve patient experience and outcomes. It provides a strategic approach to improving quality whether at the frontline, management, board or national level. The Framework is informed by international models and evidence as well as local improvement experience and learning.

The Framework is comprised of five drivers for improving quality,

1. Measurement for quality
2. Leadership and governance for quality
3. Transform and engage the health workforce
4. Ignite demand for quality
5. Re-design service delivery

Focusing on only one of the drivers within a service will not give the desired effect for improvement. It’s the combined force of drivers working together that creates the environment and acceleration for improvement. A critical element in any movement to improve quality is putting in place the supportive structures for quality and funding leadership positions to drive improvement in hospitals.

The first step in meaningfully changing quality of care is hence establishing a strong quality improvement and governance unit.

For detail structure and functions of the unit see EHSTG chapter 19.

Gaps in CG and QI units:

1. The CG and QI unit is understaffed,
2. CG and QI unit is not involved in improving the over whole quality of care given in the facilities,
3. CG and QI unit did not analyze data of the hospital to identify quality gaps, especially HMIS

Possible areas of improvement:

1. Increasing the number and mix of staffs who are assigned in this unit,
2. Involving the unit in measuring the quality of care, hence should work closely with the HIMIS team.
3. Designing data quality improvement projects throughout the hospital with staffs from each unit
4. Working closely with SMT and hospital leadership.
5. Helping staffs design QI projects, evaluate their progress and give feedback.

Driver 1- Measurement for quality

Information and measurement are central to improving the quality of care. Analysis of data relating to a service provides information that can be used to drive improvement and support assurance on the quality of care provided. It supports the identification of areas where underperformance highlights the need for an improvement response. Building measurement into all improvement initiatives is essential so that we know when improvements have occurred and when they haven’t.

There are several gaps in measuring quality of care in Ethiopia. The data collected in health care facilities does not show the actual service provision. There is gross negligence around data collection and inflated data are not uncommon. The culture of data use is limited and facilitates do not have staffs that can analyze the data.

To improve this there is a great need to minimize the measurement burden on staff by collecting data only on what really matters. There are opportunities for more intelligent use of information across the system e.g. examining variability, looking at trends over time and benchmarking with peers. Sharing and displaying information in a manner that influences behavior is critical to achieving success in improving quality. This requires services to have the capability to measure and analyses information as well as having access to information technology to enhance capability.

Gaps in measuring quality:

1. DHIS 2 and KPI are not complete, timely and data is unreliable
2. Huge gap in the number of deaths registered in the facility and in other documents like morgue, morning session reports, MDSR and other tools.
3. Significant number of patients who visit hospitals may not be registered at all.
4. HMIS and quality team do not work together.
5. Lack of dash board for CEOs to evaluate the quality of care routinely.
6. Each department or unit does not discuss on the data generated from their respective.

Key interventions:

1. Strengthening the HMIS team and creating a close working relation with CG and QI unit,

2. Measuring the quality of DHIS 2 data using the tools prepared by ministry of health – Annex 2. Improvement ideas that have worked in some hospitals
    a. Use data sources like morgue register, morning sessions, and others to triangulate the data quality assessment.
    b. Root cause analysis of data quality problems
    c. Driver diagram,
    d. Stakeholder engagement,
    e. Improving data quality and use by integrating them in QI projects
3. If resource allows establishing EMR,
4. Improving the culture of data use- (Use an audit tool that is on Annex 3.)
5. Creating dash board for hospital leaders.
6. The CG and QI unit needs to follow the quality of care provided in the hospital using DHIS2.
    a. 55 indicators selected to show the overall quality of care. (See annex 4)
    b. giving feedback to relevant units, SMT and the hospital leadership
7. Being smart in how we measure: use available data; measure once use often; look at families of measures (e.g. infection rates, hand hygiene and hospital length of stay); measure variability; trends over time; and benchmark with peers
8. Seeking transparency and honesty in the measuring, sharing and reporting of information
9. Building capability for extraction and sharing of information from data to provide assurance and support improvement. For this M and E experts are needed if possible.
10. Building data collection into routine work and record keeping
11. Building data quality component in all QI projects

Driver 2- Leadership and governance for quality

Leadership is the foundation stone within this Framework. Leadership supports and fosters a culture of continual learning and improvement: a culture that ensures patients are always at the center of care planning and delivery and where staff are supported to deliver the care they aim to deliver - safe, effective and compassionate care.

Leaders shape culture create the conditions and model the behavior necessary for quality to flourish. Governing board members, senior leaders, managers and clinical leaders must seek out and obtain all opportunities to visibly demonstrate their commitment to building a culture of quality; actively demonstrating the values of the service, regularly listening to patients and staff, seeking evidence of the quality of our services.

Leaders have the opportunity to be more than cheerleaders for improving quality of care; they can be active participants.

Key challenges in leadership and governance for quality in Ethiopia:

1. Frequent turnover of leadership
2. Lack of shared vision by management.
3. Lack of commitment.
4. Lack of skill in clinical leadership.
5. Corruption.
6. Lack/ Shortage of resourcesto fund QI projects and strengthen the CG and QI unit.
7. Lack of engaging staffs in hospital quality improvement.
8. Lack of data use to make decision.
9. Lack of accountability.

Key intervention:

1. Prioritizing a shared vision focused on quality and constantly communicated to everyone
2. Committing to building values, beliefs and norms that support quality care
3. Setting clear prioritized aims, objectives and expected outcomes for quality
4. Building and supporting clinical leadership across the system
5. Effectively engagesenior Experts and staff to improve care and work environment
6. Engaging with patients to ensure the service is built around their ideas and priorities.
7. Committing resources to fund leadership positions for quality improvement and supporting sustainable improvements in quality.
8. Preparing an action plan based on the quality improvement frame work.
9. Leverage insurance to incentivize staffs
10. using community forum feedbacks for quality planning and improvement

Driver 3. Transform and engage the health workforce

Positive staff engagement is critical to achieving high quality care. Evidence shows that services whose staff are engaged report better patient experiences, fewer errors and higher staff morale. There is a need to guide and support services in promoting meaningful staff engagement and ensuring that, similar to patients, the voices of staff are heard across organizations and used to inform improvements. An engaged workforce is one where staff are valued, listened to and provided with the tools, resources and skills to do meaningful work. The culture of an engaged organization will facilitate and encourage participation and front-line ownership by staff in the creative design, delivery and improvement of services and says thank you for a job well done.

Gaps in staff engagement, satisfaction and knowledge in Ethiopian hospitals

1. Lack of staff motivational mechanisms like staff recognition, incentives, conducive Environment
2. Lack of staff accountability
3. Poor knowledge and skill of health care providers
4. High turnover of staffs.
5. Lack of staff engagement in quality projects
6. Lack of staff self-development
7. Poor knowledge of rights and duties.

Key solutions:

1. Conducting staff needs assessment from period to period to see their needs in transport, food service, payment, team work, and so on
2. Addressing problems that are relevant to the staff needs.
3. Supporting the culture of continuous learning and development
    a. Training staff to serve as coach, trainers and mentors for hospital staffs
    b. Creating a skills lab in the hospital so that staffs can have onsite training on important skills
    c. Sensitization of all staffs about quality improvement and building their skill and knowledge
    d. Creating grand round sessions, morning presentations, forums to discuss about data from the hospital and others where by staffs discuss issues relevant to their hospital
4. Recognitions of staffs for their achieving
5. listening, hearing and valuing staff feedback and acknowledging their unique contribution to fulfilling the vision of the organization.
6. Encouraging staff to be involved in decision making and creative problem solving in delivering quality improvements.
7. Supporting team work and promoting a culture of respect, integrity, trust and open communication
8. Promoting the health and wellbeing of staff and creating a healthy workplace environment

9. Providing coaching and mentoring to staff who undertake new roles and responsibilities.
10. Meeting and exceeding the standards listed in EHSTG chapter 17 about human resource.
11. Creating opportunities for staff self-development.
12. Incorporating quality improvement activities as part of Job Description

Driver 4- Ignite demand for quality.

Engaging and involving patients in the design, planning and delivery of all care demonstrates a commitment to person centered care. It ensures that care is appropriate to patients' needs and is respectful of their preferences. Engagement builds a culture of listening to and learning from the care experiences of patients and their families. Focusing and delivering on the outcomes that matter to patients can only be achieved through meaningful engagement and partnership with patients, careers and their families

Key gaps in community Empowerment

1. Patients are not empowered to seek high quality care
2. Lack of engagement of patients and their families in improvement activities
3. Poor health literacy among patients
4. Week grievance handling mechanism

5. Clients feedback is not used for decision making
6. Lack of community ownership

Key interventions:

1. Establishing/strengthening a health literacy unit that empowers patients by educating them about their illness. Eg. In a hypertension clinic, a staff from this unit will talk about the number of visits patient's needs, adequate control of blood pressure, important investigation and what their interpretation, side effects of drugs and so on.
2. Establishing active patient groups and using them in designing service delivery and other improvement activities.
3. Using community score card.
4. Training of staffs in ethics, informed consent and autonomy.
5. Acknowledging patients as partners in their own care.
6. Providing care that is coordinated.
7. Supporting patients, families and communities to participate in service design and delivery of care.

Driver 5- System/Service re-design

There are few hospitals in the country, and they are overcrowded. Many health facilities, like primary hospitals and health centers lack essential services hence they refer cases that could otherwise be managed at lower level. People scape primary health care due to several reasons. And many hospitals also fail to provide care for services that their local community demands due to shortage of space and other reasons.

Gaps in the health system design

1. hospitals have shortage of beds and Inefficient use.

2. Weak referral system.
3. Hospitals do not provide essential services that are relevant to the community they serve.
4. Lack of standardized care.

Possible interventions,

- The CG and QI should use hospital data to analyze the number of patients that receive care in their facility, their illness, number and origin of referral ins and referral out and design mechanism to mitigate an identified gap
- Supporting nearby facilities to initiate services depending on the need minor surgeries and others to reduce referral.

Initiating new services in these hospitals based on analysis of referral out. These include dental care, ophthalmology, psychiatry and so on.

Roles andResponsibilities

Medical Services General Directorate

1. Establish and chair the national Learning Health Facility technical working group.
2. Advocate and influence ministry’s higher officials, regional health bureaus’ heads and all Ministry’s JSC members.
3. Attending, Chairing and overseeing all the nationally organized meetings.

Health service quality Directorate

1. Assign permanent senior technical or focal person who will be contacted regarding overall project's activities and implementation. status Evaluating and approving project's operational plan and requested resources
2. Setting, revising and approving criteria or standards used to select, prepare and establish Learning Health Facilityin Ethiopia
3. Mobilizing all the necessary and required resources for the effective and successful implementation of initiative's operational plan which includes requested materials, financial and technical supports.
4. Evaluate, discuss and take actions on project's performance reports, analytical findings and provide written feedbacks to concerned bodies.
5. Recognizing, registering and preparing workshops for sharing graduated QI projects on facilities.

Regional Health Bureau

1. Actively engage in selecting Facilities
2. Establish Learning health facilities Supporting team
3. Regularly follow the progress of the project in the regional senior management meeting by making the initiative's implementation status to be standing discussion agenda

Learning Health Facilities

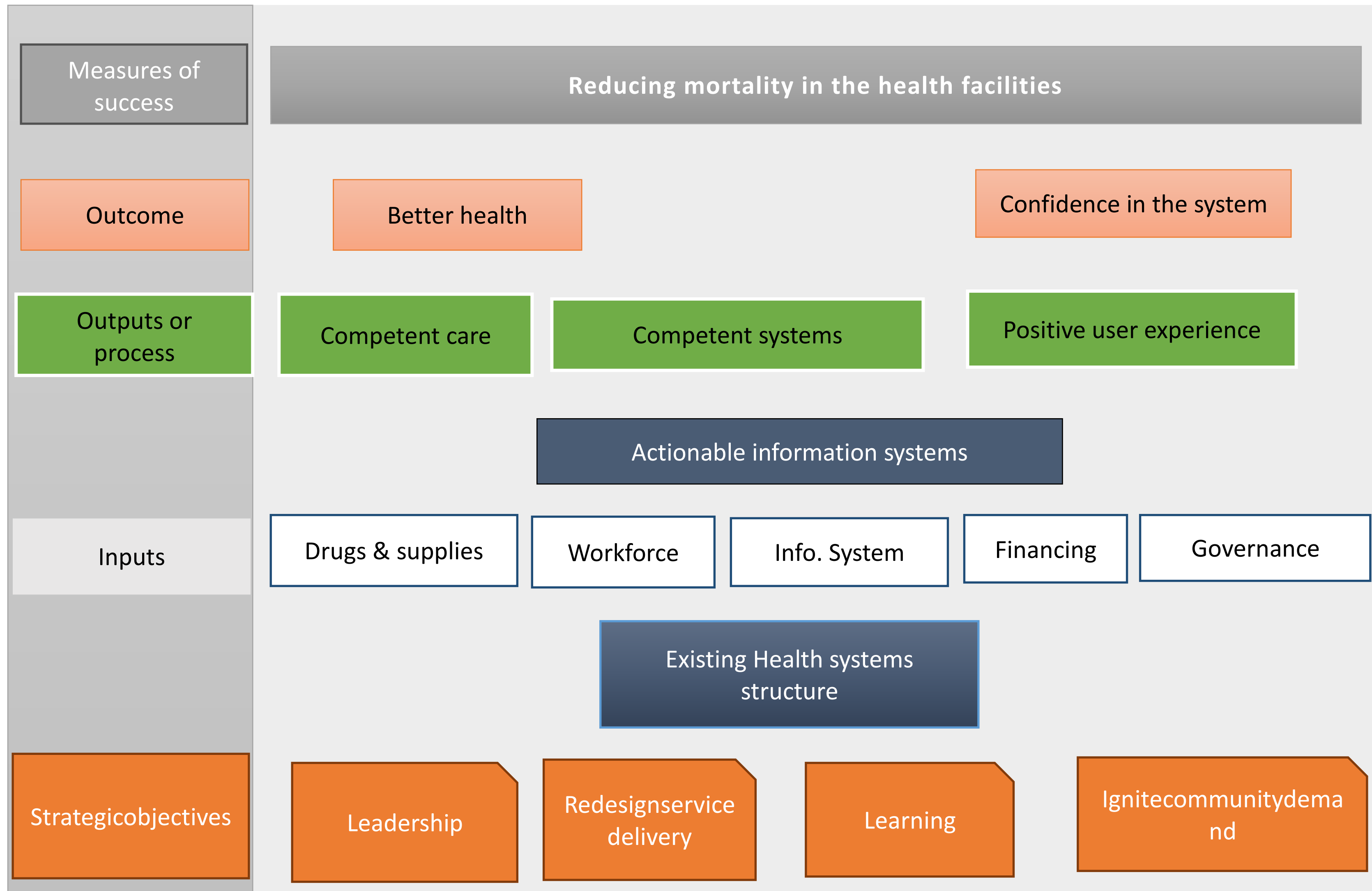
1. Assess and develop improvement plan based on the identified gaps

2. Executing QI projects based on Identified gaps.
3. Implement all the recommendations and guidance provided by both RHB and FMOH.
4. Sharing Hospitals requested documents and performance reports timely with RHB and FMOH.
5. Attend and actively participate in the Initiatives review meetings.
6. Assign focal person who will be contacted and asked updates on the initiatives implementation.

Support package

1. Technical support
2. Supportive Supervision
3. Need based training
4. Mentorship
5. Financial support
6. Material support

Monitoring and Evaluation framework



Learning health facilities

1. should send Complete and timely DHSI2 data monthly.
2. Should share the baseline evaluation results of data quality and assessment results within a month of launching of the initiative.
3. Must present the initiatives progress on review meetings.

Appendixes

Appendix 1: Assessment checklist for framework

Learning Health Facility Framework assessment tool						
		Standard	Method of evaluation	Yes	No	Remark
Data quality and use	1	The hospital QI unit is staffed with adequate number of professional. The QI unit has different professional mix	• Interview the quality unit head • View updated list of QI team members with their specific job description			
	2	The hospital displays its performance by using dashboard for hospital leaders and the hospital community(staff and Clients) at different service points .	• check the display			
	3	The hospital has an HMIS monitoring team or equivalent which collaborates with the CG & QIU in reviewing HMIS , KPI and fills DHIS2 and takes action to address any areas of concern	• View TOR of Monitoring/reviewing team view minutes of last 6 monitoring or reviewing team meetings to confirm indicators are reviewed and action taken as result • Check for the complete filling of the DHIS2			
Leadership	4	The hospital creates shared vision among the hospitals staffs	• interview staffs about the hospitals vision and priority activities of the plan.			
	5	The hospitals has clinical governance and quality improvement strategic plan	• View weather the clinical Governance and quality improvement strategy ensure the safety and risk management clinical effectiveness professional competence patient focused care patient and public involvement			

	7	The hospital involves senior staffs to improve care and work environment	• Interview the CEO/CCD/CED regarding participation of senior staffs in quality improvement activities. • Interview the senior staffs in the hospital about the quality improvement projects of the facility			
	8	The hospital introduces its annual plan for staffs	check the documents, interview randomly selected 10staff on their knowledge about the hospital annual plan.			
	10	The hospitals assesse staff needs to be fulfilled to make the working environment and conditions fertile to provide quality health care	view the assessment reports interview staffs whether their need are			
transform health workforce	11	The hospital assesses skill gaps and has established skill lab	visit skill lab			
	12	the hospital has established a system recognizes staffs for their best performance.	review the report of recognition event interview the staffs			
	13	The hospital has a system of inducing newly recruited staffs	Review the relevant document or Videos			
	14	The hospital has established Health literacy unit to give health education for clients by different methods	review materials used for health education like videos,audios, pictures and manuals			
Ignite community demand for quality care	15	the hospital uses community scorecard	review relevant documents			

	16	the hospital promotes patients associations and active patients in providing health education for patients	interview the CEO/CED/CCD			
	17	the hospital has analyzed to ten referrals in and out to redesign the service according to community need	review relevant documents			
Service redesign	18	the hospital supports other hospitals and health centers	review relevant documents			

Annex 2: Data quality assessment tool

Data Verification and System Assessment Sheet - Regional Site					
Regional Site/Organization:	-				
Region:	-				
Indicator Reviewed:	-				
Date of Review:	-				
Reporting Period Verified:	-				
Component of the M&E System		Answer Codes: Yes - completely Partly No - not at all N/A	REVIEWER COMMENTS (Please provide detail for each response not coded "Yes - Completely". Detailed responses will help guide strengthening measures.)		
Part 1: Data Verifications					
A - Recounting reported Results:					

Recount results from the periodic reports sent from the Districts to the Region and compare to the value reported by the Region. Explain discrepancies (if any).			
1	Re-aggregate the numbers from the reports received from all Service Delivery Points. What is the re-aggregated number? **[A]**		
2	What aggregated result was contained in the summary report prepared by the Intermediate Aggregation Site (and submitted to the next reporting level)? **[B]**		
3	**Calculate the ratio of recounted to reported numbers.[A/B]**	-	
4	What are the reasons for the discrepancy (if any) observed (i.e., data entry errors, arithmetic errors, missing source documents, other)?		
B - Reporting Performance:			
Review availability, completeness, and timeliness of reports from all Districts within the Region. How many reports should there have been from all Districts? How many are there? Were they received on time? Are they complete?			
5	How many reports should there have been from all Districts? **[A]**		
6	How many reports are there? **[B]**		
7	Calculate % **Available Reports[B/A]**	-	

8	Check the dates on the reports received. How many reports were received on time? (i.e., received by the due date). **[C]**				
9	Calculate % **On time Reports** **[C/A]**	-			
10	How many reports were complete? (i.e., complete means that the report contained all the required indicator data*). **[D]**				
11	Calculate % **Complete Reports** **[D/A]**	-			

Part 2. Systems Assessment

I - M&E Structure, Functions and Capabilities			
1	There are designated staff responsible for reviewing the quality of data (i.e., accuracy, completeness and timeliness) received from sub-reporting levels (e.g., service points).		
2	There are designated staff responsible for reviewing aggregated numbers prior to submission to the next level (e.g., to the central M&E Unit).		
3	All relevant staff have received training on the data management processes and tools.		
II- Indicator Definitions and Reporting Guidelines			

	The M&E Unit has provided written guidelines to each sub-reporting level on …		
4	,,, *what* they are supposed to report on.		
5	… *how* (e.g., in what specific format) reports are to be submitted.		
6	… *to whom* the reports should be submitted.		
7	… *when* the reports are due.		
	III- Data-collection and Reporting Forms / Tools		
8	Clear instructions have been provided by the M&E Unit on how to complete the data collection and reporting forms/tools.		
9	The M&E Unit has identified standard reporting forms/tools to be used by all reporting levels		
10	….The standard forms/tools are consistently used by the Service Delivery Site.		
11	All *source documents* and *reporting forms* relevant for measuring the indicator(s) are available for auditing purposes (including dated print-outs in case of computerized system).		

	IV- Data Management Processes		
12	Feedback is systematically provided to all service points on the quality of their reporting (i.e., accuracy, completeness and timeliness).		
13	If applicable, there are quality controls in place for when data from paper-based forms are entered into a computer (e.g., double entry, post-data entry verification, etc).		
14	If applicable, there is a written back-up procedure for when data entry or data processing is computerized.		
15	If yes, the latest date of back-up is appropriate given the frequency of update of the computerized system (e.g., back-ups are weekly or monthly).		
16	Relevant personal data are maintained according to national or international confidentiality guidelines.		
17	The recording and reporting system avoids double counting people *within* and *across* Service Delivery Points (e.g., a person receiving the same service twice in a reporting period, a person registered as receiving the same service in two different locations, etc).		
18	The reporting system enables the identification and recording of a "drop out", a person "lost to follow-up" and a person who died.		
19	There is a written procedure to address late, incomplete, inaccurate and missing reports; including following-up with service points on data quality issues.		

20	If data discrepancies have been uncovered in reports from service points, the Intermediate Aggregation Levels (e.g., districts or regions) have documented how these inconsistencies have been resolved.				
V - Links with National Reporting System					
17	When applicable, the data are reported through a single channel of the national reporting system.				
21	When available, the relevant national forms/tools are used for data-collection and reporting.				
22	The system records information about where the service is delivered (i.e. region, district, ward, etc.)				
23	….if yes, place names are recorded using standarized naming conventions.				

Part 3: Recommendations for the Intermediate Aggregation Level

Based on the findings of the systems' review and data verification at the intermediate aggregation site, please describe any compliance requirements or recommended strengthening measures, with an estimate of the length of time the improvement measure could take. See systems assessment functions by function area (table below) for review of system). Action points should be discussed with the Program.

	Identified Weaknesses	Description of Action Point	Responsible(s)	Time Line

1				
2				
3				
4				

Annex 3 Data Use

PART 3: Data use assessment in Health facilities

SN	Indicators	Possible Points	Points Given	Remarks
1	**Performance management team (PMT) is in place and established according to national standard** • PMT is in place and the members are put together based on the national standard – 2.5 points • PMT is in place but the members are not put together based on the national standard – 1.5 point • PMT is not established at all – 0 points Define the PMT membership as per the national standards	2.5		
2	**PMT is convening on monthly basis** • PMT has met for six or more times in the last six months - 3.75 points • PMT has met for five times in the last six months – 2 points • PMT has met four or less times in the last six months – 1.25 points • PMT has not met in the last three months – 0 points	3.75		
3	**PMT is chaired by the head of the health facility as per the national standard** • All the PMT meetings in the last six months were chaired by the head of the WoHO – 1.25 point • At least three PMT meetings in the last six months were chaired by the head of the WoHO – 0.75 point • Less than three of the PMT meetings in the last six months were chaired by the head – 0 point	1.25		
4	**PMT is reviewing key performance indicators**			

4.1	**The health facility is tracking key quality and equity indicators from the transformation plan** • Health quality and equity indicators are included in the list of indicators being tracked -5 points • Either quality or equity indicators are included in the list of indicators being tracked -2.5 points • There are no quality or equity indicators in the list of indicators being tracked – 0 points For equity: measure if there is documented information that shows comparison of key performance indicators disaggregated by age and sex There is documented evidence that shows tracking key quality indicators	5		
4.2	**Plan versus achievement based on the key indicators** • There is documented information that shows comparison was made between what is planned and what is achieved on the key indicators six times in the last 6 months- 7.5 points • There is documented information that shows comparison was made between what is planned and what is achieved on the key indicators five times in the last 6 months- 5 points • There is documented information that shows comparison was made between what is planned and what is achieved on the key indicators four or less times in the last 6 months- 2 point • There is no documented information that shows comparison is made between what is planned and achieved based on the key indicators - 0 points	7.5		

4.3	Performance gaps are identified by comparing achievement against target	2.5		
4.4	**Root cause analysis is done for low performing key indicators** • Root cause is identified for all low performing key low performing indicators – 2.5 points • Root cause is identified for only some low performing indicators – 1.5 points • Root cause is not identified for all the low performing indicators – 0 points	2.5		
4.5	**Action plan is prepared for the identified priority problems/challenges** • Action plan (with roles and responsibilities, resources and timeline) is prepared for all the identified priority problems/challenges – 7.5 points • Action plan is prepared for some of the identified priority problems – 3 points • Action plan is not prepared at all – 0 points	7.5		
4.6	**The action plan is being implemented** • There is documented evidence for actions taken – 5 points • No action is taken– 0 points	5		
4.7	**PMT action plan/meeting minutes were circulated to case teams** • PMT action plan/meeting minutes were circulated to case teams three times in the last three months – 5 points • PMT action plan/meeting minutes were circulated to case teams two times in the last three months – 2.5 points • PMT action plan/meeting minutes were circulated to case teams one time in the last three months – 1 point	5		

	• PMT action plan/meeting minutes were not circulated to the case teams at any point in the last three months – 0 Points			
5	**Written feedback was given to lower level supervisory unit or case teams on strengths and weaknesses based on the analysis** • Written feedback was provided to all lower level supervisory units six times in the last six month – 15 points • Written feedback was provided to all lower level supervisory units less than six times in the last three month – 12.5 points • Written feedback was provided to some lower level supervisory units six times in the last six month – 10 points • Written feedback was provided to some lower level supervisory units less than six times in the last six month – 8 points • The health facility has not provided written feedback to any of the lower level supervisory units or case teams - 0 points	15		
6	**The health facility has presented or disseminated at least one assessment findings in the last six months** • The health facility has conducted and disseminated at least one assessment finding in the last six months – 10 points • The health facility has presented at least one assessment findings but unable to disseminate in the last six months – 5 points • The health facility has not conducted or disseminated any assessment finding – 0 points The assessment could include client satisfaction survey, waiting time, case studies, case report, etc.	12.5		
7	**Every case team has a program performance monitoring chart** • All case teams have a performance monitoring chart - 12.5 points	12.5		

	• Only some of the case teams have a performance monitoring chart – 7.5 points • Only the HMIS unit/case team has displayed a performance monitoring chart – 2.5 point • None of the case teams have a performance monitoring chart – 0 points Provide standard list of performance monitoring charts			
8	**The health facility has displayed information in the form of table, chart, etc. based on selected indicators in the health facility compound and in the community** • Information is displayed in the health facility compound and other community locations – 7.5 points • Information is displayed only in the health facility compound – 5 points • No information was displayed either in the health facility compound or other community locations – 0 points	7.5		
9	**Information dissemination materials such as a brochure or newsletter that shows the health facility's performance is printed and disseminated to the general public** • A brochure or newsletter that shows the health facility performance was printed and disseminated every quarter - 7.5 points • A brochure or newsletter that shows the health facility performance was printed and disseminated every six months – 5 points • A brochure or newsletter that shows the health facility performance was printed and disseminated annually – 2.5 point • No brochure or newsletter is printed and disseminated in the last twelve months - 0 point	7.5		

10	**Health facility held performance review meeting with stakeholders** • The health facility held review meeting twice in the last six months – 2.5 point • The health facility held review meeting once in the last six months – 1.5 point • The health facility did not held performance review meeting in the last six months – 0 point	2.5		
	Total score	**100**		

Annex 4: Core Quality measures,

S.N.	Data source	Indicator
1	HMIS	Institutional stillbirths*1000
2	HMIS	Institutional maternal deaths*100
3	HMIS	Early Institutional Neonatal Death Rate*1000
4	HMIS	Inpatient mortality rate*100
5	HMIS	Viral load suppression among patients on ART
6	HMIS	Early viral load suppression rate
7	HMIS	TB cure rate * 100
8	HMIS	TB re-treatment rate * 100
9	HMIS	Death rate among TB cases * 100
10	HMIS	Treatment outcome of neonates admitted to NICU (Mortality) 100

11	HMIS	Treatment outcomes for management of severe acute malnutrition in children under 5 year * 100
12	HMIS	Mortality rate in intensive care unit (ICU) *100
13	HMIS	Emergency unit/Department MortalityY *100
14	HMIS	Proportion of pregnant women tested for syphilis during ANC *100
15	HMIS	Proportion of low birth weight or premature newborns for whom KMC was initiated after delivery
16	HMIS	Percentage of HIV-positive pregnant women who received ART for PMTCT during L&D *100
17	HMIS	Percentage of infants born to HIV-infected women who were started on co-trimoxazole prophylaxis within two months of birth *100
18	HMIS	Proportion of asphyxiated neonates who were resuscitated (with bag & mask) and survived *
19	HMIS	Percentage of women tested positive with acetic acid (VIA) and treated for cervical lesions *
20	HMIS	ANC dropout * 100
21	HMIS	Immunization dropout rate from penta 1 to penta 3 * 100
22	HMIS	ART retention rate * 100

23	HMIS	Leprosy treatment completion rate * 100
24	HMIS	Lost to follow up rate among new all forms of TB cases
25	HMIS	Proportion of pregnant and lactating women (PLW) screened for acute malnutrition
26	HMIS	Proportion of Sexually Transmitted Infection (STI) cases tested for HIV *
27	HMIS	TB case detection rate *100
28	HMIS	Drug Susceptibility Test (DST) coverage for TB patients
29	HMIS	HIV screening for TB patients * 100
30	HMIS	TB Screening for HIV positive Clients * 100
31	HMIS	Proportion of women age 30-49 screened for cervical cancer with visual inspection with acetic acid (VIA)

32	HMIS	AMBULANCE SERVICE RESPONSE RATE *
33	HMIS	REFERRAL RATE *
34	HMIS	Percentage of occupied beds during the period under review(Bed Occupacy rate)
35	HMIS	C-section rate * 100
36	HMIS	Immediate postpartum contraceptive acceptance rate (IPPCAR)
37	KPI	KPI 17: Births by surgical, instrumental or assisted vaginal delivery
38	KPI	KPI 6: Emergency room attendances with length of stay > 24 hours
39	KPI	Waiting time for surgeryKPI 7: Delay for elective surgical admission
40	KPI	KPI 13: Mean duration of in-hospital pre-elective operative stay(Number)
41	KPI	Surgical safety: KPI 15: Anesthetic adverse outcome
42	KPI	HOSPKPI15 - Number of inpatients who develop a new pressure ulcer during the reporting period (KPI)

43	KPI	ER timely action HOSPKPI09 -KPI 5: Emergency room patients triaged within 5 minutes of arrival
44	KPI	KPI 3: Outpatient waiting time to Consultation (in minutes)
45	KPI	KPI 16: Proportion of women Survived from PPH
46	KPI	KPI 11: Peri-operative Mortality
47	KPI	Patient satisfaction (KPI) (%)
48	KPI	KPI 18: Percentage of Clients with 100% prescribed drugs filled
49	KPI	Number of women who have received TT2/TT4 *
50	KPI	KPI 9: Surgical site infection rate (in %)
51	KPI	KPI 21: Blood unavailability ratio for surgical patients
52	KPI	KPI 4: Outpatients not seen on same day

53	KPI	KPI 24: Staff satisfaction