Execution Theory: Ethiopian Health Care Quality Initiative

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5 Core Components

1. Aim
2. Content Theory
3. Execution Theory
4. Measurement Plan
5. Dissemination Plan
Execution Theory

What will the improvement initiative do that will lead teams to adopt process changes?

Execution theory is defined as the rationale for how the experience provided by the improvement initiative (KP 1), the teaching and other activities delivered (KP 2), and the learning accomplished leads to improvement in the process (KP 3) or outcome (KP 4) measures.
Steady progress in overall maternal and child health in Ethiopia over the last ten years.

However, mortality rates for mothers and newborns remain unacceptably high.

Ethiopia Health Care Quality Initiative is a joint initiative by Ethiopian FMOH with IHI support.

Goal to achieve 30% reduction in facility-level maternal and neonatal mortality within 30 months using a multi-armed approach.
Program Components

• **Creation of Ethiopian National Health Care Quality Strategy** with the Ethiopian FMOH
  - Aligned with the Ethiopian Health Sector Transformation Plan (HSTP)
  - Builds on the existing initiatives in the country which focus on quality and equity

• **Activate a culture of continuous improvement** at all levels of the healthcare system
  - Through multi-level QI capability building training activities

• **Launch and test large-scale results-focused collaboratives** in maternal and neonatal health
  - Demonstrate impact of QI methods to accelerate change in key priority area
Reduce maternal and neonatal facility-based mortality in participating sites by 30% over a period of 30 months.

Increased Health Seeking Behavior
- Optimize the ability of the HEW to educate the community
- Community Engagement for awareness creation and positive influence
- Use culturally acceptable strategies to improve dissemination and uptake of key health messages
- Create positive experiences through every health encounter

Improved mechanisms to reach appropriate level of health care facility
- Improved referral network
- Improving transportation mechanisms (ambulance and others) for immediate response
- Maximizing the potential of nearby health facilities to avoid unnecessary referral
- Create a culture of QI and leadership

Improved quality of care at health institutions (safe, effective, patient-centered, timely, efficient, equitable)
- Availability of skilled and respectful health personnel
- Improve the reliability of the supply chain management system to deliver essential commodities all the time
- Availability of national guidelines, clinical protocols and job aids
- Timely identification, prevention and management of life threatening conditions to mothers and newborns
- Support for a care delivery system that ensures respectful care for patients

Utilize the Health Development Army structure to reach the household
- Use schools as a dissemination mechanism
- Use multimedia for Health education activities
- Use each facility visit to educate/counsel mothers towards raising their health seeking behavior
- Improved experience at care

Create structure (QI teams, committees, plan) to facilitate and execute work
- Improve data quality through DQA’s
- Create a learning platform for collaboration and routine use of data for improvement
- Increase the skills of health professionals and health managers to use QI methods and tools
- Organize learning collaborative among health facilities serving the same geographic areas (full Woreda Coverage)

Training in key MNH national protocols
- Onsite mentorship to maintain skills and address skills gaps
- Maximize efficiency of existing facility staff
- Professionals get regular updates on the management and prevention of key causes of mortality
- Address gaps in essential commodities as defined in baseline assessment
- Dissemination of existing protocols and support for local development when necessary
- Fast tracking/triaging/follow-up mechanism
- Reliable implementation of labor and delivery bundle
- Reliable implementation of the “MNH” checklists/relevant guidelines
- Incorporation of compassionate and respectful care (CRC) change ideas and training in learning sessions
- Clean, safe, comfortable spaces for patients and staff
Execution Considerations

Planning from the start for:

- Scale-up
- MOH ownership and sustainability
- Integration of QI and clinical skill building
- Adapting model to different regional contexts
**EXECUTION THEORY: LOGIC MODEL**

**Inputs**

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**Activities**

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<td>-Conduct assessment of current health system with regard to data systems: leadership and functionality; existing QI initiatives</td>
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<td>-Co-develop strategy with FMOH, inclusive of implementation guidelines and evaluation metrics and development of a Patient Rights Charter</td>
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**Improvement Collaboratives**

| Set-Up: Define clinical bundles and select core indicators with MOH approval; create all QI coaching/clinical mentorship tools, create program monitoring and implementation tools; analysis of existing strategies; baseline data collection; identify early adopters |
| Prototype Phase: Test promising changes with representative slice of health system via collaborative woredas in 3 regions (Oromia, Tigray, Amhara); test measurement system, leadership engagement, data system; test integrated clinical and QI mentoring |
| Test of Scale Phase: Expand to 21 woredas in 5 regions (Oromia, Tigray, Amhara, SNNPR, Ainar); continued mentoring of prototyping sites; test and further develop data systems and other infrastructure needs required for scale-up; engage test-of-scale implementing partner (TBD); test model of leveraging existing health structures for QI approach; begin integration with NQS |

**Team:** | Go to Full Scale: How-to guide for implementing change package nationally; QI fully integrated into health system structures |
| -QI team formation |
| -Ongoing QI team meetings and team activities e.g. testing of ideas, data collection etc. |
| -Increase knowledge and skills in QI |
| -Co-developed NQS document |

**Capacity Building**

| -20 FMOH and RHB QI coaches trained to support prototype |
| -15-30 IAs to lead and monitor quality activities nationally |
| -150 senior leaders with enhanced understanding of QI in healthcare |
| -Up to 180 skilled improvement coaches to lead QI teams |
| -Up to 150 regional, zonal, and district staff with bolstered QI leadership skills |
| -Up to 1,500 regional, district, and point-of-care staff with working knowledge of QI and capable of infusing it into standard review meetings |
| -150 trained data quality experts |

**Community Engagement And Education**

| -Work with public education development to create educational radio or TV dramas |
| -Engage HEWs to register pregnancies, promote ANC skilled deliveries, and PNC; build data collection and QI skills |
| -Develop client satisfaction feedback mechanism |

**Measurement And Evaluation**

| Baseline data, regular opportunities to reflect on progress toward aims |

**Assumptions**

What factors outside of the project may be a barrier or facilitator to reaching your desired outcomes?

External factors: What factors outside of the project may be a barrier or facilitator to reaching your desired outcomes?

Reduce maternal and neonatal facility-based mortality in participating sites by 30% over a period of 30 months.

**Ethiopia has made great progress reducing child mortality, however neonatal mortality rates remain high & maternal mortality rates have not moved since 2005.**

In partnership with the FMOH, we plan to use QI to accelerate improvement building on assets and strengths of Ethiopian health care system and working with partner organizations.

**Context**

**Office**

Space: Central office in Addis

**Staff:**

-Staff at central Addis Office

-International and US-based staff and faculty

**Operations:**

-Registration in Ethiopia

**Partners:**

-FMOH, RHBS, ZHB's, WoHO's
-10K -Evaluation partners: CPC, IDEAS

**Tools**

QI How to Guides (co-developed by IHI and Aurum Institute South Africa)

QI methodology tools harnessed from other projects

**Expected Outcomes**

-Improve health system performance in maternal/newborn care

**Assumptions**

What is necessary in order for this project to proceed and see results as planned?

FMOH, Regional, and woreda-level leadership, woreda-level change agent for joint coaching with IHI PO in prototype phase, engaged woreda-level coach in TOS phase, will for improvement at health facilities

**Explantory Notes**

Medium term Outcomes

-Improve reliability of care processes for maternal health:
  -Antenatal care
  -Promote early registration of pregnant mothers
  -Increase subsequent ANC visits
  -Screen, prevent and treat pregnancy-related conditions and complications e.g. APH, hypertension, HIV, Anemia, Malaria etc.
  -Labour & delivery
  -Increase % of skilled deliveries
  -ANMTSL
  -Provide compassionate and respectful care
  -Screen, prevent and treat L&D conditions/comlications e.g. obstructed labor, ruptured uterus, pre-eclampsia/eclampsia, PPH, PROM.

Postnatal Care

-Immediate breastfeeding
-Early postnatal care
-Routine subsequent postnatal care

**Long Term Outcomes**

-Improve reliability of care processes for newborn health:
  -Prevention of prematurity
  -Routine care of newborn
  -Screen and manage complications i.e. Pre-term care, Sepsis care, Asphyxia care etc.
  -Routine postnatal care including vaccinations

**Communities Engagement**

-Postnatal follow ups of mother/baby pair in the community
-Compassionate and respectful care at all levels of facility-based care

**Referral systems**

-Strengthen referral and transportation system
Component 1: Ethiopian National Healthcare Quality Strategy

ETHIOPIAN NATIONAL HEALTH CARE QUALITY STRATEGY

Transforming the Quality of Health Care in Ethiopia
2. Capability Building Activities

KEY

- IA Course
- QILM
- Leading & Facilitating
- Learning Sessions

FMOH Leadership across Directorates
FMOH Technical Staff for Quality Unit in MSD
RHB Head and Deputy Heads
Regional Health Bureau Technical Staff
Zonal Health Bureau Head
Zonal Health Bureau Staff
Woreda Health Office Head
Woreda Health MNCH Officer & Additional Officer (HEW Supporter/M&E Planning)
Health center heads and hospital QI leads
Facility QI Team Leaders & Data managers
Facility QI Team Staff
3. MNH Collaborative Aims

**Short-term Aim**
*End of Prototype Phase*
- Improve quality of antenatal care, delivery management, and postnatal care
- Improve management of complications related to leading causes of maternal and neonatal death
- Improve demand for care services through reduced delays in seeking and reaching quality care

**Medium-term Aim**
*End of Test-of-Scale Phase*
- Reduce maternal and neonatal facility-based mortality in participating sites by 30% over a period of 30 months

**Long-term Aim**
*End of 5 Years*
- Reduce maternal and neonatal mortality across Ethiopia by 30% over a period of 5 years

*Habits of Continuous Improvement* → *Culture of Continuous Improvement*
3. PHCU + Hospital Unit ("scalable unit")

1 Collaborative includes 7-11 QI teams (depending on # of participating hospitals)

- WHO sends 1-2 officials to participate in LS
- Referral Hospitals send 2 teams:
  - Neonatal (5 ppl)
  - Maternal (5 ppl)
  - Primary Hospitals (when present) send 1 team
- HC and linked HP send 1 team:
  - 3 ppl from HC
  - 1 from each HP

This includes Primary Hospital supported by L10K (for Agrarian regions)

HP = Health Post
3. Learning Collaborative Design

Address gaps in clinical and QI skills and supplies (training and procurement of essential supplies)

Action Period 1: Learning Session 1
Action Period 2: Learning Session 2
Action Period 3: Learning Session 3

Finalize change package, publicize & spread

Intensive coaching to support teams to improve system and skills gaps (visits, phone calls, engagement of program and supervisory managers, data collation & interpretation)

12-18 months
Framework for scale up

- **Set-up Phase**
  - Prototype/Pilot
  - Learnings incorporated into Design

- **Test of Scale**
  - Learnings incorporated into Design

- **Go to Full Scale**
  - Learnings incorporated into Design

- **Time (years)**
- **Receptivity/Will**
- **Infrastructure/Capability**

- **Size of gap and population at scale**

- Arrows indicate the flow and incorporation of learnings into design, progressing from set-up phase to test of scale and finally to go to full scale.
Program Scale-Up

Total Population:
Number of deliveries:

Aug 2015
Preparation and Operational Start

April 2016
Prototype Launch*
Five regions

Mar 2018
Test Scale Up
Five regions

~Mar 2019
National Scale Up
Eleven regions

<table>
<thead>
<tr>
<th>No Woredas/PHCUs:</th>
<th>5</th>
<th>19</th>
<th>100</th>
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<tbody>
<tr>
<td>No QI teams:</td>
<td>40</td>
<td>152</td>
<td>800</td>
</tr>
<tr>
<td>Primary Hospitals:</td>
<td>5</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td>Referral Hospitals:</td>
<td>5</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td>Health Centers:</td>
<td>25</td>
<td>95</td>
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<tr>
<td>Health Posts:</td>
<td>125</td>
<td>475</td>
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*Courses to build QI capability conducted in Oromia region in April 2016. National capability building ongoing throughout initiative.
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| **National Quality Strategy** | Individual health worker:
| - Conduct assessment of current health system with regard to: data systems: leadership and functionality; existing QI initiatives
| - Co-facilitate stakeholder sessions for syndication to gain buy-in
| - Co-develop strategy with FMoH, inclusive of implementation guidelines and evaluation metrics and development of a Patient Rights Charter |
| **Improvement Collaboratives** | **Screen, prevent and treat maternal health issues:**

| **Set-Up:** | **Antenatal care** |
| Define clinical bundles and select core indicators with MOH approval; create all QI coaching/clinical mentorship tools, create program monitoring and implementation tools; analysis of existing strategies; baseline data collection; identify early adopters |
| **Prototype Phase:** | - Promote early registration of pregnant mothers |
| Locally developed/tested change package; 150 health staff across three regions engaged in QI teams participating in collaboratives; learning shared across groups; methods for building needed infrastructure identified; full FMoH ownership |
| **Test of Scale Phase:** | - Increase subsequent ANC visits |
| Standardized process for integrating initiative into existing systems; standardized materials, including manual for coaching QI team meeting, reporting template; locally adapted QI training and reference materials printed for distribution |
| **Go to Full Scale:** | - Screen, prevent and treat L&D related conditions and complications e.g. APH, hypertension, HIV, Anemia, Malaria etc. |
| How-to guide for implementing change package nationally; QI fully integrated into health system structures |
| **Capacity Building** | **Labour & delivery** |
| - 20 FMoH and RHB QI coaches trained to support prototype |
| - 15-30 IAs to lead and monitor quality activities nationally |
| - 150 senior leaders with enhanced understanding of QI in healthcare |
| - Up to 180 skilled improvement coaches to lead QI teams |
| - Up to 150 regional, zonal, and district staff with bolstered QI leadership skills |
| - Up to 1,500 regional, district, and point-of-care staff with working knowledge of QI and capable of infusing it into standard review meetings |
| - 150 trained data quality experts |
| **Community Engagement And Education** | **Postnatal Care** |
| - Work with public education company to develop educational radio or TV dramas |
| - Engage HEWs to register pregnancies, promote ANC skilled deliveries, and PNC; build data collection and QI skills |
| - Develop client satisfaction feedback mechanism |
| **Measurement And Evaluation** | **Routine subsequent postnatal care** |
| Internal and external evaluation with development of operational research agenda to optimize local engagement |
| Baseline data, regular opportunities to reflect on progress toward aims |
| **National Quality Strategy** | **Improve reliability of care processes for newborn health:**

| - Assessment for strategy |
| - Co-developed NQS document |
| **Improvement Collaboratives** | - Prevention of prematurity |
| Set-Up: | - Routine care of newborn |
| Initial bundles ready for testing and core indicators selected; clear roles for stakeholders; early adopters engaged |
| Prototype Phase: | - Screen and manage complications i.e. Pre-term care, Sepsis care, Asphyxia care etc. |
| Locally developed/tested change package; 150 health staff across three regions engaged in QI teams participating in collaboratives; learning shared across groups; methods for building needed infrastructure identified; full FMoH ownership |
| Test of Scale Phase: | - Routine postnatal care |
| Standardized process for integrating initiative into existing systems; standardized materials, including manual for coaching QI team meeting, reporting template; locally adapted QI training and reference materials printed for distribution |
| Go to Full Scale: | **Referral systems** |
| How-to guide for implementing change package nationally; QI fully integrated into health system structures |
| **Capacity Building** | - Strengthen referral and transportation system |
| - 20 FMoH and RHB QI coaches trained to support prototype |
| - 15-30 IAs to lead and monitor quality activities nationally |
| - 150 senior leaders with enhanced understanding of QI in healthcare |
| - Up to 180 skilled improvement coaches to lead QI teams |
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| - 150 trained data quality experts |
| **Community Engagement And Education** | - Postnatal follow ups of mother/baby pair in the community |
| - Radio or TV program to spread messages related to Maternal Newborn health and/or respectful care processes |
| - Infusing it into standard review meetings |
| Community Engagement And Education | - Compassionate and respectful care at all levels of facility-based care |
| - Radio or TV program to spread messages related to Maternal Newborn health and/or respectful care processes |
| - Infusing it into standard review meetings |
| Measurement And Evaluation | - Improved data quality |
| Baseline data, regular opportunities to reflect on progress toward aims |

**Assumptions**

- What is necessary in order for this project to proceed and see results as planned?

FMoH, Regional, and woreda-level leadership, woreda-level change agent for joint coaching with IHI PO in prototype phase, engaged woreda-level coach in TOS phase, will for improvement at health facilities

**External factors**

- What factors outside of the project may be a barrier or facilitator to reaching your desired outcomes?

Turnover in health facilities, low health-seeking behaviors, low rates of facility deliveries, shifting baseline due to pastoral communities, political stability in regions of implementation

In partnership with the FMoH, we plan to use QI to accelerate improvement building on assets and strengths of Ethiopian health care system and working with partner organizations.
What factors outside of the project may be a barrier or facilitator to delivery?

Promote early registration of activities

Screen, prevent, and treat neonatal and maternal mortality.

In partnership with the FMoH, we plan to use QI to accelerate improvement building on assets and strengths of Ethiopian health care system and working with partner organizations.

EXECUTION THEORY: LOGIC MODEL

**Context**
Ethiopia has made great progress reducing child mortality, however neonatal mortality rates remain high & maternal mortality rates have not moved since 2005.

**Assumptions** - What is necessary in order for this project to proceed and see results as planned?
FMoH, Regional, and woreda-level leadership, woreda-level change agent for joint coaching with HFI PO in prototype phase, engaged woreda-level coach in TOS phase, will for improvement at health facilities

**External factors** - What factors outside of the project may be a barrier or facilitator to reaching your desired outcomes?
Turnover in health facilities, low health-seeking behaviors, low rates of facility deliveries, shifting baseline due to pastoral communities, political stability in regions of implementation

**Reducing child mortality**

- Increase knowledge and skills in QI, testing change ideas, collecting real time data for improvement and using data for decision making
- Increase clinical knowledge and skills
- Learn promising practices from peers

**Reduce maternal and neonatal facility-based mortality in participating sites by 30% over a period of 30 months**

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| Individual QI worker:<br>- Increase knowledge and skills in QI, testing change ideas, collecting real time data for improvement and using data for decision making<br>- Increase clinical knowledge and skills<br>- Learn promising practices from peers<br>Community:<br>- Increase care-seeking behavior for preventative and curative maternal/newborn care services (pre-conception, ANC, delivery, and PNC)<br>- HEWs increase tracking of data<br>Health System:<br>- National Quality Strategy to institutionalize sustainable QI<br>- Integration of quality structures and quality body<br>- Improved data quality<br>Labor and delivery<br>- Increase % of skilled deliveries<br>- Provide compassionate and respectful care<br>- Screen, prevent, and treat L&D conditions/complications (e.g. obstructed labor, ruptured uterus, pre-eclampsia/eclampsia, PPH, PROM, PPHN, Amniocentesis, Malaria etc.<br>Go to Full Scale:<br>- Regional level, IHI senior project officers, M&E officers<br>- In each phase, build leadership, managerial, and point of care capacity for QI approach; begin integration with NQS for scale<br>- Infusing it into standard review meetings<br>- Standardized process for coaching QI teams meeting, reporting template; standardized materials, including manual for integrating initiative into existing systems; 150 trained data quality experts<br>- Community Engagement and Education<br>- Engage HEWs to register pregnancies, promote ANC skilled deliveries, and PNC, build data collection and QI skills<br>- Develop client satisfaction feedback mechanism<br>- Measurement And Evaluation<br>- Baseline data, regular opportunities to reflect on progress toward aims
| Improve reliability of care processes for maternal health:<br>- Antenatal care<br>- Improve early registration for pregnant mothers<br>- Increase subsequent ANC visits<br>- Screen, prevent, and treat pregnancy-related conditions and complications (e.g. APH, hypertension, HIV, Anemia, Malaria etc.<br>Postnatal Care<br>- Immediate Breastfeeding<br>- Early postnatal care<br>- Routine subsequent postnatal care<br>Health System<br>- National Quality Strategy to institutionalize sustainable QI<br>- Integration of quality structures and quality body<br>- Improved data quality
| Improve reliability of care processes for newborn health:<br>- Prevention of prematurity<br>- Routine care of newborn<br>- Screen and manage complications (i.e. Pre-term care, Sepsis care, Asphyxia care etc.<br>Postnatal Care<br>- Immediate Breastfeeding<br>- Early postnatal care<br>- Routine subsequent postnatal care<br>Community engagement<br>- Postnatal follow ups of mother/baby pair in the community<br>- Compassionate and respectful care at all levels of facility-based care
| Referral systems<br>- Strengthen referral and transportation system
### Improve reliability of care processes for maternal health:

**Antenatal care**
- Promote early registration of pregnant mothers
- Increase subsequent ANC visits
- Screen, prevent and treat pregnancy-related conditions and complications e.g. APH, hypertension, HIV, Anemia, Malaria etc.

**Labour & delivery**
- Increase % of skilled deliveries
- AMTSL
- Provide compassionate and respectful care
- Screen, prevent and treat L&D conditions/complications e.g. obstructed labor, ruptured uterus, pre-eclampsia/eclampsia, PPH, PROM,

**Postnatal Care**
- Immediate breastfeeding
- Early postnatal care
- Routine subsequent postnatal care

### Improve reliability of care processes for newborn health:

- Prevention of prematurity
- Routine care of newborn
- Screen and manage complications i.e. Pre-term care, Sepsis care, Asphyxia care etc.
- Routine postnatal care including vaccinations

### Community engagement

- Postnatal follow ups of mother/baby pair in the community
- Compassionate and respectful care at all levels of facility-based care

### Referral systems

- Strengthen referral and transportation system
**Individual health worker:**
- Increase knowledge and skills in QI, testing change ideas, collecting real time data for improvement and using data for decision making.
- Increase clinical knowledge and skills
- Learn promising practices from peers and other change packages

**Team:**
- QI team formation
- Ongoing QI team meetings and team activities e.g. testing of ideas, data collection etc.

**Community:**
- Increase care-seeking behavior for preventative and curative maternal/newborn care services (pre-conception, ANC, delivery, and PNC)
- HEWs increase tracking of data

**Health System:**
- National Quality Strategy to institutionalize sustainable QI
- Integration of quality structures and quality body
- Improved data quality

**Assumptions** – What is necessary in order for this project to proceed and see results as planned?
FMoH, Regional, and woreda-level leadership, woreda-level change agent for joint coaching with IHI PO in prototype phase, engaged woreda-level coach in TOS phase, will for improvement at health facilities

**External factors** - What factors outside of the project may be a barrier or facilitator to reaching your desired outcomes?
Turnover in health facilities, low health-seeking behaviors, low rates of facility deliveries, shifting baseline due to pastoral communities, political stability in regions of implementation
National Quality Strategy

- Assessment for strategy
- Co-developed NQS document

Improvement Collaboratives

**Set-Up:** Initial bundles ready for testing and core indicators selected; clear roles for stakeholders; early adopters engaged

**Prototype Phase:** Locally developed/tested change package; 150 health staff across three regions engaged in QI teams participating in collaboratives; learning shared across groups; methods for building needed infrastructure identified; full FMoH ownership

**Test of Scale Phase:** Standardized process for integrating initiative into existing systems; standardized materials, including manual for coaching QI team meeting, reporting template; locally adapted QI training and reference materials printed for distribution

**Go to Full Scale:** How-to guide for implementing change package nationally; QI fully integrated into health system structures

**Inputs**

- National Quality Strategy
- Conduct assessment of current health system with regard to: data systems: leadership and functionality; existing QI initiatives
- Co-facilitate stakeholder sessions for syndication to gain buy-in
- Co-develop strategy with FMoH, inclusive of implementation guidelines and evaluation metrics and development of a Patient Rights Charter

**Activities**

- Improvement Collaboratives
  - **Set-Up:** Initial bundles ready for testing and core indicators selected; clear roles for stakeholders; early adopters engaged
  - **Prototype Phase:** Locally developed/tested change package; 150 health staff across three regions engaged in QI teams participating in collaboratives; learning shared across groups; methods for building needed infrastructure identified; full FMoH ownership
  - **Test of Scale Phase:** Standardized process for integrating initiative into existing systems; standardized materials, including manual for coaching QI team meeting, reporting template; locally adapted QI training and reference materials printed for distribution
  - **Go to Full Scale:** How-to guide for implementing change package nationally; QI fully integrated into health system structures

**Outputs**

- National Quality Strategy
- Assessment for strategy
- Co-developed NQS document

**Short term Outcomes**

- Individual health worker:
  - Increase knowledge and skills in QI, testing change ideas, collecting real time data for improvement and using data for decision making.
  - Increase clinical knowledge and skills
  - Learn promising practices from peers and other change packages

**Medium term Outcomes**

- Improve reliability of care processes for maternal health:
  - Antenatal care
  - - Promote early registration of pregnant mothers
  - - Increase subsequent ANC visits
  - - Screen, prevent and treat pregnancy-related conditions and complications e.g. APH, Hypertension, HIV, Anemia, Malaria etc.

- Labour & delivery:
  - Increase % of skilled deliveries
  - AMTS/L
  - Provide compassionate and respectful care
  - Screen, prevent and treat L&D conditions/complications e.g. obstructed labor, ruptured uterus, pre-eclampsia/eclampsia, PPH, PROM,

- Postnatal Care:
  - Immediate breastfeeding
  - Early postnatal care
  - Routine subsequent postnatal care

**Long term Outcomes**

- Improve reliability of care processes for newborn health:
  - Reduce maternal and neonatal facility-based mortality in participating sites by 30% over a period of 30 months.
**EXECUTION THEORY: LOGIC MODEL**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
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<tr>
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<td>-Assessment for strategy</td>
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<td>-Improve reliability of care processes for maternal health: Antenatal care</td>
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<td>Improve reliability of care processes for newborn health:</td>
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<td>-Routine care of newborn</td>
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<td>-Screen and manage complications i.e. Pre-term care, Sepsis care, Asphyxia care etc.</td>
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**Capacity Building**
-20 FMoH and RHB QI coaches trained to support prototype
-15-30 IAs to lead and monitor quality activities nationally
-150 senior leaders with enhanced understanding of QI in healthcare
-Up to 180 skilled improvement coaches to lead QI teams
-Up to 150 regional, zonal, and district staff with bolstered QI leadership skills
-Up to 1,500 regional, district, and point-of-care staff with working knowledge of QI and capable of infusing it into standard review meetings
-150 trained data quality experts

**Community Engagement And Education**
-Radio or TV program to spread messages related to Maternal Newborn health and/or respectful maternal care.
-Client satisfaction feedback standard materials

**Measurement And Evaluation**
-Baseline data, regular opportunities to reflect on progress toward aims

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External factors - What factors outside of the project may be a barrier or facilitator to reaching your desired outcomes?

Turnover in health facilities, low health-seeking behaviors, low rates of facility deliveries, shifting baseline due to pastoral communities, political stability in regions of implementation
**Executive Theory: Logic Model**

**Inputs**
- National Quality Strategy
  - Conduct assessment of current health system with regard to: data systems; leadership and functionality; existing QI initiatives
  - Co-facilitate stakeholder sessions for syndication to gain buy-in
  - Co-develop strategy with FMOH, inclusive of implementation guidelines and evaluation metrics and development of a Patient Rights Charter

**Activities**
- Improvement Collaboratives
  - Set-Up: Define clinical bundles and select core indicators with MOH approval; create all QI coaching/clinical mentorship tools, create program monitoring and implementation tools; analysis of existing strategies; baseline data collection; identify early adopters
  - Prototype Phase: Test promising changes with representative slice of health system via collaborative woredas in 3 regions (Oromia, Tigray, Amhara); test measurement system, leadership engagement, data system; test integrated clinical and QI mentoring
  - Test of Scale Phase: Expand to 21 woredas in 5 regions (Oromia, Tigray, Amhara, SNNPR, Afar); continued mentoring of prototyping sites; test and further develop data systems and other infrastructure needs required for scale-up; engage test-of-scale implementing partner (TBD); test model of leveraging existing health structures for QI approach; begin integration with NQS

**Outputs**
- National Quality Strategy
  - Set-Up: Define clinical bundles and select core indicators with MOH approval; create all QI coaching/clinical mentorship tools, create program monitoring and implementation tools; analysis of existing strategies; baseline data collection; identify early adopters
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**Context**
Ethiopia has made great progress reducing child mortality, however neonatal mortality rates remain high & maternal mortality rates have not moved since 2005.

In partnership with the FMOH, we plan to use QI to accelerate improvement building on assets and strengths of Ethiopian health care system and working with partner organizations.

**Assumptions**
- FMoH, Regional, and woreda-level leadership, woreda-level change agent for joint coaching with HI PO in prototype phase, engaged woreda-level coach in TOS phase, will for improvement at health facilities

**Outputs**
- National Quality Strategy
  - Program Monitoring and Implementation tools: analysis of existing strategies; baseline data collection; identify early adopters
  - Prototype Phase: Test promising changes with representative slice of health system via collaborative woredas in 3 regions (Oromia, Tigray, Amhara); test measurement system, leadership engagement, data system; test integrated clinical and QI mentoring
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**Improvement Collaboratives**
- Set-Up: Define clinical bundles and select core indicators with MOH approval; create all QI coaching/clinical mentorship tools, create program monitoring and implementation tools; analysis of existing strategies; baseline data collection; identify early adopters

**Prototype Phase**
- Test promising changes with representative slice of health system via collaborative woredas in 3 regions (Oromia, Tigray, Amhara); test measurement system, leadership engagement, data system; test integrated clinical and QI mentoring

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- Expand to 21 woredas in 5 regions (Oromia, Tigray, Amhara, SNNPR, Afar); continued mentoring of prototyping sites; test and further develop data systems and other infrastructure needs required for scale-up; engage test-of-scale implementing partner (TBD); test model of leveraging existing health structures for QI approach; begin integration with NQS

**Go to Full Scale**
- Fully leverage existing structures and meetings, add more scalable units within each of the existing 5 regions; expand to 3 new regions in first year; expanding to the remaining 4 regions in the second year; fully integrate with NQS

**Turnover in health facilities, low health-seeking behaviors, low rates of facility deliveries, shifting baseline due to pastoral communities, political stability in regions of implementation**
EXECUTION THEORY: LOGIC MODEL

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<td><strong>National Quality Strategy</strong> - Conduct assessment of current health system with regard to data systems: leadership and functionality; existing QI initiatives</td>
<td><strong>National Quality Strategy</strong> - Assessment for strategy</td>
<td>Individual health worker: - Increase knowledge</td>
<td>Improve reliability of care processes for maternal health: Antenatal care</td>
<td>Reduce maternal and infant mortality</td>
</tr>
<tr>
<td><strong>Staff:</strong> - Staff at central Addis Office - International and US-based staff and faculty</td>
<td><strong>Improvement Collaboratives</strong> - Co-facilitate stakeholder sessions for syndication to gain buy-in</td>
<td><strong>Co-developed NQS document</strong></td>
<td><strong>Facilitator</strong></td>
<td><strong>Facade</strong></td>
<td><strong>Reduce turnover</strong></td>
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<tr>
<td><strong>Operations:</strong> - Registration in Ethiopia</td>
<td><strong>Set-Up</strong> - Define clinical bundles and select core indicators with MOH approval; create all QI coaching/clinical mentorship tools</td>
<td><strong>Regional level, IHI senior project officers, M&amp;E officers</strong></td>
<td><strong>Medium term Outcomes</strong></td>
<td><strong>Facilitator</strong></td>
<td><strong>Reduce turnover</strong></td>
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<td><strong>Partners:</strong> - FMOH, RHBs, ZHB's, WoHO's - L10K - Evaluation partners: CPC, IDEAS</td>
<td><strong>Prototype Phase:</strong> - Test promising changes with representative slice of health system via collaborative woredas in 3 regions (Oromia, Tigray, Amhara); test measurement system, leadership engagement, data system; test integrated clinical and QI mentoring</td>
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<td><strong>Tools:</strong> - QI How to Guides (co-developed by IHI and Aurum Institute South Africa - QI methodology tools harnessed from other projects)</td>
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<td><strong>Capacity Building</strong> In each phase, build leadership, managerial, and point of care capacity needed for scale up to next phase via:</td>
<td><strong>Go to Full Scale:</strong> - Fully leverage existing structures and meetings, add more scalable units within each of the existing 5 regions; expand to 3 new regions in first year; expanding to the remaining 4 regions in the second year; fully integrate with NQS.</td>
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<td>- 9 L&amp;F course waves for WoHO, and facility-level staff</td>
<td><strong>Community Engagement And Education</strong> - Work with public education company to develop educational radio or TV dramas</td>
<td><strong>Medium term Outcomes</strong></td>
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<td>- 5 QILM courses for FMOH, RHB, and WoHO staff for each region</td>
<td>- Engage HEWs to register pregnancies, promote ANC skilled deliveries, and PNC; build data collection and QI skills</td>
<td><strong>Medium term Outcomes</strong></td>
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<td><strong>Reduce turnover</strong></td>
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<td>- 1-2 waves of IHI’s IA Course for coaches at the national and regional level, IHI senior project officers, M&amp;E officers</td>
<td>- Develop client satisfaction feedback mechanism</td>
<td><strong>Medium term Outcomes</strong></td>
<td><strong>Facilitator</strong></td>
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<td><strong>Reduce turnover</strong></td>
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<td>- 3 Senior Leaders’ QI Courses for leaders at the national level</td>
<td><strong>Measurement And Evaluation</strong> Internal and external evaluation with development of operational research agenda to optimize local engagement</td>
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<td>- 5 Data Quality Trainings at each prototype LS2 for facility-level staff working with data.</td>
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**Assumptions** – What is necessary in order for this project to proceed and see results as planned?

FMOH, Regional, and woreda-level leadership, woreda-level change agent for joint coaching with IHI PO in prototype phase, engaged woreda-level coach in TOS phase, will for improvement at health facilities

Turnover in health facilities, low health-seeking behaviors, low rates of facility deliveries, shifting baseline due to pastoral communities, political stability in regions of implementation
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### Assumptions
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- FMoH, Regional, and woreda-level leadership, woreda-level change agent for joint coaching with IHI PO in prototype phase, engaged woreda-level coach in TOS phase, will for improvement at health facilities

### External factors
- What factors outside of the project may be a barrier or facilitator to reaching your desired outcomes?
- Turnover in health facilities, low health-seeking behaviors, low rates of facility deliveries, shifting baseline due to pastoral communities, political stability in regions of implementation
Execution Considerations-Know your Context!

- Intentional pauses for learning and adaptation of intervention to strengthen execution and impact
- Operational approach
  - New IHI model
  - Local finance regulations that affect the way work is able to be executed
- Continuing meaningful and effective work in midst of security challenges in some regions
- Planning amidst changing funder priorities

#IHIFORUM
Execution Successes

- High levels of ministry ownership and engagement
- 150+ health system staff at all levels engaged in QI programming
- Successful LS1s with participation from staff at HP, HC, and hospitals
- Early successes during site coaching
Looking Ahead

- Completion of prototype collaboratives, regional change packages and model refinement
- Contextualizing approach to pastoralist communities
- Introduction of phase 2 design in Test of Scale with increased integration into existing system
Questions?