Situational analysis of WASH and quality in Ethiopia

November 2018; updated July 2019

Acronyms

CASH	Clean and Safe Health Facility
EHAQ	Ethiopian Health Facility Alliance on Quality
ENHQS	Ethiopian National Healthcare Quality Strategy
FMOH	Federal Ministry of Health
HCF	Health care facility
HEH	Hygiene and environmental health
IPC	Infection prevention and control
MNCH	Maternal newborn and child health
QI	quality improvement
QMU	Quality Management Unit
QOC	Quality of care
RHB	Regional Health Bureau
SDG	Sustainable Development Goals
WASH	Water sanitation and hygiene
WCO	World Health Organization country office
WHO	World Health Organization

Background

The availability of water, sanitation and hygiene (WASH) services in health care facilities, especially in maternity and primary-care settings where they are often absent, supports core universal health care aspects of quality, equity, and dignity for all people. Data published in 2019 by WHO/UNICEF show that globally, one in four health care facilities lack basic water services and one in five have no sanitation services, impacting 2.0 and 1.5 billion people respectively. Furthermore, 42% of health care facilities globally have no hand hygiene facilities at the point of care and 40% have no systems for segregation[1].

Globally, between 5.7 and 8.4 million deaths are attributed to poor-quality care each year in LMICs, which accounts for up to 15% of overall deaths in these countries[2]. Many countries are making efforts to invest in and improve the quality of health services, in tandem with efforts to achieve expanded coverage, building on commitments outlined in two World Health Assembly Resolutions (WHA69.24 and WHA64.9[3,4]), This approach involves an organized effort by all stakeholders to promote, plan, implement and account for improved quality of care. A recent call to action in a joint publication from the WHO, World Bank and OECD reinforces the necessity for all governments to take action to improve the quality of services and to develop a national direction on quality as a priority.[5] Improving access to and availability of WASH services is as an essential foundation for these efforts.[6]

Basic WASH services in health care facilities are fundamental to providing quality care and for ensuring that primary health commitments, as detailed in the Astana Declaration[7], are achieved. It can also improve health outcomes at the community level. In order to improve and sustain WASH services in health care facilities, a set of eight practical steps that countries can take at the national and sub-national level have been identified[8] (for the full list of steps, refer to Annex 1). The starting point and basis for many of the steps is to conduct a national situation analysis and assessment of WASH in health care facilities and the health system more broadly[9]. A situation analysis coupled with a recent assessment of WASH coverage levels in health care facility services provides a basis for planning and resource mobilization. It can also be used to set incremental targets toward the goal of universal access by 2030. For further information on the methodology for situational analyses, refer to the *methodology document (in press).*

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[1] WHO/UNICEF 2019. WASH in health care facilities. 2019 Global baseline report.
[2] High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health Commission on High-Quality Health Systems in the SDG era. https://www.hqsscommission.org/
[3] Resolution WHA64.9. Sustainable health financing structures and universal coverage. In: Sixty-fourth World Health Assembly, Geneva, 16–24 May 2011. Resolutions and decisions, annexes. Geneva: World Health Organization; 2011
[4] 1. Resolution WHA69.24. Strengthening integrated, people-centred health services. In: Sixty-ninth World Health Assembly, Geneva, 16–24 May 2016. Resolutions and decisions, annexes. Geneva: World Health Organization; 2016.
[5] http://www.who.int/servicedeliverysafety/areas/qhc/nqps_handbook/en/
[6] Delivering quality health services: a global imperative for universal health coverage. Geneva: World Health Organization, Organisation for Economic Co-operation and Development, and The World Bank; 2018
[7] Declaration of Astana. Global Conference on Primary Health Care. Geneva: World Health Organization, 2018.
[8] WHO/UNICEF (2019). *WASH in health care facilities. Practical steps for universal access to quality care.*
[9] For more information, refer to Practical Step 1

This report provides a summary of a situational analysis of WASH and quality in health care facilities in Ethiopia, conducted in November 2018[10] which builds upon an earlier analysis in 2016[11,12]. This analysis is part of a series conducted by WHO in three countries (Ethiopia, Ghana and Rwanda) between November 2018 and June 2019. The specific objectives of this analysis were to:

- identify key opportunities and barriers for WASH and quality improvements in health care facilities in relation to the eight practical steps;
- understand to what extent WASH is integrated with wider work on quality policies, strategies and initiatives, infection prevention and control, patient safety and maternal child health and quality of care initiatives;
- identify facility-level activities and challenges, particularly relating to quality improvement, accountability mechanisms and gain a better understanding of costs and financing mechanisms for WASH and quality improvements at the national and sub-national level;
- provide recommendations to improve implementation of WASH as part of the WHO Quality of Care network;
- review the findings and recommendations made in 2016 and progress made over the last three years, and to
- provide a set of updated recommendations for strengthening and sustaining an integrated and multisectoral approach to improving WASH in health care facilities.

The 2016 analysis explored how the Ethiopian Federal Ministry of Health (FMOH) was using WASH and infection prevention and control improvements to strengthen the overall quality of health services, improve patient satisfaction, hospital staff experience and change behaviors, with a particular focus on the Clean and Safe Health Facilities (CASH) initiative. It found that national leadership and commitment, multisectoral coordination of efforts, dedicated, regular financing and facility leadership were all important factors for improving WASH services in health care facilities. Box 1 outlines some of the key strengths and challenges that were found.

Strengths and successes	Challenges and bottlenecks
National level leadership for WASH and IPC Clean and Safe Hospital (CASH) initiative active and driving improvements Focus on behavior and attitudinal change Mentorship and peer-to-peer learning activities Patient, family and community engagement	Limited monitoring and accountability mechanisms Inadequate/inconsistent implementation of standards and policies Insufficient/inadequate Infrastructure Lack of dedicated facility-level budgets

Box 1: Strengths and challenges found during the 2016 assessment

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[10] A report from Ghana and Rwanda will be written after the assessments are completed in early 2019.
[11] WHO (2016) *Achieving quality universal health coverage through better water, sanitation and hygiene services in health care facilities: a focus on Ethiopia* http://www.who.int/water_sanitation_health/publications/uhc-thru-wash-services-ethiopia/en/
[12] WHO, 2017. *Achieving quality universal health coverage through better water, sanitation and hygiene services in health care facilities: a focus on Cambodia and Ethiopia* http://www.who.int/water_sanitation_health/publications/uhc-thru-water-sanitation-and-hygiene-services/en/

Method

Following the established "deep dive" methodology[13], the analysis begun with a rapid review of national policies and strategies relating to WASH, health systems strengthening and quality. A one-week joint mission between the Quality Systems and Resilience (QSR) and Water, Sanitation, Hygiene and Health (WSH) units, in collaboration with the Government of Ethiopia, WHO Ethiopia and WHO African Regional Office, subsequently took place in November 2018. The mission involved interviews with relevant Government departments (Quality Directorate and Hygiene and Environmental Health Directorate), facility visits to two hospitals in Addis Ababa (St Peter's and Gandhi Memorial Hospital), and a final debrief with the Quality Directorate (Federal Ministry of Health) and WHO Country Office to discuss and agree the proposed recommendations.

A full day was spent in each of the two facilities during which an informal walk through assessment of the facility was conducted followed by interviews with members of staff and a selection of patients and visitors. The purpose of the visits were to understand how policies are being implemented and applied, rather than a thorough assessment of WASH services (for a full list of people interviewed and questions asked, refer to Annex 2). A team of six local staff were hired to conduct interviews with patients, families and facility staff in Amharic. The team received a half-day orientation covering the objectives of the facility visits and interview questions. The team provided feedback on the proposed questions to adapt them further to the local context. The interview team transcribed and translated the interviews. Due to limited time in country, there was insufficient time to visit facilities outside of Addis. However, the same team had visited seven facilities during the 2016 mission and this analysis builds on those findings.

Results

"*The country is going through a shift in paradigm from access to quality. It's the difference between giving everyone a chair to sit on and making sure the chairs they sit on are comfortable. It's a systems issue*".
 - Head of Quality, Gandhi Memorial Hospital.

Overview of Ethiopia
▪ Large population (110 million) ▪ Recent change in Government (2018) ▪ Complex, decentralized health system (National, Regional, District/Woreda levels) ▪ Busy development sector (multiple actors, across all regions, competing priorities and overlapping sectors) ▪ Several programmes and initiatives (e.g. CASH, Quality of Care Network, EHAQ) which are active to varying degrees and not always sustained over time **Latest national estimates of WASH access in health care facilities[14]** **30%**   Basic water[15]

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[13] Refer to the Methodology paper, in press.
[14] To view all the country data and compare against other countries, visit https://washdata.org/data/healthcare.
[15] Improved, available and on premises.

59%	Basic sanitation[16]
64%	Basic waste management[17]
52%	Hand hygiene at points of care (no estimate for basic)
No data	Environmental cleaning

Table 2: Overview of Ethiopia and access (WHO/UNICEF JMP 2019)

National coordination, standards and accountability mechanisms

Although one of the key findings (and subsequent recommendation) in 2016, coordination at all levels continues to be a challenge. Establishing a joint WASH and health taskforce or technical working group with formally-defined terms of reference and membership could be an effective mechanism for coordinating implementation efforts and to develop a national roadmap, set targets and provide technical and political leadership.

The Ethiopian health system refers to multiple policies, strategies and guidelines. For a full list of relevant documents, refer to the 2016 report (page 18). Additional documents, released since 2016, include the National Hygiene and Environmental Health Strategy (HEH) (2016-20), Clean and Timely Care for Institutional Transformation (CATCH-IT), and new national infection prevention and control (IPC) guidelines which are due to be released later in 2019. The HEH strategy predominately focuses on community WASH but includes a small component on WASH in health care facilities. WASH, and the HEH strategy, is under the Hygiene and Environmental Directorate while IPC is the responsibility of the Quality Directorate. At the time of interview, the Quality Directorate was reportedly not aware of the existence of the HEH strategy, even though it references CASH several times. The total budget for achieving the ambitious Strategic Objective 4 (By 2020, ensure basic WASH in all institutions) is over 2.5 billion Ethiopian Birr (88.7 million USD). Funding is "*expected to come from regular government budget allocation, multilateral and bilateral sources, one WASH national program, fund raising mechanisms using a structured system and by engaging the community*". No further detail is given on how this will be achieved, whether sufficient budget has been allocated or what the breakdown of allocations will be for schools versus health care facilities.

The three main quality-related documents are the Health Sector Transformation Plan (2016 – 2020); Health Sector Transformation in Quality (2016-2020); and the Ethiopian National Health Quality Strategy (2016-2020). The Health Service Quality Directorate (HSQD) has oversight of these strategies however it reportedly has no designated funds to do so, so has to rely on funding requests to other directorates, regional health bureaus, or from the central SDG fund. Because of this funding problem, quality initiatives are not consistently rolled out throughout the health system, so some regions end up implementing activities while others are not able to secure funding. It was noted that implementation of these policy documents is a serious challenge due to lack of coordination, insufficient budget, training,

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[16] Improved, usable, dedicated for staff, sex-separated with menstrual hygiene facilities, and adapted for limited mobility
[17] Waste segregated and treated and disposed of safely.

monitoring, reporting and human resources. The Health Service Quality Directorate did mention, however, that CASH could reinvigorate the national quality agenda. Further, re-establishing the quality directorate steering committee would also enable improved coordination across sectors, levels of the health system and partners. This was noted as a priority.

Monitoring

In the WHO/UNICEF 2019 Sustainable Development Goals baseline report on WASH in health care facilities, Ethiopia had a significant amount of data, drawing upon 9 nationally representative assessments (4 PMA2020s, 2 EMONCs, 1 SARA and 1 World Vision report)[18]. While these national assessments provide valuable data, routine monitoring of WASH in health care facilities is also needed. Thirteen WASH indicators relating to the Hygiene and Environmental Health Strategy (covering community and health care facility aspects) have recently been included into the e-HMIS and these will be transferred to the DHIS2. There remains confusion about DHIS2 in some facilities - whether or not it is active, how it will replace existing monitoring mechanisms at the facility level and how the data will be used. Clearer communication is needed at all levels.

Facilities are required to monitor a large number of indicators, including but not limited to Key Performance Indicators[19], the CASH audit tool and HMIS. Such extensive monitoring places a high burden on facilities, who frequently do not have sufficient personnel to fulfil what is expected of them. At one facility, they had been reporting directly to the FMOH every week for 20 weeks on eight domains and had not yet received any feedback, saying: *"if you don't get a response back, you get frustrated by having to provide data".* They felt that monitoring is a "quick win" to provide accountability and motivation for staff, but only if the process was two-way between facilities and the FMOH. Other facilities were happy with DHIS2, using it for their own internal monitoring purposes as well as to report to the federal level. Facilities should be empowered to select relevant indicators and have the skills and time needed to analyze data to improve their own processes. A large and unbalanced focused on monitoring, especially when it is unclear how and if data is used, threatens to undermine efforts spent on the actual delivery of quality health care and cleaning and maintenance work which is critical to support safe, clean and inviting environments.

Facility observations and findings

Both the facilities visited are large tertiary hospitals and provide a wide range of services. St Peter's is managed by the FMOH while Gandhi Memorial Hospital is under the direction of the Regional Health Bureau (RHB) which has implications for funding and resource availability – facilities managed by the FMOH reportedly tend to have better resource availability. At each facility, the team interviewed the CEO, head of quality, and a selection of facility staff. (For a full list of themes and questions asked, refer to Annex 2).

Infrastructure

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[18] Refer to the Ethiopia country file and associated data at https://washdata.org/data/healthcare#!/
[19] McNatt et al. 2015 A national system for monitoring the performance of hospitals in Ethiopia. Bulletin of the World Health Organization 93:719–726.

Gandhi Memorial Hospital (GMH) is a relatively old hospital with outdated infrastructure, overstretched by high patient loads. The incinerator and laundry machines were all broken and sewerage pipes were old and had been leaking for 10 months at the time of the visit. There was lots of broken equipment piled up in the facility grounds, but the system to get rid of it was "*very bureaucratic with many stages*", meaning equipment builds up. The Head of Quality was frustrated by the lack of direction and buy-in from senior management stating that "*the infrastructure issue could be solved but we need a clear agenda of where we're going. It shouldn't just be talk of the week. We need a foundation that will continue*". There are simple measures that can be taken to improvement infrastructure which do not require huge resources but there needs to be more autonomy for quality teams to implement such improvements. Facilities will not be able to their improve quality of care if infrastructure remains this way; better systems and budgets for routine monitoring, maintenance and repair of equipment are needed. The quality of infrastructure, especially toilets, was frequently reported by patients as negatively impacting their quality of care.

Figure 1 Old equipment at Gandhi Memorial Hospital

At GMH, plans for new buildings were underway. The health sector directorates had been involved in the development of these plans but the facility was concerned that no one from other sectors, including the Ministry of Infrastructure, had been involved. Without their involvement, the facility was worried that the new infrastructure would not be fit for purpose.

Even in facilities which have more recently been renovated, such as St Peter's, there are still many challenges. The hospital is located at the top of a hill and suffers problems of water availability due to pumping costs leading to an intermittent water supply in many rooms and a lack of water in showers and at many of the sinks for hand washing. There was also poor management of medical waste, with a shortage of bins and safety boxes (reportedly a problem nationwide) and limited waste segregation. New trainees receive orientation on how to handle waste but in practice do not end up following national guidelines.

Figure 2 Departments at St Peter's Hospital, yet to be renovated

One facility reported that the average life span of a toilet was three years and noted that simpler infrastructure was always better. One strategy they had implemented was to shift from automatic hand sanitizer dispensers to manual ones using locally made disinfectant, which break less quickly and are easier to repair or replace.

Management and human resourcing

Hospital management structures (which vary from hospital to hospital) and human resourcing also have an impact on quality activities. Some quality management units (QMU) report to the hospital CEO, and others to the CMO. In those hospitals where the CEO does not have a clinical background, it can be

harder for QMUs to put forward ideas: "*HR is really fundamental for quality decisions, especially when [decisions] are being made by people with non-medical backgrounds*". Public facilities are assigned a set number of staff by the FMOH, according to the services they deliver. Detailed justification must be given to recruit more staff and the process takes a long time. This was reported as a huge block to improve quality. Quality activities do not have a dedicated budget, so the QMU have no authority or power to make decisions. Lastly, where quality sits in the organogram also has an impact; at GMH, quality is a unit while in other hospitals, it is a department which has more power.

Quality improvement initiatives
"Quality is not about technology or infrastructure. It is a systems approach", CEO, St Peter's.

Both hospitals had active an QMU and energetic committed quality focal points. At GMH, the QMU had identified staff attitude and knowledge as areas for improvement and wanted to get each department initiating continuous quality planning. A weekly forum provided an opportunity for staff to discuss issues of concern directly with the Medical Director although the QMU reported in general the hospital management prioritizes medical issues before looking at quality and environmental issues.

Facilities need leadership to champion QI and quality teams. At Gandhi, the QMU reported that their biggest hinderance was not having a budget to implement changes or any authority to activate quality-related interventions with limited buy-in from other departments. While the QMU was supported by the CEO, other departments "needed convincing". High staff turnover and lack of structure for implementing QI activities also reportedly hampered activities.

At St Peter's, the QMU holds a more formal weekly quality council at which data from around the hospital are discussed, which provides a mechanism to hold departments to account for the care they provide. The council reviews data and stories from around the facility to determine which areas should be prioritized for quality improvement activities. St Peter's uses a range of quality improvement (QI) approaches, including the Model for Improvement, 5s-Kaizen and Plan, Do, Study, Act (PDSA) cycle. The CEO held a Master's in business management and approached quality improvement from a business angle. The maternity and surgical departments were most actively implementing QI because they were identified as the greatest source of hospital-associated infections.

There are lots of initiatives which come from the national level (for a detailed description, refer to Annex 3) and it seems there is fatigue of having to respond to yet another visit from a partner, or work on a new initiative. At the facility, the quality focal point said that there is an expectation when people come to visit the hospital from outside (for example FMOH, RHB, WHO or other partners), that there will be some kind of benefit conferred to the facility in return, such as documents, a short training or other technical support. She reported the "*fatigue, frustration and resentment*" of being required to work on so many new initiatives, especially when they are not sustained: "*we need the right people in management. They say that 'evolution lasts longer than revolution' and though there is always energy at the beginning of these initiatives, the challenge is making the energy last*".

Health workforce development
Turnover of staff is a major problem as it is many health care settings in low-income countries. This could be in part be due to low staff satisfaction, which was recognised in one of the facilities, to minor

things that staff felt could be changed (lack of training, late payments and dirty duty rooms) and in part due to other things out of the facility's control (patient load and crowding). This had an impact on staff taking responsibility for quality: "*It's not laziness. Four people can't do everything to sustain change. The primary person has to be involved, like the midwife. They think it's the QMU's job, but people need to take responsibility".* It was felt that by improving interpersonal relationships and staff getting to know each other and understand their roles better, this would in term impact people's work and eventually quality of care. An annual staff festival was planned with presentations, short dramas, speeches by known orators on interpersonal relationships, games and other activities.

Community engagement and patient experiences

Community members and community organizations play an important role in ensuring that health care facilities provide the level of care citizens deserve and expect. At St Peter's, there was an active community committee which the manager reported had had a positive impact in the community's trust in the facility by translating patient feedback into quality improvement plans at the facility. In general, patient perspectives were positive across all the patients interviewed, recognizing there may be bias in giving honest opinions. Women were, in general, happy with the care they had received during labour and delivery, but there were a few areas they felt could be improved, such as increasing privacy for women, providing a place for women to leave their belongings and clothes, and having water for washing. Women would like to have greater opportunity to provide anonymous feedback in future and for their feedback to have more impact.

Recommendations

Ethiopia has also has a very strong quality agenda with multiple supporting policies. In all the facilities visited, there were dynamic and dedicated quality focal points who were clearly passionate about the importance of quality improvement and eager to translate Ethiopia's national policies into action. While there has been lots of progress in developing a culture of quality improvement, progress over the past few years seems to have stalled, with a slowing down of CASH activities, a change in some national level initiatives (e.g. EHAQ) and limited resources to drive quality improvements. There is often excitement for new initiatives but sustaining these over time, particularly when there are no budgets to do so, is difficult. Institutionalizing existing programmes, rather than creating new ones, should be the priority.

A series of recommendations (categorized according to the eight practical steps) are presented below and show where progress has been made or challenges remain since 2016. The recommendations were discussed and agreed with the CASH focal point (FMOH/Quality Directorate).

Practical step	Current situation and 2016 recommendation	2018
Coordination and leadership	National level collaboration between Ministries and partners remains a challenge. 2016: Coordination and information sharing between partners, public and private organizations could be improved	Coordination needs to be strengthened between Directorates of the FMOH (notably Quality and Hygiene and Environment Health) and between the FMOH and other relevant ministries, specifically the Ministry of Water, Irrigation and Electricity, and Ministry of Urban Development and Construction and sub-national parts of the health system, e.g. Regional Health Bureaus and the District Health Officers.

		It is strongly recommended that a national level "taskforce" or technical working group for WASH and IPC in health care facilities is re-established. This group should have clear terms of reference, defined membership and should meet regularly (e.g. quarterly). Membership should include, at least, the Quality and Hygiene and Environmental Health Directorates, partners (e.g. WHO, UNICEF, WaterAid, World Vision, IRC), Ministry of Water , Irrigation and Energy, Regional Health bureau (at a minimum for Addis).
Standards and accountability mechanisms	Programmes such as EHAQ include mechanisms for peer-to-peer learning and to hold facilities to account No formalized accreditation or performance-based financing mechanism	EHAQ is not national and not sufficiently funded in the few facilities where it is supposed to be active. FMOH should review and invest in the EHAQ program to reinvigorate learning and benchmarking for quality-related issues between health facilities A formalized mechanism, based on a set of standards would help hold facilities to account and incentivize improvements over time
Data review and monitoring	Lots of data is available from Ethiopia from national surveys DHIS was recently introduced and is active in many facilities	More communication and training is needed about DHIS2, for example how data will be used so that facilities are clear on their data collection responsibilities FMOH to provide more regular feedback to facilities as and when they submit their data
Improve and maintain infrastructure	Much infrastructure is old and outdated and cannot cope with patient loads. 2016: Review and revise the CASH tool. (FMOH undertook a formal review of the CASH audit tool in 2017) 2016: Ensure momentum for CASH is sustained	Consider "simple" infrastructural solutions where possible, for example locally produced dispensers for alcohol hand rub, rather than complicated designs that break and are difficult to fix. Regulations should be in place to ensure that new infrastructure that is built is fit for purpose and has the approval of Ministry of Infrastructure and Ministry of Health Facilities need dedicated budgets in order to upgrade, maintain and sustain their infrastructure (e.g. one hospital had a budget to replace toilets every 2-3 years as they were so heavily used). CASH has become less visible in some facilities. Activities that were originally part of CASH could be reignited, including the recognition system and spontaneous spot checks for monitoring CASH.
Develop health workforce	Staff are actively engaged to improve facility cleanliness and IPC through the CASH banner of "cleanliness is everyone's responsibility"	- Review the curricula for pre-service trainings and academic assessments, and incorporate elements of WASH and IPC in order to further institutionalize CASH and other QI mechanisms, with built in processes to evaluate the effectiveness of these programs. Staff need to be mentored to support implementing new practices and helping to understand how their role impacts wider health gains (i.e. outside of their ward or immediate job description) and receive non-financial recognition of the work. To ensure buy-in from all staff, staff could be engaged in co-developing a mission statement for the facility and for their specific wards so that there is a vision that all staff can work towards.

Community engagement	Community strongly engaged in CASH and mechanism exist for them to provide feedback and demand services	Community engagement continues to be used to drive change
Operational research and learning	The FMOH have requested technical support from WHO (specifically the WCO) to strengthen surveillance of healthcare-associated infections and to improve measurement of practices in facilities (rather than purely infrastructure), specifically on hand hygiene and health care waste management practices (e.g. waste segregation).	The notion of "quality" in Ethiopia is not always clear. The FMOH asked for support to better define "what is quality". WHO/QSR agreed to produce a one-page brief outlining "what is quality" in alignment with the Ethiopian National Healthcare Quality Strategy (ENHQS), to be used as an advocacy tool at national and local levels.

Limitations

A number of limitations of this work should be acknowledged. Firstly, only five days were spent in country, which limited the number of people that could be interviewed. The limited time also meant that only a small selection of facilities were visited and all in Addis. The findings from the facility while they cannot be extrapolated for the whole country, they are broadly representative of other facilities the team has visited in Ethiopia previously, including other facilities of a similar size and smaller, rural facilities. Finally, it seemed to be difficult to get the interviewees to say anything negative in response to the questions asked. In future, using known, trusted community members to conduct interviews may help mitigate this.

Conclusion

Ethiopia has a strong policy landscape with a large number of recent and relevant policies and standards relating to WASH in health care facilities, IPC, maternal and child health and quality of care. The problem lies in how to effectively implement and finance these strategies in a country with a large, predominately rural population, almost 20,000 facilities, a complicated, decentralized health system. This report is not intended to be exhaustive but provides a few key areas which have been identified for improvement which may help inform national and partner activities. The root of many of the problems identified lies in poor coordination, both within and between sectors and partners. Beginning with a national level taskforce or technical working group that brings together the relevant ministries and partners is an important basis for this. At the facility level, initiatives such as CASH, the Ethiopian Hospital Alliance for Quality and the Network for Quality of Care have the potential to make a positive impact, if they can be adequately financed, institutionalized and sustained and build in infrastructural improvements and behavioral changes. Building the community's voice into quality improvement cycles also provides a powerful opportunity for change.

Acknowledgements

Annex 1: Eight practical steps

1. **Conduct situation analysis and assessment.**
A situation analysis examines health and WASH policies, governance structures, and funding streams, whereas an assessment provides updated figures on WASH coverage and compliance. Together, these documents form the basis for prioritizing action and mobilizing resources.

2. **Set targets and define roadmap.**
The roadmap, supported by an intersectoral national team, should clearly define the approach, intervention areas, responsibilities, targets, and budget for WASH improvements over a defined time period.

3. **Establish national standards and accountability mechanisms.**
National standards should reflect the national context and provide the basis for design, costing, implementation and operation of WASH services. Accountability mechanisms should ensure that all facilities meet national standards.

4. **Improve and maintain infrastructure.**
WASH infrastructure should be improved to meet national standards and be accompanied by policies, resources, and strategies to keep infrastructure and services operational over time.

5. **Monitor and review data.**
WASH indicators can be integrated into routine data collection and review processes for health care. The data can be used to measure progress and hold stakeholders accountable.

6. **Develop health workforce.**
All workers engaged in the health system, from doctors, to nurses, midwives, and cleaners should have access to up-to-date information on WASH and infection prevention and control practices during pre-service training and as part of regular professional development.

7. **Engage communities.**
Community members serve an important role in defining, demanding, using and providing feedback on health services. They ought to be included in the development of WASH policies and in the regular review of WASH coverage and implementation data.

8. **Conduct operational research and share learning.**
External review and research is important for testing and scaling-up innovative approaches and reflecting on and revising programmatic strategies.

Annex 2: Interview details

List of people interviewed

	Area	Number interviewed
Federal Ministry of Health (FMOH)	*Hygiene and Environmental Health Directorate*	2
	Quality Directorate	3
Hospitals: **St Peter's** **Gandhi** **Memorial**	*CEO*	2
	Quality Management Unit	4
	Data management (St Peter's only)	2
	Midwives	3
	Nurses	7
Patients and families	*Women in maternity ward*	5
	Postnatal women	8
	General patients	3

QUESTION GUIDES FOR INTERVIEWS

PATIENTS
1. What matters to you most when you come to the hospital?
2. What does "quality" health services mean to you?
3. What improves your overall experience at the facility? What are the biggest barriers to you receiving care?
4. Are there any factors that would make you more likely to attend a facility? Less likely?
5. Have you ever had the chance to provide feedback/ input into your local health care facility? In what way? And what, if anything, changed as result?
6. Do you feel people listen to your opinions if you would like to change something about the facility or the care that you receive?
7. Is there anything specifically you would like to say about the handwashing facilities, sinks, showers, toilets and other sanitation facilities of the facility?
8. What should the role of the community be in the health care facility?

WOMEN THAT HAVE DELIVERED AT THE FACILITY
In addition to the questions above, please ask the following questions:
1. Did you deliver your child at this facility and if so, how long ago did you deliver?
2. When you delivered, what aspects of the facility were you most concerned about? What were you most impressed by? (e.g. the delivery room, the toilets, the clinical care, having a family member with you).
3. Did you feel that the facility was "clean"? What does "clean" mean to you? Do you think there are any risks to your baby if you deliver somewhere that is not very clean? Please explain your answer.
4. Did you have any (other) concerns about the environment in which you delivered? If so, please explain.
5. Would you be happy to deliver at the facility again? Would you recommend a relative to deliver there? If not, what alternatives would be available to you and why would they be preferable?

6. What items and/or services were missing that you would most like to have? Do you feel able to suggest these things?
7. Finally, what recommendations, if any, do you have for the facility?

QUALITY FOCAL POINT (CEO, QUALITY MANAGEMENT UNIT OR SIMILAR)
1. What is your personal vision for the facility?
2. What motivates you in your role?
3. What changes have you seen in the facility since the Network started? (consider organisational, clinical, infrastructural, quality changes etc).
4. Can you share the results of the baseline assessments for WASH? Did you have any problems using or interpreting the indicators?
5. What is your definition of quality? What are the biggest challenges facing the facility in terms of quality?
6. What are the biggest issues relating to WASH? Why do you think these are? What would you most like to change? (*we would like to understand to what extent WASH is seen as a priority for quality*).
7. How is the hospital funded? Do critical gaps exist? Do patients pay out of pocket? What resources has the country committed to improve the quality of care?
8. How is the budget from the Network being used?
9. Is there facility policy or strategy that you follow? What about national policy or strategy?
10. What data is collected and given to the managers? How is this data reported to the region?
11. Is there training for staff on quality of care? What does it consist of (e.g. elements of IPC, WASH, quality)?
12. Do you think the national direction on quality might impact this facility? What extra resources, training or other input would help you deliver quality of care ?

MIDWIVES AND NURSES
1. What motivates you in your work?
2. If you could improve anything about the facility what would it be? What would you change about the ward where you work?
3. What does "quality care" mean to you? What are the biggest challenges facing the facility in terms of quality?
4. Do you feel able to support patients and women who are in labour/delivery to the standard of quality you would like to? If not, why not? What factors are preventing you? Does senior management support you to deliver quality of care?
5. Are there any problems relating to water, sanitation, hygiene (WASH) and health care waste management in the facility and specifically in your ward/delivery room? Why do you think these are? What would you most like to change?
6. Have you received training on any element of quality? If so, please provide details (e.g. what did it consist of? who led it? How long did it last?). Are there refresher trainings?
7. Are you aware of any quality improvement activities at the facility? (*Prompt: Quality of Care network*). If so, can you please explain what has happened? What were the outcomes of the activities? (*Prompt: Organizational, clinical, infrastructural, quality changes etc.*).
8. What tools or policies are available to support quality of care at the facility? Do you use these tools in your work? If so, please provide details.
9. How would you describe the organizational culture of the facility? (*Prompt: positive or negative aspects, e.g. nurturing, safe, competitive, compassionate*).
10. If/when you have a problem in your work, what mechanisms exist for reporting it? Who do you report to? Can you provide an example of when this has been happened and what was the outcome?

11. What data are routinely collected from the delivery room/ward(s) in which you work? Who collects them and where are they sent/how are they used?
12. Is there any kind of communication and/or comparison between wards and service areas? How do you feel your ward compares to others in the facility?

Annex 3: National initiatives

While there are many quality-focused strategies and programmes active across Ethiopia, there are three key ones of note: the Clean and Safe Health Facilities (CASH) initiative, the Ethiopian Hospital Alliance for Quality (EHAQ) and the Quality of Care Network for Maternal and Newborn Health (QoC Network) which are described here.

Overview & main components of CASH

STARTED 2014

AIM to reduce healthcare associated infections and make hospitals safer, by improving infection prevention and control and patient safety

COVERAGE initially hospitals, but later extended to all health care facilities

ACTORS supported by partner organizations, well known public figures and community representatives.

TARGETS Patients; Infection prevention and control teams; Quality management teams; Staff; Visitors; Health facilities; Regional Health Bureau; and the Federal Ministry of Health.

safe and sufficient water supply and sanitation,
facilities and health care waste management,
improving hospital grounds,
visitor crowd management systems
kitchen and laundry services.

METHODS attitudinal shift
implementation of CASH audit tool
staff training
cleanliness charters
internal & external audits
assign empowered ward masters
intra- and inter-facility competitions

Box 1 Overview of CASH

Clean and Safe Health Facilities initiative: A detailed explanation of the CASH initiative is provided in the previous report, and a short summary in Box 1. CASH continues to be active across Ethiopia and, since 2017, has been extended from hospitals to all health facilities. Momentum for CASH was temporarily lost during the change in national governments and leadership in 2017/8, however the new Minister of Health would like it to continue. Among those familiar with the initiative, CASH is seen as a structured and multimodal way to improve health service delivery and those health care facilities that have implemented it would like to see the programme continued, strengthened and institutionalised. It is not clear, for example, the extent to which CASH is being integrated into emerging efforts on quality,

including those focused on child and maternal health. Now is an opportune moment to foster such linkages. The new global and national baseline data on WASH in health care facilities provide a sound basis from which to act, and Ethiopia has some of the poorest WASH in health care facility services in the world. Quality efforts ought therefore to focus on these foundational elements and commit more resources to improve WASH in health care facilities.

In both the facilities visited, CASH was being implemented and seemed to be well accepted by staff. Feedback from facilities was that the system that supports CASH must be strengthened and coordination between the various departments within the Ministry of Health needed to be strengthened. At both the national and facility level, there are no funds for operation and maintenance, and this makes it difficult to provide, repair and maintain much needed infrastructure. Implementing hospitals reported that they do not have consistent technical and financial support from the regional health bureaus. For many indicators, the CASH audit tool is too simplistic and not specific enough for to collect information on quality. A review of the audit tool was carried out in late 2016, but it is not clear whether all facilities are using the updated version, or whether the updated version is fit for purpose. A further review is needed.

Quality of Care Network: Ethiopia is one of eleven member countries of the Network for Improving Quality of Care for Maternal, Newborn and Child Health (the Quality of Care Network) which aims to reduce by half maternal and newborn mortality by 50% and to halve intra-partum stillbirths and to improve every mother's experience of care[20]. Activities are based around eight essential standards for quality of care, including water, sanitation and hygiene and essential physical resources as a standalone standard[21]. Quality of care is a core element of the Ethiopian Health Sector Transformation Plan (2016 – 2020) and a flagship area for the Minister of Health. Quality standards have been developed in which maternal, child, newborn and adolescent (MNCH) health are prioritized as one of five key areas. Implementation of the Network activities is in the early stages and in the two facilities visited, neither had heard of the Network or yet begun activities, despite being members of the Network. Going forward, it is important that WASH is adequately built into activities from the start to ensure WASH is addressed in tandem with other quality interventions to maximize outcomes and support sustainable services.

Ethiopian Quality Alliance on Quality (EHAQ): The EHAQ is a learning and benchmarking initiative involving 8-10 health facilities. It was initiated by the FMOH in 2012 as a mechanism to facilitate peer learning among participating facilities. The premise is that facilities are assigned a leadership role in a designated quality improvement area and support other facilities to improve that area, at regular face-to-face meetings. Unfortunately EHAQ is not currently functioning due to human and financial resource constraints, but most agree that it should be re-ignited. Facilities agreed that EHAQ could help strengthen quality cost-effectively and there was real value to peer-to-peer learning mechanisms and they would like to see it active again. Informal learning exchanges and communication should continue between health facilities in absence of a formal initiative.

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[20] More information on the Network is available at https://www.who.int/maternal_child_adolescent/topics/quality-of-care/network/en/
[21] WHO 2016. Standards for improving quality of maternal and newborn care in health facilities. World Health Organization, Geneva. https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/