



Federal Democratic Republic of Ethiopia
Ministry of Health

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"ADDRESSING THE GAP: EQUITY IN HEALTH CARE TO ENSURE HIGHEST POSSIBLE LEVEL OF HEALTH FOR ALL ETHIOPIANS"

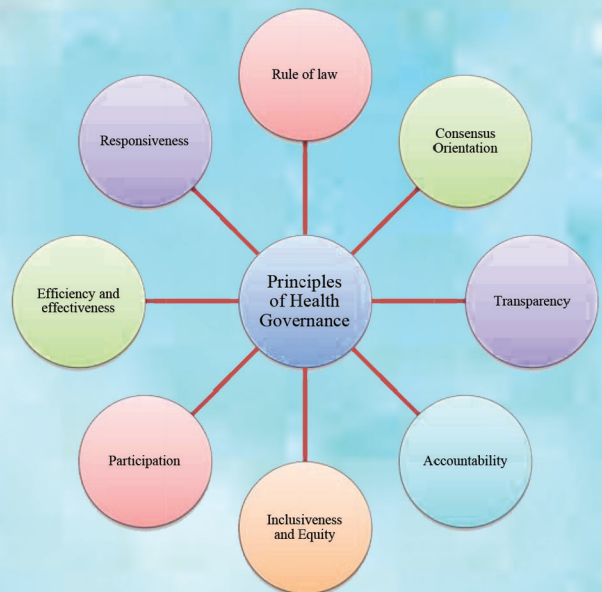


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Health Governance Watch





Federal Democratic Republic of Ethiopia

Ministry of Health

Health Governance Watch 2016

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ACRONYMS

AA	Addis Ababa
ALERT	All Africa Leprosy, TB Control Rehabilitation & Training Center
ANC	Antenatal care
APTS	Auditable Pharmaceutical Transactions and Services
ART	Anti Retroviral Treatment
BCG	Bacillus Calmette–Guérin
BSC	Balanced Score Card
CAR	Contraceptive acceptance rate
CEO	Chief Executive Officer
CI	Confidence Interval
CPS	Community Pharmacy Service
EAA	Ethiopian Anesthesia Association
EFY	Ethiopian Fiscal Year
ENT	Ear, Neck and Throat
ESRD	End Stage Renal Disease
FGD	Focus Group Discussion
FP	Family Planning
GGI	Good governance index
HC	Health Center
HCMIS	Health Commodity Management Information System
HDA	Health Development Army
HEW	Health Extension Workers
HMIS	Health Management Information System
HP	Health Post
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
ICU	Intensive Care Unit
IFRR	Internal facility reporting and requisition form
KPI	Key Performance Indicators
LIS	Laboratory Information System
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MD	Medical Doctor

ACRONYMS

MDG	Millennium Development Goal
MDR-TB	Multi-Drug Resistance Tuberculosis
MIA	Major Initiatives Assessments
MNCH	Maternal, Newborn and Child health
MTCT	Mother to Child Transmission
MOH	Ministry of Health
MRI	Magnetic Resonance Imaging
NGO	Non Governmental Organization
NICU	Neonatal Intensive Care Unit
ODF	Open Defecation Free
OPD	Outpatient Department
PAB	Protection at Birth
Penta	Pentavalent Vaccine
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care Units
PLHIV	People Living with HIV
PNC	Postnatal Care
PPD	Policy Plan Directorate
RHB	Regional Health Bureau
RRF	Reporting and Requesting Form
SBA	Skilled Birth Attendant
SNNP	Southern Nation's Nationalities and Peoples
SPHMMC	Saint Paul Hospital Millennium Medical College
TB	Tuberculosis
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid Vaccine
VCT	Voluntary Counseling and Testing
VIF	Variance Inflation Factor

Forward by the Minister of Health



The Ministry of Health is committed to making EFY 2008 a year to enhance good governance in the Health Sector. The existence of inequality, poor quality of health services and a high burden of communicable diseases coupled with a notable number of less performing entities, some unethical health care professionals and an inadequate system to enforce accountability puts good governance in to question.

Cognizant of this fact, the Ministry of Health (MOH) prioritized good governance as one of the strategic objectives of the health sector transformation plan. The secret of transformation lies in shifting the mindset of making decisions. Simply put, good governance is the process of decision making based on principles. However, it is a complex phenomenon which is not always easy to define.

Good governance principles in the health system work on the basis of: *“If we listen to the voice, interest and perspective of stakeholders and then- redirect our effort toward creating on inclusive, transparent and accountable health system, then there is a high likelihood of improving the health status of our citizens in an affordable and responsive manner”*

As part of the monitoring and evaluation of the good governance strategy, the policy and plan directorate (PPD) has produced a bulletin called “*The Health Governance Watch*”. The bulletin is organized under three parts, namely engaging the stakeholders, cultivating accountability and enhancing the health governance contribution.

The 1st part, *Enhancing Good Governance*, clearly shows the contribution of good governance in improving the performance of health facilities. It presents articles on the current status of good governance, and service delivery performance of regional and university hospitals. It also presents the good governance index; the first tool of its kind to measure the state of good governance and objectively monitors performance across health facilities.

The 2nd part, *Engaging Stakeholder*, presents the *VOICE* of stakeholders. It shows the level of patients’ satisfaction and complaints with the health service, and their participation in the decision-making processes. It also examines the level of inequality in health outcomes disaggregated by socio-economic factors and stakeholder involvement in a 360-evaluation of performance-based feedback for successful organizational development.

The 3rd part, *Cultivating Accountability*, is about good practices to improve transparency and accountability in the health system. It includes articles on the use of information technology to improve the queue system and laboratory services and rewards for the best performing Woredas.

Dear reader, I strongly recommend you to go through the articles to unpack the concept of good governance in practice and enjoy examining the process of health system decision making.

Kesete-Birhan Admasu (MD, MPH)

Minister

Section 1:

Enhancing Good Governance



Good Governance Index: Quantitative measurement of the state of good governance in the health facilities

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¹ Monitoring and Evaluation Senior Experts, Policy Plan Directorate, Ministry of Health

Introduction

The Government of Ethiopia initiated the good governance movement in EFY2008 to accelerate economic and democratic development and the citizen's intense pursuit of change.

Despite, the impressive changes in access to health services and improvement in health outcome, the health sector still suffers from the existence of inequality, poor quality of health service and a high burden of communicable and non communicable disease. There is an increasing trend of community dissatisfaction with the health system. According to the good governance package for the health sector, the major

reasons are unavailability of service, unaffordable cost, unethical health professionals, frequent service disruption and poor service quality.¹ Further drilling down the problem proves that bad governance is one of the underlying causes as expressed by theft of medicines, diversion of patients to private facilities, health workforce absenteeism, corruption, weak regulation and inadequate accountability. In addition, notable numbers of leaders at all level of the health system are not willing to respond to the demand of the community as well as to the questions raised by health service clients. These reasons characterize the health institutions as poorly performing entities.

¹ Ministry of Health, Good Governance Package, EFY2008

Cognizant of this fact, the Ministry of Health (MOH) prioritize good governance as one of the strategic objectives of the health sector transformation plan. Simply put “governance” means: **the process of decision-making and the process by which decisions are implemented (or not implemented).**² Good governance is a complex phenomenon often with an elusive meaning. There are eight principles of good governance. This article describes the good governance index which is an indicators based measurement of the state of good governance.

Conceptual Framework

The state of Good Governance is a dynamic and complex phenomenon. The health sector adopted a conceptual framework of good governance using the World Health Organization, health system building blocks and the government growth and transformation plan direction which is based on the 8 principles of good governance. The dimensions of the good governance conceptual framework are Community demand and grievance, government commitment, media involvement, health system (infrastructure, information, pharmaceuticals, finance, leadership, human resource and service delivery), citizen life style and the status of health outcome and impact.³ The conceptual framework assumes all dimensions interact in a complex way to drive change. A strong monitoring and evaluation system is required to guide decision making in the process of continues improvement of good governance.

Good Governance Index

Various monitoring and evaluation methods are used to measure the implementation of initiatives to enhance good governance, principles of good governance, and identify determinant factors of good governance. The good governance index is one of the methods to measure the state of good governance. It is a quantitative measurement based on key indicators. The main purpose of the good governance index is to comprehensively measure the state of good governance

Indicators

Twenty one priority indicators are selected for good governance index as shown in the following table.

Table 1: Priority indicators of health sector good governance index, June 2016

Indicator	Weight	Indicator	Weight
Client Satisfaction Rate	18	Proportion of patients complaints resolved	3
Proportion of patients receiving comprehensive information on their health states and treatment	5	Rate of budget utilization	2
Proportion of patients receiving all prescribed medicine	5	Average Lot Quality Assurance Sampling score (LQAS)	2
Proportion of availability of essential medicine out of the health facility essential list of drug	25	Bed Occupancy Rate	5

and to objectively compare different health facilities. The processes of development of the good governance index are as follows.

- 1. Prioritize indicators:** Select priority indicators involving key stakeholders. Indicators selection is based on these criteria, the relevance in HSTP, being a major source for public compliant, and reflects the state of principles of good governance. The MOH chose 21 key indicators and 16 secondary indicators to measure good governance index. The indicator selection considers a balanced reflection of building blocks of the health system. Data for some of the indicators is obtained using a population based survey. In this study 15 indicators with complete data were included to compute the good governance index. Six indicators were not included due to incomplete data.
- 2. Weight indicators:** Give weight for each indicator based on the extent of public complaints. In this study, the majority of the score is calculated based on the availability of drugs compared to the hospital’s own drug list, the availability of laboratory tests from the 85 tests on the national menu, patient satisfaction applying a LIKERT scale during patient exit interviews, and the quality of service delivery in the hospital. Quality of service indicators are Bed Occupancy Rate, average length of stay and emergency triage waiting time. The total weight of the indicators is out of 100.
- 3. Collect data and compute the average:** Collect data from key performance indicators, the health management information system, administrative reports, patient interviews, observation, and inventory. If there are missing data, do not use the indicator during the calculation of good governance index. Shift the weight of the indicator with no reliable data to a related indicator or adjust the sum of the weight of available indicators to 100.

²United Nations Economic and Social Commission for Asia and the Pacific, 2008

³Ministry of Health, Good Governance Monitoring and Evaluation Framework, EFY2008

Proportion of available laboratory tests out of the total (85 tests) as per MOH standard	15	Average length of stay	3
Proportion of patients who received all ordered laboratory or imaging services	5	Proportion of emergency patients triaged within 5 minutes	3
Staff attrition rate/ Absenteeism	3	Proportion of patients staying in emergency room for more than 24 hours	2
Major surgery per surgeon/ Health Workforce Productivity	4	Good Governance Index	100

Additional key indicators to calculate the good governance index are:

- Health workers per 1,000 population
- Inequality Index (*for skill birth attendant among socio-economic determinates*)/ health policy index
- Potential Primary health care coverage/ Proportion of health facilities with functional electricity, water, sanitation and networking equipment
- Proportion of appropriate referral / proportion of patients diverted to a private facility/ proportion of patients who provided a bribe for health professionals
- Out of Pocket Expenditure as a share of total health expenditure
- Number of healthcare facilities implementing the national healthcare facility standard/ Inspection coverage of health facilities

Data Collection

Data was collected from 26 hospitals including regional, federal and University hospitals. Data collection was from March to June 2016.

Table 2: Hospitals sampled to calculate Good Governance Index, June 2016

Name of Hospital	Region	Name of Hospital	Region
Tikur Anbessa Specialized Hospital	Addis Ababa	St. Pauls hospital millennium medical college	Addis Ababa
Gonder University Hospital	Amhara	Ghandi Memmorial Hospital	Addis Ababa
Ayder Referral Hospital	Tigray	Tirunesh Bejing hospital	Addis Ababa
Arsi University Asela Referral Hospital	Oromia	Ras Desta Hospital	Addis Ababa
Hawassa Referral Hospital	SNNP	Yekatit Hospital	Addis Ababa
Welaita Sodo University Hospital	SNNP	Minilik Hospital	Addis Ababa
Dilla University Referral Hospital	SNNP	Zewuditu Hospital	Addis Ababa
Jimma University Specialized Hospital	Oromia	Debre Birhan Hospital	Amhara
Hiwot Fana Specialized University Hospital	Hareri	Bishoftu Hospital	Oromia
Adama Hospital	Oromia	Mekele Hospital	Tigray
St. Peters TB specialized Hospital	Addis Ababa	Dil Chora Hospital	Dire Dawa
ALERT Center	Addis Ababa	Jugal Hospital	Hareri
Amanuel psychiatric specialized Hospital	Addis Ababa	Adare Hospital	SNNP

Result

The results showed that the Good Governance Index ratings ranged from 42% to 74%. In other words, hospitals were 58% to 26% short of achieving the maximum possible good governance rating. However readers have to be curious about the interpretation that achieving 100% does not means achieving good governance to the maximum state. The median good governance index was found to be 63%.

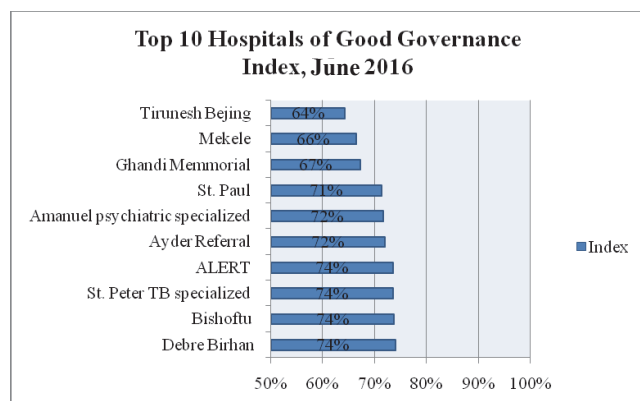


Figure 1: Top 10 hospitals based on good governance index, June 2016

The performance of the 26 hospitals good governance indicator is summarized as minimum, maximum and median. Table 3 shows high variability of performance in most of the indicators. Hospitals were performing well in budget utilization, data quality as measured by lot quality assurance sampling (LQAS), emergency triage and bed occupancy rate. In most of the hospitals the budget allocated for the period was utilized. The median budget utilization rate was 95%. All hospitals were checking the recording and reporting accuracy using LQAS. The median LQAS was 85%. Availability of prescribed medicine, availability of laboratory test, availability of imaging diagnostics service, patients who get information and health work productivity were key challenges. The proportion of patients receiving all prescribed medicine ranged from 35% to 73%.

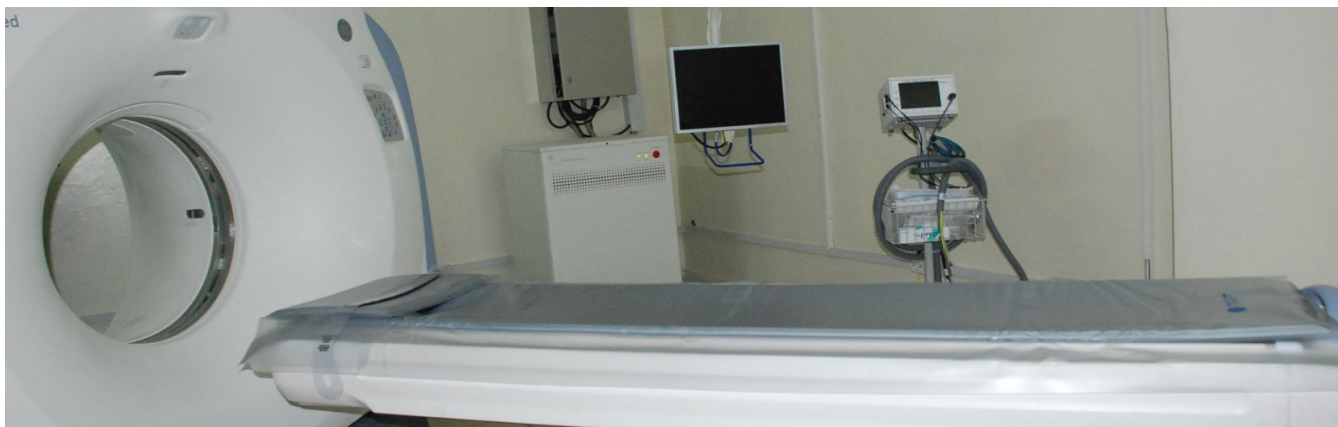
Table 3: Performance of hospitals based on key indicators of good governance, June 2016

Indicator	Weight	Minimum	Median	Maximum
Client Satisfaction Rate	18	60%	73%	92%
Proportion of patients who received comprehensive information on their health state and treatment	5	40%	55%	70%
Proportion of patients who received all prescribed medicines	5	35%	62%	73%
Proportion of availability of essential medicines out of the health facility essential list of drug	25	38%	54%	77%
Proportion of available laboratory tests out of the total (85 tests) as per MOH standard	15	55%	69%	82%
Proportion of patients who received all ordered laboratory or imaging services	5	42%	65%	71%
Bed Occupancy Rate	5	75%	80%	90%
Proportion of emergency patients triaged within 5 minutes	3	70%	78%	89%
Proportion of patients staying in emergency room for more than 24 hours	2	48%	72%	86%
Staff attrition rate/ Absenteeism	3	10%	6%	4%
Rate of budget utilization	2	89%	95%	100%
Average Lot Quality Assurance Sampling score (LQAS)	2	70%	85%	95%
Good Governance Index	100	42%	63%	74%

Conclusion and Recommendation

This study showed that Good Governance Index is a reliable measure to monitor the state of good governance in Hospitals. It showed the median good governance index at hospital level was 63%. There is high variability across hospitals ranging from the 42% to the 74%. Patient complaint was 27%. Budget utilization rate, bed occupancy rate and emergency triage were found to be the strong part of hospital good governance. The major challenges of good governance in the hospitals were stock out of essential drugs, lack of laboratory or diagnostics services, and low productivity

of physicians or specialist's. Good governance issues such as an inadequate patient and staff complaint handling system, lack of transparent and accountable decision making practice and low staff skill and motivation reduced the service delivery performance. The study suggests the introduction of initiatives that improve accountability, responsiveness and stakeholder engagement to enhance good governance of hospitals. The study also suggests the need to standardize the tools to include other variables that were not addressed in this study.



State of Good Governance in University Hospitals

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Introduction: State of Good Governance was studied in 10 University Hospitals, in May- June 2016. The study aim to identify governance problems, services with the most public complaints, measure good governance index and explore the perceptions and opinions of hospital staff on hospital governance. Method: Both quantitative and qualitative method utilized using a case study approach. A total of 863 patients, 20 focus group discussions with 8-12 participants and 345 experts, team leaders and department heads were included in the study.

Result: Good Governance Index of hospitals ranges from 42% to 72%. General patient satisfaction was 63%. Nearly 3 out of 4 patients recommend the university hospitals for friends or relatives and prefer from previously visited health facilities.

Major strength were service expansion, increasing trend of service utilization, emergency service, liaison, implementation of auditable pharmaceutical transaction services, preparation of strategic plan and involvement of senior specialists in visiting patients.

Key challenges: Shortage of medicine, interruption of laboratory and imaging services, delay in elective surgeries, inadequate patient engagement, staff turnover and dissatisfaction, weak grievance handling mechanism, sub optimal functionality of health development army, weak referral linkage, gap in use of evidence for planning and resource allocation and inadequate synergy between the University and health science collages.

Recommendation: Improve community and public wing engagement, strengthen patient and staff grievance handling mechanism, focus on system improvement in biomedical engineering, pharmacy and laboratory service, and strengthen evidence based planning and resource allocation.

1.1 Introduction

The Millennium Development Goals (MDG) implementation period concluded in 2015 with Ethiopia achieving many of the MDG targets such as improving maternal health and reducing child mortality, and making great progress towards combatting HIV/AIDS, Malaria and TB.⁴ Nevertheless, Ethiopian citizens show dissatisfaction with the health system.⁵ Complaints by the public have been increasing in type, magnitude and depth. People have been expressing their voice regarding poor service quality, unethical behavior of health workers, unavailability of medicines or lab service, and high cost of the health services. The managers at all level do not properly understand the community demand or provide a timely response.

Cognizant of this fact, and with stringent direction given by the government, the MOH identified enhancing good governance as one of the strategic objectives in the Health Sector Transformation Plan (HSTP).⁶ This led to the preparation of the Good Governance Package and Good Governance Monitoring and Evaluation Framework. The package was launched at the beginning of EFY2008 with the involvement of key stakeholders such as community, regions and development partners.

1.2 General objective

An assessment of 10 federal university hospitals in Ethiopia was conducted in 2016. The objective of the evaluation was to measure the state of good governance in federal university hospitals and to generate recommendations for advocacy, program improvement and resource allocation. Ten out of 33 federal university hospitals were included in the assessment, selected based on implementation of the integration of health science teaching department with the service delivery.

1.3 Specific Objectives

- To identify governance problems within the different departments of the hospitals
- To identify services with the most public complaints

- To measure good governance index for each hospital
- To explore the perceptions and opinions of hospital staff on hospital governance

2.1 Methodology

State of Good Governance is a dynamic and complex phenomenon. The health sector adopted a conceptual framework of good governance using the World Health Organization health system building blocks and the government growth and transformation plan good governance direction (which is based on the 8 principles of good governance). The dimensions of the good governance conceptual framework are Community demand and grievance, government commitment, media involvement, health system (infrastructure, information, pharmaceuticals, finance, leadership, human resource and service delivery), citizen life style and status of health outcome and impact. The conceptual framework assumes all dimensions interact in a complex way to drive change.

This study uses both quantitative and qualitative methods to measure state of good governance. An index of 15 indicators representing the building blocks of health system and community satisfaction level is calculated to get an indication on the state of good governance in federal hospitals.

Case studies were used to understand the complex features of good governance problems. Quantitative and qualitative data were collected using a semi-structured questionnaire. Quantitative data collection included collection of key performance indicators (KPI) and data collected from patients using a structured questionnaire using LIKERT-scales. Qualitative data collection included separate focus group discussions with health professionals and administrative workers based on structured topics and sensitizing concepts, visual inspection of infrastructure, and review of documents, minutes, guidelines and service areas.

⁴Assessment of Ethiopia's Progress towards the MDGs report, published in 2015 by UNDP, available here: <http://www.et.undp.org/content/ethiopia/en/home/library/mdg.html>

⁵MOH, Good Governance Package, 2008EFY, 2015

⁶Ministry of Health Ethiopia, Health Sector Transformation Plan, 2015/16-2019/20, 2015

Using these techniques, the views of leaders, health professionals, admin staff and patients were included in the evaluation. The assessment was performed during the period of May-June, 2016.

Sample Size: A total of 863 patients, 20 focus group discussions with 8-12 participants and 345 experts, team leaders and department heads were included in the study. The FGD participants comprised of separate team from supportive departments such as human resource, finance, administration, student affair departments and technical departments such as in- patient, outpatient and emergency departments, pharmacy department, laboratory and imaging departments. In the technical

FGDs physicians, pharmacists, laboratory technicians, nurses and biomedical engineers were participated.

Data collection Team: Data was collected by three teams. Each team was comprised of a senior expert from the education sector, a senior monitoring and evaluation expert, and clinicians from the Clinical Service Directorate of the MOH. The assessment tools were pre-tested at St. Paul Hospital. All team members participated in an assessment of good governance in Tikur Anbessa Hospital as part of field testing training.

Table:1 List of Hospitals included in the assessment

Name of Hospitals		
1. Tikur Anbessa Specialized Hospital, Addis Ababa	2. Hawassa Referral Hospital, SNNPR	3. Jimma University Specialized Hospital, Oromia
4. Gonder University Hospital, Amhara	5. Welaita Sodo University Hospital, SNNP	6. Hiwot Fana Specialized University Hospital, Oromia
7. Ayder Referral Hospital, Tigray	8. Dilla University Referral Hospital, SNNP	9. Adama Hospital, Oromia
10. Arsi University Asela Referral Hospital, Oromia		

3. Result

3.1 Service Delivery

3.1.1 Strengths

Service expansion: Within the last 3 years, the hospitals introduced new specialty services, including plastic surgery, intensive care, pediatric clinics, ophthalmic clinics, ear, nose throat (ENT) services and ophthalmology services. The hospitals also expanded their premises investing huge amounts of their budgets.

Utilization of Service: The number of patients utilizing the hospitals was increasing dramatically. For example, OPD attendance per day increased from 300 on average

in 2007 EFY to an average of 500 to 700 in Welaita Sodo University Hospital. Patients that had been referred to Addis Ababa or to private hospitals got a chance to use the hospitals with a reasonable amount of cost. A patient interviewed in Welaita Sodo University Hospital Said 'ከቅርብ ጊዜ ወዲህ የዚህ ሆስፒታል በስፔሻሊስቶች መደራጀቱ ወደ አዋሳኝ ከምናደርገው ሩጫና ወጪ እረፍት ሰጥቶናል.... ይሁን እንጂ አሁንም በሶዶ ላሉ የግል ተቋማት ለመድሃኒትና ምርመራ መገበራችን አልቀረም.....' *It is to say 'recently the increasing number of specialists in this hospital brought a relief from running to Hawassa and the extra cost.... However in Sodo, the unnecessary costs we are paying to private for medicine and diagnosis was still not resolved*

Emergency Service: There was a considerable improvement in emergency patient triage. The proportion of patients triaged within 5 minutes was 79%. Also, emergency referral and mortality were significantly reduced. However, the proportion of patients that stayed in the emergency room for more than a day remains a challenge due to the low number of inpatient beds in most of the hospital. Around half of the patients interviewed stayed for more than a day in the emergency room.

Liaison: All hospitals included in the evaluation had a liaison office. The liaison officers were coordinating admission, referral, ambulance service, and bed management activities. Establishment of liaison offices improved Bed Occupancy Rate (BOR), information sharing between departments, and follow up of patients on the waiting list. For instance, in Jimma Hospital, the BOR was 90%, which was above the national average of 75% in 2007EFY.

Nursing Care: Most of the staff noted that the nursing care has improved significantly within the past two years. Nursing care had been limited because of lack of skill to provision of medicine and securing an IV fluid for patients. Nurses in most of the hospitals have increased their role and are now providing comprehensive services, including nursing assessment and psychological support. Some of the main change drivers were improved communication between nurses and other health professionals, trainings in focused problem solving and nursing skill, and improvements in follow up, and compliance with nursing care standards. In the assessment, two thirds (68%) of patients in the inpatient departments, expressed satisfaction with nursing care. In the emergency departments, 83% of patients were satisfied with health workers ethical practice and respect.

3.1.2 Weaknesses

Delays in receiving elective services: In most of the hospitals there were long delays for patients to receive elective services at the time of data collection. Patients were appointed for more than a year to get elective

services. Delays were longest for orthopedics and elective surgery. There were patients waiting for more than 3 years for orthopedic surgery. Shortage and high turnover of specialists, inadequate infrastructure such as surgical theaters and beds, limited working days and hours (most specialty clinics were working only 2 days per week) and low productivity of providers were found to be the major challenges. For instance, major surgery per surgeon per day was found to be less than 1, which is too low compared to the waiting list.

Referral: Though improvements were made in terms of organizing the liaison offices and establishing a quality teams, inadequate referral services were a barrier to patients accessing quality services. The assessment team observed that a considerable proportion of referrals coming to the tertiary hospitals being assessed could have been managed at the health center or primary hospital level. The federal hospitals in the assessment did not provide feedback on referrals. Also, referral information was not analyzed to measure performance and take corrective action. There were inadequate referral networks and lack of planned support for the catchment health facilities.

3.2 Supply system

3.2.1 Strengths

Auditable Pharmaceutical Transactions and Services (APTS): Most of the hospitals were implementing APTS. Renovation and furnishing of the central dispensary had been carried out, which had required allocation of thousands of birr from hospital budget. For Example, Sodo University Hospital allocated more than 800,000 birr to renovate and furnish the central dispensary. The number of pharmacists working in a dispensary was increasing as per the APTS requirement. Tikur Anbesa hospital alone had recruited more than 80 pharmacists. Each hospital has allocated more than 1 million birr from the previous year to improve drug availability. APTS implementation was improving availability of essential drugs, patient counseling, and prescription monitoring, and providing drug information to clinicians. In addition, APTS had reduced the wastage

rates of drugs. In Hawassa University, for example, the wastage rate of drugs had declined from 10% to <2% within a year after the introduction of APTS.

Service integration: The number of dispensaries has been increasing to align pharmacy services with patient flow. In TASH there were 10 pharmacy outlets to provide services for different specialties. Pharmacists said that increasing the number of outlets had improved efficiency of service provision, as well as quality of pharmaceutical care given to patients. Emergency departments were getting the most benefit from the expansion of outlets, as drugs were immediately dispensed to patients, and there were improvements in real time stock monitoring. All hospitals have had also established a Drug and Therapeutics Committees (DTC) to lead the pharmacy service. DTC improved the participation of different departments in the management of the pharmaceutical services. DTC developed guidelines for procurement, drug lists, formularies, waste management etc that suit their hospitals context.

Drug Information System: Hospitals were using the Reporting and Requesting Form (RRF), the Internal Facility Requesting and Reporting forms, and bin cards. These reporting forms facilitate information flow within hospitals (from departments to the pharmacy units), and from the hospital to the Pharmaceutical Fund and Supply Agency (PFSA). Almost all facilities were using electronic Health Commodity Management Information System (HCMIS) to improve the commodity management. Some hospitals were monitoring availability of vital drugs weekly.

3.2.2 Weaknesses

Availability of drugs: Availability of drugs, laboratory reagents, and medical supplies was a critical challenge for the hospitals. Hospitals were providing only 40% to 60% of items from the essential drug list. The patient surveys showed, that the availability of all prescribed medicine was 65%. Similarly, from the expected 85 laboratory tests that should be available as per the national menu, availability was found to range

from 40% to 80%. Patient surveys showed that only approximately half of patients received their full tests from the hospitals. This implies that many patients might be forced to go to private facilities or travel a long distance (up to Addis Ababa) to get services. The contributing factors for stock outs of drugs were found to be from both the facility and from PFSA. (See figure 1)

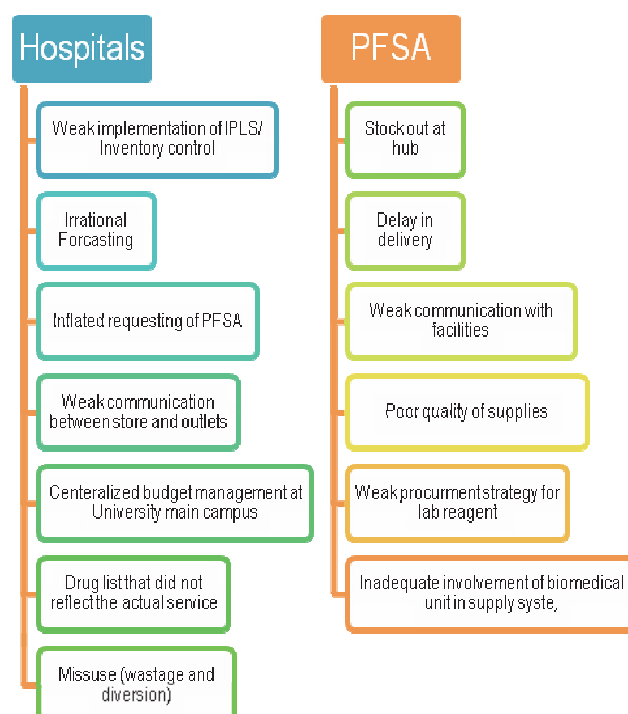


Figure 1: Key reasons for shortage of drugs at federal hospitals, 2016

Participation: The pharmacy departments manage the supply of drugs, biomedical equipments, medical supplies and reagents. However, the pharmacy departments do not have the required knowledge and skill to lead the supply system. There was a weak link in specification development for medical equipment and in storage of reagents and the biomedical equipment. The spare parts for biomedical equipments were not being correctly quantified and procured ahead of time. The assessment showed that there was weak involvement or unorganized participation of the biomedical units and laboratory units in the supply system. There were occasions where services were interrupted because equipment, such as a microscope, heater or centrifuge, etc that were in the store will not be dispatched to departments due to weak communication between departments and the pharmacy store.

3.3 Internal Process

3.3.1 Strengths

Strategic Management: The hospitals developed their strategic plans, which cascaded from the universities' 5-year plans. The strategic plans consider both the University plan and the Health Sector Transformation Plan (HSTP). At the time of the assessment, the annual plans were developed and were being followed every quarter. Hospitals had prepared a Good Governance Plans for year 2008EFY, with the involvement of key stakeholders. They have had started discussion with the public wing about the hospital service delivery and good governance. The KPIs and HMIS were used mainly for performance reviews. All hospitals follow data quality checks using inbuilt data quality assurance mechanism called Lot quality assurance sampling (LQAS). The LQAS result was 85% to 90%.

3.3.2 Weaknesses

Organizational Structure: There are finance, planning, and human resource units in each of the assessed hospitals. However, these units have not been delegated the necessary authority to smoothly carry out their function. Many decisions are being carried out in a centralized manner by the main administration of the universities. The interviewees agreed that providing complex health services, which are demanding, and fast-paced, require a long term perspective, and need independent support units to facilitate the work of the clinical departments. The allocated budgets for the year 2008 EFY did not reflect the actual plan of the hospital. That means budget allocated for the hospitals were too small to cover the cost for priority interventions according to the plan. There was no clear discussion and involvement in the budget approval process.

Reform and Good Governance: The governance of the hospitals was being carried out in compliance with the Hospital Service Delivery and Teaching Integration Guideline.⁷ All health science college heads held the vice president position in the hospitals. However, the

leading role of hospitals reforms and implementation of good governance was at university level. The good governance structures at hospital level were not capable of implementing reform and good governance programs such as strengthening the health development army, establishing staff and patient grievance handling system, facilitating engagement of the community in hospital governance, and improving partnership and coordination with stakeholders. For example, the functionality of grievance handling system was still lagging behind expectations, as measured by staff dissatisfaction and levels of high patient grievance. Patient grievance ranges from an average of 16% for OPD health professionals respect to 65% for medicines availability.

Hospitals did not have systems to organize a staff grievance, such as grievance handling committee involving staffs. Patient complaint handling offices were not adequately organized. In some hospitals the staffs grievance handling committee exist but are not functional. Similarly, the implementation of the Citizen Charter as per the service delivery standard was in question. Though there were health development army (HDA) networks, they were not meeting regularly, or discussing and handling real issues to improve their work. Discussions to improve the attitude and motivation of staff and create a spirit of supporting each other were in its infancy stage. In most of the meetings, staffs identify problems of other department rather than their own, and the meetings were not based on evidence.

3.4 Linkage of service delivery with teaching

3.4.1 Strengths

Previously, there had been separate administration structures for teaching and for service delivery. During the time of the assessment, there was an encouraging process of integrating hospital service administration with teaching administration in all hospitals. They were both being administered under a Chief Executive

⁷Ministry of Health of Ethiopia, Hospital Service Delivery and Teaching Integration Guideline, 2015

Officer acting as a Vice President of the university. The operational processes, such as finance, human resource administration, general service, etc. were almost integrated. Most senior medical staffs, such as specialists, were providing equal attention to service delivery, as well as to teaching. In some of the hospitals senior medical staffs and residents fully attend the hospital morning sessions. The residents were working in good spirit with other service delivery staff, which was not previously the culture as explained by interviewee in Jimma, Tikur Anbessa, Arsi and Adama University Hospitals.

Discussion with students also revealed that there were encouraging improvements in areas of providing induction training about the medical equipments and working environment. Improvements were explained about the relationship between lecturer and students particularly freely discussing on the process of examination of students performance and in the process of expressing their view during practical sessions. They stressed that the distance between seniors and students were becoming narrower. They had witnessed expressions of grievances about teaching and service provision being given to the appropriate person.

3.4.2 Weaknesses

Patient Engagement: There was a noticeable gap in involving patients in decision making during teaching and service provision. Patient rights were not particularly being respected in their choice, confidentiality, keeping privacy, and ensuring continuity of care. Participants identified that the key reasons were low levels of patient's health literacy, high student to patient ratios, and high student to senior specialist ratios. In all hospitals the study team observed that the inpatient departments were crowded with students. On average, 20 to 30 students were attending major rounds. In some hospitals, intern students were independently diagnosing and treating patients without the consultation of physicians.

Readiness of the system: Participants revealed that there was an increasing trend of health student enrolment. This brought challenges in providing

quality teaching for students, and in service provision for the patients. There was also reducing trend of practical sessions, shortages of teaching aids, overlap of courses, shortages of skill/ computer labs, and limited examination of student competency based on subjective analysis and judgment.

3.5 Client satisfaction

Patient opinion and experience were assessed using a Likert scale. The tool was developed using 32 items. The questions followed patient flow, starting from the entrance through to discharge. Patients rated their opinions or experiences as very poor, poor, adequate, good and very good. Data was collected from 863 patients. The results are categorized into two groups: patients who rated the service delivery as "very poor" and "poor" were categorized as "Public complaint", while patients who rate the service delivery as "adequate", "good" and "very good" are categorized as "Public satisfaction".

3.5.1 General Satisfaction

The general patient satisfaction was 63%. That means on average, in federal hospitals around 2 out of 3 patients were satisfied by the service. Willingness of patients to recommend to friends or relatives to utilize the federal hospitals was 76%. In other words, on average 3 out of 4 patients would recommend this hospital to their relative or friends to get service. Similarly, 3 out of 4 patients were more satisfied with the current hospital relative to the health facilities they had previously utilized. This finding implies that a considerable proportion of clients were not satisfied with the hospital service provision. (See figure 2)

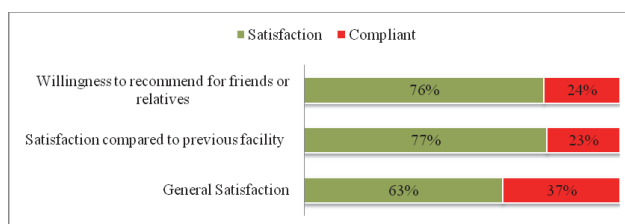


Figure 2: General satisfaction of patients on federal hospitals, June 2016

3.5.2 Top ten sources of satisfaction and complaint

Health workers respect for patients, pharmacy counseling, and triage services were the top themes of patient satisfaction. Around 84% of patients were satisfied with health workers respect towards patients. One interviewee compared the satisfaction related to health workers respect for patients with their experience the previous year. That patient said *“That is to say although there is no medicine, the respect of health workers, particularly nurses, was increasing from the previous year.”*

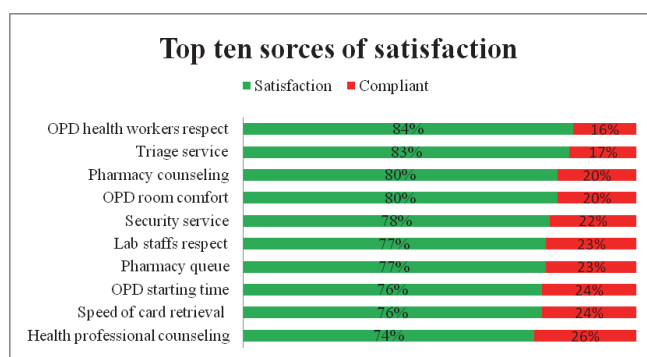


Figure 3: Sources of satisfaction among patients in federal hospitals, 2016

With regard to sources of patient dissatisfaction, inavailability of all prescribed medicine, inavailability of all ordered laboratory or imaging services, lack of transparent information, and inefficient patient complaint handling system were the top sources of patient dissatisfaction. For instance, about 2 out of 3 patients (65%) did not get all their prescribed medicines from the hospital they visited.

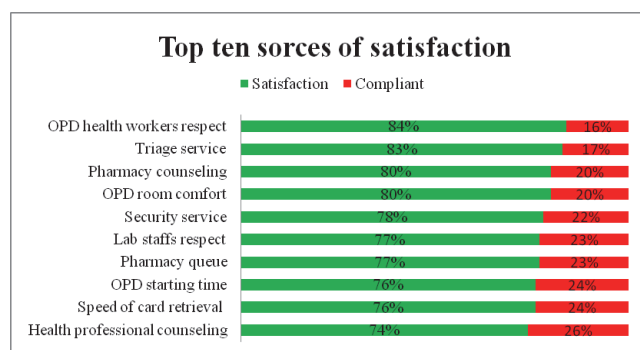


Figure 4: Sources of complaint of patient in federal hospitals, 2016

3.6 Staff perspective

Perspectives and experiences of staff were explored using focus group discussions (FGD). Eight to 12 hospital staff, including instructors, students, and supportive staff were grouped together for the FGDs. A total of 40 FGDs were carried out. Major themes raised by staff in the FGDs were as follows:

3.6.1 Strengths

- Hospitals have started implementation of Balanced Score Card, Citizen Charter, and Business Process Re-engineering, which are core for management
- The hospital administration have started discussions with staff about the hospital's performance, as well as about the administration culture
- There is an increasing culture of discussion within a team

3.6.2 Weaknesses

- There is weak induction given to new staff, and the existing staff are not fully aware of civil service reforms
- The motivation schemes are more biased to the instructors and physicians than to other health professionals and supportive staff. Even the risk allowances were not given for some professions
- There is a gap in perceptions of transparency and accountability in the management of human and financial resources
- There were no staff complaint handling system or they were nonfunctional

3.7 Good Governance index

The Good Governance Index is a calculation based on 15 selected indicators from the six building blocks of the health system. Weight is given for each indicator, based on the extent of public complaint on each of

the indicators. The majority of the score is calculated based on the availability of drugs compared to the hospital's own drug list, the availability of laboratory tests from the 85 tests on the national menu, patient satisfaction applying LIKERT scale during patient exit interviews, and the quality of service delivery in the hospital. Quality of service indicators were BOR, average length of stay and emergency triage waiting time. The results from applying the Good Governance Index in the assessed hospitals showed that the Good Governance Index ratings of federal hospitals ranged from 42% to 71.9%. In other words, hospitals were 30% to 58% short of achieving the maximum possible good governance rating. However readers have to be cognizant that achieving 100% does not mean achieving good governance to the maximum state.

Table 2: Good Governance Index of Federal Hospitals, June 2016

Name of Hospital	Index
Tikur Anbessa Specialized Hospital	57%
Gonder University Hospital	51%
Ayder Referral Hospital	72%
Arsi University Asela Referral Hospital	42%
Hawassa Referral Hospital	57%
Welaita Sodo University Hospital	54%
Dilla University Referral Hospital	51%
Jimma University Specialized Hospital	62%
Hiwot Fana Specialized University Hospital	59%
Adama Hospital	63%

4. Limitations of the Assessment

- Generalization is not possible from this study
- Incomplete data to calculate some indicators such as staff attrition rate, budget utilization rate, physician productivity etc.

5. Recommendation

Based on the findings of all components of this assessment, the study team has prepared the following recommendations. Variation in performance by different hospitals will require each facility to carefully assess the findings specific to their facility to tailor the improvement plans to their own gaps. Overall, the

following are thought to have a positive impact on improving the governance and functioning of facilities.

- Revisit the structure of health science college administration to efficiently carry out human resource administration, finance administration and enhance reform activities.
- Improve community and public wing participation in hospital governance.
- Link planning, and budgeting with evidence. Hospitals should be involved in the universities budget process and defense before approval. The planning process of hospitals which was using "one health tool" as per MOH guidance should be accepted in the budget allocation process at University level.
- Improve pharmaceutical supply system
- Give priority for a biomedical unit
- Strengthen patient complaint handling systems and implement staff complaint handling systems.
- Improve engagement of staff in hospital management
- Improve transparency of human resource administration by preparing staff manual, providing orientation for new staffs and existing staffs on civil service directives and manuals and using information technology to improve communication among staffs.
- Link human resource development with individual performance



Good Governance Assessment Results from Regional and Federal Hospitals in Addis Ababa

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Key notes (good governance assessment hospitals in Addis Ababa)

- Good governance index ranges from 59.8%-73.6%
- Average patient satisfaction was found to be 89%
- Top/ major problems found are shortage of drugs, lack of laboratory and imaging tests, shortage of enough and clean toilet

Introduction

The Ethiopian Government has taken a firm stance on identifying and taking strong measures on good governance problems which hamper the growth and development of the country.

Despite the Health Sector Growth and Development Plan have been met the complaints of the community are increasing in type, amount and complexity. The people have been expressing their complaints and concerns on service availability, delay in getting services and high health service costs through any available means. Above all there were no tangible responses given to these complaints by the respective bodies so far.

The Health Sector Transformation plan was developed and is being implemented with goals to solve the many aspects of good governance problems in the Health Sector. This was followed by the preparation of the

Good governance package and the monitoring and evaluation framework with the participation of federal ministry of health officials, regional health bureau heads and Agencies.

Consequently, the Good governance monitoring and evaluation framework contains tools to evaluate the service delivery of health facilities which been piloted and put in to practice. The assessment of six Addis Ababa and four Federal Hospitals was performed using the tool during the period from Mar. - June 2016.

General objective

To identify problems and strengths within the facilities, to measure the good governance index of the facilities and to give important recommendations to solve identified gaps.

Specific Objectives

- To identify good governance problems within the different departments of the hospitals
- To identify services with the most public complaints through patient and staff assessment
- To measure the good governance index of each hospital

Methodology

Case study was used to understand the complex features of good governance problems. Both quantitative and qualitative data were collected using a semi-structured questionnaire.

Quantitative data collections included collection of key performance indicators (KPI) and data collected from patients using a structured questionnaire in LIKERT-scale. Qualitatively, focus group discussions with Health professionals and administrative workers separately based on structured topics and sensitizing concepts, visual inspection of infrastructure, documents, Minutes, guidelines and service areas, views of leaders, health professionals, admin staffs and patients were included.

Introductory meetings were held at each hospital and feedback and exit discussions were also conducted at the end of the assessment of each hospital. Finally, agreement was reached to prepare an action plan based on identified gaps by classifying them according to the time of implementation, whether the identified problem will be solved in the short, medium and long term.

The departments evaluated during the assessment include Supply management, Emergency, OPD, Inpatient, Laboratory, Radiology, Human resource, Finance, Liaison, card room, Planning, monitoring and evaluation, MCH, TB and chronic care rooms.

The assessment was performed during the period of March-June, 2016.

Table 1. List of hospitals included in the assessment

S. No	Name of Hospital	Accountability
1	St.Pual Millennium Medical College	FMOH
2	St. Peter TB specialized Hospital	FMOH
3	ALERT Center	FMOH
4	Amanuel psychiatric specialized Hospital	FMOH
5	Tirunesh Bejing hospital	AA RHB
6	Minilik Hospital	AA RHB
7	Ghandi Memmorial Hospital	AA RHB
8	Zewuditu Hospital	AA RHB
9	Ras Desta Hospital	AA RHB
10	Yekatit Hospital	AA RHB

Results

Delivery and quality of services

This section includes the assessment results of departments including OPD, inpatient, Emergency room, Liaison, Referral and Ambulance services.

Strengths of hospitals which need to continue

The results shows that there were elements of strong service delivery areas which included service expansion, the starting of new and valuable services which such as kidney transplantation (St. Paul), neuro-surgery and artificial dental implantation (Zewuditu), neonatal intensive care unit (NICU), legal services for cases of (Ghandi), higher eye care and treatment (Minilik), skill assessment of nurses every six months to improve quality of services (Tirunesh Bejing).

The other common strengths of the studied hospitals were a continuous increase of service utilization by the community, increase in bed occupancy rate, better implementation of hospital reform, coordinated emergency services with the central command post in Addis Ababa, emergency rooms were open for 24 hours, improvement in the ethical practices of practitioners, good involvement and capacity building for catchment health centers, liaison rooms to provide information

for waiting patients via telephone, implementation of electronic medical record at all hospitals and securing of medico-legal cards using locks.

Areas which need improvement

Many areas were identified which needed strong commitment by the hospital and other respective leaders to be improved. These included lack of appropriate infrastructure to give emergency services according to the required standard, shortage and crowding of service delivery rooms, shortage of beds, presence of high numbers of patients who did not get service on the same day, physicians did not start services on time, name and photo of service providers were not posted on the corresponding rooms, unsuitable and very narrow waiting areas at OPD, long surgical waiting time (esp. for major eye surgery, orthopedic, plastic and neuro-surgery areas), lack of implementation of nursing care according to the standard, low average number of major surgical procedures per surgeon per month.

Emergency service areas which need improvement Include; the presence of low quality medical equipments in emergency, OPD and inpatient (such as BP apparatus, suction machine etc.), emergency rooms were giving service for non emergency cases and were very crowded; many emergency patients were not triaged within 5 minutes; many patients stayed more than 24 hours at the emergency rooms; the absence of emergency drugs and medical equipments at emergency according to the standard; the lack of proper communication between emergency, liaison and inpatient departments to continue uninterrupted care for patients; the lack of proper communication among different hospitals; shortage of toilet and lack of cleanliness of available ones; the shortage of enough water for service delivery rooms and Increasing inappropriate referrals from health centers and hospitals.

Supply management

This part contains the assessment results of departments including pharmaceutical supply management, laboratory, imaging, and biomedical activities in the hospitals.

Strengths which need to continue

Some of the hospital strengths which were identified during the study include; drug and therapeutic committees have been established and had regular meetings. RRF was regularly filled (every two months) and sent to PFSA. Establishment of a drug information centre and trying to provide current information on drugs to health workers and patients, Most of the time there was enough budget for procurement of drugs and reagents, improvement in the quality of laboratories from time to time, decentralization of laboratory services to different departments, list of laboratory services and their costs were prepared and posted to patients. Either biomedical engineers or technicians or both were assigned and started service at each hospital, Medical equipments inventory was being done annually at majority of the hospitals.

Weakness which need improvement

The following areas were identified as weakness of the hospitals that need planned action for improvement; Lack of implementation of APTS according to the standard, very low availability of essential drugs based on own drug list, presence of expired drugs at medicine store and lack of disposal, PFSA avails, on average, less than half of the requested drugs, some drugs were available at hospital stores but not at the dispensary, the number of provided laboratory services was low compared to the hospital standard, there was shortage of laboratory reagents and frequent interruption of services, many laboratory machines were found damaged and not maintained at lab Rooms.

Concerning Biomedical departments, lack of strong coordination with other departments, lack of proper organization of biomedical rooms due to less attention given by leaders of the hospitals, Lack of skill of biomedical workers to maintain damaged machines like chemistry, hematology, CT scan and MRI., absence of organized biomedical workshops with enough spare parts and maintenance kits, coordination gaps by biomedical workers with other health workers, modern

imaging machines like CT scan, MRI were either not available at most hospitals or were damaged.

Internal process

This section contains the assessment results of departments including Human Resource, Finance, Planning, M&E, Reform and good governance

Strength

Areas identified as strength in internal process include; strategic plan (except Amanuel) and annual plans were prepared by most of the hospitals, board committees were organized by most of the hospitals, implementation of Human Resource Information System, availability of human resource essential management guidelines, staff and service user compliant handling committees were organized in most of the hospitals, controlling mechanisms of middle and lower level professionals were in place by using manual signatures, health development army structures were organized in most hospitals and functional in some of them, public wing were identified and meetings were arranged regularly, good governance plans and citizen charters prepared.

Weaknesses which need improvement

Internal process areas which need improvement include; the annual plan were not cascaded to individual level by Federal hospitals; lack of transparency in selection of short term and long term training opportunities; most hospitals were not staffed according to the standard; modern time worker controlling mechanisms such as digital signatures were not implemented in the majority; there was no a single mechanism to control and follow the activities of general practitioners and specialists; the absence of organized training need identification and documentation, delay in purchase of personal protective supplies, delay of incentive payments such as duty and overtime payments.

Good governance activities were being performed as an additional duty; there was no hired or assigned focal person in most of them. Assessment and revision of the citizen charter was not conducted in most hospitals. In

some hospitals performance monitoring team meetings were irregular and action plans were not prepared for identified performance problems, SMART care was not implemented in most hospitals, low performance of health education and public awareness activities, weakly organized complaint handling procedures, get-togethers to increase inter-staff coordination were rarely done, weak implementation of health care financing at federal hospitals and lack of reimbursement of fees.

Self reported patient satisfaction Result

The patient satisfaction was assessed using 5-point LIKERT scale (very good [1] to very bad [5]), Very good, good and medium were grouped as satisfaction while very bad and bad were grouped as dissatisfaction.

Inpatient service

According to the response given by customers on in-patient services, the satisfaction rate was 77% for duration of surgical appointment, 82% for preparation in advance of discharge?, 79% for level of follow up by Doctors, 78% for level of follow up by nurses and 81% for counselling given for discharged patients where as from 18%-23% were dissatisfied for the above inpatient services (Figure 1).

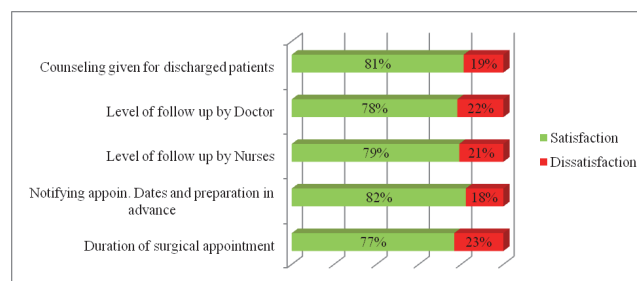


Figure 1. Customers' satisfaction level by in-patient services of selected public hospital in Addis Ababa

Emergency service

The response given by clients at emergency services show satisfaction rate of 86% for triage within 5 minutes, 84% for privacy of emergency room, and above 93% for service like suitability of emergency room, drug and medical equipment availing, emergency room workers respect and service provision and payment status (Figure 2).

The highest dissatisfaction (27%) was found on not being transferred to inpatient within 24 hours.

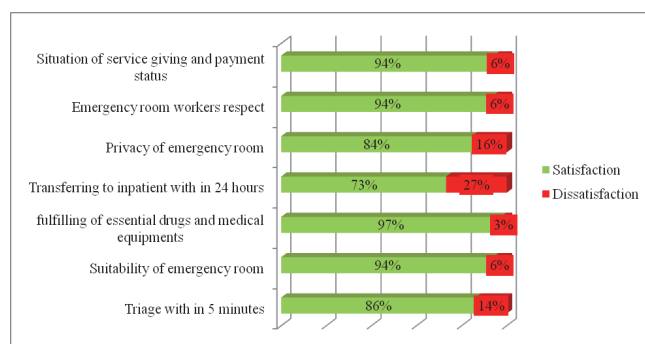


Figure 2. Customers' satisfaction level by emergency services of selected public hospital in Addis Ababa

Rate of satisfaction

The general satisfaction rate of customers of the selected public hospitals in Addis Ababa was 89%, and 88% of them would recommend the hospitals to friends and other relatives (Figure 3). Whereas, 87% were satisfied by the services when comparing it with their previous experience in another hospital.



Figure 3. Customers' satisfaction level by services in general of selected public hospital in Addis Ababa

Top ten causes of customer satisfaction in selected public hospitals in Addis Ababa

The top ten causes of satisfaction of customers by service of Hospitals in Addis Ababa were found to be OPD health workers respect, counseling given by health workers, security situation of the hospital, triage service, starting of OPD services on time, laboratory room queue, comfort of OPD room, pharmacy room queue, laboratory and imaging workers respect and fast retrieval of medical records constitute from top to bottom.

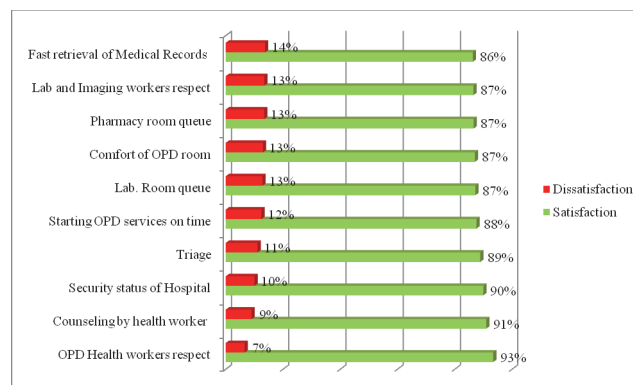


Figure 4. Top ten causes of customers' satisfaction by selected services of public hospital in Addis Ababa

Top ten causes of dissatisfaction at Addis Ababa Hospitals

The top ten causes of dissatisfaction according to the finding were getting all medicines at facility, getting all laboratories and imaging services at facility, knowing current health situations, availability and ease of complaint handling procedures, information desk services, knowing the prescribed lab exams, comfort of toilet etc. up to OPD queue constitute from top to bottom.

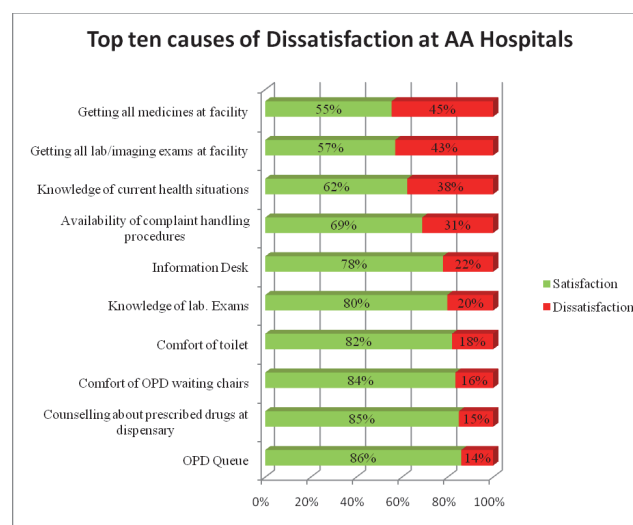


Figure 5. Top ten causes of customers' dissatisfaction by selected services of public hospital in Addis Ababa

Patients' suggestions

Besides the quantitative responses, patients gave many suggestions which included providing enough drug and laboratory services, improve toilet and water supply services, improve ethical problems among some health professionals, priority to customers from remote areas and clients with special need, avail enough service delivery rooms and beds, improve condition of waiting areas.

Focus Group discussion result

Strengths identified by discussants

The strengths identified during focus group discussion included increase in magnitude of service delivery, good cooperation and collaboration among health care workers in the hospitals, workers in most hospitals try their best to give services for the community despite severe shortage of resources.

5.2. Weaknesses

The discussants identified the following areas as weaknesses: less attention given by hospital leadership to fulfill worker incentives, lack of coordination among

human resource, finance and planning departments in implementing incentive packages, less availability of work-area health protective supplies, unsafe and unsuitable working environments, education opportunities and other incentives are unavailable for administrative staffs, lack of transparency among leaders in giving education and other opportunities to workers, very limited participation and involvement of all staffs in major and important decisions and incapable individuals are being recruited and assigned in leadership positions.

Good Governance Index of hospitals

The Good Governance Index (GGI) of each hospital was calculated based on fifteen selected indicators using the available hospital data. The majority of the score was calculated on the availability of drugs based on own Hospital drug list, the availability of laboratory reagents and tests, and the quality of service delivery in the hospital. The GGI of the study hospitals in Addis Ababa ranged from 60% to 74 % (

Table 1); they were 26% to 40% away from ensuring good governance.

Table 2. Good governance index of selected public hospitals in Addis Ababa

Name of Hospital	Accountability*	Good Governance index
St. Peter TB specialized Hospital	FMOH	73.6%
ALERT Center	FMOH	73.6%
Amanuel psychiatric specialized Hospital	FMOH	71.6%
St. Paul millennium medical college	FMOH	71.3%
Ghandi Memmorial Hospital	AA RHB	67.2%
Tirunesh Beijing hospital	AA RHB	64.3%
Ras Desta Hospital	AA RHB	62.9%
Yekatit Hospital	AA RHB	62.6%
Minilik Hospital	AA RHB	60.2%
Zewuditu Hospital	AA RHB	59.6%

* FMOH and AARHB: Federal Ministry of Health and Addis Ababa Administration Health Bureau

Recommendations

- All hospitals need to assess good governance in-depth and take appropriate corrective measures.
- Enough attention should be given to avail enough and clean toilets to patients
- Develop and implement staff retaining and motivating mechanisms

- Improve resource mobilization and utilization
- Improve services delivered to populations who require special needs
- Assessing and rearranging organizational structures in a way to give better services Improve coordination and collaboration among different departments within the hospitals and with other hospitals
- Improve health education and health awareness creating mechanisms
- All hospitals need to have service delivery and financial systems with transparency and accountability



Good Governance Assessment Report on Regional Hospitals in Six Regions

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- The results show that the good governance index of regional hospitals range from 52.3% to 74% showing that they are around 26% to 47% far from ensuring good governance.
- The overall clients' satisfaction with the regional Hospitals care was 78%.
- The top causes of clients' dissatisfaction were;
 - Getting prescribed medicines at the facilities,
 - Obtaining laboratory and imaging services
 - Convenience and cleanliness of the toilets,

Introduction

Ethiopia has started implementing the Health Transformation plan in order to fulfill the vision of being in the level of middle income countries. The government is working in strong commitment by identifying good governance problems identified in all sectors and trying to give solutions by increasing commitments at different governing levels. in order to

ensure the fair and quality services reform and good governance works should be integrated. Based on the identified problems Good governance package and the monitoring and evaluation framework were prepared with the participation of Federal Ministry of Health officials, RHB heads and Agencies. So, the assessments of six Regional hospitals were performed using the approved tool during the period from February - March 2016. These were Amhara (Debre Birhan), Tigray (Mekele Hospital), Oromia (Bishoftu Hospital), SNNP (Adare Hospitals), Dire Dawa (DilChora Hospital), and Harara (Jugal Hospital).

Methodology

Two teams from good governance case team and quality case team of Medical Services Directorate, each comprised of 3 experts were formed and conducted good governance assessment in the selected hospitals from February-March 2016.

Quantitative Data- questioners were prepared and pre tested in st. Paul Millinium Referral Hospital. All the necessary issues were included and the tools become approved by the regional and agency heads. It included key performance indicators (KPI) and the data were collected from patients using questionnaire in prepared in a Likert scale.

Qualitative data- were collected from health professionals and administrative workers through focus group discussions using semi-structured interview guides. In addition, visual inspection of infrastructure, review of documents such as minutes and guidelines, and observation of service areas with checklists were conducted.

Before data were collected, introductory meetings were held in each hospital and feedback and exit discussions were conducted at the end the assessment. Following the assessments, agreement was reached with hospital management teams to prepare an action plan based on the identified gaps such as classifying the problems according to time of implementation, whether the identified problem will be solved in the short, medium and long term.

The departments assessed during the evaluation include supply management, emergency department, outpatient, inpatient, laboratory, radiology, human resource, finance, liaison, card room/ reception, planning, monitoring and evaluation, maternal and child health, TB and chronic care

General objective

The general objective of the assessment was to strengthen good governance in the health sector through the implementation of national health sector good governance package using the monitoring and evaluation framework. The purpose of the assessment was to identify successes/ strengths and weaknesses/ gaps and to measure the good governance index of the hospitals and to provide recommendations to solve the identified gaps.

Specific Objectives

- To identify good governance problems in the different departments of the hospitals
- To identify services with the most clients satisfaction and complaints with the services
- To measure the good governance index of each hospital

- To forward recommendations based on the identified gaps

A) Findings of the qualitative assessment (observation and inventory)

Service Delivery and Quality of Service

In the aforementioned regional hospitals, it was observed that most of the hospitals initiated new services and carried out expansions of the existing services. For instance, Debre Birhan & Mekele hospitals had started neonatal intensive care unit (NICU) services and improvements were reported in neonatal deaths. Debre Birhan hospital had begun viral load testing service.

The number of clients and bed occupancy rates in each hospital had increased and all emergency rooms provided 24 hour services. Some of the regional hospitals supported their catchments facilities by supplying materials and maintenance. The automated medical record units were implemented in most hospitals, however, in their effort to avoid duplication, much time was wasted and caused long waiting times and clients' dissatisfaction.

Gaps observed during the assessment

Some of the gaps observed and reported in the regional hospitals have been reported below. .

Hospital Environment

The environments of the hospitals were congested. Since the hospitals were established many years ago they appeared to be old, and contained limited beds. During the assessment, many patients were waited long for surgery and the chairs for waiting clients were inadequate and uncomfortable. It was noticed that there were patients who did not get hospital service within the same day due to the load of patients and lack of investigations. It was also observed that the toilets in most of the hospitals were inadequate and unclean. The hospitals face shortage and unreliability of water and electric power.

Hospital Equipment

It was reported from key informants interview that the quality of medical equipment (such as BP Apparatus, suction machine, etc.) was not good as well as they were inadequate. In addition, maintaining and fixing broken equipment were challenging to the hospitals due to the lack of spare parts in the local markets.

Care Giving

During the assessment, the following gaps concerning care giving were observed and/ or mentioned: problems of respecting patients, unrestricted visits for inpatients/wards, non-standard nursing care, low or very low physician productivity (in most hospitals the ratio of surgery/surgeon is less than 1), narrow emergency rooms and long hospital stays (of patients) i.e. >24 hours for emergency patients. Furthermore, information transaction gaps between emergency rooms and inpatient/ wards on the availability of beds were reported as challenges. In most OPDs, it was reported by the clients, that physicians did not start their work on time and the clients had no options of knowing physicians assigned to consults them or their contact addresses were not displayed anywhere.

Some of the reported challenges related to referral and linkage were shortage of bed compared to the number of clients and cases coming to the hospitals, many clients came from non-catchments areas, inconsistency in providing referral feedbacks, and limited information exchanges between the liaison and different departments on bed availability. In addition, the clients were not communicated well about their appointments and bed information. Most of the hospitals focused less on services for people with special needs (with hearing and speaking disability), and the hospitals were challenged with shortage of physicians in some specialty such as orthopedics and dermatology.

Hospital Supply and Logistics

Concerning the supply continuous meeting and follow ups of Drug Therapeutic Committee (DTC), sending the filled Report and Requisition Form RRF for the

Pharmaceuticals Fund and Supply Agency (PFSA), in most hospitals establishing drug information center for disseminating drug information was a positive development. Most regional hospitals stepped up to improve the quality of laboratory services, opened decentralized laboratories (for emergency and inpatient department- IPD). The type of laboratory tests available, fees for each lab test and the average time required for waiting, taking samples and providing lab test results were displayed in most of the hospitals assessed. Most of the hospitals had biomedical engineers who conducted annual inventories - differentiated functional and non-functional machineries in each unit and fixed some broken equipment upon availability of spare parts.

However, many gaps of the logistics and medical supplies were observed/ reported in the hospitals assessed. Although the Auditable Pharmaceutical Transactions and Services (APTS) reform activities were implemented, the standards were not fully adhered in most of the hospitals. Inadequate supply of some essential drugs and supplies from PFSA was found to be a prominent challenge while other drugs came in excess and were neither transferred to other facilities nor destroyed when they expired. Furthermore, some drug dispensaries fell short of essential drugs and supplies while the stores were stacked with them. Laboratory departments also faced shortage of reagents and some of the equipments were not functioning – this being the cause of unavailability of some standard lab tests in all hospitals.

It appeared that less attention was given to the biomedical department and relevant staff participation in the selection and procurement of machineries and their installment. Biomedical engineers in the hospitals happened less trained and/ or less equipped with essential tools, and their integration with pharmacy and laboratory staffs/ departments was intangible. The problem is aggravated with the lack of spare parts in the stores and local markets. Some equipment which needed minor repair or replacement stood non-functioning due to the shortage of spare parts. Despite

the challenges mentioned above, fewer measures were taken by the hospitals i.e. limitations on identifying training gaps and designing strategies to avail essential spare parts, etc. and weak integration with EPHI's biomedical engineers to build the capacity of their staffs. When equipment are available in the market, the procurement had to pass through a long and time taking procedures. It was observed that patient cards were often misplaced or could not be found in some instances due to irregularities in returning and filing in their respective folders. This affected MRU functions while MRU has not been initiated in some hospitals.

In some regional hospitals, had shortage of ambulance problem due to unavailability and maintenance issue and served only limited number of clients due to narrow space and shortage of specialties such as Orthopedics, irregularities in labeling and distributing the beds specific to specialists that caused patients stay unreasonably long and congested service delivery rooms. In addition, shortage of night clothes and bed sheets were identified in many hospitals assessed. Inconveniences due to the above factors sometimes forced some people to go to private hospitals and exposed them to unnecessary costs.

Internal Processes of the Hospitals

Almost all hospitals were moving forward in creating clean and safe hospital. Most regional hospitals' human resources introduced and implemented the hospital guidelines and rules and regulations for staffs and established a team for handling complaints. All hospitals prepared good governance plan and each had a strong board management and held meetings regularly and discussed good governance issues. The hospitals conducted Lots Quality Assurance Sampling (LQAS) for improving data of care and used the information to assist with decision making every month. In this regard, the assessment found over 85% success.

Despite the above successes, unavailability of a system and difficulty in controlling staff time especially for physicians and specialists was reported. In addition, the hospitals did not assign a responsible person to

follow up and handle and report the matters of hospital good governance. This was pretty evident as a range of gaps in citizen charter achievements (assessments and revision not conducted) and irregularities and not using the standards in providing health education and information to the clients regarding service availability. In addition, appropriate and adequate action plans were not set for problems identified during performance revision.

B) Finding of the quantitative assessment

A total of 540 patients from inpatient (IPD), Outpatient (OPD), Emergency, were interviewed using the questioners on different services provided by security, medical record unit (MRU), OPD, inpatient, emergency, laboratory and pharmacy units. The following were key points raised by the clients during the interview.

- The toilet were unclean and there was water shortage
- Some healthcare workers disrespected clients and did not provide care with dignity
- Physicians did not appear on time for work and caused congestions
- The clients coming from farther and rural areas were not provided priority care and help was not available for them in some hospitals
- Shortage of beds and long appointments
- Disrupted services in pharmacy and laboratory units
- Priority care was not available for people with special need (those with hearing disability, old people, etc.)
- Inconvenient chairs and space for waiting

Below are provided the details of the problems mentioned above.

Inpatients service

Clients in inpatient care were interviewed regarding the services provided by nurses and physicians care

i.e. the quality of counseling on drugs, interaction with and respect for clients and other nursing and physician ethical aspects of care, consultations and room cleanness.

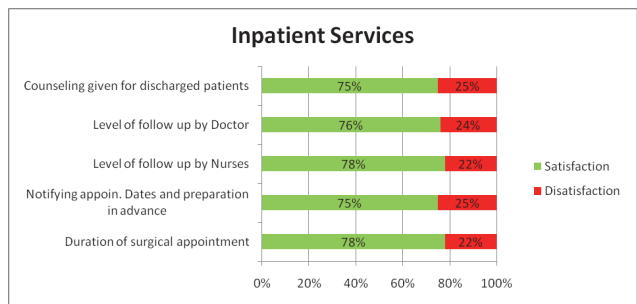


Figure 1: Clients perceptions of inpatient care in hospitals

For 22% of the clients’ surgical appointment provided was very long and disappointing. One-fourth of the patients said the appointments (schedules) were not communicated to them in advance. Some clients, 22% and 24% of the respondents said they were not satisfied with the nursing care and physicians’ follow up respectively. In 25% of the cases, counseling was not provided on discharge from the hospitals.

Emergency Service

The following figure shows the experiences of patients with medical care provided in emergency care unit in the hospitals assessed.

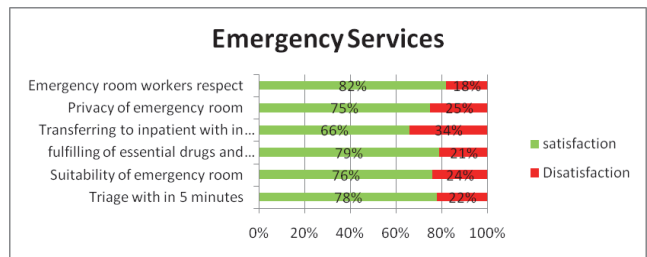


Figure 2 Patient experiences with emergency care in regional hospitals

Over two-third (78%) of the clients in emergency care units were provided care inside 5 minutes of arrival and it took longer than 5 minutes for the rest (22%). Over one – fifth (21%) of the clients said not all essential drugs were available in the emergency rooms and 34% were not transferred to inpatient, home or other

hospitals when it was indicated and stayed over 24 hours in the emergency room.

Clients General Satisfaction

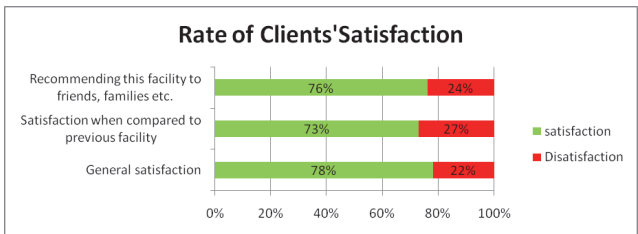


Figure 3 Clients satisfaction with care in regional hospitals

The overall clients’ satisfaction with the hospital care was 78% and 73% of the clients were satisfied with the hospitals being assessed compared to other hospitals visited, and 76% said would recommend it to their friends and family members. However, dissatisfaction with the hospitals assessed was 22%, 27% and 24% respectively and necessitates the initiation of interventions to improve satisfaction.

Fig 4 shows top ten causes of client satisfaction with hospital services. According to the patient assessment finding, the top ten causes of client satisfaction with services in the hospitals assessed from top to bottom were respect for clients in OPD, lab & imaging services, hospital security staff hospitability, convenience of chairs in the waiting areas, convenience of the OPD rooms, timeliness of the OPD services, orientating clients on the lab investigations sought, waiting time for OPD and fast retrieval of medical records.

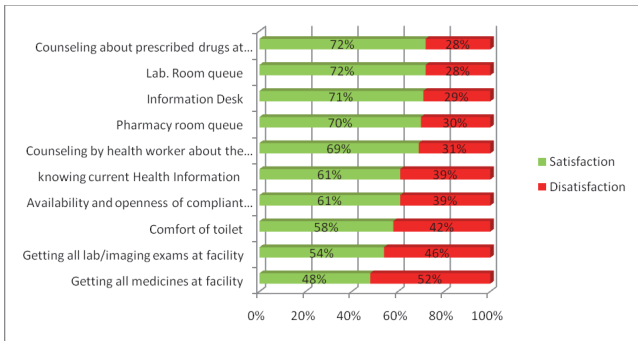


Figure 4 Top ten causes of client satisfaction with regional hospitals

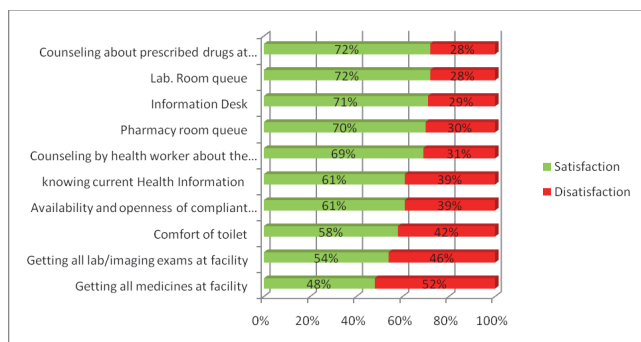


Figure 5 Top ten causes of patient dissatisfaction with regional hospitals

The top ten causes of dissatisfaction (from top to bottom) according to the finding were getting prescribed medicines at the facilities, obtaining laboratory and imaging services in the hospitals, convenience and cleanliness of the toilets, availability and ease of compliant handling procedures, knowing the health situations information, counseling provided to clients, pharmacy room queue, information desk services, waiting time for laboratory services and getting counseling on dispensing drugs.

C) Findings of the qualitative assessment (FGDs)

Two focus group discussions with 8-10 participants formed from administrative (one) and clinical staffs (six to nine) were conducted in each hospital. The discussions were done using structured questioners and the staffs raised different issues on the strengths and weaknesses of the hospitals.

FGD discussants indicated that the quality of services had been improved and being expanded over time to meet the growing needs. In most hospitals, staffs developed plans and conducted performance evaluations. Hospital management and board meetings happened on the scheduled time. Hospital administrators invented different organizational and social platforms for the staffs to organize get-together and other events to build strong staff relationships and good working environments.

However, there remained challenges as well. In the FGDs the administrative and clinical staff mentioned the following problems and difficulties.

- Difficulties and irregularities in approaching and solving staff complaints and their reported challenges by the hospital managements
- Irregular staffs meetings
- Lack of interactions and cooperation between different departments
- Unsafe and uncomfortable working environments to staffs
- Gaps identifying and arranging capacity buildings to the supportive staffs
- Problem of distributing supplies to staffs on time (uniforms and infection prevention materials)
- variations on risk allowance rate for health professionals and also between supportive staffs
- Unavailability of shower and toilets for the staffs

D) Good Governance Index of Regional Hospitals

Fifteen indicators were selected to calculate the good Governance index of each hospital. Some of the data were found from the good governance assessment and some of them from the KPI data of the hospitals. Majority of the score was calculated on the availability of drugs based on own Hospital drug list, availability of laboratory reagents and tests, and the quality of service delivery in the hospital. The results show that the good governance index of regional hospitals range from 52.3% to 74% showing that they are around 26% to 47% far from ensuring good governance.

Table 1 Good governance index of hospitals

S r . No.	Name of the hospitals	Good Governance Index
1	Debre Birhan Hospital	74
2	Bishoftu Hospital	73.8
3	Mekele Hospital	66.4
4	Dil Chora Hospital	62.6
5	Jugal Hospital	57.5
6	Adare Hospital	52.3

The Way Forwards

- All hospitals should conduct in-depth good governance assessments and solve the problems observed or reported in each department
- All departments should check their organizational structure for solving good governance issues of the clients and staffs and solve the gaps identified
- Departments/Units should strengthen cooperation with other departments
- Strategies should be designed and implemented in order to increase the productivity of physicians and nurses

- Focus should be given especially in nursing and physicians care
- Strategies should be designed and implemented to encourage and increase staff retention
- Improve logistics management and strengthening resource mobilization
- Develop and implement strategies to improve services for people with special needs
- Automate the information and record retrieval system in order to give fast, complete and quality services
- Strengthening responsible and transparent management/ governance system in hospitals

Reference

- The Federal Democratic Republic of Ethiopia. Health sector transformation plan / HSTP/ 2008- 2012 EFY (2016- 2020). Addis Ababa; 2005.
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Achievement of high performing woredas on key health governance and service delivery indicators: Tracking woreda transformation

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Introduction

The twenty-year health sector development program (HSDP) concluded in 2007 EFY with remarkable improvement in access to health service delivery and health outcomes. By the end of 2007 EFY, Ethiopia has achieved the MDG-4 with a 67 percent drop in under-five mortality from the 1990 estimate. Also, the country achieved a 69 percent decrease in maternal mortality from the baseline of 1400 per 100,000 live births.⁸

Mortality and morbidity due to HIV/AIDS, Tuberculosis and malaria have reduced noticeably. The country achieved the targets set for tuberculosis prevention and control; Tuberculosis mortality and prevalence have declined by more than 50%. Deaths due to malaria have declined, and there has been a significant decrease in the number of admissions and deaths of under-five children due to malaria by 81% and 73% respectively.⁹

Despite the above successes, the country is still facing a triple burden of diseases consisting of communicable diseases, non-communicable diseases and injuries. On top of this, addressing equity in access to health care, and quality in health services provision still remain key challenges. There is still visible inequality of health outcomes across regions, across districts and across segments of the population.

To address these challenges, the government of Ethiopia has envisioned 'Path towards Universal Health Coverage through Strengthening Primary Health Care'. The first phase of it is the Health Sector Transformation Plan (HSTP) which sets out four transformation agenda. Woreda Transformation is one of the agenda. The Woreda Transformation aims at creating high performing woredas through achieving

high performing primary health care units and model kebeles, and covering all residents of the woreda by community based health insurance. This assessment is about measuring the status of the top 10% of the woredas based on their performances on health development army, state of good governance and service delivery.

Woreda Transformation

Woreda is an administrative division in Ethiopia with an average population of 100,000. It is managed by democratically elected council that forms a local government. Woredas are composed of a number of **Kebeles**, which are the lowest administrative units. As per the national standard for health facilities, on an average, a woreda is expected to have 20 health posts, 4 health centers and a primary hospital. In general, one health center along with 5 health posts around it form a primary health care unit. The woreda health office is organized to provide administrative and technical support to all of these primary health care facilities.

Rationale for Woreda Transformation

Evaluation of the 20 years of implementation of the health sector development program (HSDP) showed that there is high degree of variation in performance of the public health sector across settings and population segments. These evaluation findings point towards the necessity to narrow the gap across socio-demographic dimensions, if Ethiopia is to achieve equitable improvement in health of the population. One of the means to narrow the gap is through engaging the community in planning, resource allocation and decision making. The other way is to create an accountable, learning and responsive health system. Woreda is at

⁸Ministry of Health, Health Sector Transformation Plan EFY2008-EFY2012, EFY2007

⁹Ministry of Health, Health Sector Transformation Plan EFY2008-EFY2012, EFY2007

the center of the decentralized governance system of Ethiopia, and is best placed as the nucleus of all initiatives to narrow the gap on health service delivery, its outcome and the underlying cause. Transformation of the woredas will bring high performing health system near to the community and, at the same time, translate the health policies and strategies in to actions.

Woredas are the main development hubs; enhancing the implementation capacity of Woredas plays a massive role to accelerate general developmental activities including the growth and development of the health sector. The Woreda Transformation plan intends to assure the equity and quality of primary healthcare services by creating awareness and public participation in health service delivery.¹⁰

Objectives

The objectives of this study were to:

- Measure the level of implementation of health development army mechanism at woreda level
- Measure the state of good governance at woreda level
- Identify gaps on service delivery between woredas on selected Key Performance Indicators
- Measure the extent of high performing

Methodology

The study used both quantitative and qualitative methods of validation. Sample size selection was purposive, based on criteria. The study was done in two phases. In the first phase, regions selected high performing woredas based on the tool adapted and modified from the woreda transformation implementation manual. Woredas that got above 70% of their respective region's aggregate were selected. In the second phase, validation teams were recruited from MOH, development partners and hospitals. The teams visited woreda health offices and health centers for validation.

A total of 87 woredas were selected. The sample size is around 10% of the total 840 woredas in the country. The

study took place from June 20- July 11, 2016. A total of 21 teams, each team comprised of 3 public health professionals with a minimum of 5 year experience were involved in the validation. Data collectors were trained by principal investigator for one day on purpose of the study, meaning of each question and validation techniques. The team observed open defecation free (ODF) verification process, plans, review meeting agenda, facility HMIS and administrative data. At health facility level the team carried out accuracy checks by comparing reports with registers and tally sheet.

Table 1: Number of Woredas selected by region

Region	Number of Sample Woreda	Region	Number of Sample Woreda
Afar	3	SNNPR	10
Tigray	13	Gambela	3
Amhara	10	Benishangul Gumz	3
Oromia	13	Harrari	9
Somali	3	Dire Dawa	10
Addis Ababa	10		

Analysis

The performance of service coverage indicators are categorized using a scorecard approach as (1) high performing, (2) medium performing, and (3) low performing. The cut-off points were agreed upon at national level aiming to influence decision making towards achievement of Woreda transformation. Low performing woreda or red colored woreda indicates the need to prioritize effort. Medium performing (yellow color) woreda indicates that the woreda could reach high performing status with close follow up and support. High performing (green color) indicates the woreda is on the right track to transformation.

¹⁰Ministry of Health, Implementation Manual of the Woreda Transformation Plan, 2016

Table 2: Woreda Transformation Scorecard, EFY 2008

Indicators	HSTP Baseline	Red	Yellow	Green
Long term family planning method mix	NA	<30%	30%-40%	>=40%
Option B+ Coverage	59%	<75%	75%-94%	>=95%
Skill delivery coverage	60%	<60%	60%-94%	>=95%
Early post natal coverage	90%	<60%	60%-94%	>=95%
Dropout rate (Penta 1 to Penta 3)	10%	>10%	5%-10%	<=5%
Fully Immunized children coverage	86%	<75%	75%-94%	>=95%
Proportion of HIV +ve adults and children who are currently on ART	55%*	<75%	75%-89%	>=90%
Proportion of all forms of TB cases detected	61%	<75%	80%-89%	>=90%

NB: The “currently on ART” baseline data is only for adults (age 15+). The baseline is 14% for pediatrics.

Result and Discussion

Data was collected from a total of 87 woreda in all regions. The result of the study was categorized into three sections. These are the status of the Health Development Army, state of good governance, and that of service delivery. The analysis of data is performed using SPSS Version17. Descriptive statistics such as frequency and mean are computed. Tables and charts are used to present the data.

Woreda BSC Plan

The woreda planning process is being prepared using a balanced score card (BSC) approach. The BSC is a strategic planning and management system designed to help everyone in the woreda to understand and work towards a shared vision and strategy. It aligns the woreda strategy with individual behavior and day to day operation.¹¹ The study found that all woredas prepared their 2008 EFY annual plan. In the process of preparation of the woreda plan, primary health care units (PHCU) and key stakeholders such as line sectors, local NGOs, women forum, and religion organizations are expected to participate and get orientation on approval of the plan. The study showed that nearly 91% woredas provided orientation to PHCUs and key stakeholders.

Performance Review

Health Development Army (HDA) guideline states that to improve the performance of priority indicators close follow up and decision making should be carried out by the command post (Management body). Command post is a governance body of the woreda comprised of members such as woreda administrator, woreda health office head, and heads/representative of the woreda women office and other related sectors. They are meeting every two weeks to follow the performance of health facilities on selected 7-10 key indicators.¹²

The study found that in just more than half of the woredas (53%), command posts reviewed performance every two weeks and provided feedback during the past 1 year; 29 percent of woredas were conducting performance review monthly and 18 percent woredas were doing so at least quarterly.

Report Quality

Representative completeness refers to the proportion of health facility reports received at woreda office at specified time out of the total health facilities in the woreda.¹³ Report completeness was measured taking Miazia 2/2008EFY as a reference point to receive health facility report. The study showed that representative completeness was 82%. That means around 8 out of 10 woredas received megabit month report from all the health facility within their jurisdictions.

Health Development Army

In 2004EFY, MOH started implementation of health development army (HDA) at in the health system. HDA refers to an organized, inclusive and collaborative movement of the community through participatory learning and action. The HDA provides a platform which is inclusive and allow all members of the community to be organized and engaged in improving their own health status together with the HEWs. At community level, model family or better performing family form a network with 5 nearby families based on physical proximity (neighborhood) and socio-cultural relation. A functional HDA network prepare plan, regularly meet to discuss and solve health problem of the community. Guideline was developed to support the functionality of networks. The study showed that 51 out of 87 woredas have had more than 90% functional 1 to 5 HDA network.

¹¹ Ministry of Health, Balanced Scorecard Implementation Guideline, EFY2005

¹² Ministry of Health, Health Development Army Implementation Guideline, EFY2003

¹³ Ministry of Health, Health Management Information System, Indicator definition technical guideline, EFY2006

Home Delivery Free Kebeles

Skill birth attendance is one of the key factors to reduce maternal mortality. Thousands of mothers die due to delivery at home. Several studies show that three-fourth of maternal mortality could be averted by skill delivery.¹⁴ The 2007EFY report shows that about 7 out of 10 births were attended by skilled health personnel. That means 3 out of 10 births were attended at community level. Home delivery free implementation guideline states that cultural, religious, traveling distance to health facility and economic factors are barriers to institutional delivery.¹⁵ The study measured kebeles that are home delivery free. Twenty seven out of 87 (31%) woredas have more than 85% home delivery free kebeles.



Open Defecation Free Kebele

The Health Extension Program is one of the government's primary vehicles to drive the improvement of sanitation at kebele level. Kebeles that declared open defecation free were assessed. Twenty four out of 87 woredas have more than 85% of their kebeles declared open defecation free.

Good governance

Implementation of the principles of good governance in the health sector requires creating enabling environment such as planning and review state of good governance, developing citizen charter (service standard), integrating supportive supervision, and including the marginalized segment of the community in planning and service provision. These four criteria are set as mandatory for all health institutions to be fulfilled.¹⁶ The fulfillment of the above four criteria is measured as met and not met. A composite score is calculated based on meeting the above criteria as shown in Figure 1 below. The figure showed that only 4 out of 10 woredas met the enabling environment criteria for good governance. Also 6% of woredas did nothing regarding fulfillment of good governance plan, inclusion of community that need special support, integrating supportive supervision and development of citizen charter.

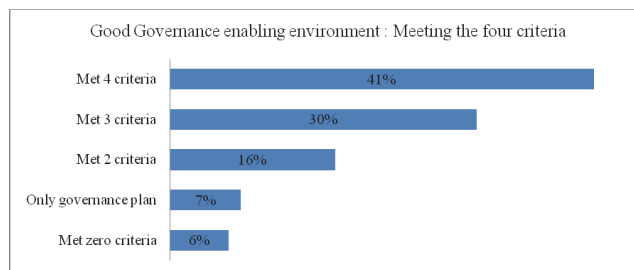


Figure 1: Proportion of woredas that met good governance infrastructure (Good governance plan & review, integrating in supportive supervision, inclusion of population need special attention and preparation of citizen charter), EFY2008

According to the guide to enhance good governance in health system of low and middle income countries, collaboration, participation, inclusion are elements of engaging stakeholders.¹⁷ Inclusion and collaboration are two important principles that enable effective governance. Being inclusive involves engaging all relevant stakeholders—across gender, age, race and ethnic groups, socioeconomic status, health and disability status, and location—in the decision-making process. Collaboration involves building partnerships across ministries, sectors, and levels of authority, private-for-profit and nonprofit groups and civil society organizations and NGOs.

In this assessment, stakeholder engagement practices were assessed based on four criteria: (i) conducting regular public forum, (ii) preparing joint plan and overseeing with partners and sectors, (iii) addressing gender responsiveness by conducting gender analysis, and (iv) addressing health inequality by conducting equity analysis. The fulfillment of the above four criteria is measured as met and not met. A composite score is calculated based on meeting the above criteria as shown in Figure 2 below. The figure shows that half of the woredas met all the four stakeholder engagement criteria. One in five woredas met only one criteria of stakeholder engagement.

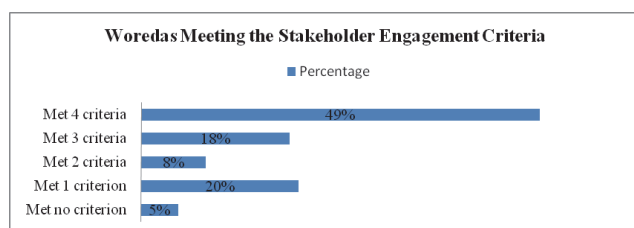


Figure 2: Proportion of woredas that met stakeholder engagement criteria (Joint plan, Regular public forum, Gender analysis and Equity analysis), EFY2008

¹⁴ WHO, UNICEF, the World Bank. Trends in maternal mortality 1990 to 2008: estimates, 2010

¹⁵ የፌዴራል ጤና ጥበቃ ሚኒስቴር፣ ቤት ከመውለድ ሃገ የሆኑ ቀበሌዎችን የማፍረያ የአተገባበር መመሪያ፣ 2006 ዓ.ም

¹⁶ Ministry of Health of Ethiopia, Good Governance Monitoring and Evaluation Framework, EFY2008

¹⁷ USAID-LMG Project, Guides for Enhanced Governance of the Health Sector and Health Institutions in Low- and Middle-Income Countries: Engaging Stakeholders for health systems strengthening, 2014

Health equity at outcome level refers to coverage of high impact intervention disaggregated by relevant equity dimensions. A trend analysis of EDHS 2000 to 2014 showed, widening trend of inequality in skill delivery between rural and urban as well as between the poor and rich. State of inequality of woreda was measured based on absolute difference between the woreda average and the lowest PHCU on skill delivery coverage. Figure 3 shows that, 4 in 10 woredas have had more than 15% difference of coverage between the woreda average and the low performing PHCU on skill delivery. The result reflects the need to additional effort in narrowing performance gap among PHCUs.

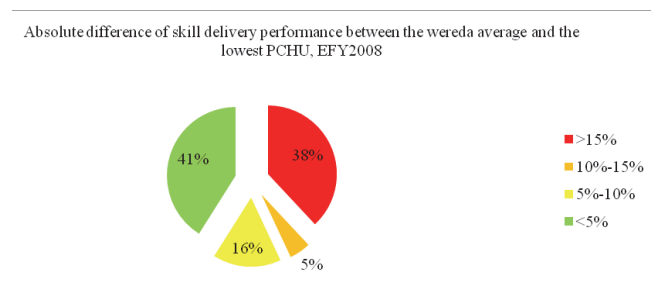


Figure 3: Proportion of woreda with skill delivery coverage difference between the Woreda average and the lowest performing PHCU

Service Coverage

The performances of the woredas were measured based on 8 service coverage indicators. The indicators show status of service delivery in maternal health, family planning, immunization, TB and HIV/AIDS prevention and control programs. The indicators are categorized into three based on the achievement of the expected changes according to the Ministry of Health's Woreda Transformation implementation manual. Woredas are classified as low performing (red color), medium performing (yellow color) and high performing (green color). Figure 4 and 5 show the proportion of woredas that met transformation target and proportion of low performing woredas respectively.

The MOH has aggressively been scaling up long acting family planning methods starting from EFY2003 (Implanon) and from EFY2004 Intra Uterine Device. According to the 2014 EDHS, Injectables and Pills comprise 74% and 6% respectively while Implanon and Intra Uterine Device comprise 12% and 3% respectively of the method mix. Improving the method mix of long term family planning improves contraceptive prevalence rate and reduces unmet need for family planning. This study showed that 38% of woredas have more than 40% long term family planning accepters. That means nearly 4 out of 10 woredas met target set for transformation. Conversely, similar proportions (40%) of woredas were low performing towards the transformation and rated as red.

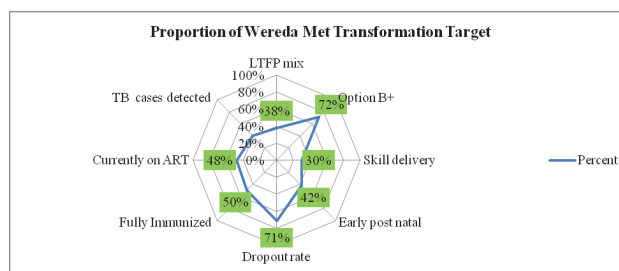


Figure 4: Proportion of Woredas that met transformation target, 2008EFY

Improving the health of mothers and newborns is among the main priorities of health sector transformation plan. Number of high impact and cost effective initiatives are being applied focusing mainly on increasing service utilization for Maternal, Neonatal and Child Health (MNCH) services. The study showed that nearly 3 out of 10 woredas achieved more than 95% of births attended by skilled health personnel. Four out of 10 woredas met the target set for transformation of on early post natal care coverage. However, 38% and 26% of woredas were low performing for skill delivery and early PNC services.

The MOH has been implementing an integrated register to follow the mother and baby as a paired cohort (option B+) to improve prevention of Mother to Child Transmission (MTCT) of HIV, in the study three-fourth of the Woredas have had more than 95% coverage of Option B+. That means 3 out of 4 pregnant and lactating mothers tested positive for HIV were receiving ART at antenatal care, labor and delivery or postnatal care based on option B+.

Regarding child health, HSTP sets a target to increase fully immunized children coverage from 86% to 95% and dropout rate (Penta 1 –MCV1) from 10% to 3% from the baseline year EFY2007 to EFY2012. The study showed that nearly half (49.4%) of the woredas achieved more than 95% fully immunization coverage. However, 1 out of 4 woredas had immunization coverage less than 75%. Drop out of children who were vaccinated for Penta 1 but did not get vaccinated for Penta 3 was calculated. About 7 out of 10 woredas achieved <5% dropout rate.

According to the “HIV related estimates and projections for Ethiopia-2012”, the adult HIV prevalence is estimated at 1.1% (0.8% in males and 1.5% in females) and the adult HIV incidence at 0.03% in EFY2007. A linear increase was observed in the number of People Living with HIV (PLHIV) currently on ART from 247,805 in EFY2002 to 375,811 in EFY2007.¹⁸ This study showed, nearly half of woredas achieved more than 90% (from their target) for adults and children who are currently on ART. However, a third of the woredas achieved low performance.

¹⁸ Ministry of Health, HSDP IV Annual Performance Report, EFY2007

Ethiopia is among the 22 high TB burden and 27 high MDR TB burden countries in the world with an estimated number of 233,000 new cases of TB (incidence rate 224 per 100,000 populations) reported in 2013¹⁹. This study showed that 41.4% (N=36) woredas achieved more than 90% of TB case detection rate (all forms), while nearly half of the woredas achieved less than 75% of TB case detection rate (all forms).

immunization program and on prevention of mother to child HIV transmission using option B+. Performances on TB case detection, use of long term family planning method and skill delivery were challenges for the notable number of woredas.

The findings of this assessment suggest that the need to improve the functionality of health development army,

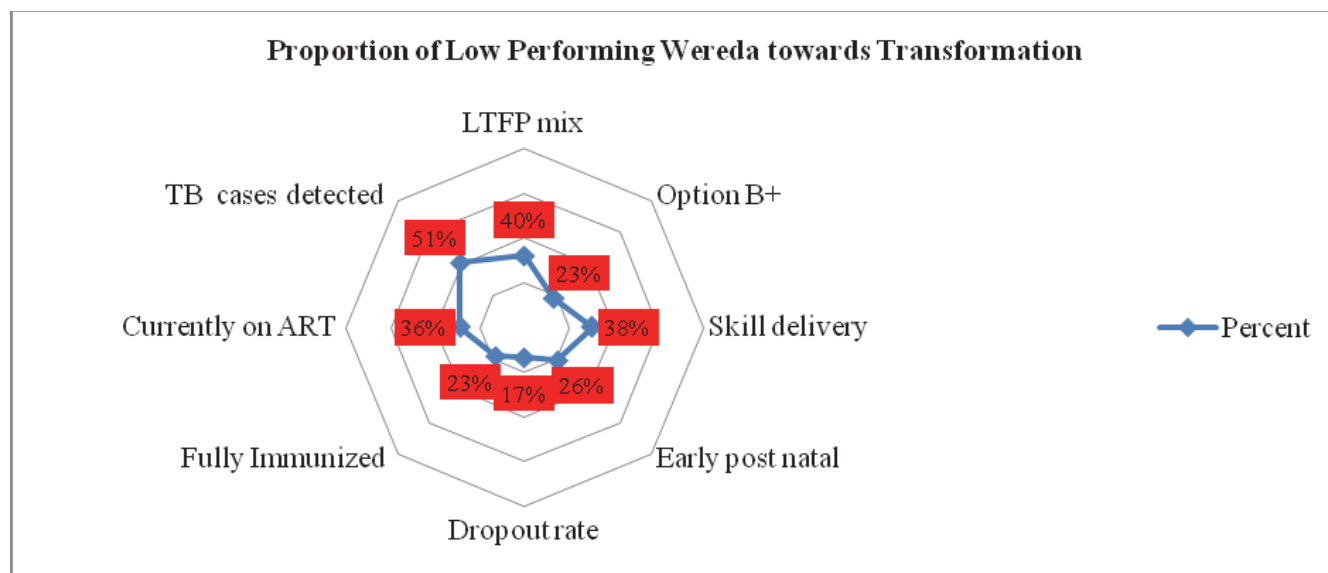


Figure 5: Proportion of low performing Woredas towards transformation, EFY2008

Conclusion and Recommendation

The validation study highlighted the performance of top 10% woredas in the country. Almost all woredas prepared annual plan and communicated to the key stakeholders. The Woreda Command Posts oversee priority programs using key indicators on bi-weekly or on monthly basis. In most of the woredas complete reports was being utilized for decision making. However, the functionality of 1 to 5 networks was at sub-optimal level. In only about 30% of woredas more than 85% of kebeles declared free of open defecation and home delivery.

Implementation of good governance principles in structured manner is a recent phenomenon. Less than half of the woredas were implementing initiatives such as engaging stakeholders, developing citizen charter, addressing equity, and integrating supportive supervision to enhance good governance. There was high variation in implementation of good governance across woredas.

Regarding service coverage, there was an encouraging performance of meeting the target set for woreda transformation considering the baseline of HSTP. Most woredas were on track to transformation on

enhancing good governance and addressing variability of performance across woredas. The performance of home delivery free kebeles, skill delivery coverage and its inequality at PHCU level could be a good indicator (litmus blue) to monitor woredas transformation. The team also suggests further in-depth analysis to explore the meaning beyond the quantitative result. Also, the sample woredas are top performing, and therefore, there is a need to include low performing woreda at the bottom end to have a better understanding of the factors impeding achievements in those woredas as well.

¹⁹ Global TB Report, 2014. WHO. Geneva

Section 2:

Engaging Stakeholder



General satisfaction rate and associated factors among users of public Regional, Federal and University hospitals in Ethiopia

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Abstract

Identifying the factors which influence the satisfaction of patients is crucial in planning and improving the quality of health services to fulfill the needs of those who utilize them.

The objective of this study was to identify the factors which are associated with satisfaction of hospital service users and to measure the rate of satisfaction in regional, federal and university hospitals in Ethiopia.

A cross sectional study was conducted in 18 federal, regional and university hospitals of Ethiopia and 1450 patients were interviewed among whom 781 (54.1) were females, 949 (65.1%) were aged between 20 and 40 years,

The rate of general satisfaction in this study was 51.8% and the factors associated with general satisfaction in

this study were found to be starting of hospital services on time, lab tests queue, getting all lab tests at the same facility, getting all medications at the same facility, shorter surgical appointment and having organized compliant handling procedure. Properly addressing these issues will likely result in improved general satisfaction of patients at Ethiopian hospitals.

Introduction

Patient satisfaction is the fundamental importance as a measure of the quality of care because it gives information on the provider's success in meeting client values and expectations, matters on which the client is the ultimate authority (1). The Health Sector Transformation plan (HSTP) was developed and implemented with many goals aiming at solving

the many aspects of good governance problems in the Health sector which is directly associated with increasing patient satisfaction. This was followed by the preparation of the Good Governance package and the good governance monitoring and evaluation framework which was developed with the participation of Ministry of Health officials, regional health bureau (RHB) heads and agencies (2, 3).

The quality assurance and accreditation process in most countries requires that the satisfaction of clients be measured on a regular basis (5). According to Donabedian the effectiveness of care, in achieving or producing health and satisfaction, is the ultimate indicator of the quality of care (6). Studies in developed countries have noted that hospitals with more satisfied patients generally provided higher quality of care as measured by validated quality metrics using standard methodology. Studies around the world have also noted that patient satisfaction is associated with increased compliance with the prescribed treatment and discharge instructions, reduction of complaints against the institution and improvements in morale and job satisfaction among health-care providers; this in turn can be of benefit to both patients' health outcomes and relationships with health-care professionals. Patient's experience of care is becoming a more and more important indicator of quality of care which is tightly associated with patient satisfaction (7).

A study conducted in Hong Kong indicated that respect and patient engagement in provider-patient relationship communication, are important in determining patient's satisfaction. There is evidence that patient socio-demographic characteristics also affect patient satisfaction level. Satisfaction can be associated with patient characteristics, including age, gender, race, educational level and health status. In addition, previous admissions and the length of the current admission also affect the patient satisfaction response (8, 9). A study done in Bangladesh indicated that perceived technical quality of care for the client plays a lesser role in affecting satisfaction than the interpersonal nature of care, access to care, or continuity of care. In this study, the most powerful predictor for client satisfaction with the government services was provider behavior, especially respect and politeness. The second most powerful predictor for being satisfied was the respect for privacy, followed by short waiting times (10). A study done in an Indian tertiary care hospital, the highest level of health care, on inpatient satisfaction indicated that patients were more satisfied with the behaviour of doctors, but dissatisfaction regarding cleanliness in the toilets (62%) and wards (40%). Twenty six percent of the clients were dissatisfied with the number of visits of the doctors (11).

The study findings from Jimma specialized hospital showed the highest patient satisfaction (82.7%) with the way the doctors examined them. however they also had the highest reported dissatisfaction with the time spent to see a doctor (46.9%). Satisfaction with health care was found to have a significant association with the older age of the respondents ($p=0.034$) and educational level of the respondents ($p=0.003$) (4). The results on the patient's satisfaction in Eastern Ethiopia indicated that, unlike in Jimma, the satisfaction with health care services significantly associated with waiting time, the availability of drugs, and also free user's and rural patients' level of satisfaction tend to be higher (12).

The components of factors affecting patient satisfaction were described in the journal of innovative medicine as follows (4);

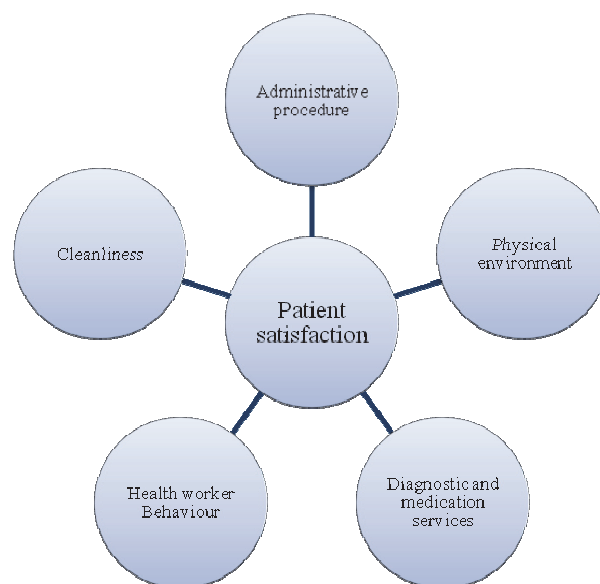


Figure 1. Factors affecting patient satisfaction at hospitals (adapted and modified from Dhynna and Dr. R.venkatesh)

The Government of Ethiopia is firm about establishing good governance in the health system, particularly in the hospitals which is very closely related to patient satisfaction. The government also sees good governance as directly contributing to patients' satisfaction with the health services and as such, alleviating the currently increasing trend of patient complaints with the services provided at the hospitals and health centres.

Study objective

The general objective of this study was to identify associated factors of patient satisfaction, to measure patient satisfaction on regional, federal and university hospital services and to forward important recommendations

Specific Objectives

- To identify factors which contribute to higher satisfaction of patients with hospital care
- To identify the rate of satisfaction on selected hospital services and
- To forward relevant recommendations based on identified factors

Methodology

A hospital based cross sectional study was conducted from February to August 2016. A total of 18 hospitals were included in the study. Six hospitals one from each of the four agrarian and two city administrative regions were randomly selected from the regions. Two federal hospitals in Addis Ababa and all of the 10 university hospitals in the country were included in the study.

The study population for this study was clients coming to regional, federal and university hospitals, who were aged 15 years and above. Those under 15 years and critically ill were excluded from the study.

The sample size was calculated using the formula $n = (z\alpha/2)^2(p)(1-P)/D^2$ Where $z = 1.96$, marginal Error (D) $= 0.03$ and taking $p = 0.5$ conservatively, the sample size needed to do the study was 1067. A total of 1450 patients were interviewed during the study, after cleaning and rejecting inconsistent questionnaires.

The data collection in each hospital was performed using a structured and pretested questionnaire and was done by the respective hospital staffs, usually from planning and quality department, after getting detail orientation. It took from 3-5 days and was collected in the morning when there was a high flow of clients. In each hospital 100 samples were allocated to be collected. The non-respondent rates varied from hospital to hospital. During sample collection proportional allocation based on patient load was used at all hospital sites by allocating half of the samples to OPD, and one quarter of the samples to emergency and inpatients each.

Quantitative data was collected from patients using structured questionnaire in a scale of five LIKERT-scales from “very good” to “very bad”. And data was collected during the period from Feb. - June 2016.

Each questionnaire was coded. Data was entered in

to excel, cleaned and exported to for multivariate analysis. Frequencies, proportions and significance tests among some variables, degrees of association between dependant and independent variables using odds ratio and 95% Confidence level were analyzed. Ordered logistic regression was used to identify the factors related to satisfaction and to control for confounding. Parallel regression assumption was tested using brant detail and the p value was 0.152 which is not significant. So the proportional assumption in the model was not violated. The model fitted was also tested for multicollinearity and goodness of fit.

Definition of terms:

Service Rating: The hospital services were rated on a five LIKERT scale from very good to very bad. The criteria for rating were based on the available national standards for each indicated service.

General satisfaction: the perception of a service user on the clinical and administrative services given by the respective hospital

Starting services on time: it is the starting of clinical and administrative services at the appropriate time of the day or work start hours (8:30 am) by the hospital.

Getting all labs: getting every necessary lab and radiology investigations at the same facility where services were sought.

Getting all medicines: getting every necessary prescribed medicine at the same facility where services were sought.

Surgical appointment: time between requesting appointment, and attending appointment especially for elective surgery.

Ethical consideration

Authorization to conduct the study was received from MOH. Written permission was received from each hospital prior to implementation. Before conducting each interview informed consent was obtained from each participant.

Results

Table 1: List of Hospitals and number of clients included in the assessment

<i>Hospital name</i>	<i>Region</i>	<i>number</i>	<i>Percent</i>
<i>Adama</i>	<i>Oromia</i>	<i>70</i>	<i>4.8%</i>
<i>Adare</i>	<i>SNNP</i>	<i>66</i>	<i>4.6%</i>
<i>Amanuel</i>	<i>Adis Ababa</i>	<i>90</i>	<i>6.2%</i>
<i>Arsi</i>	<i>Oromia</i>	<i>85</i>	<i>5.9%</i>
<i>Ayider</i>	<i>Tigray</i>	<i>93</i>	<i>6.4%</i>
<i>Black lion</i>	<i>Addis Ababa</i>	<i>73</i>	<i>5.0%</i>
<i>Debreberihan</i>	<i>Amhara</i>	<i>85</i>	<i>5.9%</i>
<i>Dilchora</i>	<i>DireDawa</i>	<i>49</i>	<i>3.4%</i>
<i>Dilla</i>	<i>SNNPR</i>	<i>88</i>	<i>6.1%</i>
<i>Gonder</i>	<i>Amhara</i>	<i>84</i>	<i>5.8%</i>
<i>Hawasa</i>	<i>SNNP</i>	<i>96</i>	<i>6.6%</i>
<i>Hiwot Fana</i>	<i>Hareri</i>	<i>64</i>	<i>4.4%</i>
<i>Jimma</i>	<i>Oromia</i>	<i>98</i>	<i>6.8%</i>
<i>Jugal</i>	<i>Hareri</i>	<i>50</i>	<i>3.4%</i>
<i>Mekelle</i>	<i>Tigray</i>	<i>85</i>	<i>5.9%</i>
<i>Sodo</i>	<i>SNNPR</i>	<i>80</i>	<i>5.5%</i>
<i>St Peter</i>	<i>Adis Ababa</i>	<i>98</i>	<i>6.8%</i>
<i>Yirgalem</i>	<i>SNNPR</i>	<i>96</i>	<i>6.6%</i>
<i>Total</i>		<i>1450</i>	<i>100.0%</i>

As shown in Table 5, there were some missing socio demographic characteristics that were not responded. Among the respondents 781(54.9%) were females, and the majority (949, 65.1%) were aged between 20 and 40 years and 899 (62.0%) were married. Regarding their educational status 446(30.8%) had secondary school education followed by 398(28%) who had above secondary school level.

With regard to the employment of the respondents 233 (16.1%) had no job, 311(21.4%) did farming, 358(24.7%) were government employees, 398(27.4%) did private jobs. Concerning the monthly income of respondents 257 (17.7%) had no income, 368(25.4%) earn between 700 and 1500 birr and 394 (27.2%) earn above 1500 birr. The majority 961(66.3%) were paying customers, while 364 (25.1%) were free service users.

Table 2: Socio- demographic characteristics of users of selected services of hospital regional and federal hospitals, Ethiopia

Variables		Number	Percent
Sex	Male	663	45.7
	Female	781	54.9
	Missing	6	0.4
Age	<=20	147	10.1
	>20-40	949	65.1
	>40-60	283	19.7
	>60	71	5.1
Marital Status	Married	899	62.0
	Unmarried	409	28.2
	Missing	142	9.8
	Illiterate, Read and write	283	19.5
Education status	Primary	296	20.4
	Secondary	446	30.8
	Above Secondary	398	27.4
	Missing	27	1.9
Residence	Urban	893	61.6
	Rural	452	31.2
	Missing	105	7.2
	No Job	233	16.1
Work	Farming	311	21.4
	Govt. employee	358	24.7
	Private	398	27.4
	Student	150	10.3
Monthly income	Poor	257	17.7
	<700	344	23.7
	<1500	368	25.4
	>1500	394	27.2
	Missing	87	6
	Free	364	25.1
Service type	Paying	961	66.3
	Fee waiver	64	4.4
	Missing	61	4.2

Rating of selected hospital services by users

According to the respondents starting OPD services on time were rated “very good” by 419(30%), “good” by 400(28.7%), “medium” by 263 (18.8%), “bad” by 149 (10.7%) and “very bad” by 165 (11.8%). Getting all the necessary laboratory tests in the same facility was rated “got all tests” by 624(49.7%) and ‘did not get at least one test’ by 632 (50.3%). Laboratory queue were rated as “very good” by 254(19%),

“good” by 387(29%), “medium” by 365 (27.4%), “bad” by 190 (14.2%) and “very bad” by 138 (10.3%). Getting all the necessary medicines in the same facility were rated “got all medicines” by 522(40.4%) and “did not get at least one medicine” by 770 (59.6%). Complaint handling at facility was rated as “very good” by 251(19%), “good” by 277(21%), “medium” by 239 (18.1%), “bad” by 248 (18.8%) and “very bad” by 307 (23.2%). These results as well as others are described in table three

Table 3: Rating of selected hospital services by users

Variables		Number	Percent
Fast card Retrieval	Very good	405	27.9
	Good	462	31.8
	Medium	253	17.5
	Bad	156	10.8
	Very bad	174	12.0
Health workers respect	Very good	501	35.0
	Good	455	31.7
	Medium	264	18.2
	Bad	134	15.1
	Very bad	96	6.2
Start services on time	Very good	430	30.0
	Good	411	28.7
	Medium	274	18.8
	Bad	160	10.7
	Very bad	175	11.8
Getting all lab tests	Got all lab tests	721	49.7
	Did not get at least one	729	50.3
Laboratory queue	Very good	277	19.0
	Good	410	29.0
	Medium	388	27.4
	Bad	213	14.2
	Very bad	162	10.3
Getting all medicines	Got all medicines	601	40.4
	Did not get at least one	849	59.6
Complaint handling	Very good	277	19.0
	Good	303	21.0
	Medium	265	18.1
	Bad	273	18.8
	Very bad	332	23.2
Toilet cleanness	very good	269	18.4
	Good	305	24.1
	Medium	291	20.1
	Bad	208	13.9
	Very bad	356	26.5

State of General satisfaction by hospital service users

When analyzing General patient satisfaction the Likert scale was merged from five response options in to three categories of “satisfied”, “neutral” and “unsatisfied” by merging good and very good as satisfaction and bad and very bad as dissatisfaction while the neutral scale remains as it was. The rating produced for general satisfaction indicates that 725(51.8%) were “satisfied”, 297(21.2%) were “neutral” and 377(27%) were “unsatisfied” with the services given. When respondents compared the current facility with the previous facility they visited, 807(58.4%) were more satisfied with the current hospital, 303(21.9%) were neutral and 273(19.7%) said their satisfaction with the current facility was below the satisfaction level for previous last facility they visited.

Table 4: State of general satisfaction by hospital service users

Variables		Number	Percent
General satisfaction	Satisfied	725	51.8
	Neutral	297	21.2
	Unsatisfied	377	27.0
Satisfaction when compared-satisfied to previous facility		807	58.4
	neutral	303	21.9
	Unsatisfied	273	19.7
Recommending this Facility to others	Satisfied	842	60.2
	neutral	286	20.4
	Unsatisfied	271	19.4

Key factors affecting satisfaction of hospital service users in Federal, regional and university hospitals in Ethiopia

Table five summarizes the variables which were associated with general satisfaction. The general ordered logit model was significant with X^2 value of 178.02 and a p-value <0.0001. The model’s assumption of parallel regression was tested using brant test and it was not significant (p=0.152) indicating that the assumption was not violated. Reliability of the model was also tested and the Cronbach’s alpha was high, 0.910.

Unlike the other studies socio demographic variables were not associated with general

satisfaction in this study. As observed in the analysis a unit increase in starting services on time i.e. an increase from “very bad” to “bad” to “medium”, etc the odds of being in a high level of general satisfaction is 1.57 times higher given that all the other variables in the model were held constant (P= 0.001, CI=1.19-2.07). Similarly, patients were 1.30 times more satisfied with the hospital when they were satisfied with lab tests queue (p= 0.03, CI= 1.03-1.65) given that all the other variables in the model were held constant. A unit increase in getting all lab tests at facility i.e. from “miss at least one test” to “get all tests”, the odds of being in a high level of general satisfaction was 1.40 times higher given that all the other variables in the model were held constant (p= 0.00, CI= 1.20-1.62).

As shown in the table below getting all medicines at facility would result in a 1.28 times higher

general satisfaction (p= 0.004, CI= 1.08-1.52) given that all the other variables in the model were held constant. A unit increase in surgical appointment time i.e. from “very bad” to “bad” to “medium”, etc the odds of being in a high level of general satisfaction was 1.25 times higher given that all the other variables in the model were held constant (p= 0.019, CI=1.04-1.51). General satisfaction was also associated with having organized complaint handling procedures. The odds of being in a high level of general satisfaction was 1.24 times higher, (p= 0.04, CI= 1.01-1.53), when there was organized complaint handling procedure, given that all the other variables in the model were held constant.

Table 5: Ordered Logit Estimation of Key Drivers for Patient Satisfaction

Independent Variables	OR	Std. Error	Z Value	Sig.	95% CI	
(1) Age , <=20	0.1	0.794	1.56	0.212	-0.57	2.55
[Age, >20-40]	-0.44	0.628	0.5	0.48	-1.67	0.79
[Age, >40-60]	-0.06	0.684	0.01	0.932	-1.4	1.28
[Age, >60 base]	0	.	.	.	.	.
(2) M. status=not married	0.12	0.301	0.153	0.696	-0.47	0.71
M. status=married	0	.	.	.	.	.
(3) Residence=rural	0.04	0.328	0.012	0.913	-0.61	0.68
[Residence=urban	0	.	.	.	.	.
(4) Education=read and write	-0.39	0.47	0.675	0.411	-1.3	0.53
Education =primary	0.2	0.39	0.259	0.611	-0.57	0.96
Education=secondary	-0.08	0.324	0.066	0.798	-0.72	0.55
Education=higher Edu.	0	.	.	.	.	.
(5) Work=no work	0.07	0.544	0.011	0.917	-1.01	1.12
Work=farmer	0.03	0.556	0.003	0.955	-1.06	1.12
Work=Govt. employee	0.77	0.538	2.04	0.154	-0.29	1.82
Work=private	0.13	0.505	0.066	0.797	-0.86	1.12
Work=student base	0	.	.	.	.	.
(6)monthly pay= poor	-0.34	0.48	0.499	0.48	-1.28	0.6
monthly pay = <700	0.14	0.375	0.144	0.704	-0.59	0.88
monthly pay = <=1500	-0.41	0.321	1.603	0.205	-1.04	0.22
monthly pay =>1500	0	.	.	.	.	.
(7) Card Retrieval	0.99	0.12	-0.08	0.93	0.78	1.25
(8) Start on time	1.57	0.22	3.21	0.001**	1.19	2.07
(9) OPD queue	0.92	0.12	-0.63	0.53	0.71	1.19
(10) Health workers respect	1.21	0.18	1.3	0.19	0.91	1.61
(11) Lab tests queue	1.3	0.16	2.22	0.03**	1.03	1.65
(12) Getting all lab tests	1.4	0.11	4.35	0.00 **	1.2	1.62
(13) Health w. counseling	0.96	0.11	-0.35	0.73	0.76	1.21
(14) Toilet	1	0.1	0	0.1	0.82	1.23
(15) Pharmacy room queue	1.15	0.13	1.22	0.22	0.92	1.44

(16) Getting all medicines	1.28	0.11	2.9	0.004**	1.08	1.52
(17) Surgical appointment	1.25	0.12	2.34	0.019**	1.04	1.51
(18) Nurse follow up	1.17	0.13	1.37	0.17	0.93	1.47
(19) Doctor follow up	0.88	0.1	-1.11	0.267	0.7	1.1
(20) Discharge counseling	1.01	0.13	0.1	0.922	0.79	1.3
(21) Complaint handling	1.24	0.14	1.92	0.040**	1.01	1.53

Note: **significantly associated factor

Model fitting information

Multicollinearity test was performed to the ordered logit model being fitted, by evaluating the variance inflation factor (VIF) values of independent variables. As shown in Table 6, none of the key drivers of patient satisfaction have VIF values more than 10 and no serious multicollinearity problem was found.

Table 6: Multicollinearity Test

Variable	VIF	1/VIF
Age	1.27	0.79
Work	1.25	0.80
Service type	1.21	0.82
Marital status	1.19	0.84
Residence	1.35	0.74
Start on time	2.37	0.42
HW respect	2.11	0.47
OPD queue	1.97	0.51
Nurse follow up	1.80	0.56
Card retrieval	1.77	0.56
Dr follow up	1.74	0.57
Education	1.72	0.58
Discharge counseling	1.69	0.59
HW counseling	1.59	0.63
Pharmacy queue	1.58	0.63
Getting all labs	1.55	0.65
Complaint handling	1.52	0.66
Lab queue	1.50	0.67
Monthly pay	1.46	0.68
Getting all medicines	1.44	0.69
Toilet	1.43	0.70
Surgical appointment	1.37	0.73

Mean VIF = 1.59

Table 7 indicates the measures of fit values of the ordered logit model being fitted. Since the model has very small Akaike and negative Bayesian Information Criteria, it may be suggested that the model has acceptable measures of fit.

Table 7: Goodness of fit

Measures of fit criteria	Value
Log-Likelihood Intercept Only:	-604.539
Log-Likelihood Full Model:	-512.804
LR (279):	1025.609
P > LR:	0.000
Adjusted R2:	0.412
Akaike information criteria:	3.548
Bayesian information criteria:	-567.601

Discussion and recommendation

Understanding the factors that influence the satisfaction of service users is necessary to improve the quality of health services so as to meet the expectations of service users (5). Among the respondents a slight majority were females which may be due to the fact that mothers came to health facilities for maternal checkups and are also more likely to bring their children for different services. The majority were aged between 20 and 40 years followed by the age group 40-60 years. This reflects that adults in their reproductive years especially those who were married were most likely to use health services. Most of the respondents were paying and earn above 1500 birr per month. This could reflect the fact that the country is growing fast and is reducing the number of absolute poor or could indicate that the very poor are not seeking hospital care due to inability to pay, and a perceived or real inability to receive care without payment. Unlike other studies (4, 5) in this study, socio demographic variables like age, education and work were not significantly associated with general satisfaction. This may be due to the difference in the study population.

The general satisfaction rate of clients in this study was found to be 51.8%. This rate is slightly lower than the satisfaction assessment performed exclusively on university hospitals in Ethiopia which was 63 % (13). This may be due to a difference in the nature of the study population. It is however comparable satisfaction reported in a study conducted in Debreworkos hospital which was 56% (14).

In this analysis starting services on time, lab tests queue, getting all lab tests at the same facility, getting all medicines at the same facility, short surgical appointment waiting time and complaint handling procedures were found to be independently associated with high satisfaction. This finding is comparable with the study in eastern Ethiopia where the satisfaction with health care was found to be significantly associated with waiting time, the availability of drugs, and the payment status of the respondent (12). This is also in agreement with many studies performed on satisfaction of hospital services (15, 16, and 17).

In this study starting hospital services on time was 1.57 times more associated with high general satisfaction, similar to the other studies (18) where waiting after registration was negatively associated with satisfaction. This might be because patients are disappointed when the service rooms remain closed after the service start time should have started, and also patients are likely satisfied when the rooms are open on time. Lab tests queue was also found to be associated to high general satisfaction. This might be because patients expect to get their test results immediately, and when results are delayed they may develop a negative picture of the overall facility service, hence leading to a general dissatisfaction. The other associated factor was getting all the prescribed laboratory services at the same facility. This may indicate that going outside the facility for a specific test may be unaffordable in terms of price and time, and the lab test may not even be available outside the hospital. This might lead to the negative perceptions that can reduce the overall satisfaction at the facility.

Getting all medicines at the same facility was 1.28 times more associated with greater general satisfaction which is similar to other findings (14, 18). Similar to above this may be because going outside the facility for a specific medicine may be unaffordable in terms of price, time, and transportation and the medicine may not be available in the surrounding town. This might lead patients to feel that the hospital is not meeting their needs which can reduce the overall satisfaction about the facility. The other associated factor in this study was the duration of surgical appointment waiting time. The longer the waiting time for an appointment a hospital gives, the more the client is dissatisfied with the hospital which is similar to other studies (9, 12). This may be due to the fact that when a patient

has a disease and is appointed with a long waiting time they may suffer for a long time or fear they could die without getting treatment. Having a good complaint handling procedure was found to be one of the factors related to high satisfaction. This may be because patients may feel served when they can easily present their complaints easily and be heard. Easy accessibility of the complaint handling services and fast resolution of problems might lead the patients to have a positive attitude toward the hospital, and thus a high satisfaction.

Though not significantly associated with high satisfaction in this study, fast card retrieval, health workers respect, toilet cleanliness, health worker counselling, nurse and doctor close follow up are very important variables to be considered for patient satisfaction improvement. This is because a significant number of the respondents indicated dissatisfaction in the above, listed individual services.

In conclusion general patient satisfaction of hospital services is low, standing at 51.8%. A lot of efforts are needed to fulfill the required services at hospitals in a satisfactory way. All hospitals need to follow strict rules to start treatment services on government start time and to minimize any sources of delays, like morning sessions in order to satisfy their patients. They also need to expand their laboratory infrastructure and/or staffing to reduce the lab test queue as this may be a source of dissatisfaction by patients.

All efforts by concerned bodies such as government, NGOs and other stakeholders are needed to fulfill every laboratory test and prescribed medicines in the same hospital where the clients are being treated. By doing this, the costs incurred on patients in terms of time, money and other resources will be saved and patient satisfaction would increase. By availing the necessary resources such as infrastructure and man power, surgical appointment waiting time can also be shortened. Every hospital should have an organized complaint handling procedure with enough man power, easily identifiable working rooms and well established complaint assessment and intervention methods.

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A performance-based 360 degree feedback for successful organization development: Current scenarios and recommendations in Ethiopian Federal Ministry of Health

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Background

Feedback mechanisms are very important to improve organizational Performance. Federal Ministry of Health (FMOH) applies a variety of evaluation techniques among which 360 degree feedback mechanism is one of them.

360 degree feedback is a systematic process in which employees receive confidential, anonymous feedback from the people who work around them. This typically includes the employee's manager, peers, and direct reports. The feedback forms include questions that are measured on a rating scale and also ask raters to provide written comments (1).

360-degree feedback is very important since it receives input from various stakeholder groups, including supervisors, peers, subordinates, and the individual's self-evaluation (2). In this regard, feedback from multiple sources is found

to typically yield higher quality feedback that is more valid and reliable than feedback from a single source.

Stakeholder involvement is very crucial as it is key principle of good governance and a tool that drives to achieve health sector transformation goals. With this understanding, FMOH established strong bilateral collaborations with 11 Regional Health Bureau (RHB), 6 Agencies, 4 Federal hospitals and Public wings.

Stakeholders' perspectives and issues that matter to them need to be taken seriously for their critical importance and contribution in the successful evaluation and utilization of the findings.

Stakeholders should be consulted and play a vital role during planning and implementing evaluation programs. By doing so, organizations incorporate their views and priorities to learn about their organizations and develop plausible solutions to their challenges. Furthermore, stakeholders participation in organizational evaluation assists with developing sound and credible evaluations methods, identifying good data sources, analyzing data and synthesizing evidence to inform performance and designing appropriate ways to improve organizational performance in the future (3).

The ministry started to use 360 degree feedback evaluation system from 2007 EFY. It was conducted to monitor and evaluate the performance of each directorate's plan and achievements. The evaluation was performed by peers, stakeholders (regional health bureaus, federal hospitals and agencies), public wings and self-assessments by staffs and directors.

This commentary article will uncover how stakeholder involvements are crucial in checking organizational overall performance which will bring successful organizational development.

Objective of 360 degree feedback

The general objective of the 360 evaluation is to ensure the participation of all stakeholders in the health sector in measuring health achievements, to measure performance of directorates and to recognize best performer directorates.

Specific objectives

1. To measure the performance of directorates at ministry of health
2. To ensure the participation of all stakeholders in the performance evaluation

3. To encourage and recognize best performer directorates

Approaches

FMOH comprises a total of twenty two directorates. Eleven regional health bureaus, six agencies and four federal hospitals that are directly accountable to MOH were involved in the evaluation process. Furthermore, to make the evaluation holistic, professional associations, public organizations and patient associations that closely work with MoH were also part of the evaluation.

Institutional based cross-sectional quantitative and qualitative evaluations have been carried out twice a year, at the end of each two semesters. The evaluation was conducted in Ethiopian Federal Ministry of Health, on the performance of directorates.

A simple five point LIKERT-scale structured self administered questionnaire was prepared based on extensive literature review, and was used for self evaluation and for evaluation by stakeholders. Participant's choose from a range of possible responses to a specific question; typically include "Excellent", "Good", "Satisfactory", "Poor", and "Very poor". Data were also collected using interview of employees working in those organization included in the evaluation. The questionnaire comprised of health development army, good governance and other organizational and technical variables. It was prepared in Amharic (Local language) and translated to English. Survey-monkey online data collection tool was deployed.

A team composed of fifteen data collectors and three supervisors participated in the data collection and evaluation process. The data collectors and supervisors were from Monitoring and Evaluation and health informatics backgrounds.

Half day training was given to the team prior to the evaluation on the objective of the evaluation and data collection procedures. The principal investigator and supervisors did a daily supportive supervision on data collectors.

Data back-up activities, like storing data at different places and putting data in different formats (hard and soft copies) were performed to prevent data loss. Data was numerically coded, transformed, and entered in to Microsoft Excel 2013. Descriptive statistics was done to describe the characteristics of users. Sequential mixed method analysis (quantitative data analysis supplemented by qualitative data analysis) was conducted; as a result, findings were triangulated in order to fully explain and make accountable conclusions and recommendations from the evaluation.

Current scenarios (*results of the 360 evaluation the past three consecutive six months*)

Overall the evaluation was divided in to six categories. It includes major initiative (40%), self-assessment (10%), peer (10%), Regional Health Bureau (RHB) (15%), federal hospitals and agencies (15%) and public wings (10%).

Major initiative evaluation was carried out on the basic assumption of plan versus achievement comparison for each two semesters. Final approved plans and performance reports were primarily utilized in the process. All of the strategic initiatives were considered and assessed in terms of performance, budget and time dimensions. At the mean time in depth discussions were organized between the evaluators and members of the directorate revealing important feedbacks that will further improve performances. Major initiative evaluation value was to be found lying between 73.3 and 78.3 during 2007 and 2008 EFY.

Self assessment carried out by the participants (directorates and case teams) themselves to review their performance based on Health Development Army, Case Team and Transformation Forum performance, good governance issues handling system, building developmental thinking, avoiding and managing rent seeking behavior, implementing good governance principles and democratic directorate issues. The result obtained was discussed among all team members in order to ensure ownership. The self assessment obtained during the second half of 2007 EFY was 83 and 88.3 during the 1st and 89.7 during the second six months of 2008 EFY. The self assessment results were increasing during the three evaluations.

Peer evaluation was conducted on directorates to check their work relationships with other directorates. Its main focuses were on service providing, work communication, giving support and strong involvement, and efforts to solve clients and staff grievance in that specific directorate. In the 1st six months of 2008 EFY the peer evaluation value was highest (69.8). During the second half of the 2007 (66) and 2008 (66.7) the evaluation value obtained to be more or less the same.

Regional Health Bureau (RHB), federal hospitals and Agencies evaluated the performance of each directorates based on the strong work bondage created (assigning focal or direct communication), plan alignment, consideration of the aligned plan on the current situation, ability of the aligned plan, follow ups and feedbacks based on the identified indicators or strategic initiatives, fulfilling equipments adequately and timely, solving and responding to problems timely, rent seeking behavior, transparency, supportive supervision and field visits discipline, integration during preparing training, field visits and reviewing performance,

integration of HDA, level of leadership and using resources efficiently. Based on the above mentioned criteria's the head quarter got similar results from RHB, agencies and hospitals (64.7) during the second half of 2007 EFY. In 2008 EFY the average evaluation value increased during the first six months (77.85) and decreased in the second six months (68.9). This shows that directorates engaging regions, agencies and federal hospitals vary from time to time and decreased at the end of the year 2008.

Public wing evaluation generally focused on the attitude, service delivery, accountability, transparency, and clients' compliant handling system of each directorate. Communication aspects and the extent of stakeholders' involvement in the planning, aligning, commitment and execution of performance evaluations of the directorates were also assessed and evaluated. Associations involved during the evaluation process were EPHA (Ethiopian Public Health Association), EMA (Ethiopian Medical Association), EAA (Ethiopian Anesthesia Association), ERA (Ethiopian Religious Association), and EPTA (Ethiopian Physiotherapy Association). The result showed that the value was 65 and 67 during both fiscal years 2007 and 2008. As compared with the others the value of points obtained from the public wing is low. For further results refer the following figure.

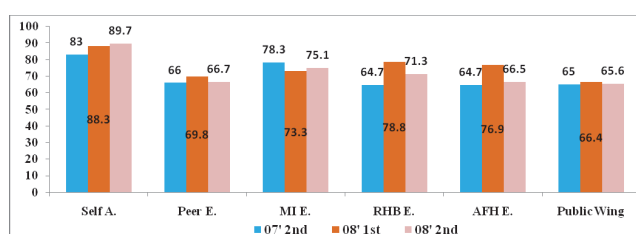


Figure 1: Results obtained from 360-degree evaluation feedback, FMOH, Addis Ababa

From the above results the self assessment evaluation results shows increment followed by major initiatives evaluation, while others (peer, RHB, AFH and public wing) vary from time to time. A lot of assignments are still there especially in engaging and working with stalk holders.

Each directorate gave highest results for themselves comparing to the results given by the stakeholders. What the directorates see and evaluate themselves and what the stakeholders expects differs and led to different results. This may be due to the fact that the services provided by the directorates are less than the public wings expectations.

Key gaps identified during the evaluation

The key gaps during 360 evaluations were found to be as follows.

- Gaps during planning, aligning the plan and implementation within and between the directorates.
- Irregularities in conducting monthly follow ups and providing timely feedbacks on key performance indicators and strategic initiatives
- Difficulties in making appropriate and timely planning for the procurement of medical equipment and inefficiencies in delivering the goods.
- Inadequacy of public wing engagements in the implementation and monitoring and evaluation activities
- Irregularities in promptly responding to the concerns of the public wing
- Irregularities and inadequacy of supportive supervisions to strengthen public wing engagement

- Inadequate and lack of sustained public wing commitment and poor responses to their concerns

Future perspectives

The results indicated that the evaluation created a big opportunity to reveal gaps and important feedbacks to further strengthen organizational development. Based on the results revealed, authors forwarded the following points to be considered:

- Planning should be done jointly with stakeholders and it should be aligned with that of stakeholders to harmonize and achieve better results.
- Regular follow ups should be made and joint performance reviews should be conducted to improve performance and increase ownership.
- The concerns, grievances and recommendations made/ identified during the forums with stakeholders should be addressed, and measures taken or the respective directives should be formally

communicated by the directorates or other responsible bodies.

- The public wing should strengthen its commitment, responsiveness and engagement.

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St. Peter TB Specialized Hospital Good Governance Best practices

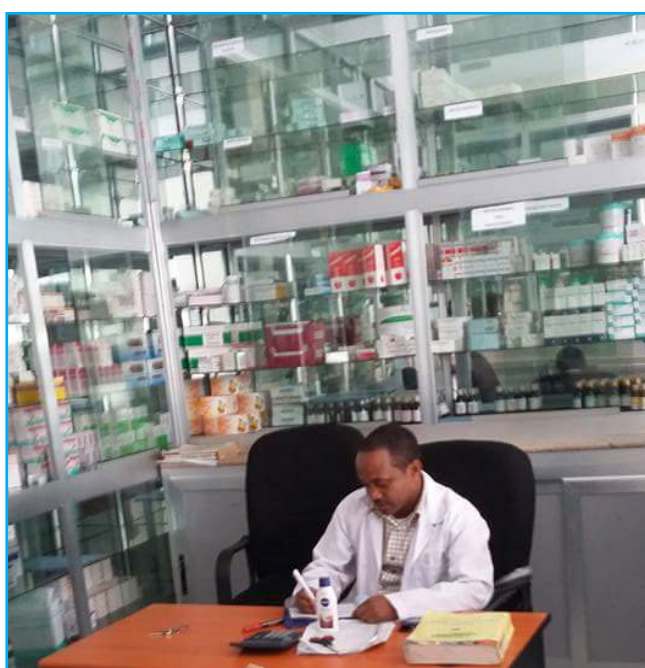
Yakob Seman, St. Peter's TB Specialized Hospital, CEO, mekbul2008@yahoo.com

Background

St. Peter's TB Specialized Hospital was established in 1953 as the first TB referral hospital in Ethiopia. In the 1960s, it was named TB Demonstration and Training Centre and Sanatorium. Subsequently it grew into a multi-services health institution. The additional services included medical and pediatrics, dental, gynecological, dermatological, physiotherapy, MCH, ART & VCT and Surgery.

In 2009, St. Peter's became the first hospital in Ethiopia to care for MDR-TB patients. Nationally, it has been providing inpatient and outpatient services for individuals with MDR-TB. It was also recognized by the Ministry of Health as a Centre of Excellence for MDR-TB since 2012.

Community Pharmacy Service



Introduction

A Community Pharmacy Service (CPS) is an essential component of healthcare. Effective pharmaceutical services promote the safe, rational and cost-effective use of drugs thus maximizing health gain and minimizing risk to patients. The service provided by St. Peter's TB Specialized Hospital is regularly interrupted by lack of resources and unavailability of drugs and supplies. Promotion of rational use of drugs is one of the main objectives of the hospital in order to ensure the community has access to a safe, efficient and timely pharmaceutical service.

Problem statement

One of the transformation agenda of the five year strategic plans of the hospital is ensuring quality of health service delivery to all clients. Its effective implementation will be determined by availability of drugs, supplies and reagents. In August 2016, the availability of essential drugs was 45.4%, far below the expected level. Meanwhile 41% of clients were referred to private or other government institution to buy a drug or supplies. Also drug expiry rate of 13% and stock out duration of hospital specific drugs was around 5.6 days. There was no stock card or bin card system to manage drugs, supplies or reagents stock.

Both nationally and in Addis Ababa the availability of essential drug and essential lab test was a major challenge. In 2013, a study of government hospitals in Addis Ababa showed that the in-hospital availability all for prescribed drugs was around 24%, two prescribed drug was 39% and a single prescribed drugs was 51%. So a community pharmacy is established to minimize the burden of the problem.

Process of implementation

St. Peter Hospital has taken several measures in phases to implement community pharmacy service. The phases were preparation, implementation and monitoring.

Preparation

- Establishment of a committee and assignment of a full time pharmacists that can lead the overall process to run the CPS
- Development of CPS management guideline and its approval by the hospital board
- Development of a project proposal and resource mobilization to open the initial pharmacies

- Experience sharing and documentation of governmental and private pharmacies in CPS
- Preparation of an appropriate place for the CPS
- Hiring of 12 pharmacy professionals to run the CPS
- Organization pharmaceuticals store with a computerized stock management system
- Procurement of vital signs equipment and all necessary materials for office and compounding

Implementation

Two community pharmacies were opened at the gate of the hospital and around Lideta residency area. These community pharmacies have the following main functions:

Dispensing service: Adhering to regulations, our community pharmacies strive to provide safe, effective and efficient control, storage and dispensing of all medications to clients from public and private institutions. Relying on the authority, responsibility and reliability of the community pharmacist, patients often look to our community pharmacy for a variety of healthcare needs.

- **Non prescriptions items sell service:** The community pharmacy sells prescription free, healthcare or retail products directly to the public.
- **Free health screening and community service:** Other functions of the community pharmacy consist of serving the public with additional healthcare related services. Such services included health screenings, monitoring blood pressure, screening for diabetes, and running weight-loss programs.
- **Compounding service:** Our community pharmacy produces a particular pharmaceutical product to fit the unique need of a patient. Compounding pharmacists combine or process appropriate ingredients using various tools. This may be done for medically necessary reasons, such as to change the form of the

medication from a solid pill to a liquid, to avoid a non-essential ingredient that the patient is allergic to, or to obtain the exact dose(s) needed or deemed best of particular active pharmaceutical ingredient(s).

Monitoring phase

All CPS were audited clinically and reports were generated and reported regularly to the senior management. Financial transactions of the community pharmacy is explicitly based on the APTS principles

Achievement

A well-organized pharmaceutical service ensures the continuous availability of all pharmaceuticals that are required for patient care. At the same time, an effective pharmaceutical service should be able to respond to sudden increases in drug demand, ensuring that adequate supplies are available to deal with any emergencies that arise.

In our hospital after the implementation of community pharmacy and full scale APTS, availability of essential drugs based on the hospital drug list was increased from 45.4% to 78%, referral of clients to private or other government institution to buy a drug or supplies decreased from 41% to 22%, drug expiry rate decreased from 13% to 4.2% and stock out duration of hospital specific drug was reduced from 5.6 days from 1.8 days.

Lesson learned

Many lessons were learnt and series of challenges encountered during implementation of each phase of community pharmacy initiative.

Successes factors

- Drugs, supplies and reagents availability could be improved with commitment
- APTS implementation can dramatically improve availability of drugs, supplies and reduce wastage
- Patient involvement is the primary factor for service improvement

- Effective communication with PFSA, MOH and other institutions can easily improve the availability and flow of drugs, supplies and equipment
- Introduction of hospital level critical drug list and weekly monitoring can improve senior management understanding to follow drug availability.

Challenges

- Lack of nationally approved community pharmacy implementation guideline that outlines the benefit package for professionals
- Very long procurement system in the country
- Inconsistency at PFSA to avail essential drugs, supplies and reagents
- Low awareness of the community on generic

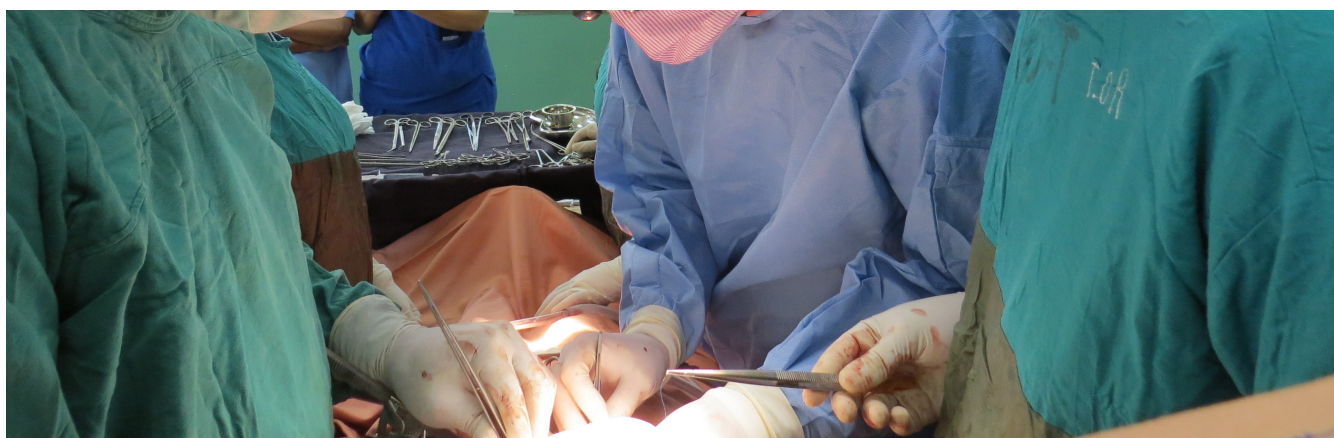
drugs and adherence to prescribed drugs

- Shortage of resources such as car, human resource, and rooms

Way Forward

St. Peter's Hospital recommends the following points related for the implementation of CPS:

- Drugs, supplies and reagents availability can be improved by implementing CPS in all public health facilities
- All health facilities must commit to implement the APTS to improve drugs, supplies and reagents availability and reduce loses
- Establishment of well functional and standardized storage and supply management system at hospital level is the key elements of pharmaceuticals management system.



Kidney Transplantation, St. Paul Hospital

St. Paul's Hospital Millennium Medical College Best Practices

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St. Paul's Hospital was established by Emperor Haile Selassie in 1954 with the support of German Evangelical Church who named it St. Paul General Specialized Hospital until 2007. St. Paul's Hospital is one of the leading public hospitals in Ethiopia and provides medical service to low-income and rural populations. It was reorganized as a medical college in 2007 by the council of ministers and renamed it as St. Paul's Hospital Millennium Medical College (SPHMMC). Its reorganization was completed in accordance with the Ministers' Council Regulation No. 2000/2003 in the era of the Ethiopian Millennium.

SPHMMC is committed to providing high quality health services at affordable cost and provides waiver for the people who are unable to afford medical care. Currently, SPHMMC has a catchment population of 5 million, has 392 beds for inpatient care, and provides medical care for an average of 200,000 patients every year. Kidney transplant center and health services for people with special needs best practices are described in this section.

Kidney Transplant Center

Introduction

Kidney transplant is a new introduction to the country; it is a big breakthrough and success story in tertiary care. The idea kidney transplant becoming more of public issue when the number of ESRD is alarmingly increasing and the cost of renal replacement therapy like hemodialysis is unaffordable to most patient and kidney transplant abroad is unthinkable to all except for the few well to do families. The first successful

kidney transplant at the center conducted on Sept 23 /2015 (beginning of September EFY2007). Transplant was done for twenty people until August 2016 with more than 95% success rate on mission based surgery in collaboration with university of Michigan.

Selected staffs mainly surgeons, nephrologists and anesthesiologist of SPHMMC were trained abroad by University of Michigan. The center is also rendering service to many of the patients who had a kidney transplant abroad.

Statement of the problem

Though the program is a big success story, it created motivation in different disciplines of medicine for starting tertiary services at public centers and it was not without a challenge. Of the challenges: lack of permanent or standing kidney surgeons and nephrologists, limited space and continuous supply of consumables are important ones. Currently there are above 56 patients on waiting list for the transplant. For the fact that transplant surgery is undertaken on mission bases, once every four to six weeks as the lead surgeon is coming from University of Michigan. In each mission on average three surgeries were done. The number is limited because of inadequate space.

Lack of ability the patient (receiver) to get compatible organ (donor) timely and the fact that some samples would be sent abroad for lab. Examinations are also becoming other challenges for the surgery to go efficiently.

The transplant center has only one Ethiopian nephrologist who prepares patients for the surgery

and performs post-surgery care and follow-up. There are also four kidney transplant fellow surgeons, five anesthetists and one anesthesiologist. In addition, SPHMMC deployed nephrologists from abroad to fill existing gaps of skilled professionals. However, it is expected that there should be four kidney transplant surgeon and three nephrologists to undertake the surgery in regularly as a minimum standard. It is also witnessed that some medical equipments and supplies are not available in the local market and/or were not listed in the national drug list and lacks restock timely.

Process of implementation of the good practices

Following the establishment of strong partnership and growing collaboration with the University of Michigan since 2013, clinical training on the procedures and management of kidney transplant was conducted for doctors, nurses and laboratory technicians. They also had practical exposures and shared experiences with senior consultants at the University of Michigan. The development of legal frame work on organ transplant, development of clinical protocols, procuring different equipments, medicines and reagents, personnel development with short term exposure trainings and renovation of old building have been established ahead of the implementation. In addition, practicing clinical trial (swine simulation) was also applied to check the system and surgical instruments.

Achievements

Kidney transplant center for our people has been established locally.

Lesson Learned

The following were recognized as the best practice in the process of implementing kidney transplant program;

- Over dedication of all transplant unit workers along with hospital's leader,
- Strong team spirit among surgeon's, nephrologists, core staffs of each transplant unit
- Collaborative work with Ministry of Health. MOH

is helping in establishment of the legal framework, and equipping and supplying the transplant center

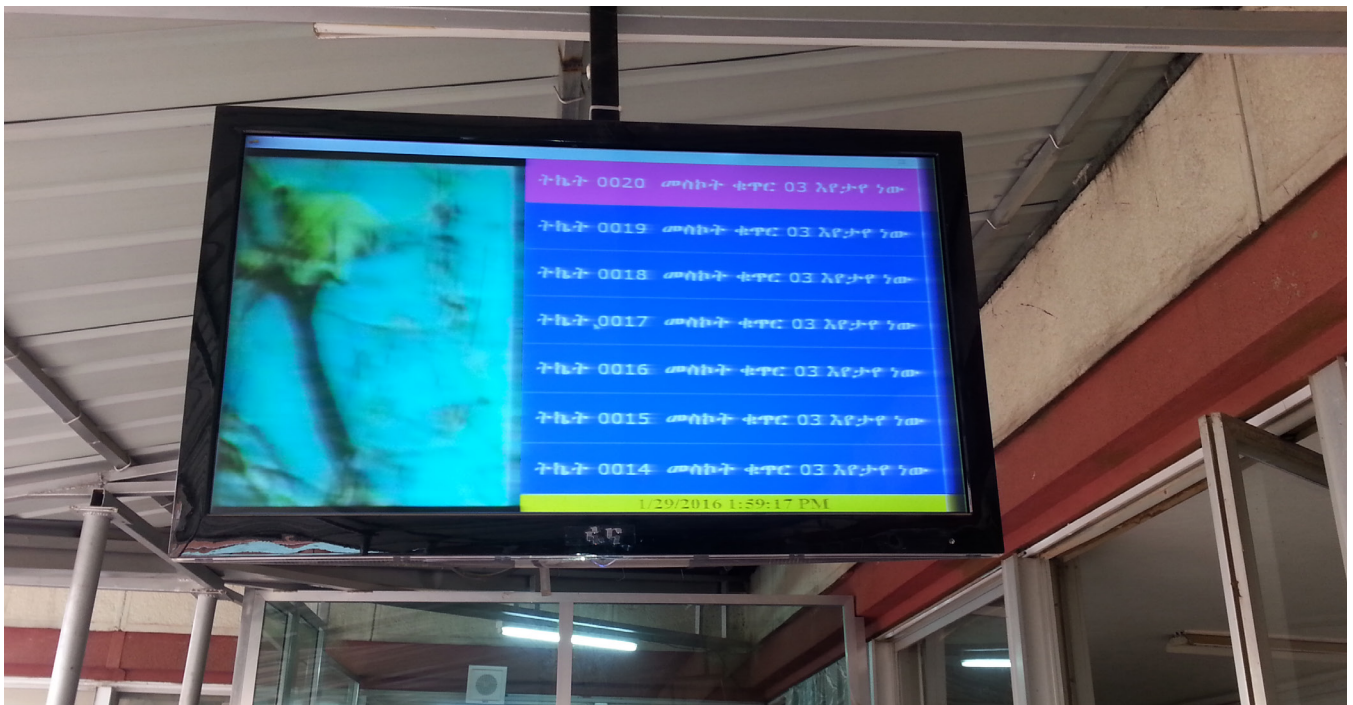
- Establishment of strong partnership with University of Michigan and other countries. The written clinical protocol is adapted from university of Michigan transplant center.
- Using High Standard Quality Medical Supplies and Pharmaceuticals. The center is supported by Michigan University which has been ranked in the top ten university hospital since 1971 Using modern surgery of *laparoscopic donor nephroectomy*, unlike other African countries where open nephrectomy is the norm, which is the 2^{1st} Century Advanced Technology. It gives the donor's fast recovery, less pain and good cosmetic effect.
- Deploying kidney transplant surgeons and nephrologists from abroad to fix the shortage. Though is not cost effective hiring from abroad, it helps to establish partnership with centers that have expertise aiming on skill transfer to local professionals to make the system sustainable. As a consequence, both Kidney transplant surgery and Nephrology fellowship trainings are underway at the center. Doing so, the Center is also contributing great in saving citizens' from paying high medical costs in abroad.

Challenges

- Human resource shortage, especially of nephrologists and kidney transplant surgeons
- Shortage of medical and pharmaceutical supplies
- Delay of the delivery of procured medical supplies and equipment
- Difficulty of finding essential medical supplies and equipment in local market
- Delay in implementing the Deceased Organ Donation and Transplantation project

Ways forward

- Increase the number of beds in Hemodialysis unit to accommodate the increasing demand
- Additional construction and expansion of the transplant process to increase patient numbers
- Acceleration of deceased organ transplant project in the country. That means, harvesting organs (kidney) from dead patient and giving to needing patient that is thought to be cost effective and avoids surgical stress of the donors.
- SPHMMC should emphasize on the training of more staffs on nephrology and kidney transplant to ensure sustainability



Queue System, St. Paul Hospital



Introduction

People with disabilities encounter difficulties obtaining proper health care services. Of them, people with hearing impairment face a range of barriers in accessing health care due to communication problems with care providers. Difficulties in communicating their health problems and lack of care providers or assistants deter their access to medical care. When medical care is provided in such conditions, misunderstandings between the provided and the patients are unavoidable and compromise treatment effectiveness. Cognizant of this challenge, SPHMMC hired and trained 21 staff on sign language. They are being assigned in different departments and assist with translating communications with people with hearing impairment.

Similarly, special support staffs called “Min Lirdawo” have been hired to assist patients with walking impairments. Min Lirdawo staffs have an identifiable dress especially prepare for such purpose with “Min Lirdawo” label on it. They are always in stand-by and assist needy people all the way from the gate to service outlets and when the clients leave the hospital premises. Among many others, Min Lirdawo staffs help patients in accessing wheelchair and conduct triaging to provide priority medical service. When some clients have financial constraints, Min Lirdawo staffs contact the social workers of the hospital and assist with fee waiving process.

Despite the availability of trained staffs on sign language, not all staffs in the service delivery points were aware of these services. This has often resulted in difficulties in assisting needy clients i.e. they did not know where to send them or where to get help. Some clients also reported having difficulties in properly interpreting the sign language. As a result, the following are recommended.

- Additional staff need to be trained, and

refreshment training should be arranged periodically to ensure effective communication with people with hearing impairment

- Patient with special need should get critical attention and priority medical service
- The availability of assistance for people with hearing and walking impairments should be formally communicated and help should be provided whenever need arises.

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Telephone call registration system for clients of private wing medical care, ALERT Federal Hospital

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Introduction

Since the commencement of the private wing service initiative on average, ALERT Federal Hospital has been providing medical service for 400 clients per day. Some of the medical care's provided in the private wing are for ophthalmologic, dermatologic, orthopedic, cosmic (plastic surgery), maternity and dental conditions.

In ALERT hospital, private wing services are routinely provided from 5pm to 9pm, and are rendered without restriction. For example, the private wing service clients coming from rural and further areas of not presenting a referral slip and identification card which are the general requirements to use services from tertiary hospitals. This has become a pull factor and enhanced the use of medical care in ALERT's private wing, and the demand for such services is increasing from time to time.

Problem statement

Challenges the medical care in the private wings are mainly queue and scheduling. First, they had to arrive at 6:00am or earlier, queue for registration and get an appointment. Second, they have to return on the scheduled time (specifically at 5:00pm) to use the private wing services. These were particularly very challenging for clients and their attendants coming from distant or rural areas i.e. they had to stay in the hospital premises or find other alternatives from 6:00am to 5:00pm. As the daily consulting capacity of the private wing for the services demanded is limited,

there is a chance the clients must return for registration to try their luck for a second time.

The Good practice

In recognition of the hassles clients' had experienced and to avoid unnecessary wastage of time and money, ALERT Federal Hospital decided to simplify the procedures for using the private wing services. In February 2016, it bought easily memorable telephone lines and initiated telephone call registration system. The system enables clients register remotely over telephone i.e. without the need to visit the hospital.

Process of implementation

ALERT Center is geographically located distant from the center of Addis Ababa, this condition is challenging for both regional and Addis residents. The new system of phone call registration assists with planning the travel and knowing the waiting time for the services that increases satisfaction with the services. There are four telephone line dedicated for phone call registration: one for ophthalmology, two for dermatology and one for other medical conditions. Two telephone lines have been assigned for dermatology commensurate with the high number of clients' seeking the care. Accordingly, before arriving at the private wing for the care desired, the clients have to get an appointment by calling the dedicated telephone numbers for. There are four staffs who are information desk personnel who answer all

the calls and booked the names of. The calling price is under the normal Ethiopian telecom call tariff. The numbers are 0947 808080 for ophthalmology service

0947818181 and 0947848484 for dermatology and 0947828282 for other medical service

Achievements

The telephone call-based registration system has brought the following results and benefits to the clients and the hospital.

- The clients do not need to appear in person to register and get an appointment thereby reduced inconveniences and avoided travel related expenses.
- The clients do not need to visit the private wing early in the morning or queue for registration.
- The clients have to arrive in the hospital for the booked service only on the scheduled time.
- Information on what services are available and how they can be accessed is available for clients from the telephone operator (receptionist).
- Telephone call system has simplified the registration process and found to be more convenient for the clients and hospital staff. It assisted in creating a fair and organized registering system

Lesson Learned

Early in the initiation phase, Yekatit EFY2008, telephone call registration system appeared challenging for several clients. For instance, many clients booked the service over telephone (made many calls for one booking) and also appeared early in the hospital premises and waited until the appointment at 5:00pm – this was due to the lack of trust in the new system and an attempt to secure the appointment. However, through continued reassurance, the clients have put trust in and become more comfortable with the system.

Success Factors

Lessons from the phone call registration system indicate that the success factors of the initiative were advertising the telephone numbers widely and encouraging clients to use them, strong follow up on the implementation.

Challenges

The challenges encountered in implementing the telephone call registration system are lack of awareness, lack of trust in the system and many calls being made by some clients for one booking. These challenges necessitate the need for more advertising and promotion of the system.

Implication:

Private wing health service is expanding from time to time and the number of people using the service is increasing. Hence, registering clients through a more convenient and simplified system of telephone call is timely. ALERT's telephone call registration system has demonstrated that it could be easily instituted, implemented and could assist in reducing the inconveniences associated with booking appointments for private wing services. Awareness about the registration system can be raised by using media communications and promoting the system. Equally important, the hospital should put in place a strong follow up and reinforcement system for the adoption of the system and to speed up its implementation.

Section 3:

Cultivating Accountability

St. Peter TB Specialized Hospital Good Governance Best practices

Staff mobilization and timely decision making

Background

St. Peter's TB Specialized Hospital was established in 1953 as the first TB referral hospital in Ethiopia. In the 1960s, it was named TB Demonstration and Training Centre and Sanatorium. Subsequently it grew into a multi-services health institution. The additional services included medical and paediatrics, dental, gynaecological, dermatological, physiotherapy, MCH, ART & VCT and Surgery.

Introduction

Our hospital transformation plan has set very ambitious goals and aspires to transform the hospital service to deliver equitable, safe, timely, patient centered and quality healthcare for all customers. This will only be possible if the staff performances are transformed into high-performing entities that translate the hospital level aspirations and the desires of the client into a reality. The staff transformation initiative will build on the existing system of hospital governance by increasing the accountability of service providers to beneficiaries and by encouraging people to engage as active partners in service delivery. According to the Hospital Health Development Army guideline, case teams and staffs are the lowest management units in the hospital. Case team plays an important role ranging from day to day service provision to the implementation of national, regional and hospital based initiatives. Staff in case

teams are mainly responsible for the provision of day to day clinical care and follow up and tracking of national level indicators

Problem statement

Staff mobilization activities and decision making capacities of each member of staff were assessed the level of health development army implementation status of the hospital. An assessment done by the hospital management in Sept 2016 showed that only 10 (17%) of the 57 case team networks were meeting and functioning as per the guideline.

The functionality of the hospital management team and the hospital board is a critical management function at the hospital level. In the Sept 2016 assessment it was found that the hospital management team and the board conducted 76% and 67% of the meeting as per the guideline respectively. Functionality of critical teams like transformation forums, directorate forums and DTC team were null at the time of assessment.

Process of implementation

To ensure mobilization of the majority of staff towards a positive influence and to make sure that staffs were parts of hospital level critical decision, the following initiatives were carried out.

Restructuring of the management system

To ensure effective, efficient and timely decision making, “**Morning Decision Team**” was established and met three days in a week to act on critical hospital level problems. This team was led by the CEO and comprised the Medical director, Nursing Director, Finance Director, Plan Director, Human resource Director and Legal Director. The team has its own terms of reference and action plan. The Hospital Senior Management function was supported by regular stand by committees like CASH committee, Drug and Therapeutic Committee, Infrastructure Committee and Morning decision team. The hospital governing board meeting schedule, annual plan and biannual evaluations were done for the first time, which improved the meeting time of the hospital board

Regular staff meeting

There are two types of regular staff mobilization meetings. The first is a monthly *voluntarily* based meeting which focuses mainly on complaints raised from clients and staff. In this meeting monthly model case teams were recognized based on the integrated quality improvement and recognition program criteria. The recognition is different monthly, quarterly and bi annually and annually. The monthly recognition is a 200Birr mobile card for each member of the case team.

The second type of meeting is a *mandatory* where more than 75% of staffs are expected to attend. In this quarterly meeting hospital performance were presented and discussed, next quarter focuses area and plan are outlined and discussed. Quarterly integrated quality improvement and recognition program winner case team recognized. Selected topics are presented by experts for discussion and awareness creation are made mainly on team building, quality of health service, ethics and behavioral change communication.

Good governance forum: to lead this forum our hospital developed St. Peter Good Governance Package, St. Peter Good Governance implementation manual, Good Governance plan and disaggregated monthly and major problem menu.

This forum is conducted every month with all management members, case team leaders, head nurses, supervisor nurses and patient representatives were participants. In this meeting the last months performance will be presented and discussed, major problems raised in this month will be listed and bottleneck analysis will be done. Every member of the meeting will have a problem to handle and solve on the coming month. After each meeting, the next month joint good governance plan is prepared and presented to the participants for comments and task sharing

Communication

Smooth and transparent communication between management members, with all staff and the community is critical to tackle all the problems raised during service provision. To improve our hospital communication system formal and informal ways of communications were advocated.

- Posting cell phone numbers of the hospital management members throughout the hospital compound helps all staff and customers to communicate smoothly and to share any areas for improvement
- Creation of St. Peter Information Page/ Viber group: In this group around 286 St. Peter hospital staffs were members and as a rule everybody can write whatever he/she wants about St. Peter that can outline strength, weakness, best experiences and areas for improvement in our hospital
- St. Peter Face book page: In this page major achievements of St. Peter were announced, future priority points of St. Peter were posted, national and international experience be shared and comments and feedbacks from the community received.
- St. Peter Hospital mail pool: This pool helped our hospital to share hospital policy procedures, national guidelines/policies and procedures were shared and communicated
- Development of St. Peter ethics guideline and print and distribute to all hospital staff members

- Communication of the 5 year plan and transformation agendas progress regularly

Staff incentives package and recognition

To ensure staff motivation we established a transparent system to provide already known incentives like duty payments, uniforms and other personal protective equipments. All St. Peter health professionals and at risk administrative staff were given HBV. As a hospital we developed a transparent hospital performance evaluation manual and set a system to recognize highly performing staff.

Strong monitoring and evaluation system

There is a surprise supportive supervision program from the morning decision team and the hospital management. We have a benchmarking program for nationally well performing hospitals and our hospitals best practices were documented and shared to other hospitals.

Achievement

Our hospital has many successful stories regarding staff mobilization and creating motivated staff. Current assessment showed that health development army implementation status of the hospital has improved from 17% to 78% by the end of May 2016. The functionality of the Hospital management team and the hospital board transformed dramatically from 76% to 100% and 67% to 120% at the end of April 2016.

Functionality of critical teams like transformation forums, directorate forums and the Drug and Therapeutic Committee were very poor almost null at the time of baseline assessment but the current assessment proved that all forums were functioning as per the guideline.

Implementation of major reforms has fundamentally improved hospital reform implementation from 58% to 93.4%, CASH standard implementation from 12% to 92% and the good governance index also better than other Addis Ababa hospitals which is 74%.

Lesson learned

Success factor

- Staff mobilization is a backbone of change
- Synergy between morning decision team, senior management team and hospital governing board ensures timely decisions and its implementation
- The level of adherence of staff with all laws and regulations relate with the level of management team member being “Role Model”
- Introduction of integrated quality improvement and recognition program is synergy for improvement
- Regularity and objectivity of staff meeting and good governance forums is central to its legitimacy

Challenges

- Setting incentives and payments as a precondition for service provision
- Different payment and duty taxation system in Addis Ababa and Federal Hospital
- Lack of senior specialists
- Poor data utilization culture at hospital and staff level
- Culture of poor time management specially by high level professionals

Way forward

- All Hospitals should take the staff mobilization and motivation campaign as a main agenda for the facilities
- Integration of good governance with other reform activities in a facility can boost the implementation and ensure sustainability
- All facilities should establish a system to involve and participate patients and clients on provision of service



Laboratory Service and Information System

Introduction

Laboratory service is an essential component of healthcare. Effective laboratory services are a key to health service quality and equity and maximize health gain and minimize risk to patients. Laboratory Information System (LIS) was introduced which can help us to ensure effective and efficient utilization of our resources and efficient management of time for clients and staffs. The service provided by St. Peter's TB Specialized Hospital was regularly interrupted by lack of resources and unavailability of laboratory service for the past many years. Introduction of information system at laboratory service is one of the main objectives of the hospital in order to ensure the community has access to safe, efficient and timely investigation service.

Problem statement

One of the transformation agenda in our hospital five year strategic plan is ensuring quality of health service delivery to all clients and ensuring a strong information management system. This agenda will be highly compromised by problems like in availability of reagents and supplies. In August 2008 EC the availability of essential laboratory service was 39.3% and far below the expected level. Moreover, half (47%) of the clients were referred to private or other government institution for laboratory service.

Stock out of essential lab tests mainly because of manually organized laboratory and poor monitoring and evaluation of laboratory mini stores

As a country and in our capital city Addis Ababa the availability of essential lab test were living challenges. A master thesis conducted in Addis Ababa hospital at 2013 shows the availability of requested lab test in government hospital is low. The result showed the availability of all prescribed lab test is around 19%, two prescribed test is 41% and single prescribed test availability is 69%.

Process of implementation

The following measures were taken to implement LIS in St. Peter Hospital.

- Establishment of a committee and assignment of a full time laboratory technologist that can lead the overall process to run the laboratory information system service
- Development of laboratory assurance and management guidelines to manage all the activities related to the service and approval from the hospital management.
- Development of a project proposal and resource mobilization to network the hospital laboratory units and connection with major clinical services.
- Experience sharing and documentation of governmental and private laboratories
- Preparation of an appropriate place for the

laboratory service and information system with result distribution and sample collection and labeling

- Recruitment of an additional 7 laboratory technologists and one computer science professional to run the laboratory service information system.
- Organization of a state of the art laboratory unit with all necessary machines and mini laboratory store

Achievement

Hospital level assessment in August 2016 showed that availability of essential laboratory service increased from 39.3% to 79% and the proportion of clients that were referred to private or other government institution decreased from 47% to 19%.

Sample collection, sample rejection, sample transportation and result delivery time were highly improved after the implementation of the laboratory management information system.

Lessons learned

Successes factors

- Computerization of the laboratory service is a driver for lab service quality improvement.
- Effective communication with PFSA, MOH and other institutions can easily improve the availability and flow of reagents and equipment in the city
- Introduction of a hospital level critical lab list and weekly monitoring can improve senior management understanding to follow drug availability.
- Auditable Pharmaceutical Transaction and Services implementation can dramatically improve availability of laboratory reagents

Challenges

- A very long procurement system in the country
- Lack of national monitoring of the LIS implementation support
- Lack of back up machines in all departments
- Drug and reagent supply disruption

Way Forward

St. Peter Hospital recommends the following points related to the implementation of a laboratory information system and service initiative

- Essential tests and reagents availability can be improved by implementing an information system
- Establishment of a well functioning and standardized laboratory mini storage and supply management system at hospital level is the key element of a laboratory information management system.

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Lessons from Internal Audit: Cultivating accountability and transparency in the health sector

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Good governance which constitutes mainly accountability and transparency continues to be a dominant agenda of the public sector. Accountability is the process whereby public sector entities, and the individuals within them, are responsible for their decisions and actions. This includes their stewardship of public funds and transparency, which is the openness of a public sector entity to its constituents. They are the founding pillars of good governance and the pivotal areas of focus for internal audit.

The objective of internal audit is to provide independent, objective, assurance and consulting services. It is designed to add value and improve the Ministry's operations and systems of internal controls, risk management, and governance processes. This practice describes the improvement in the internal audit process in MOH

Historical problems

There were challenges in the areas of good

governances within the ministry. It used to be evidenced through backlogs in the financial closings, qualified external audit reports with material audit findings, long and large sums of outstanding and un-liquidated balances, absence of clear transparency and accountability in public asset use, misuse of program funds for non program related activities which seldom went to the extent of cancellations of programs and/or reimbursement being required by development partners and reported incidences of embezzlements and fraud.

Key activities: In response to a clear and focused good governance direction given by the top management,

- Capacity building with new recruitments
- Multiple efforts being put to investigate report and follow court decisions for reimbursements of public money which were embezzled.
- Achievements of participatory and inclusive procurement practices where the internal

audit attending all material procurement and bid opening process,

- Effectively communicating risk and control information to appropriate areas of the ministry
- Effectively communicating information for top management's attention and following up the presented recommendations.
- Improved effort in providing access to audit information to stakeholders
- Review audit performance between MOH, RHBs and other related agencies where the audit findings are one of the major agendas of the joint steering committee meetings.
- Fund utilization follow up
- Ensure use of partners template and presentation and the delivery of correct, relevant and timely information
- Follow up of implementation of external auditors recommendations to justify only minor and fewer observations by the external auditors,

Achievements

- Improved coverage and timeliness of internal audit eliminating backlogs and improving the audit coverage to 100% by incorporating

audits of the RHBs at a national level.

- 100 % program and treasury accounts being closed before the end of the time frame presented.
- Improvements in the timing of unqualified audit reports issued by the external auditors to the audits conducted at MOH
- 100% timely reply of request
- The absence or zero severe fraud and corruption reports and claims,
- Introduction of 100% risk based and standardized audit practices,

Challenges

- Despite their importance, audit recommendations are not being dealt in a timely way by the responsible management
- Turnover in the sector
- Limitations in continuous internal audit capacity building schemes and

While good governance is now becoming a matter of major public concern the internal audit is and has been an active agent in building a public confidence on the ministry in the area of accountability, transparency and integrity.



Tracking HSTP Good Governance Performance: State of inequality between developing regions and the national average

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Introduction

Enhancing good governance in the health sector requires implementation of the principles of good governance in the health sector. These principles include rule of law, transparency, inclusiveness and equity, responsiveness, efficiency and effectiveness and participatory engagement of citizens. For good governance to prevail there is a need for strong leadership and commitment by governments, robust participation of civil societies and involvement of the private sector in upholding the principles of good governance. Good governance in health systems promotes effective delivery of health services. Also critical are appropriate standards, incentives, information and accountabilities, which induce high performance from public providers. Good governance discourages corruption and rent seeking practices, which directly affects the performance of the health sector. This descriptive analysis shows the

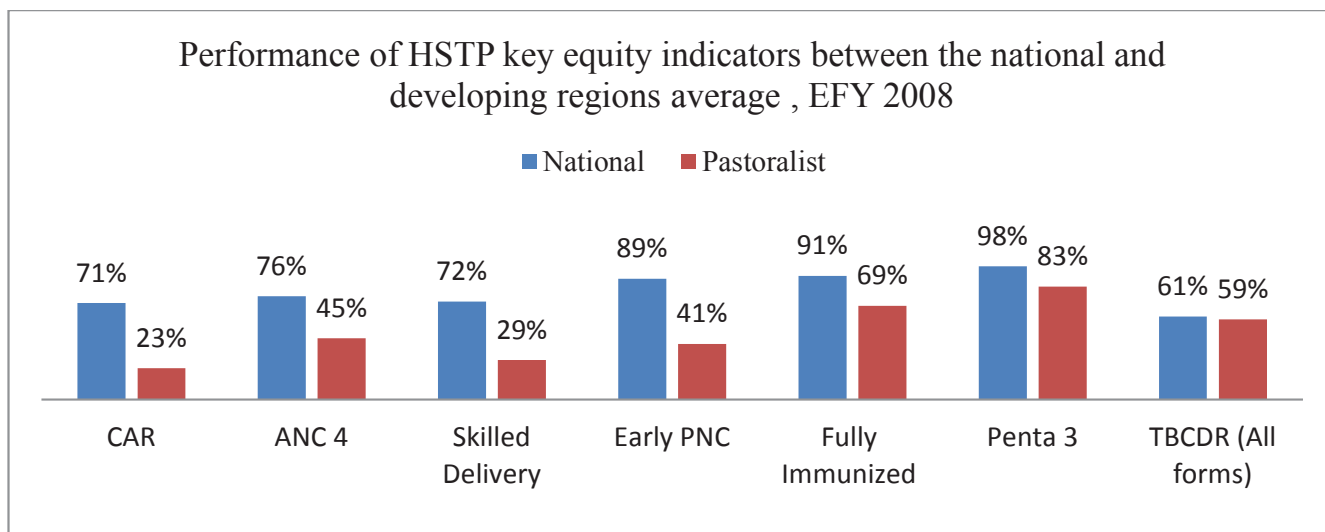
state of good governance using equity lenses between developing regions and the national average.

Target

By 2020, developing regions will have performance levels of priority intervention similar to the national average.

Methodology

Data source for the analysis of the performance of good governance is taken from health management information system EFY2008. It covers 12 month data from all health facilities of the country. The eligible population for each indicator is taken from central statistics agency estimation.



Result

The following chart shows the performance of developing regions (Afar, Somali, Benishangul gumz and Gambela) and the national average.

Figure 1: Performance difference of HSTP key equity indicators between the developing regions and the national average, EFY2008

The result showed the 7 key good governance indicators that reflect the inequality between developing regions and the national average. Figure 3 shows that the absolute difference ranges from 2% to 48% between the developing region and the national average. There was narrow range in performance of TB case detection of all forms. The national average for TBCCR was 61% and the developing regions were 59%. There were high variability between developing region and

the national average in contraceptive acceptance rate, early postnatal care and skill delivery. Skilled delivery national average was 72% which was more than 3 times the average of the developing region which was 29%.

The descriptive statistics from HMIS suggests the need to focus on developing regions to address inequality, particularly in areas of skill delivery and postnatal care.

