National Healthcare Quality Strategy (NHQS) 2024-2028

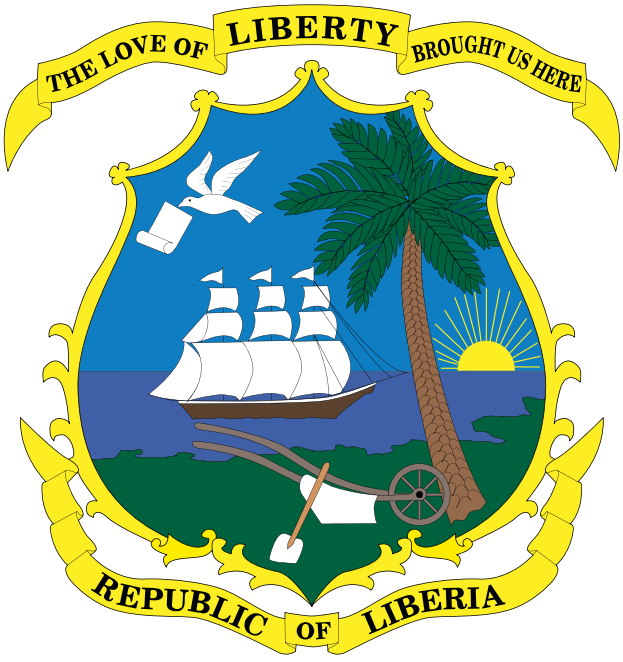

Table of Contents

List of Tables

List of Figures

List of Acronyms

AE	: Adverse Event
CHTs	: County Health Teams
CHV	: Community Health Volunteers
CSOs	: Civil Society Organizations
DHTs	: District Health Teams
DPS	: Division of Pharmaceutical Services
EPA	: Environmental Protection Agency
EPHS	: Essential Package of Health Services
GoL	: Government of Liberia
HIS	: Health Information Systems
HMER	: Health Information System, Monitoring & Evaluation and Research
HQMU	: Healthcare Quality Management Unit
IHR	: International Health Regulation
LPAB	: Liberia Physician Assistants Board
LPB	: Liberia Pharmacy Board
M&E	: Monitoring and Evaluation
MoH	: Ministry of Health
NGOs	: Non-Governmental Organizations
NHP	: National Health Policy
NHQS	: National Healthcare Quality Strategy
NPHIL	: National Public Health Institute of Liberia
OICs	: Officers-in-Charge
PAPD	: Pro-Poor Agenda for Prosperity and Development
QoC	: Quality of Care
TWG	: Technical Working Group
UHC	: Universal Health Coverage
UNICEF	: United Nations Children's Fund
US-CDC	: United States- Centers of Disease Control and Prevention
WHO	: World Health Organization

Foreword

It is my pleasure to launch this National Healthcare Quality Strategy (NHQS) for the period 2024-2028. This strategy covers the seven quality dimensions in healthcare and will contribute towards our journey to attain Universal Health Coverage (UHC) and other Sustainable Development Goal (SDG)3 targets.

In this new strategy, we focus on addressing key quality issues across all the seven quality dimensions to ensure that everyone who needs quality health care can have it at all times and without enduring financial hardship.

This goal will be achieved by our collective efforts across all the level of care in Liberia through evidence-based Primary Health Care approach to deliver the Essential Package of Health Services (EPHS) II.

The Ministry of Health (MoH) remains committed and determined to guide and transform the health sector to deliver effective, equitable and quality health services and move towards attainment of Universal Health Coverage (UHC) and other SDG 3 targets.

I count on our partners, private sector, academia and the Liberian people to support the implementation of the interventions to achieve the targets set out in this costed strategy.

Finally, I would like to acknowledge the support of our development partners who supported the development of this strategy and our efforts to deliver quality healthcare to the Liberian people. I am confident that we can achieve the goal and objectives of this strategy to improve the quality of health services for the people of Liberia.

Catherine Cooper, MD

Dr. Catherine T. Cooper
Deputy Minister/Chief Medical Officer
Ministry of Health, Republic of Liberia

Acknowledgement

This NHQS (2024-2028) was elaborated after the expiration of the NHQS (2017-2021) with technical guidance and support from the World Health Organization (WHO). The WHO guidance for NHQS was extensively used to guide and inform the structure and contents of the document in addition to national health policy and strategic documents. We appreciate the support from the National Healthcare Quality Technical Working Group (NHQTWG), which conducted the desk review, key informant interviews, and stakeholders' consultations and elaboration of the strategy.

Special appreciation goes to the directorates of the Healthcare Quality Management Unit (HQMU) of the MoH for leading this process. Profound gratitude goes to the Deputy Minister for Health Services, Hon. Dr Francis Kateh and Assistant Minister for Curative Services, Dr. Gorbee G. Logan, for providing the needed oversight during the development of this strategy.

We greatly appreciate the extensive contributions from all the MoH programs and stakeholders from the national and sub national level including County Health Officers, Medical Directors of hospitals, Officers in Charge (OICs), and clinicians and general population.

Special thanks go to WHO and all partners agencies that contributed to the development of this strategy, such as UNICEF, UNFPA, US-CDC, USAID-STAIP, Jhpiego and Last Mile Health. Worth appreciating the profound technical contribution from the WHO Headquarters (HQ), Regional Office for Africa (AFRO), and the WHO Country Office Team [Dr. Clement Peter (WHO Representative), Dr. Charles Ocan (HSS Advisor), Dr. Louis Ako-Egbe (HSS Consultant), Moses Bolongei (HSS Officer)].

Dr. Cecelia Woods-Cheneyon
Director
Healthcare Quality Management Unit
Ministry of Health, Republic of Liberia

Executive summary

Introduction

In 2016, the MoH developed the NHQS (2017–2021) to facilitate the attainment of quality of care (QoC) and patient safety goals outlined in the 2011–2021 National Health Policy and Plan (NHPP). The document was developed after the establishment of the HQMU within the MoH in 2015 to lead all quality and patient safety efforts. The strategy provided a medium-term framework to address and improve quality and patient safety related issues in the Liberia health systems.

Since the NHQS expired in 2021, the MoH and partners decided to review its implementation and develop the next one for the period 2024–2028. This process was aligned to and part of the overall NHPP review and development of the next national health policy 2022–2031 and health sector strategic plan 2024–2028, as well as other key policies and strategies that had expired in 2022. The review of the NHQS took stock of its implementation to determine achievements and document lessons learnt and recommendations that informed and guided the development of the next strategy (2024–2028).

The NHQS review and elaboration process

The process to review the NHQS (2017–2021) and elaborate the NHQS (2024–2028) was led by MoH and supported by multiple stakeholders. It involved technical consultations with all the relevant stakeholders across all the levels of the health systems in Liberia, desk review and primary data collection from Key Informants, and visits to selected facilities. The following stakeholders were consulted; MoH (national and sub national levels, development partners (i.e., WHO, UNICEF, UNFPA, US-CDC, USAID-STAIP, Jhpiego, Last Mile Health), training and academic institutions, private health sector (faith-based, self-financing), patients and community members.

Primary data was collected via key informant interviews with selected stakeholders and facility visits to further enrich the situation analysis.

Extensive desk review was conducted to analyse/review secondary data using key national, regional and global health quality and patient safety

documents including the latest WHO handbook on development of national health quality policy and strategy. A five-day technical consultative workshop with key stakeholders from all the 15 counties and across all the levels of the health system (i.e., national, county, district, and facility) was conducted. The 5-day workshop was also used to validate the initial draft of the situational analysis report and to further gather insights on the state of quality and the extent of implementation of the NHQS (2017-2021) and recommendations. Insights from these data collection culminated into the development of a situational analysis report.

In addition to the situation analysis, there was drafting of the various sections and components of the NHQS based on the WHO guidelines by TWG led by an international Consultant seconded by WHO. The teams that supported the drafting of the document consisted of MoH (national and sub national) and partners including the three levels of WHO, US-CDC, UNICEF, LMH, UNFPA and Jhpiego.

The following eight essential elements (WHO) guided and informed the strategy development process. National health priorities, local (Liberia) definition of quality, mapping and engagement with stakeholders, situation analysis, governance and organization structure (all levels of health care), improvement methods and interventions (what actions and how), HMIS and data systems, quality indicators and core measures.

The seven quality dimensions were included and covered during the review and elaboration of the strategy. They will inform the basis of implementation as well.

Situational analysis

Key Findings, policy and strategic recommendations

The key findings from the situational analysis, organized around the six WHO health systems building blocks are outlined below.

1. Leadership & Governance
   Although the HQMU was established at national level, the Quality Management Teams (QMTs) were not established in all the facilities as envisioned, where they exist, most of them were

sub-functional. Similarly, the national HQMU is not currently fully functional due to funding, capacity and resource constraints. Policy environment: although there was a NHQS (2017-2021), a few of the key stakeholders noted that they had not seen a copy and they were not aware of its existence. There was also no existing quality policy to guide and direct interventions concerning QoC and patient safety prior to the elaboration of this strategy.
Key policy and strategic recommendations included, building the capacity of directors and heads of units in healthcare quality to facilitate the effective implementation of the NHQS (2024-2028) and integrate/mainstream quality into all programs and units of the MoH, and ensure that planning for service delivery reflects all the quality dimensions (i.e., safety, timeliness, equity, efficiency, effectiveness, people-centeredness and integrated).

Coordination of quality improvement (QI) and patient safety efforts at national and sub national levels was not fully functional. The following recommendations were made establish a multi-stakeholder National Healthcare Quality Technical Working Group (NHQTWG) and/or National Healthcare Quality Advisory Board (NHQAB) to oversee the implementation of the NHQS (2024-2028).

In terms of Regulation, there are health regulatory bodies responsible for the regulation of health care workers practice, functioning of facilities as well as ensuring that all health products and medicines in Liberia are safe and efficacious and meet required standards. They have capacity and resource limitations to accredit, licence, renew, monitor, supervise, enforce and provide technical support and guidance to improve quality and patient safety. The regulatory bodies were not implementing some of their interventions to protect the population and ensure that healthcare meets the required quality and standard.

Key policy and strategic recommendation to MoH and partners is to strengthen the health regulatory bodies by the provision of logistics and human resources to facilitate the planning, implementation, and monitoring and their core functions.

2. Health Information Systems, including Monitoring & Evaluation

Although there are core monitoring & evaluation (M&E) indicators for the health sector, most of quality indicators that cover all the quality dimensions (i.e., safety, timeliness, effectiveness, efficiency, equity, people centeredness, and integrated) to monitor, track, and report on quality and patient safety in the health system are not being captured.

3. Financing NHQS
   Each year, the MoH and partners develop an annual operational plan (national and county) to deliver health interventions in Health Sector Strategic Plan (HSSP). However, contrary to mobilizing/allocating resources for QI efforts from Government of Liberia (GoL) as envisioned by the NHQS (2017-2021), funding of QI projects and programs across the various levels of the health system were mostly donor dependent. Like most of the other programs within the MoH, there was no specific budget provision for quality improvement activities within the GoL allocation to health.

4. Access to essential medicines, vaccines, diagnostics and technology
   Access to essential medicines and other supplies play a critical role in the quality of the services provided as well as patient safety. Key gaps identified during the implementation of the NHQS (2017-2021) included frequent stock outs especially for essential medicines and infection prevention and control (IPC) supplies such as gloves that affect quality of the services delivered, irrational and wide usage of antibiotics, which predisposes to Antimicrobial Resistance (AMR), and unnecessary costs to the sector. The Antimicrobial Stewardship Program and efforts to control the spread of AMR are still weak and need to be strengthened at national and sub national levels across the facilities. The post-market surveillance and pharmacovigilance systems are also very weak and need further strengthening. From the service availability and readiness assessment (SARA) survey 2016 and 2018, there was also inadequate and limited diagnostic capacity with most laboratories unable to do very basic and essential diagnostic tests such as haemoglobin (Hb), malaria test, blood glucose, urine glucose, and urine protein tests. The public supply chain management (PSCM) system needs to be strengthened

including the review and elaboration of the supply chain management plan (SCMP), essential medicine list (EML), standard treatment guidelines (STGs), among other efforts.

5. Human Resource for health
   There have been investments aimed at improving the human resource for health situation in Liberia, which is evidenced by the improvement in the core health workforce density from 8.6 per 10,000 population in 2015 to 12.8 per 10,000 population in 2020. The human resource challenges include inadequate numbers of core/key skilled-HR, inequitable distribution, and lack of flexibility with the staffing criteria. Furthermore, it was reported that some staff are practising without current or valid licences.

6. Delivery of quality essential health Services
   Delivery of quality essential health services was assessed using the seven dimensions of quality i.e., safety, effectiveness, timeliness, equity, efficiency, effectiveness and people centred care. The following observations were made: Clinical audit programs exist but for maternal and perinatal audit and it is not being implemented in all the main facilities. Although there are protocols, standard operating procedures (SOPs), guidelines, and checklists available for many programs/activities they do not cover all conditions, and their adherence by providers is suboptimal. For instance, the surgical safety checklist was not available and in use in all operating theatres in the country. There was no comprehensive occupational health and safety program for members of staff across all the levels of the health system. There were no systems for documenting and acting upon staff incidents. Adverse event/incident reporting systems are not available for both staff and patients. For example, no adverse event/incident list, register, and no SoP/guideline on adverse event/incident reporting. There was no specific emphasis of equity and people-centeredness in the NHQS (2017-2021). Efficacy and timeliness in the provision of health care is affected by the frequent stock out of essential medicines and supplies.

In summary, the goals and objectives of the NHQS (2017-2021) were not fully implemented and achieved mainly because of major health systems barriers and bottlenecks that significantly affected its operation-

alization, implementation, coordination and monitoring and evaluation. The recommendations outlined below defined key priorities that were identified through desk review, stakeholders' consultations and interviews with key informants. The recommendations form the basis for the goal, strategic objectives, and interventions for the next NHQS (2024-2028).

Priorities for the new NHQS:

a. Extensive distribution and implementation of the document and its content

b. Regulation (HR, Facilities & Medicines); accreditation/credentialing and licensing

c. An elaborate M&E or performance indicator framework aligned to the national M&E framework

d. An elaborate Patient Safety program/agenda consistent with the Global Patient Safety Plan (2021-2030)

e. Should comprehensively address all the 7 dimensions/domains of quality

f. Meticulous documentation of change packages

g. The quality governance arrangements and its level of effectiveness including arrangements & coordination with County/Facility QMTs

h. Capacity of frontline staff QI methods and the application of basic QI tools to identify and solve problems

i. Role of community members and opinion leaders in driving the demand side of quality

j. Sustainability issues must be considered

Goal of NHQS

Improved health quality and safety for better health outcomes for the population in Liberia

Strategic Objectives

Strategic objective 1

SO1: To strengthen health systems governance, organization, and management to deliver quality essential services (systems environment improvement)

Strategic objective 2

SO2: To improve clinical effectiveness

All health facilities (HFs) and community health workers (CHWs) will ensure that the most appropriate treatments, interventions, support, and services are provided at the right time to everyone who will need and will always benefit from it. This will be done in the most cost-effective and safe manner. All HFs and CHWs will also work to improve upon their care outcomes such as the mortality and morbidity rates.

Strategic objective 3

SO3: To ensure patient and/or provider safety

This SO focuses on ensuring that there will be no avoidable harm or injury to clients/patients who receive healthcare, and to healthcare workers who are providing care; and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

Strategic objective 4

SO4: To deliver People-centered Care, engage and empower patients, families and communities.

All HFs will work towards developing a mutually beneficial partnership between our clients, their families and relations that will be based on respecting their individual needs and values, and which demonstrates compassion, continuity, clear communication and shared decision-making. There will be ef-

forts made to improve the provision of care for the whole pathway of care for patients with specific conditions by engaging with all the relevant partners and stakeholders in health and social care to deliver more effective care.

Strategic Interventions (aligned along the following broad areas)

1) System environment

2) Improving clinical care

3) Reducing harm

4) Engaging and empowering patients, families and communities.

Financial implication

The implementation and sustainability of the interventions in this strategy would require financial resources estimated at USD 61, 873,090.

1.0 Introduction and Background

In 2016, the MoH developed the NHQS (2017-2021) to facilitate the attainment of QoC and patient safety goals outlined in the 2011-2021 NHPP. The document was developed after the establishment of the HQMU within the MoH to lead all quality and patient safety efforts. The strategy provided a medium-term framework to address and improve quality and patient safety related issues in the Liberia health systems.

Further, there are a number of policy and strategic documents such as the EPHS I (2011-2021)(3), the National Health and Social Welfare Policy and Plan (2011-2021)(2), the Investment Plan for Building a Resilient Health System (2015-2021)(4) and the UHC Roadmap for the Pro-Poor Agenda for Prosperity and Development (PAPD)(5) that have stressed the importance of quality and patient safety in health service delivery in the country.

1.1 Organization of Healthcare delivery systems in Liberia

Liberia's health system is described as pluralistic with a variety of direct service providers including government and private sector *(i.e., self-financing, faith-based and NGO-owned)*. Administratively, the health system is organized at 5-levels including the central MoH, County Health Teams (CHTs), District Health Teams (DHTs), Health facilities and Communities. The central MoH is responsible for setting policies, strategic direction, stewardship and guidelines, monitoring, evaluation and supervision. The CHTs oversee program implementation in each county, while the DHTs oversee and supervise district and HF and community health programs operations. The HFs provide both preventive and curative services under the supervision of the district while Community Health Volunteers (CHVs) and Community Health Assistants (CHAs) provide selected health services in communities targeting specific populations (6).

There are 3 main tier system for health service delivery in Liberia i.e., primary *(consists of community and facility-based services in clinics)*, secondary *(consists of all aspects of primary healthcare plus 24-hour care for most hospitalizations, emergency, diagnostic, comprehensive emergency obstetrics care, emergency surgical services)* delivered at PH centres and coun-

ty/district hospitals and tertiary *(consists of specialized consultative care, teaching and learning oriented but will not divert excessive resources from the primary and secondary levels of care)*. Each level uses a defined criterion to screen patients. Written referrals *(except emergencies)* are required of clients who require care at the higher levels from referring facilities.

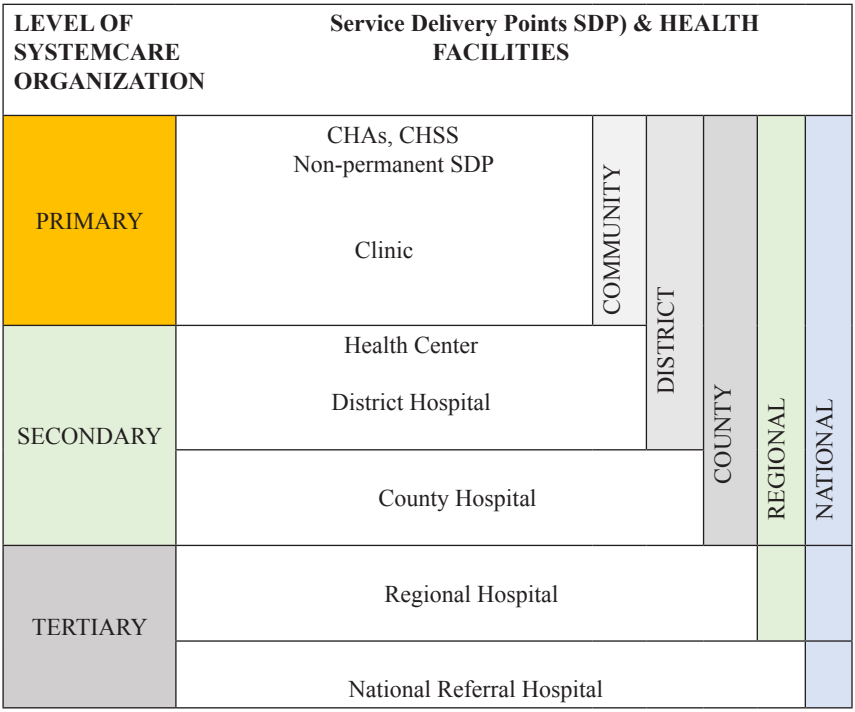

Figure 1: Levels of the Liberian health system

1.2 Quality of healthcare and patient safety

Quality healthcare has been highlighted as a precursor for UHC and health security. This implies that as countries including Liberia commit to achieving Health for All, it is an imperative to ensure that health services provided meet the seven quality dimensions. That means the services are effective, efficient, equitable, safe, timely, integrated and people centered.

Box 1: the seven dimensions of quality and their definitions

1. **Effectiveness:** the extent to which the right care is provided every time guided by the available evidence

2. **Efficiency:** the extent to which care is provided without wastage of available resources

3. **Equity:** the extent to which care is provided with fairness and without discrimination

4. **Timeliness, Accessibility and Affordability:** the extent to which care is provided without harmful delays and needless waits. People receive care when they need it. Reducing financial risks for service users and any other access barriers; and promoting care that can be afforded by them .

5. **Safety:** the extent to which service users and healthcare providers are protected from avoidable/preventable harm from the care that is meant to help them

6. **People-centered care:** the extent to which care is provided to service users in a manner that treats them with dignity, respect and compassion; and ensuring that the values, preferences and needs of patients guide all clinical decisions

7. **Integrated:** the extent to which care is provided in a "one-stop-shop" i.e., continuity and transition without fragmentation in the care process

The global Covid-19 pandemic has modified the healthcare delivery landscape and revealed the vulnerabilities of health systems especially in Lower-Middle-Income Countries (LMIC) including Liberia. Notwithstanding this, it is important to note that QoC is an important aspect of preparedness and response to COVID-19 and any other future pandemic or health threat. It is therefore necessary to focus on strengthening the health systems even during public health crises or emergencies. In its NHP (2022-2031) and HSSP (2022-2026), the Liberia MoH has pri-

oritized four policy/strategic objectives to improve access to and utilization of quality essential health services towards UHC; strengthening the capacity of the health workforce; sustaining the current community health program; and implementing the International Health Regulation (IHR) 2005. These are all in its quest to ensure the delivery of quality health services across all levels of the health system and ensure health security.

To build a resilient health system, and from lessons learnt from the 2014-2016 Ebola Viral Disease (EVD) outbreak in Liberia, the institutional capacity for healthcare quality was established and the NHQS (2017-2021) was developed. The former included the creation of the Healthcare HQMU within the MoH in 2015 and other governance structures for quality as part of recommendations from the Investment Plan for Building a Resilient Health System (2014 -2021).

1.3 Rationale for revision of the NHQS (2017-2021) and elaboration of the NHQS (2024-2028)

Since the NHQS expired in 2021, the MoH and partners decided to review its implementation and develop the next strategy for the period 2024-2028. This process was aligned to and part of the overall NHPP review and development of the next national health policy (2022-2031) and health sector strategic plan (2022-2026) as well as other key policies and strategies that had expired in 2022. The review of the NHQS took stock of its implementation to determine achievements, lessons learnt, challenges, and recommendations that informed and guided the development of the next strategy (2024-2028). Careful review of the achievements, lessons learned, and challenges from implementation of NHQS (2017-2021) was undertaken. The findings informed and guided the NHQS (2024-2028).

The purpose of this NHQS (2024-2028) is to facilitate the institutionalization of the culture and practice of quality across all the levels of the health system, irrespective of ownership. This strategy seeks to further ensure that quality along all its dimensions *(i.e., safety, timeliness, efficiency, equity, effectiveness, people centeredness and integrated)* is pursued

in our quest to achieve UHC, including ensuring the aversion of preventable harm to service users and providers of the health system.

1.4 Review of NHQS (2017-2021) and NHQS (2024-2028) development process

The process to review the NHQS (2017–2021) and elaborate the NHQS (2024–2028) was led by MoH and supported by multiple stakeholders. It involved technical consultations with all the relevant stakeholders across all the levels of the health systems in Liberia, desk review and primary data collection from Key Informants and visits to selected facilities. This NHQS (2024–2028) was developed closely and in consultation with key stakeholders from the MoH, development partners *(i.e. WHO, UNICEF, USAID, US-CDC, Jhpiego, Last Mile Health, regulatory bodies (Liberia Medical and Dental Council, Liberia Nursing and Midwifery Board, Pharmacy Board, Physician Assistants Board)*, training and academic institutions, private health sector (faith-based, self-financing), patients and community members. The process was led by the NHQTWG with technical guidance from a WHO NHQS Consultant. Colleagues in the WHO offices (Country office, Africa region and Headquarters) supported and made inputs into the document via regular calls and virtual meetings.

There was an extensive stakeholder engagement process and data collection from both primary *(key informant interviews, health facility visits and stakeholder workshop)* and secondary sources *(review of the NHQS (2017–2021) and other national policies, plans, strategies and reports relevant to quality healthcare in Liberia and the Africa region)*, which culminated into a situational analysis report of the current state of healthcare quality in Liberia. The primary data collection assessed the extent of reach, effectiveness, adoption/uptake, implementation, and sustainability of the NHQS (2017–2021). Both data collection methods also looked at the enablers and barriers to the implementation of the NHQS (2017–2021); lessons learnt, what should be done differently, what changes and strategies should be introduced in the NHQS (2024–2028) to ensure its successful implementation and accelerate the efforts at institutionalising the culture and practice of quality in the Liberian healthcare system. In addition, the primary data collection sought to understand the leadership and function of healthcare quality in Liberia.

The finding of the situational analysis was validated at a 5-day workshop with key stakeholders: national level policy makers, technical officers (including program coordinators), county health team members (including County Health officers and county clinical supervisors) and partners.

Finally, the process was iterative with the Consultant working closely with the HQMU in the MoH to prioritize the strategic interventions and key actions. The prioritization was guided by the findings from the situational analysis including the stakeholder workshop and desk review of key national documents, such as the NHP, the EPHS to ensure alignment and synergy. Various versions of the draft document were shared with the HQTWG members and other key stakeholders by the HQMU via mail. A shared drive was also created to harvest inputs from WHO colleagues in AFRO & HQ.

Figure 2: Stakeholders' consultative workshop

2.0 State of healthcare quality and patient safety in Liberia (Situation Analysis)

2.1 Overview of Liberia Health Systems Performance

There are 962 health facilities of different levels spread across 15 counties with public facilities accounting for 49.62% (477) and these include 41 hospitals, 64 health centres and 857 clinics[3] .

However, physical access (population living beyond 5km radius or 1hour walk) is still a challenge for about 30% of the total population. For instance, about a fifth of the 15 counties have 50% of their population living beyond 5km or an hour walk to reach a health facility (2, 6). The country has a health facility density per 10,000 persons of 1.95 per 10,000 persons, an increase from 1.7 per 10,000 in 2016 but this varies significantly across the counties.

Despite this, accessibility is still a challenge and is affected mostly by the geographical location of the facilities, deplorable road networks, limited referral facilities, and unavailability of an efficient public transport system. In 2006, as part of the efforts by the government to ensure equitable access to healthcare, user fees were abolished. Less than 15% of the total population aged 15-49 years have health insurance. Only 7% of men and 4% of women have health insurance. It is instructive to note that most (5% men and 3% women) of the insurance is employer-based. The percentage of Liberians who do not have insurance have remained the same since 2013[4] . There are consistent reports about informal payments at service delivery points by patients, relatives and the communities[5] .

2.2 Review of the Implementation of the NHQS (2017-2021)

The NHQS (2017-2021) had 7 strategic goals organized around the six-WHO Health Systems Building Blocks i.e., 03 broad objectives organized around the dimensions of quality[6] . The national definition for quality was *"the degree to which health services for individuals and populations, and all components of the health system, increase the likelihood of desired health outcomes and are consistent with current professional knowledge, standards, and health structures".*

This section outlines the key findings from the review of the NHQS (2017-2021) implementation and the state of QoC and patients' safety in Liberia. The analysis was conducted along the six health systems building blocks. It was also guided and informed by the results framework of the NHQS (2017-2021) including analyzing the extent to which its stated goals and objectives were implemented and achieved. The results framework of the NHQS (2017-2021) was also organized and analyzed according to the six building blocks of the health system. The analysis used a mixed approach and methodology and consisted mainly of extensive desk review (secondary data and information), stakeholders' consultations (technical and their perceptions/options) and in-depth interviews with selected key informants and direct observation during visits to some facilities (primary data collection). The findings were presented and further validated during stakeholders' consultation workshops with key participants from national and sub national levels.

2.3 Current state of Quality in Liberia

The review revealed that the implementation of the first NHQS emphasized the establishment of quality governance structures such as the HQMU and QMTs at all levels of the health system, and on improving infection prevention practices at the HF and community levels. Interventions also focused on primary healthcare facilities. However, there were weaknesses in all the components of the health system building blocks especially leadership/governance, human resource and financing, which posed significant barriers to the successful implementation of the strategy. An analysis of the extent to which the 12 illustrative activities of these objectives were achieved revealed that 42% were achieved and 33% was not achieved, while 25% of activities were being implemented (ongoing). Details of this are presented separately in the Situational Analysis Report of the NHQS (2017-2021).

It can be inferred from the above that the existing health systems building blocks are extremely weak and create little room and incentive to facilitate and support the provision of quality healthcare. Any successful quality strategy will have to be hinged on improving the robustness of the components of the health system and particularly aim at addressing barriers related to human resource, leadership/governance, medical products/technology and finance in this order as shown in Figure 3.

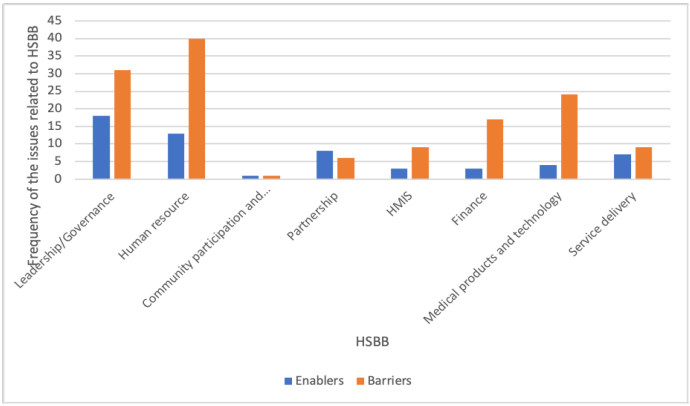

Figure 3: The health systems building blocks and the extent to which they influenced the implementation of the NHQS (2017-2021)

Some words that were used to describe the current state of quality by participants at an NHQS (2017-2021) review workshop via a Mentimetre poll were: substandard, inadequate, weak, struggling etc. Further details are presented in Figure 4.

In ONE word, describe the current state of healthcare quality in Liberia.

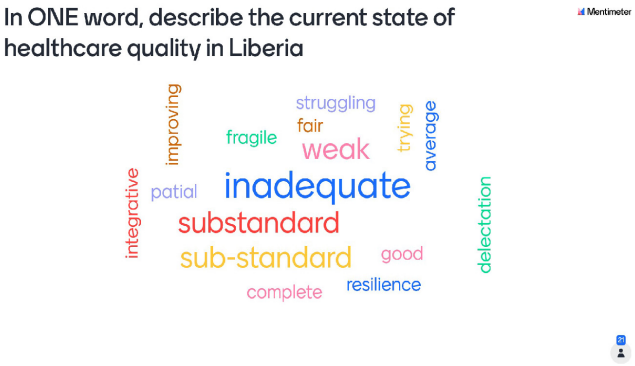

Figure 4: Participants' description of the current state of quality via a Mentimetre poll

2.4 Desired State of Quality in Liberia

The desired state of quality in Liberia was described by participants at a workshop to review the NHQS (2017–2021) via a Mentimetre poll as: equitable, excellent, good, etc. Other descriptions are presented in Figure 5 below.

In ONE word describe the desired state of healthcare quality in Liberia

Figure 5: Participants' description of the desired state of quality via a Mentimetre poll

2.5 Key Health Systems issues that affected Quality and Patient Safety (implementation of the NHQS (2017-2021))

2.5.1 Leadership & Governance

The regulatory systems are generally inadequate and sub functional for all the health regulatory bodies:

1. Inadequate oversight of health professionals.
2. License renewal for most cadres is mostly via the payment of fees without any competency assessment or CMEs/CPDs.
3. Regulatory bodies are mostly working in silos with no schedules for regular meetings among themselves or with the MoH.
4. The regulatory bodies are saddled with capacity and logistical challenges making inspections and monitoring less effective.

5. The Liberia Medical & Dental Council (LMDC) is playing a dual role of personnel and facility regulation.

2.5.2 Quality Governance

1. QMTs are not available in all the over 900 health facilities as envisioned, where they exist, most of them are less functional.

2. Facility QMTs exist and were functional (i.e., meeting regularly per their schedule with evidence of minutes) in the selected facilities visited except the private. However, there was no evidence of documented QI projects nor adoption of any change packages. This is so even for IPC that takes 100% of QMT activities in facilities.

3. QMTs have a very broad membership in the facilities and discuss a broad range of issues that affect QoC.

4. There are IPC focal persons in most facilities who are expected to play a dual role to include quality but that does not happen.

5. There is documentation of IPC meetings in some of public facilities visited but limited in the private facilities.

6. The quality program is mostly focused on IPC other than some other key quality domains. This probably is so because of the history and antecedents particularly with Ebola.

2.5.3 Human Resource

There are some human resource challenges across all levels of the health system that are also affecting the implementation of a national quality program:

1. Weak and in some instances absence of accountability systems and measures and this makes people get away with anything (lack of accountability).

2. High levels of attrition which have generally been blamed on poor working environments and conditions.

3. Very committed but poorly incentivized health workforce.

2.5.4 Medicines, Vaccines & Technology

1. Availability of medical supplies and consumables is also challenged. There are frequent stock outs for medications and IPC supplies especially gloves that are affecting quality service delivery. In one facility, it was observed that health care providers in an ER were dressing wounds with bare hands. In another facility labor room, health workers indicated they had to use their own money to purchase gloves or ask the patients to purchase them for use. These undermined all the IPC efforts.

2.5.5 Service delivery

2.5.5.1 Clinical effectiveness

1. There is absence of quality measures/metrics that are being tracked across all the facilities except in Performance Based Financing (PBF) implementing facilities. Even in these facilities (i.e., PBF implementing), these indicators are only for MNCAH and do not include the other areas of care.

2. Though protocols are available for most clinical procedures, their adherence is suboptimal.

2.5.5.2 Quality & Patient Safety

1. Adverse/incident reporting systems generally do not exist. There are no adverse events lists for the health system that must be reported except for maternal deaths.

2. There is a general culture of non-disclosure and people wanting to cover up when things go wrong. This, according to providers, is as a result of the culture of blaming, naming and shaming.

2.5.5.3 Provider safety

1. There is no system of documenting staff-related incidents.

2. There are suboptimal IPC practices including hand hygiene, waste management, etc.

3. Availability of the requisite logistics and conducive work environment is lacking in most facilities.

4. There is an absence of occupational health and safety for members of staff.

2.5.5.4 Transfusion safety

1. There is no system for hemovigilance including a system for documenting AEs related to transfusion when they occur and capacity building.

2. Blood grouping and cross matching is basic with types. One other facility indicated the use of tubes but did not find (from literature, interviews or facility visits) any using immunoglobulins or water bath.

2.5.5.5 Medication safety

1. The pharmacovigilance (PV) system is weak and, in most cases, does not exist. There have been only 240 qualified PV reports since 2013.

2. Appropriate storage of medications is also challenged.

3. Availability of emergency medicines for all care areas was a challenge. In most instances, prescriptions are given to relatives of patients to buy.

4. The AMR efforts and the program are also weak.

2.5.5.6 Surgical safety

1. The surgical safety checklist was in use at one of the secondary facilities visited. However, in other facilities visited, this was not the case.

2.5.5.7 Waste segregation

1. This is ongoing in many facilities for sharps but not for the other types of waste. Further, waste segregation is not happening at the final disposal sites.

2. There were no pedal-operated bins in health facilities.

3. There is a National Waste Management Guidelines (2022) that is yet to be fully implemented.

2.5.5.8 Data management and use

1. Data use in the facility by providers was weak and, in some instances, non-existent. It was observed that data was routinely collected but transmitted through the system without any use of it at the facility level. In one facility, partographs and consent forms were completed and stashed in files.

2.5.5.9 People-centered care

1. There are no systems for collecting client (i.e., patients, providers, and relatives) feedback and integrating same to improve the quality-of-service delivery. It does not happen.

2.5.6 Health financing

1. The free healthcare is also challenged and not happening as expected. In most instances, a prescription is given to patients to go and get their medications and consumables before they are treated. This affects the efficacy of treatment and timeliness to the provision of care.

2. There is also the absence of a dedicated funding/allocation to support the HQMU in implementing its activities.

2.5.7 Partners

1. There is some support for various quality-related programs by partners, such as WHO, UNICEF, UNFPA, Jhpiego, US-CDC, US-AID, GIZ, GF, WB, LMH, CHAI etc.

2. Some Partners provide incentives to selected frontline health-care workers to facilitate their program activities. This is not sustainable in the long term.

3.0 Key National Health Priorities that guided and informed the NHQS (2024-2028)

According to the NHP (2022-2031), the overall goal of the health sector is "to Improve the health and wellbeing of all in Liberia".

1. Strengthen Governance, Leadership and management at all levels of the health care delivery system and devolve management responsibilities, resources and authority to the lower levels in line with the Local Government Law and National Policy on Decentralization and Local Governance

2. Ensure the availability and retention of highly skilled and well-motivated health workforce for the sector, including strengthening pre-service health education systems and absorption and retention to close workforce gaps.

3. Improve access to and utilization of quality essential health services at all levels of care to all persons, regardless of gender or social status through standardized, integrated and sustainably financed health programs including community health, quality essential medicines and vaccines supplies, and diagnostics.

4. Ensure that health security is guaranteed through National Frameworks aligned with IHR 2005.

These priorities are expected to accelerate the efforts of Liberia to attain UHC and health security to significantly improve the health of the population.

At the same time, the health sector must become more efficient by:

a. Allocating resources to counties and health facilities according to their population size, disease burden, workload, and utilization.

b. Decentralizing health system management to the appropriate levels based on their capacity.

c. Creating the culture of data use and analysis for programming, planning, and decision making.

d. Improving the coordination of all efforts to support the delivery

of quality affordable and universal health services, eliminating fragmentation, duplication, and minimizing gaps and,

Creating a culture at all levels of the health system that values and endeavours to do more for the population within available resources.

4.0 National Health Quality Strategy (2024-2028)

4.1 National Quality definition

In Liberia, quality shall be known and defined as:

"The degree to which health services for individuals and populations, and all components of the health system, increase the likelihood of desired health outcomes and are consistent with current professional knowledge, standards, and health structures" (NHQS (2017-2021))

4.2 Scope

This NHQS (2024-2028) will pursue improvement in healthcare quality across all the levels of healthcare in Liberia. It will also cover every provider of healthcare and/or social welfare service irrespective of ownership. Further, it covers all the quality dimensions of effectiveness, efficiency, equity, timeliness (including accessibility and affordability), safety, people-centeredness and integrated.

4.3 Guiding Principles for NHQS development and its implementation

The guiding principles that informed the elaboration of the NHQS as well as its implementation included:

1. Client (People) focused/centered: relationship will be a shared purpose informed by what matters most to the service users/clients and a departure from a provider-driven approach to improving care, trust, openness, an ability to respectfully listen to one another and willingly confront any power imbalances among actors.

2. Partnership: this will focus on ensuring that partnership will be built between providers and service users (patients and families) as well as among MOH and key stakeholders in quality and patient safety in Liberia. We will seek to engage and involve those who are closest to an issue being addressed or are affected/im-

pacted. Service users and providers will be empowered to make the necessary transitions.

3. Responsiveness of health services: the NHQS focuses on ensuring that the services are responsive to preferences, needs and values of individuals, and ensure that all clinical decisions are guided and informed by them.

4. Integration of services, systems, and processes: this will focus on integration of efforts and services ensuring alignment and synergies of all the interdependent groups of people or processes working together to facilitate the attainment of the desired goals and objectives.

5. Existing evidence (use of data and information): we used existing data (quantitative and qualitative) and information to guide and inform the elaboration of the NHQS. Similarly, the implementation will focus on the use of data in measuring our efforts at improving the quality of healthcare along all the dimensions. Measurement is necessary for us to assess the outputs, outcomes, and impacts of our interventions and efforts against the set improvement objectives. We will seek to measure the changes that are occurring as we test our interventions so that we can refine them over time in response to the data.

6. Safety culture: Instil a safety culture in the design and delivery of health care.

7. Contextualization: Based on policies, strategies, and interventions/actions that fit Liberia (local) health care context and settings.

4.4 Core values

The core values to guide the implementation of the NHQS (2024-2028) were generated by participants during the stakeholders' consultative workshop via a Mentimeter poll.

What one core value would you recommend guiding the NHQS 2024-2028 implementation?

Figure 6: Core Values of the NHQS 2024-2028

4.5 Goal, strategic objectives, and interventions

This section espouses the goal(s) and strategic objectives that will be pursued by the NHQS (2024-2028) in contributing to the overall health sector "to improve the health and wellbeing of all people in Liberia". These quality goals and strategic objectives are designed to address the gaps identified in the situational analysis and to facilitate the attainment of the desired state of quality in Liberia. These goals, strategic objectives, strategies, and strategic interventions were informed by the stakeholder analysis and 5-day-stakeholders' meeting held to review the implementation of the NHQS (2017-2021). It has taken into consideration the key issues that were identified and offers appropriate strategies to facilitate improvement in the outcomes of care and the larger health system over the next five (5) years.

4.5.1 Goal

The goal of the NHQS (2024-2028) is to ensure improved healthcare quality and safety for better health outcomes for the population in Liberia

4.5.2 Strategic Objectives

Four strategic objectives will guide the implementation of the NHQS. These four strategic objectives provide the necessary focus that will guide all the strategic interventions towards the delivery of quality care to people of Liberia.

4.5.2.1 Strategic objective one: To strengthen health systems (HS) governance, organization, and management to deliver quality essential services (systems environment improvement)

4.5.2.2 Strategic objective two: To improve clinical effectiveness

All health service delivery points (facilities and communities) will ensure that the most appropriate treatments, interventions, support, and services are provided at the right time to everyone who will need and benefit from it at all times. This will be done in the most cost-effective and safe manner. All health facilities will also work to improve upon their care outcomes such as the mortality and morbidity rates.

4.5.2.3. Strategic objective three: To ensure patient and provider safety

This SO focuses on ensuring that there is zero avoidable harm/injury to clients/patients who receive healthcare, and to healthcare workers who are providing care in health facilities or communities. It also emphasizes the provision of an appropriate, clean and safe environment for the delivery of healthcare services at all times.

4.5.2.4 Strategic objective four: To deliver People Centered Care, engage and empower patients, families and communities

All health facilities will work towards developing a mutually beneficial partnership between clients, their families and relations based on re-

specting their individual needs and values, whilst demonstrating compassion, continuity, clear communication and shared decision-making along the continuum of care.

4.5.3 The Quality Framework Driver Diagram

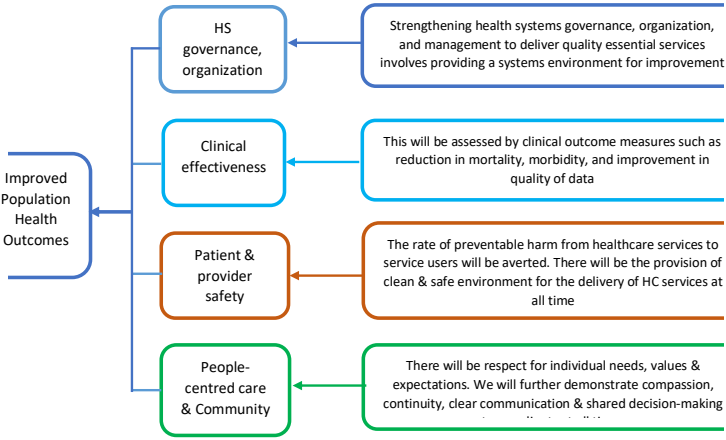

Figure 7: Liberia Quality Framework Driver Diagram

4.5.4 Strategic objectives & interventions

The strategic objectives and respective interventions are outlined in this section. They are designed to address the gaps identified in the situational analysis and stakeholders' consultation to achieve the strategic objectives and goal.

Table 1: Summary of strategic interventions according to the objectives

No.	Goal	Strategic objective	Strategic interventions
1.	To ensure improved health quality and safety for better health outcomes for the population in Liberia	1.0 To strengthen health system governance, organisation and management to deliver quality essential health services	1.1 Build and strengthen the national and sub-national institutions and health facilities, mechanisms and quality governance structures at all levels of the health system for improving quality of care in the health sector
			1.2 Establish and strengthen monitoring, evaluation, and learning mechanisms for the improvement of QoC at all levels of the health system
			1.3 Build and strengthen capacity of health care workers to provide quality improvement and care at all levels of the health system for in-service and pre-service training
			1.4 Strengthen the health regulatory bodies' capacity to effectively regulate healthcare service delivery (without necessarily compromising their independence)
			1.5 Establish mechanisms across all levels of the health system that incentivizes, recognizes, and rewards quality healthcare
			1.6 To strengthen collaboration between all actors within the health sector (including the private sector) to support quality improvement efforts

No.	Goal	Strategic objective	Strategic interventions
2.		To improve clinical effectiveness	2.1 Develop and/or strengthen existing data systems to integrate QoC measures/indicators and use data for improved care
			2.2 Ensure that essential medicines, IPC supplies, logistics, and other requisite consumables are available at all levels for service delivery
			2.3 Implement interventions to address gaps identified in clinical competencies
			2.4 Redesign the process of care (including clinical processes) across all levels of the health system to ensure that they are beneficial to patients (e.g. reducing waiting times)
3.		To ensure patient and/or provider safety	3.1 Develop and sustain a "quality & just culture"3 that promotes learning and accountability other than blaming and retribution across all the levels of the health system
			3.2 Put mechanisms in place to ensure that the provider documents all clinical procedures and treatment, and ensure the safety and confidentiality of the medical records
			3.3 Disseminate and implement a Patients' Rights Charter and Professional Code of Ethics
			3.4 Put mechanisms /systems in place in all health facilities that can objectively assess and categorize patients according to their severity (i.e., triage) including training of health care workers

No.	Goal	Strategic objective	Strategic interventions
			3.5 Implement strategies to enhance medication safety, pharmacovigilance and ensure systems in place to report adverse events
			3.6 Improve and strengthen the referral practices between health facilities, and enhance the referral systems and feedback mechanisms
			3.7 Strengthen implementation of guidelines on patient safety (surgical safety, blood transfusion, laboratory safety procedures) in all health care facilities
			3.8 Design health care settings, environments and practices to provide the safest circumstances and equipment for health workers (Occupational health safety), ensuring IPC measures in place minimizing healthcare-associated infections
4.		To deliver People-Centred Care, engage and empower patients, families, and communities	4.1 Empower clients, family/relations and community to speak up and take responsibility for their health outcomes
			4.2 Encourage patient-provider dialogues to share care plans, identify gaps in care and assess the extent to which reasonable progress has been made to enable decision-making
			4.3 Establish functional client (patient, provider and relative) information and feedback (complaints, compliments and suggestion) system (e.g., suggestion boxes, client experience centres, client experience teams who will be integral part of the facility QMTs) in all health facilities, and use of routine information management system.

Strategic objective 1: To strengthen health system governance, organization, and management to deliver quality essential health services

Strategic Interventions 1.1

Build and strengthen the national and sub-national institutions and health facilities, mechanisms and quality governance structures at all levels of the health system to improve QoC in the health sector.

Activities

1. Create awareness on healthcare quality services at national and sub-national levels.
2. Establish, reactivate, and strengthen QMTs at national and sub national levels.
3. Conduct healthcare quality management training at national and sub-national levels.
4. Conduct quarterly review and supervision of the healthcare quality management implementation at national and sub national levels.
5. Mobilize resources for healthcare quality management system at national and sub national levels.
6. Establish a ministerial, multi-stakeholder NHQAB to oversee the implementation of the NHQS (2024-2028).

Strategic intervention 1.2

Establish and strengthen monitoring, evaluation, and learning mechanisms for the improvement of QoC at all levels of the health system.

Activities

1. Conduct healthcare quality management training for national and county monitoring and evaluation staff.
2. Train facility QMTs in monitoring and evaluation of health care quality service and reporting.
3. Support data collection, reporting, and data quality improvement.
4. Implement periodic QI program performance reviews including clinical audits.

5. Document and share best practices in health care quality and patient safety.

Strategic intervention 1.3

Build and strengthen capacity of health care workers for QI and care at all levels of the health system through in-service and pre-service training.

Activities

1. Engage healthcare training institutions to include QI methods in health care in their curriculum.
2. Adapt, integrate, and roll out Global Patient Safety curriculum for pre-service and in-service capacity development.
3. Advocate for the integration of the health service quality and resilience training package into pre- and in-service training programs.
4. Conduct in service training in healthcare quality and patient safety for professional health workers at all levels of the health system.

Strategic intervention 1.4

Strengthen the health system regulatory bodies' capacity to regulate healthcare service delivery (without necessarily compromising their independence).

Activities

1. Collaborate with Liberia Medical & Dental Council (LMDC) to develop and roll out the health facility accreditation standards.
2. Collaborate with health regulatory bodies to integrate occupational health and safety standards guidelines into the national accreditation standards.
3. Establish a coordinating committee to review and update health facility accreditation standards.
4. Collaborate with health professional bodies to improve quality of care at all levels.

Strategic intervention 1.5

Establish mechanisms across all levels of the health system that incentivizes, recognizes, and rewards delivery of quality healthcare.

Activities

1. Develop criteria/guideline or SoPs for recognition of excellence among health facilities and health workers.
2. Institutionalize excellence by integrating recognition-based motivation system into regular performance review processes.

Strategic intervention 1.6

Strengthen collaboration between actors within the health sector (including the private sector) to support quality improvement efforts.

Activities

1. Support meaningful engagement between HQMU-PSE/MoH and key private sector actors (Healthcare Federation of Liberia (HFL), CHAL etc) to improve the quality of care.
2. Support the implementation of the Private Sector Engagement Strategy to enhance quality of care.

Strategic objective 2: To improve clinical effectiveness and care outcomes

Strategic intervention 2.1

Develop and/or strengthen existing data systems to integrate quality of care measures/indicators and use data for improved care.

Activities

1. Develop and print priority registers and ledgers (SoPs, Job aids, treatment charts, algorithms, occupational health and safety, Adverse Events reporting etc) and collaborate with the Health Information System (HIS) to ensure that performance indicators related to quality of care are captured.

2. Integrate the healthcare quality improvement routine reporting (where applicable) into the HMIS/DHIS2.
3. Conduct regular clinical audits.

Strategic intervention 2.2

Ensure that essential medicines, IPC supplies, logistics and other requisite consumables are available and accessible at all levels for service delivery.

Activities

1. Procure and distribute essential medicines and supplies to health facilities in a timely manner.
2. Improve monthly, quarterly, and annual ordering and forecasting of essential medicines and supplies using supply consumption data (using the eLMIS).
3. Support measures to reduce and address AMR.

Strategic intervention 2.3

Improve clinical competencies and skills of health care workers.

Activities

1. Organize periodic post-supervision feedback sessions to disseminate findings from JISS.
2. Establish an accountability mechanism to follow on recommendations from the post-supervision sessions.
3. Conduct mentorship and on-the-job coaching using QI methodologies (such as Plan-Do-Study-Act (PDSA) cycle).
4. Trainings of health care workers on QI to improve competencies and skills.
5. Promote and strengthen the implementation of Liberia CPD framework.

Strategic intervention 2.4

Improve the process of care (including clinical processes) across all the levels of the health system to ensure that they are beneficial to patients (e.g. reducing waiting times, hospital length of stays, use of triage, etc).

Activities

1. Support innovative approaches (e.g., bring husband jump queue in ANC) in service delivery.
2. Conduct QI review meetings to identify gaps in care processes and propose mitigation measures.
3. Promote the use and adherence to Standard Treatment guidelines (STGs) during patients care and consultations.

Strategic objective 3: To ensure patient and/ or provider safety

Strategic intervention 3.1

Develop and sustain a quality & "Just culture" that promotes learning and accountability other than blaming and retribution across all the levels of the health system.

Activities

1. Develop and implement MoH guidelines and SOPs to promote and reinforce "just culture" in all health facilities.
2. Train health care workers on patient safety (including "just culture") in all health facilities.
3. Commemorate World Patient Safety Day and other related national events to sensitize and increase awareness of the public on the "just culture."
4. Advocate for administrative and legal processes to protect those who raise concerns about the safety of services and/or report adverse events/incidents.

Strategic intervention 3.2

Put mechanisms in place to ensure that the provider documents all clinical procedures and treatment and ensure the safety and confiden-

tiality of the medical records.

Activities

1. Develop and roll out SOPs & guidelines on charting, filing, and storing of clients' medical records.
2. Establish Electronic Medical Records (EMR) governance structure to manage patient electronic records.
3. Provide standard electronic or manual patient registry that maintains confidentiality of patient information and records.

Strategic intervention 3.3

Disseminate and implement a Patients' Rights Charter and Professional Code of Ethics.

Activities

1. Print and roll out Patients' Rights Charter and Professional Code of Ethics.

Strategic intervention 3.4

Put mechanisms/systems in place in all health facilities that can objectively assess and categorize patients according to their severity (i.e., triage) including training of health care workers.

Activities

1. Strengthen existing triage systems/mechanisms in all health facilities.
2. Train health workers on the use of triage to assess the severity of patient illness and guide management.
2. Establish a client feedback system (e.g. suggestion box, patient exit interviews).

Strategic intervention 3.5

Implement strategies to enhance medication safety, pharmacovigilance, and ensure systems in place to report adverse events.

Activities

1. Develop, update, and regularly publish list of accredited suppliers of medicine in Liberia.
2. Capacity building to supply chain/clinical teams on the safe transportation, handling, storage, and administration of essential medicines.
3. Monitor the prescription patterns of essential drugs to ensure adherence to the National Standard Treatment Guidelines (NSTG).
4. Collaborate with Liberia Medicines and Health Product Regulatory Authority (LMHRA) to implement post-market surveillance (PMS) for essential medicines.
5. Train relevant staff on SOPs/guidelines on Adverse Drug Reporting (ADR) and PV.
6. Strengthen the implementation of the Antimicrobial Stewardship Program in health facilities.

Strategic intervention 3.6

Improve and strengthen the referral practices between health facilities and enhance the referral systems and feedback mechanisms.

Activities

1. Develop and roll out national SOP/ guidelines for the referral of patients from one facility to another and feedback mechanisms.
2. Institute a counter-referral feedback system.
3. Monitor compliance to the ambulance/fleet management policy.
4. Provide targeted training for ambulance teams on safe referral practices.
5. Equip health facilities with standardized tools for referrals and feedback mechanism.

Strategic objective 3.7

Strengthen implementation of guidelines on patient safety (surgical

safety, blood transfusion, laboratory safety procedures) in all health care facilities.

Activities

1. Develop, print, and roll out guidelines/SOPs on patient safety, such as surgical safety, blood transfusion and laboratory safety.
2. Monitor adherence and usage of patient safety guidelines.

Strategic intervention 3.8

Design health care settings, environments, and practices to provide the safest circumstances and equipment for health workers (occupational health safety) ensuring IPC measures in place minimizing healthcare-associated infections.

Activities

1. Develop and implement national SOP/ guidelines on Occupational health safety
2. Provide health facilities with standardized tools, equipment and guidelines for Occupational health safety.
3. Train health workers on national SOP/ guidelines Occupational health safety, IPC guidelines and monitor implementation and institute in health institutions training curriculum.

Strategic objective 4.0: To deliver People-Centered Care, engage and empower patients, families and communities.

Strategic intervention 4.1

Empower clients, family relations, and communities to speak up and take responsibility for their health outcomes.

Activities

1. Conduct awareness raising on health literacy through community engagement programs.
2. Carry out peer support and patient expert group discussions.

3. Conduct client satisfaction survey to access the level of quality care provided to the community.

Strategic intervention 4.2

Encourage patient-provider dialogues to share care plans, identify gaps in care, and assess the extent to which reasonable progress has been made to enable decision-making.

Activities

1. Provide education to clients on clinical care processes and disease conditions, including options for management.
2. Develop/adapt patient self-management tools/technologies that will be used to manage health issues outside the formal health facility.
3. Conduct clients exit interviews to assess knowledge gaps in person-centered care.

Strategic intervention 4.3

Establish functional client (patient, provider and relative) information and feedback (complaints, compliments and suggestion) system (e.g., suggestion boxes, client experience centres, client experience teams who will be integral part of the facility QMTs) in all health facilities and use of routine information management system.

Activities

1. Set up information systems to collect patient feedback on the quality of care in the health facility.
2. Support operationalization of the Citizen Feedback Mechanism (CFM) www.libtalk.gov.lr in targeted facilities.

5.0 Implementation matrix, roles and responsibilities, and logical framework

The MoH shall lead and coordinate the implementation of the NHQS (2024-2028) with the support of key stakeholders and partners. The implementation of this NHQS (2024-2028) will be aligned and integrated with other health sector policies and strategies, which primary intent is to improve health outcomes across all levels of the health system and ensure synergy and complementarity.

- At the national level, the Minister of Health shall provide leadership and oversight of a multidisciplinary NHQAB, facilitate resource mobilization (such as requisite financial, human resource, and all others that will ensure a successful implementation), advocacy and ensure that it is mainstreamed into other sector policies and strategies including annual operational plans. The Assistant Minister of Health for Curative Services will be responsible for ensuring effective collaboration and coordination between all the directorates of the MoH to elicit their support towards successful implementation of the NHQS (2024-2028). He/she will provide overall leadership and management in the implementation and ensure that the various strategic objectives are optimized; and further ensure that adequate resources are mobilized and allocated to quality through the annual planning and budgeting systems and processes. He/she will also lead in and ensure that an enabling environment is created to facilitate collaboration and coordination with other stakeholders for healthcare quality improvement in Liberia. He/she will also collaborate with all the Programs and Units of the MoH and partners to provide oversight, supportive supervision, capacity building, and dissemination from the national to the subnational levels.

- The Director of the HQMU will conduct and facilitate regular meetings for planning and joint implementation activities to avert duplication and enhance synergy. He will oversee the overall implementation of the NHQS (2024-2028) and report to the Minister through the Assistant Minister for Curative Services. He will reinvigorate all the existing QMTs and governance structures across all the levels of the health system and make them functional and accountable. The NHQTWG will also be reinvigorated

to develop and implement the relevant interventions and activities of the NHQS (2024-2028). The NHQTWG will also provide central level technical oversight of all the activities and interventions of the NHQS (2024-2028). Annual operational plan and budget will be prepared and included in the annual operational plans at national and county levels.

- The CHTs, DHTs and facility OICs will ensure that QI activities are included in the annual operational plans, implemented, coordinated, monitored, and reported on. They will also support resource mobilization and advocacy efforts.

Further, there shall be the reviving of dormant QMTs and establishment of new governance structures in the counties, districts, facilities and communities. There shall also be the designation and appointment of dedicated quality focal persons that will oversee the planning, implementation, monitoring, coordination, and reporting of quality-related activities at these levels to the HQMU and the national level. Counties, districts, and facilities will further explore various innovative mechanisms consistent with domestic resource mobilization to augment the national MoH efforts.

Other GoL line ministries and institutions (e.g. MFDP, NPHIL, LMHRA) shall be engaged during the roll out, implementation, coordination and M&E of the strategy.

Coordination shall be strengthened using existing coordination platforms (e.g. HSCC, HCC, TWGs) and as well as county coordination structures.

The detailed implementation matrix and indicators/means of verification are outlined in the log framework in Table 2 below.

The governance structure and organogram of the HQMU, including their roles and responsibilities regarding specific strategic objectives are included in Annex 1.

Key partners that will be part of the NHQS implementation and M&E include donors, UN agencies, Civil Society Organizations (CSOs) including Non-governmental Organizations (NGOs), academia, and the private sector.

To achieve the intended outcome, the NHQS (2024-2028) will leverage on existing policies and quality initiatives. It will create a system of continuously learning from its successes and challenges through the continuous use of data to improve its performance and care outcomes.

Table 2: Implementation Matrix (Log Frame)

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
1	1.0 To strengthen health system governance, organization and management to deliver quality essential health services	1.1 Build and strengthen the national and sub-national institutions and health facilities, mechanisms, and quality governance structures at all levels of the health system for improving QoC in the health sector	1. Create awareness on health care quality services at national and sub national levels 2. Establish QA and improvement management committees at national and sub national levels 3. Conduct health care quality management training at national and sub national levels	1. % of planned/ targeted health care quality management stakeholders' meetings conducted (Disaggregate by type of meeting; TWG, advisory board, etc.)	HQMU HQMU/ M&E/ HR-Training	TBD TBD	70% 70%	TBD TBD	1.	1.0 To strengthen health system governance, organization and management to deliver quality essential health services	1.1 Build and strengthen the national and sub-national institutions and health facilities, mechanisms, and quality governance structures at all levels of the health system for improving QoC in the health sector	1. Create awareness on health care quality services at national and sub national levels 2. Establish QA and improvement management committees at national and sub national levels 3. Conduct health care quality management training at national and sub national levels

			4. Conduct quarterly review and supervision of the healthcare quality management implementation at national and sub national levels 5. Mobilize resources for health care quality management system at national and sub national levels 6. Establish a ministerial, multi-stakeholder NHQAB to oversee the implementation of the NHQS (2024-2028)	2. Percentage of targeted stakeholders who have received health care quality related trainings (basic QMI concepts, WASH, IPC, AMR, etc) during the last year								4. Conduct quarterly review and supervision of the health-care quality management implementation at national and sub national levels 5. Mobilize resources for health care quality management system at national and sub national levels 6. Establish a ministerial, multi-stakeholder NHQAB to oversee the implementation of the NHQS (2024-2028)

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
		1.2 Establish and strengthen monitoring, evaluation and learning mechanisms for the improvement of quality of care at all levels of the health system	1. Conduct health care quality management training for national and county M&E staff 2. Train facility QMT in monitoring and evaluation of health care quality service and reporting 3. Support data collection, reporting and data quality improvement 4. Implement periodic QI program performance reviews	1. Percentage of planned QI program performance review meetings conducted as per SOP 2. % of planned virtual experience sharing fora with at least 60% of targeted participants in attendance 3. # of publications on Health Care Quality and safety produced	HQMU HQMU HQMU/ M&E/ Communication	TDB TBD 0	TDB TBD 0	70% 60% TBD	TBD TBD 0	50% 40% 4	1.2 Establish and strengthen monitoring, evaluation and learning mechanisms for the improvement of quality of care at all levels of the health system	1. Conduct health care quality management training for national and county M&E staff 2. Train facility QMT in monitoring and evaluation of health care quality service and reporting 3. Support data collection, reporting and data quality improvement 4. Implement periodic QI program performance reviews 5.Document and share best practices in health Care Quality and patient Safety

			5.Document and share best practices in health Care Quality and patient Safety	4. % of health facilities with all tracer HIS Items (Trained staff for reporting, tool and ledgers, etc.) for reporting	MoH	TBD	TBD	60%	TBD	40%		
		1.3 Build and strengthen capacity of health care workers to provide quality improvement and care at all levels of the health system for in-service and pre-service training	1. Engage health care training institutions to include QI methods in health care in their curriculum 2. Adapt, integrate, and roll out Global Patient Safety curriculum for pre-service and in-service capacity development	% of accredited training institutions for health sciences that are using the integrated training package for healthcare quality and patient safety	HR-Training unit	0	60%	0	20%	30%	1.3 Build and strengthen capacity of health care workers to provide quality improvement and care at all levels of the health system for in-service and pre-service training	1. Engage health care training institutions to include QI methods in health care in their curriculum 2. Adapt, integrate, and roll out Global Patient Safety curriculum for pre-service and in-service capacity development

No	Strategic objective	Strategic interven-tions	Key activities	Core indi-cator(s)	Respon-sible unit/ entity	Base-line	Tar-get	Timelines				
								2024	2025	2026	2027	2028
			3. Advocate for the integration of the health service quality and resilience training package into pre-ser-vice and in-service program 2. Conduct in service training in healthcare quality and patient safety for profession-al health workers at all levels of the health system									3. Advocate for the integration of the health service quality and resilience training pack-age into pre-service and in-service program 4. Conduct in service training in healthcare quality and patient safety for professional health workers at all levels of the health system

		1.4 Strengthen the health regulatory bodies' capacity to effectively regulate healthcare service delivery (without necessarily compromising their independence)	1. To collaborate with LMDC to develop and roll-out the health facility accreditation standards 2. Collaborate with health regulatory bodies to integrate occupational health and safety standards guidelines into the National accreditation standards 3. To establish a coordinating committee to review and update health facility accreditation standards	1. # of health facilities accredited using the accreditation standards 2. # of health facilities meeting minimum threshold on accreditation standards 3. % of active clinical staff practising with up-to-date licence 4. % of planned (annual) meetings to review and update the health facility accreditation standards conducted	HQMU/ LMDC/ Professional Boards HQMU/ LMDC/ Boards HR/LMDC HQMU/ LMDC/ Boards	14% (2013) 14% (2013) TBD TBD	80% 80% 80% 100%	TBD TBD TBD TBD	20% 20% 30% 25%	40% 40% 50% 50%	1.4 Strengthen the health regulatory bodies' capacity to effectively regulate healthcare service delivery (without necessarily compromising their independence)	1. To collaborate with LMDC to develop and roll-out the health facility accreditation standards 2. Collaborate with health regulatory bodies to integrate occupational health and safety standards guidelines into the National accreditation standards 3. To establish a coordinating committee to review and update health facility accreditation standards

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
		1.5 Establish mechanisms across all levels of the health system that incentivizes, recognizes and rewards quality healthcare	1 Develop criteria guideline, SOPs for the recognition of excellence 2 Institutionalize excellence by integrating recognition- based motivation system into regular performance review processes	proportion of health facilities that have incentives, rewards or recognition systems for their staff	HQMU/ M&E/ Health Finance	TBD	80%	TBD	20%	40%	1.5 Establish mechanisms across all levels of the health system that incentivizes, recognizes and rewards quality healthcare	1 Develop criteria guideline, SOPs for the recognition of excellence 2 Institutionalize excellence by integrating recognition-based motivation system into regular performance review processes
		1.6 To strengthen collaboration between all actors within the health sector (including the private sector) to support quality improvement efforts	1 Support meaningful engagement between HQMU-PSE/ MoH and key private sector actors (Healthcare Federation of Liberia, CHAL etc) to improve the quality of care	1. # of Joint Integrated Supportive Supervisions (JISS) carried out by CHTs	HQMU/ M&E HQMU/ PSE/ External Aid	TBD TBD	16 50	TBD 20	4 30	8 40	1.6 To strengthen collaboration between all actors within the health sector (including the private sector) to support quality improvement efforts	1 Support meaningful engagement between HQMU-PSE/ MoH and key private sector actors (Healthcare Federation of Liberia, CHAL etc) to improve the quality of care

			2. Support the implementation of the Private Sector Engagement Strategy to enhance quality of care	2. # of partners, private sector or institutions supporting quality improvement efforts of the MoH/ health regulatory bodies 3. % of private health facilities reporting through MoH reporting system	M&E	TBD	60%	TBD	30%	40%		2. Support the implementation of the Private Sector Engagement Strategy to enhance quality of care
2.	To improve clinical effectiveness	2.1 Develop and/or strengthen existing data systems to integrate quality of care measures/indicators and use data for improved care	1. Develop and print priority registers and ledgers (occupational health and safety, staff training register, Adverse Events Reporting etc), and collaborate with the	. Proportion of health facilities with access to QoC reporting tools 2. Health care QI report completion rate by the facility type	HQMU/ M&E HQMU/ M&E	TBD TBD TBD	80% 100% 100%	TBD TBD TBD	2.	To improve clinical effectiveness	2.1 Develop and/or strengthen existing data systems to integrate quality of care measures/indicators and use data for improved care	1. Develop and print priority registers and ledgers (occupational health and safety, staff training register, Adverse Events Reporting etc), and collaborate with the National Health Information System (NHIS) to ensure that

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
			National Health Information System (NHIS) to ensure that performance indicators related to quality of care are captured 2. Integrate the health-care quality improvement routine reporting, where applicable, into the national HIS	3. % of health facilities for which the most recent eJISS feedback was provided. 4. % of identified gaps (from JISS) at the level of the facility/ care that were mitigated	MoH/ partners HQMU/ M&E	TBD TBD	100% 85%	TBD TBD				performance indicators related to quality of care are captured 2. Integrate the health-care quality improvement routine reporting, where applicable, into the national HIS
		2.2 Ensure that essential medicines, IPC supplies, logistics and other requisite consumables are	1. Procure and distribute essential medicines and supplies to health facilities in a timely manner.	. Number of health facilities that report availability of essential medicines and commodities in the last	MoH NPHIL Partners HHFA	TBD	80%	TBD		40%	2.2 Ensure that essential medicines, IPC supplies, logistics and other requisite consumables are	1. Procure and distribute essential medicines and supplies to health facilities in a timely manner.

		available at all levels for service delivery	2. Improve annual forecasting of supplies using supply consumption data (using the eLMIS)	3 months prior to reporting							available at all levels for service delivery	2. Improve annual forecasting of supplies using supply consumption data (using the eLMIS)
		2.3 Implement interventions to address gaps identified in clinical competencies	1. Organize periodic post-supervision feedback conferences to disseminate findings from JISS 2. Establish an accountability mechanism to follow on risk mitigation action points from the post-supervision conferences 3. Conduct mentorship and on-the-job coaching using QI methodologies (such as Plan, Do, Study and Act (PDSA) cycle)	1. % of post-supervision feedback conferences conducted 2. % of action items resulting from post-supervision conference resolved as per schedule 3. Proportion of health facilities that have quality management teams and implement the PDSA cycle	MoH/ LMHRA/ partners MoH/ LMHRA/ partners HQMU	TBD TBD TBD	80% 80% 80	TBD TBD TBD			2.3 Implement interventions to address gaps identified in clinical competencies	. Organize periodic post-supervision feedback conferences to disseminate findings from JISS 2. Establish an accountability mechanism to follow on risk mitigation action points from the post-supervision conferences 3. Conduct mentorship and on-the-job coaching using QI methodologies (such as Plan, Do, Study and Act (PDSA) cycle)

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
		2.4 Redesign the process of care (including clinical processes) across all levels of the health system to ensure that they are beneficial to patients e.g. reducing waiting times	1. Support innovative approaches (e.g., bring husband jump queue in ANC) in service delivery 2. Conduct QI review meetings to identify gaps care processes and propose mitigation measures	1. # of health facilities that have a redesigned/ updated process of care 2. # of relevant healthcare workers that have received training in patient safety (including "just culture")	HQMU/ NPHIL/ Partners HQMU/ NPHIL/ partners	TBD 0	300 800				2.4 Redesign the process of care (including clinical processes) across all levels of the health system to ensure that they are beneficial to patients e.g. reducing waiting times	1. Support innovative approaches (e.g., bring husband jump queue in ANC) in service delivery 2. Conduct QI review meetings to identify gaps care processes and propose mitigation measures
3.	To ensure patient and/or provider safety	.1 Develop and sustain a "quality & just culture"3 that promotes learning and accountability other than blaming	Develop and implement MOH guidelines and SOPs to promote and reinforce "just culture" in all health facilities.	1. # of health facilities that are implementing guidelines/ SOPs on "just culture"	HQMU	0	85%	0	3.	To ensure patient and/ or provider safety	3.1 Develop and sustain a "quality & just culture"3 that promotes learning and accountability other than blaming and retribution	Develop and implement MOH guidelines and SOPs to promote and reinforce "just culture" in all health facilities.

		and retribution across all the levels of the health system	Train health care workers on patient safety (including "just culture") in all health facilities Commemorate World Patient Safety Day and other related national events to sensitize and increase awareness of the public on the "just culture" Advocate for administrative and legal processes to protect those who raise concerns about the safety of services and/or report adverse events/incidents	2.% of health workers trained or orientated on AER and "just culture" at national and sub-national levels 3.% of clinicians not penalised on account of self-reporting of adverse events 4. # of adverse events reported by county monthly	HQMU/ HR-Training HR unit HQMU/ HIS/M&E	0 TBD TBD	85% 20% 95%	0 TBD TBD			across all the levels of the health system	Train health care workers on patient safety (including "just culture") in all health facilities Commemorate World Patient Safety Day and other related national events to sensitize and increase awareness of the public on the "just culture" Advocate for administrative and legal processes to protect those who raise concerns about the safety of services and/or report adverse events/ incidents

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
		3.2 Put mechanisms in place to ensure that the provider documents all clinical procedures and treatment, and ensure the safety and confidentiality of the medical records	Develop & roll out SoPs and guidelines on charting, filing and storing of clients' medical records Establish Electronic Medical Record (EMR) Governance structure to manage patient electronic records Provide standard electronic or manual patient registry that maintains confidentiality of patient information and records	.% of facility that comply with SoPs for managing patient records 2. # of health workers trained on the developed guidelines. 3.#of referral hospitals that are using the guidelines/ SOPs on patient documentation and medical records	HQMU/ M&E HQMU/ HR-training HQMU/ EMS/CHS	TBD TBD TBD	90% 800 50	TBD TBD 10	30% 200 20	60% 200 30	3.2 Put mechanisms in place to ensure that the provider documents all clinical procedures and treatment, and ensure the safety and confidentiality of the medical records	Develop & roll out SoPs and guidelines on charting, filing and storing of clients' medical records Establish Electronic Medical Record (EMR) Governance structure to manage patient electronic records Provide standard electronic or manual patient registry that maintains confidentiality of patient information and records

		3.3 Implement a Patients' Rights Charter and Professional Code of Ethics	Print and roll out Patients' Rights Charter and Professional Code of Ethics	# of health facilities that are displaying the patient's rights charter and professional code of ethics	HQMU/ CHS/ partners	TBD	60%	TBD	20%	30%	3.3 Implement a Patients' Rights Charter and Professional Code of Ethics	Print and roll out Patients' Rights Charter and Professional Code of Ethics
		3.4 Put mechanisms / systems in place in all health facilities that can objectively assess and categorize patients according to their severity (i.e., triage) including training of health care workers	1-Strengthen existing triage systems/ mechanisms in all health facilities. Train health workers on triage for the assessment of patient severity of illness and management 2-Establish a client feedback system (e.g. suggestion box, patient exit interviews)	1.% of health facilities that have a functional system of triaging (from assessment) 2.% of health facilities with a functional client feedback system (from assessment)	HQMU/ NPHIL/ HQMU/ M&E/HIS	TBD TBD	60% 80%	TBD TBD	30% 20%	40% 40%	3.4 Put mechanisms /systems in place in all health facilities that can objectively assess and categorize patients according to their severity (i.e., triage) including training of health care workers	1-Strengthen existing triage systems/ mechanisms in all health facilities. Train health workers on triage for the assessment of patient severity of illness and management 2-Establish a client feedback system (e.g. suggestion box, patient exit interviews)

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
		3.5 Implement strategies to enhance medication safety, pharmacovigilance and ensure systems in place to report adverse events	1-Develop, update and regularly publish list of accredited suppliers of medicine in Liberia 2-Capacity building to supply chain/clinical teams on the safe transportation, handling, storage and administration of essential medicines 3-Monitor the prescription patterns of essential medicines to ensure adherence to the National Treatment Guidelines.	1. % of health facilities with standard warehouses/pharmacy. 2. %of health facilities/ clinicians that are adhering to the National Treatment Guidelines. 3. % of drug samples that comply with national medicine regulatory standards	MoH/ LMHRA/ LPB/partners MoH/ LMHRA/ LPB/partners MoH/ LMHRA/ LPB/partners MoH/ LMHRA/ LPB/partners	TBD TBD TBD TBD	80% 80% 90% 70%	TBD TBD TBD TBD			3.5 Implement strategies to enhance medication safety, pharmacovigilance and ensure systems in place to report adverse events	1-Develop, update and regularly publish list of accredited suppliers of medicine in Liberia 2-Capacity building to supply chain/clinical teams on the safe transportation, handling, storage and administration of essential medicines 3-Monitor the prescription patterns of essential medicines to ensure adherence to the National Treatment Guidelines.

		4-Collaborate with LMHRA to implement post-marketing surveillance for essential medicines 5-Train relevant staff on SOPs/ guidelines on Adverse Drug Reporting (ADR) and Pharmacovigilance (PV) Strengthen the implementation of the Antimicrobial Stewardship Program in all health facilities	4. % of health facilities that are implementing an antimicrobial stewardship program						4-Collaborate with LMHRA to implement post-marketing surveillance for essential medicines 5-Train relevant staff on SOPs/ guidelines on Adverse Drug Reporting (ADR) and Pharmacovigilance (PV) Strengthen the implementation of the Antimicrobial Stewardship Program in all health facilities

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
		3.6 Improve and strengthen the referral practices between health facilities, and enhance the referral systems and feedback mechanisms	Develop and roll out national SOP/guidelines for the referral of patients from one facility to another and feedback mechanisms. Institute a counter-referral feedback system Monitor compliance to the ambulance/fleet management policy Provide targeted training for ambulance teams on safe referral practices	1. # of health workers trained on the referral's SOPs/ guidelines and feedback mechanism 2. % of referral health facilities that have all tracer items (functional ambulance, nurse, essential medicines and equipment, driver, fuel log etc) for referral	HQMU/ HR/EMS/ NPHIL HQMU/ HR/EMS/ NPHIL	TBD TBD	70% 80%	TBD TBD			3.6 Improve and strengthen the referral practices between health facilities, and enhance the referral systems and feedback mechanisms	Develop and roll out national SOP/guidelines for the referral of patients from one facility to another and feedback mechanisms. Institute a counter-referral feedback system Monitor compliance to the ambulance/ fleet management policy Provide targeted training for ambulance teams on safe referral practices Equip health facilities with standardized tools for referrals and feedback mechanism

			Equip health facilities with standardized tools for referrals and feedback mechanism									
		3.7 Strengthen implementation of guidelines on patient safety (surgical safety, blood transfusion, laboratory safety procedures) in all health care facilities	Develop, print and roll out guidelines/SoPs on patient safety such as surgical safety, blood transfusion and laboratory safety Monitor adherence and usage of patient safety guidelines	1. %of health facilities that have access to patient safety guidelines and checklists. (surgical safety, blood transfusion, lab safety) 2. %of health facilities that meet minimum patient safety compliance standards*	HQMU/ partners HQMU/ partners	TBD TBD	80% 80%	TBD TBD	50% 50%	60% 60%	3.7 Strengthen implementation of guidelines on patient safety (surgical safety, blood transfusion, laboratory safety procedures) in all health care facilities	Develop, print and roll out guidelines/ SoPs on patient safety such as surgical safety, blood transfusion and laboratory safety Monitor adherence and usage of patient safety guidelines

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
		3.8 Design health care settings, environments and practices to provide the safest circumstances and equipment for health workers (Occupational health safety) ensuring IPC measures in place minimizing hospital acquired infections	Develop and implement national SOP/ guidelines on Occupational health safety Provide health facilities with standardized tools, equipment and guidelines for Occupational health safety Train health workers on national SOP/ guidelines on Occupational health safety, IPC guidelines and monitor implementation and institute in health institutions training curriculum	1.% of health facilities implementing an OSH program 2.% of health facilities that meet minimum requirements (available items) for occupational safety and IPC 3. # of health professional boards that have incorporated OSH and IPC in their training curriculum	HQMU/ HR/ NPHIL/ EPA/Partners HQMU/ HR/ NPHIL/ EPA/Partners HR-Training/ NPHIL/ Boards/ Partners	TBD 10% (IPC items) TBD	50% 50% TBD	TBD 10% TBD	20% 20% 2	30% 30% 4	3.8 Design health care settings, environments and practices to provide the safest circumstances and equipment for health workers (Occupational health safety) ensuring IPC measures in place minimizing hospital acquired infections	Develop and implement national SOP/ guidelines on Occupational health safety Provide health facilities with standardized tools, equipment and guidelines for Occupational health safety Train health workers on national SOP/ guidelines on Occupational health safety, IPC guidelines and monitor implementation and institute in health institutions training curriculum

4.	To deliver People-Centred Care, engage and empower patients, families and communities	4.1 Empower clients, family/relations and community to speak up and take responsibility for their health outcomes	1.conduct awareness on health literacy through community engagement program 2.Carry out peer support and expert patient group discussions 3.Train healthcare workers in people-centred care 4. Conduct client satisfaction survey to access the level of quality care provided to the community	1. % of district conducting peer support and expert patient group discussions/ awareness carried out 2. % of clients who are knowledgeable about their rights and responsibilities 3. % of healthcare workers trained in people-centred care (i.e., customer care) 4.# of facilities meeting the minimum score for client satisfaction survey	HQMU/ HFs HQMU/ M&E/HFs HQMU/ HR-Training HQMU/ M&E/ partners	TBD TBD TBD TBD	50% 60% 60% 85%	10% 20% 20% TBD	4.	To deliver People-Centred Care, engage and empower patients, families and communities	4.1 Empower clients, family/relations and community to speak up and take responsibility for their health outcomes	1.conduct awareness on health literacy through community engagement program 2.Carry out peer support and expert patient group discussions 3.Train healthcare workers in people-centred care 4. Conduct client satisfaction survey to access the level of quality care provided to the community

No	Strategic objective	Strategic interventions	Key activities	Core indicator(s)	Responsible unit/ entity	Baseline	Target	Timelines				
								2024	2025	2026	2027	2028
		4.2 Encourage patient-provider dialogues to share care plans, identify gaps in care and assess the extent to which reasonable progress has been made to enable decision-making	1.Provide education to clients on clinical care processes and disease conditions, including options for management 2.Develop/ adapt patient self-management tools/technologies use to manage health issues outside formal health facility 3.Conduct clients exit interviews to assess knowledge gaps in person-centred care	% of facilities with a minimum score on person-centred care (PCC) standards	HQMU/ M&E/HIS/ partners	TBD	70%	TBD	20%	40%	4.2 Encourage patient-provider dialogues to share care plans, identify gaps in care and assess the extent to which reasonable progress has been made to enable decision-making	1.Provide education to clients on clinical care processes and disease conditions, including options for management 2.Develop/ adapt patient self-management tools/ technologies use to manage health issues outside formal health facility 3.Conduct clients exit interviews to assess knowledge gaps in person-centred care

		4.3 Establish functional client *(patient, provider and relative)* information and feedback *(complaints, compliments and suggestion)* system (*e.g., suggestion boxes, client experience centres, client experience teams who will be integral part of the facility quality management teams)* in all health facilities and use of routine information management system.	Set up information systems to collect patient feedback on the quality of care in the health facility Support the operationalization of the Citizen Feedback Mechanism (CFM) www.libtalk.gov.lr in targeted facilities	1. % of facility assessed & taken positive action during the last 3 months to address citizens' feedback 2. % of sampled health facilities with functional client information and feedback systems 3. Client satisfaction rate 4. Staff satisfaction rate 5.% of health facilities creating awareness on the use of the Libtalk system (score)	HQMU/ M&E/HIS HQMU/ M&E/HIS HQMU/ M&E/HIS HQMU/ M&E/HIS HQMU/ M&E/HIS	TBD TBD TBD TBD TBD	80% 90% 70% 80% 60	TBD TBD TBD TBD TBD	20% 30% 30% 20% 30%	40% 60% 45% 40% 40%	4.3 Establish functional client (patient, provider and relative) information and feedback (complaints, compliments and suggestion) system (e.g., suggestion boxes, client experience centres, client experience teams who will be integral part of the facility quality management teams) in all health facilities and use of routine information management system.	Set up information systems to collect patient feedback on the quality of care in the health facility Support the operationalization of the Citizen Feedback Mechanism (CFM) www.libtalk.gov.lr in targeted facilities

6.0 Strategy dissemination and roll out

As part of the implementation, this strategy will be disseminated to all stakeholders to raise awareness, elicit their commitment, support, and buy-in to ensure successful implementation. A successful dissemination of this strategy is very important milestone based on lessons learnt from the NHQS (2017-2021). Both soft and hardcopies of the NHQS (2024-2028) will be made available at national, county, and district levels including major hospitals to motivate and inspire every actor to take appropriate action in contributing towards the attainment of the stated goal and objectives.

There will also be dissemination and roll out workshops organized at national and county levels targeting various stakeholders.

7.0 QI methods and approaches

To achieve the stated goal, a consistent approach will be used to deliver the necessary quality improvements to our clientele. The MoH/HQMU recommends the use of proven quality improvement methodologies, tools and techniques to achieve the stated objectives.

8.0 Monitoring and Evaluation

The M&E of the NHQS (2024-2028) shall be part of the overall health sector M&E framework and plan, including research. Additional key healthcare quality indicators shall be included in the DHIS2 platform and captured in the National IPC Strategy and Health Sector Strategic Plan (2022-2025). M&E of this strategy shall be integrated into the overall M&E processes of the MoH and carried out at regular intervals to provide required data and information, assess progress, and determine the impact of the various QI interventions that would be implemented. It will track the extent to which the implementation is on course and how much progress is being made towards the achievement of the goal and strategic objectives. The findings of M&E will be used to guide and inform decision-making and further contribute to the attainment of the NHQS goal and objectives.

There will be evaluation of all the quality initiatives at mid-term and at end of the NHQS implementation period to determine the extent to which the outcomes have been achieved. These evaluations will reflect the nature and scope of investment. For instance, counties/facilities implementing various QI projects/programmatic interventions will have those projects reviewed and or evaluated to determine their outcomes and impacts.

Further, routine M&E will also be conducted by individual national (MoH) programs, counties, and hospitals/facilities through the collection, analysis, and reporting of their routine data (e.g. using DHIS2 platform and/or assessments and surveys). This would enable the various levels to pay attention to efforts put in and determine the extent to which they are contributing to the achievement of the overall national healthcare quality goal and strategic objectives.

A mid-term and end term evaluation will be done in 2025 and 2028, respectively, to determine the extent to which the set objectives have been achieved. The findings of the mid-term evaluation will be used to address any deviations and inconsistencies in the implementation and initiate measures to get them addressed.

Further, at a minimum, key project or program-based QI initiatives will be encouraged to conduct:

a. A baseline assessment during the preparatory design phase of the project.

b. Mid-term review at the mid-point of the project to assess progress against the stated objectives and provide recommendations for corrective measures/actions.

c. End term evaluation at the end of the project.

Monitoring will be done monthly, quarterly, and annually by the district, county, and national health QMTs as indicated in the M&E framework (Annex 2). Supervision reports will be submitted according to the reporting system of the MoH.

Annual reviews will be built into the existing annual review mechanism of the MoH.

Table 3: Monitoring & Evaluation Framework

Quality Dimension	Indicator	Indicator type	Data source	Frequency	Baseline (2024)	Target (2028)
Effectiveness	Reported institutional maternal mortality ratio	Impact	MDSR Audit/review report	Monthly	TBD	
	Perioperative mortality rate	Impact	HMIS	Monthly	TBD	
	TB treatment success rate	Impact	HMIS	Annual	78%	85%
	TB notification rate	Impact	HMIS	Annual	163/100,000	196/100,000
	ART retention rate	Outcome	HMIS	Annual	84%	95%
	Adherence to clinical standards (STGs) for tracer conditions	Output	Observation/records review	Annual	No data	80%
	Number of health facilities that report no stock out of tracer essential medicines in the last 3 months prior to reporting	Input	eLMIS/HHFA	Quarterly	35%	80%
Equity	% of reduction in inequity in access to healthcare by 20%	Outcome	Survey report	Annually	50%	30%
	% of reduction in the variation in health facility delivery by 50% among counties	Outcome	Survey report	Annually	46%	23%
	% of reduction in the inequity in core health workforce density ratio by 50% among counties	Inputs	Survey report/HRHIS	Annually	13/10,000	6/10,0000
	% of reduction in the variation in OPD utilization rates by 50% among counties	Outcome	HMIS	Annually	0.8	0.4
	Reduce the variation in DPT3 coverage by 50% among counties	Outcome	HMIS	Quarterly	49%	24%

Integrated	Service specific availability and readiness (for continuum of care)	Output	HHFA	Biennial	N/A	80%
	% of facilities implementing IMNCI/IMAI	Input	Survey/program report/HHFA	Annually/ Biennial	TBD	80%
	% of facilities implementing EPHS	Input	Survey/program report/HHFA	Annually/ Biennial	TBD	80%
Efficiency	Bed occupancy rate	Outcome	HMIS	Monthly	TBD	
	Average length of stay	Output	Hospital records/ HMIS	Monthly	TBD	
	Providers case load	Outcome	HMIS/Survey	Monthly	TBD	
Safety	% of reduction in health care associated infections	Outcome	IPCAF report	Annual	TBD	50%
	% of reduction in adverse events reported by counties on a quarterly basis	Output	HMIS	Quarterly	TBD	50%
	% of facilities participating patient safety incident reporting system and learning	Outcome	Project / program activity report	Annual	TBD	60%
	% of clinicians not penalised on account of self-reporting of adverse events	Outcome	MoH Implementation fidelity assessment report	Annual	TBD	TBD
	% of facilities that comply with SoPs for managing patient records	Outcome	MoH Implementation fidelity assessment report	Semi-annual	TBD	90%
	% of drug samples that comply with national medicine regulatory standards	Output	Pharmacovigilance activity report (LMHRA)	Annual	60%	95%

Quality Dimension	Indicator	Indicator type	Data source	Frequency	Baseline (2024)	Target (2028)
	% of clinicians that are adherent to the National Treatment Guidelines	Output	Health Facilities Accreditation Survey Report/ PPS	Biennial	TBD	80%
	# of health facilities that have access to patient safety guidelines and checklists. (surgical safety, blood transfusion, lab safety)	Output	Harmonized Health Facility Assessment report (HHFA)	Biennial	TBD	TBD
	# of health facilities that meet minimum patient safety compliance standards	Outcome	HHFA report	Biennial	TBD	TBD
	# of health facilities implementing an Occupational Health & Safety program	Output	HHFA report	Biennial	TBD	TBD
	% of health facilities that meet minimum requirements for occupational safety and IPC	Outcome	HHFA report	Biennial	TBD	TBD
	# of health professional boards that have incorporated OSH in their training curriculum	Outcome	Project / program activity report	Annual	TBD	TBD
People centredness	% of sampled health facilities that are displaying the Patients' Right Charter and Professional Code of Ethics	Outcome	MoH Implementation fidelity assessment report	Semi-annual	TBD	80%
	% of health facilities with a functional client feedback system (from assessment)	outcome	MoH Implementation fidelity assessment report	Semi-annual	TBD	80%
	# of peer support and expert patient group discussions carried out	Output	Project / program activity report	Annual	TBD	TBD

	% of sampled clients who are knowledgeable about their rights and responsibilities	Output	MoH Implementation Fidelity assessment report	Semi-annual	TBD	75%
	% of healthcare workers trained in people-centred care (i.e., customer care	Input	Project / program activity report	Semi-annual	TBD	80%
	# of facilities meeting the minimum threshold score for client satisfaction survey	Outcome	Stakeholders' satisfaction survey report	Semi-annual	TBD	85%
	% of facilities with a minimum threshold score on PCC standards	Outcome	HHFA or QoC Assessment Report	Biennial	TBD	70%
	% of health facilities accessed and positive action taken to address citizens' feedback during the last 3 months	Outcome	MoH Implementation Fidelity Assessment Report	Semi-annual	TBD	80%
	% of sampled health facilities with functional client information and feedback systems	Output	MoH Implementation Fidelity Assessment Report	Semi-annual	TBD	90%
	% of sampled health facilities creating awareness on the use of the LIBTALK system (score)	Output	MoH Implementation Fidelity Assessment Report	Semi-annual	TBD	90%
	Client satisfaction rate	Outcome	Stakeholders Satisfaction Survey report	Semi-annual	TBD	70%
	Staff satisfaction rate	Outcome	Stakeholders Satisfaction Survey report	Semi-annual	TBD	80%
Timeliness	% of health facilities that have a functional system of triaging (from assessment)	Input	MoH Implementation fidelity Assessment report	Semi-annual	TBD	80%
	Waiting time	Output	Exit interviews/client satisfaction survey	Annual	TBD	TBD
	% of facilities that provide 24/7 services	Output	HHFA/supervision	Biennial	TBD	TBD

9.0 Financing the strategy

Following the development of the NHQS (2024-2028), the MoH, with support from WHO and other partners, embarked on a costing exercise to estimate the total cost of implementing the plan over the five-year period. The Activity Based Costing approach was used to cost the plan, which also involved wide and intensive consultations with stakeholders.

The costing focused on ascertaining resource requirements to implement activities under the four strategic objectives, namely:

Strategic Objective 1: To strengthen health systems governance, organization, and management to deliver quality essential services (systems environment improvement).

Strategic objective 2: To improve clinical effectiveness.

Strategic objective 3: To ensure patient and/or provider safety.

Strategic objective 4: To deliver People-centered Care, engage and empower patients, families, and communities.

The results of the costing analysis (Scenario 1) reveal that the NHQS would cost approximately USD61,873,090 to implement over the five-year period. Strategic Objective 4 accounts for the largest share (39%) of the total plan costs, followed by Strategic Objective 2 with a relative share of total plan costs of 36%. Training amounts to a total of US$ 18,928,715 claiming 31% of the total costs of the plan, whilst Advocacy claims a relative share of 24% of total costs.

Scenario 2 projections which assume a 50% reduction of cost drivers indicate that a total of US$30,936,545 would be required for implementing the plan over the period of five years. On the other hand, Scenario 3 projects total costs of US$15,468,273 over five years.

The cost analysis shows that the NHQS total cost (Scenario 1) as a percentage of the MoH budget for FY2023/24 is 20%; 10% for Scenario 2 and 5 % Scenario 3. The MoH would therefore need to exert more effort towards mobilizing additional resources.

Table 4: Summary costs for the NHQS 2024-28 (Base scenario)

The full cost of implementing the plan is USD61,689,699 and the breakdown is provided in the table below.

	2024	2025	2026	2027	2028	Total
1. Training						
1.1 In-service / Refresher Training	5,723,855	3,683,404	2,977,423	3,189,254	3,087,513	18,661,449
1.2 Training of Trainers	205,200	14,400	15,120	15,876	16,670	267,266
2. Supervision						
3.1 Coordination Meetings	0	54,000	56,700	59,535	62,512	232,747
3.2 National Staff Visiting Local Staff	161,000	407,470	428,746	451,175	474,825	1,923,216
4. Monitoring and Evaluation						
4.3 Design/Review of Data Management Systems	7,500	7,875	8,269	8,682	9,116	41,442
4.4 Data Collection and Analysis	0	1,500	1,650	1,815	1,997	6,962
4.5 Quality Control/Quality Assurance	58,800	107,880	116,508	125,891	136,098	545,177
5. Infrastructure and Equipment						
5.2 Equipment upgrades for lower tier facilities	112,355	123,591	135,950	149,545	164,499	685,939
5.3 Equipment upgrades for hospitals	400,000	420,000	441,000	463,050	486,203	2,210,253
7. Communication, Media & Outreach						
7.2 Mass media	322,000	319,250	322,663	323,096	323,550	1,610,559
7.3 Printed Materials	1,964,594	1,797,391	1,967,171	2,149,049	2,454,405	10,332,610
8. Advocacy						
8.2 Advocacy Activities	4,406,000	3,768,875	3,065,294	2,337,597	1,636,920	15,214,686
9. General Programme Management						
9.1 Design and Review of Country Strategy	331,500	34,200	31,020	34,122	37,534	468,376
9.4 Programme Coordination Meetings	1,079,044	1,580,750	1,220,484	1,287,709	1,357,917	6,525,904
9.6 Situation Analysis	79,100	52,135	55,380	58,851	62,565	308,030
9.7 Office equipment and supplies	454,020	442,298	514,169	586,199	658,400	2,655,085
Total	**15,304,968**	**12,815,018**	**11,357,545**	**11,241,445**	**10,970,723**	**61,689,699**

The table above presents the base scenario. Two alternative scenarios were produced for comparison and in consideration of the resource envelope as outlined above.

10.0 References

Adde HA, van Duinen AJ, Sherman LM, Andrews BC, Salvesen, Dunbar NK, et al. A Nationwide Enumeration of the Surgical Workforce, its Production and Disparities in Operative Productivity in Liberia. World J Surg [Internet]. 2021; Available from: https://doi.org/10.1007/s00268-021-06379-8

Bhakta N, Martiniuk ALC, Gupta S, Howard SC, Essuman VA, Braimah IZ, et al. UHC in Africa: A Framework for Action Executive Summary [Internet]. Vol. 35, West African journal of medicine. 2016. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29607471

Ethiopia Ministry of Health. Ethiopian National Health Care Quality, Transforming the Quality of Health Care in Ethiopia. 2020;86.

Ezra B, Yin X. A Multi-Stage Stochastic Programming Approach to Epidemic Resource Allocation with Equity Considerations. 2021;1–57.

Gerrard A and SJ. Liberia Private Health Sector Assessment. Washington, DC: Palladium, Health Policy Plus; 2019.

Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Heal. 2018;6(11): e1196–252.

Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems-time for a revolution: Report of the Lancet Global Health Commission on High Quality Health Systems in the SDG Era [Internet]. 2018. Available from: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30386-3/fulltext

Liberia Institute of Statistics and Geo-Information Services (LISGIS), Ministry of Health, The DHS Program I. Demographic and Health Survey, Liberia 2019-20. 2019;594. Available from: https://pdf.usaid.gov/pdf_docs/PA00XD41.pdf

Liberia Ministry of Health and Social Welfare. Republic of Liberia Ministry of Health and Social Welfare National Health and Social Welfare Policy and Plan 2011–2021. 2011;29. Ministry of Health and Social Welfare of Liberia. Essential Package of Health Services Secondary and Tertiary, 2011.

Ministry of Health & Social Welfare (MoHSW). Liberia National IPC Covid-19 Response Interim Guidance Document May 2020. 2020.

Ministry of Health & Social Welfare (MoHSW). Strengthening Infection Prevention and Control (IPC) Standards through facilitated implementation of IPC Practices in healthcare facilities February - March 2021 Health Quality Management Unit, Ministry of Health, Health Systems Strengthening Cluster. 2021.

Ministry of Health (MoH) G. National Community-Based Health Planning and Services (CHPS) Policy. Accra; 2016.

Ministry of Health (MoH) Ghana. Ghana National Healthcare Quality Strategy. Accra: Ministry of Health (MoH); 2016.

Ministry of Health Government of Liberia. Investment plan for building a resilient health system in Liberia. Vol. 12, Monrovia, Ministry of Health. 2015.

Ministry of Health Liberia. Revised National Community Health Services Policy [Internet]. Monrovia; 2015. Available from: https://www.exemplars.health/-/media/files/egh/resources/community-health-workers/liberia/revised-community-health-services-policy-20162021.pdf

Ministry of Health of Liberia. National Health Observatory Report. Paper Knowledge. Toward a Media History of Documents. Monrovia-; 2014.

Ministry of Health of Liberia. Service Availability and Readiness Assessment (SARA) & Quality of Care (QOC) 2018 Final Report. 2018;(November).

Ministry of Health of Sierra Leone. QUALITY OF CARE STRATEGIC ROAD MAP REPRODUCTIVE MATERNAL NEWBORN CHILD AND ADOLSCENT HEALTH DIRECTORATE OF REPRODUCTIVE AND CHILD HEALTH. Freetown; 2020.

Ministry of Health Republic of Liberia. Interdisciplinary Practical Guidelines on Antimicrobial Stewardship Programming in Liberia (2022-2027). Monrovia; 2022.

Ministry of Health Republic of Liberia. Liberia National Community Health Services Strategic Plan 2016-2021.pdf - Google Drive [Internet].

2015. Available from: https://drive.google.com/file/d/1x3cV8xelOdhYJ-Tob8d_5-Tl6TZeJsHyx/view

Ministry of Health Republic of Liberia. Ministry of Health Annual Operational Plan for Fiscal Year 2020/2021 (July 1, 2020–June 30 2021). Monrovia; 2021.

Ministry of health. Quality management policy for the health sector. Malawi Gov [Internet]. 2017; Available from: https://www.health.gov.mw/index.php/policies-strategies?download=55:quality-management-policy

Ministry of Health. REPUBLIC OF LIBERIA MINISTRY OF HEALTH NATIONAL HEALTH ACCOUNTS FISCAL YEAR 2015 / 2016. Monrovia; 2016.

Ministry of Health/WHO. Liberia Coronavirus (Covid-19) Pandemic Situation Report [Internet]. 2021. Available from: https://www.afro.who.int/sites/default/files/2021-09/Sept17_Liberia weekly COVID-19 -Sitrep Narrative 12 2021.pdf

MoH Liberia. ACTION BRIEF – MAINTAINING QUALITY ESSENTIAL HEALTH SERVICES DURING COVID-19: LIBERIA Quality Essential Health Services and COVID-19 – lessons from countries. 2020.

MoH, KOICA, WHO. Strengthening maternal, newborn & child health quality of care in health facilities through training and supportive supervision. Monrovia; 2020.

MoH. National Action Plan on Prevention and Containment of Antimicrobial Resistance in Liberia. Monrovia; 2022.

Republic of Liberia. Republic of Liberia Pro-Poor Agenda for Prosperity and Development (PAPD) [Internet]. Vol. 231. Monrovia; 2018. Available from: https://www.emansion.gov.lr/doc/Pro-Poor Agenda For Prosperity And Development book for Email sending (1).pdf - Compressed.pdf

United States Agency for International Development (USAID). Liberia National Health Quality Strategy 2017-2021. 2017;(June 2017).

WHO & WORLD BANK GROUP. Delivering quality health services: a global imperative for universal health coverage [Internet]. World Health Organization, World Bank Group, OECD. Switzerland; 2018. 1–100 p. Available from: http://apps.who.int/bookorders.

WHO (World Health Organization). Handbook for national quality policy and strategy [Internet]. WHO. 2018. 72 p. Available from: http://www.who.int/servicedeliverysafety/areas/qhc/nqps_handbook/en/%0Ahttp://apps.who.int/iris/bitstream/handle/10665/272357/9789241565561-eng.pdf?ua=1

WHO, KOICA. Korea International Cooperation Agency (KOICA) Project on Making Health Services Resilient with Quality and Emergency Preparedness for Response: Health Workforce Competency Assessment on Quality and Resilience Assessment Report. Monrovia; 2020.

WHO, KOICA. Strengthening Health Facilities Quality Management Teams to Enhance Routine Health Services and During Outbreaks 14-20 February 2021. Health Quality Management Unit, Ministry of Health, Health Systems Strengthening Cluster, WHO Country Office, Monrovia. 2021.

WHO, UNICEF, UNFPA WBG and U (MMEIG). Trends in Estimates of Maternal Mortality Ratio (MMR; maternal deaths per 100,000 live births) maternal deaths and lifetime risk of maternal death, 2000-2017. 2019.

WHO. Global Patient Safety Action Plan 2021-2030 Towards Zero Patient Harm in Health Care [Internet]. Geneva: WHO Document Production Services; 2020. Available from: https://extranet.who.int/dataformv3/upload/surveys/959279/files/First draft Global Patient Safety Action Plan August 2020.pdf

WHO. Joint External Evaluation of IHR Core Capacities of the Republic of Liberia. Geneva; 2016.

WHO. Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and. 2010;110.

World Health Organization (WHO), KOICA. Making Health Services Resilient with Quality and Preparedness for Emergency Response: LIBERIA SITUATIONAL ASSESSMENT REPORT. Monrovia; 2019.

World Health Organization (WHO). Baseline assessment of Antibiotic Consumption and Resistance using the Point Prevalence Survey. WHO Off Lib. 2021.

Annex

Annex 1: Governance/Organization of Quality in Liberia

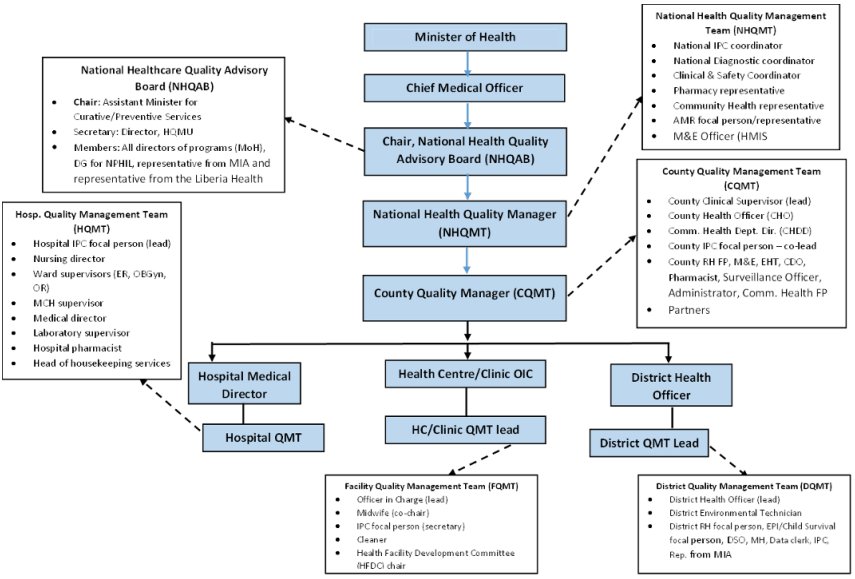

Figure 8: Governance structure of the National Quality Program

At the national level, the HQMU in the MoH shall spearhead the implementation of the NHQS (2024-2028). There shall be a multidisciplinary NHQAB chaired by the Assistant Minister of Health for Curative Services, with membership from across Directorates of the MoH, Health Regulatory Bodies, Partners and other key stakeholders that will be identified by the MoH. The functional organogram of the HQMU to facilitate an effective coordination and successful implementation of the strategy is shown in Figure 8.

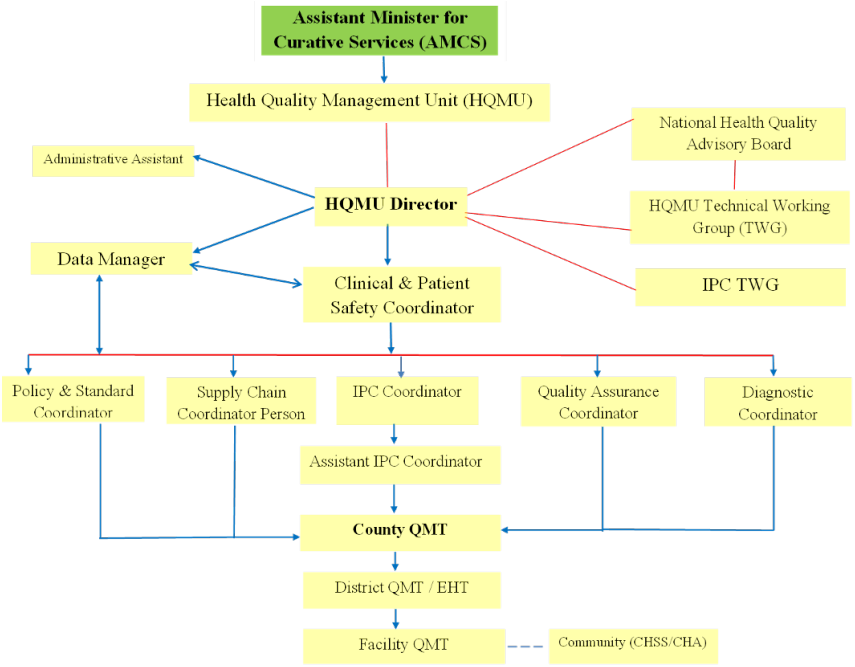

Figure 9: Functional Organogram of the Healthcare Quality Management Unit (HQMU)

Clinical & Patient safety

These personnel shall be responsible for the following:

Patient safety (National)

1. Lead serious safety event investigations and improvement activities in conjunction with managers.
2. Analyze data, identify trends, and develop mitigation strategies based on current evidence and identified best practices.
3. Work with leadership to identify resource needs for mitigation efforts.

4. Promote a strong patient safety culture via assessments, staff education, and modelling a non-punitive approach to mistakes and accidents that foster open communication among all clinical disciplines.

5. Participate in proactive risk assessments, utilizing failure mode, effects and critical analysis techniques.

6. Ensure meaningful and effective flow of data and information across various levels.

7. Serve as leader of patient safety activities including education, data management, event analysis and communication with key stakeholders.

8. Design mechanisms for data collection, management, and analysis related to adverse events.

9. Lead in the creation of awareness on patient safety.

Patient safety (Facility/Hospital)

1. Provide continuous observation of patients who may be at risk for adverse events such as falls, self-injury or harm to others (Facility/Hospital).

1. Assists in the provision of a clean environment.

2. Design mechanisms for data collection, management and analysis related to adverse events.

3. Facilitate capacity building programs related to patient safety.

4. Lead in the creation of awareness on patient safety.

5. Prevent future harm by initiating and overseeing proactive evaluation and redesign of systems to improve care processes.

6. Perform patient safety rounds that identify patient safety risks.

7. Partner with facility leadership to establish activities that enable and sustain an open and fair environment promoting learning, safe systems, and appropriately managing behavioral choices related to patient safety.

8. Present informative and actionable patient safety reports to appropriate committees to include high-level presentations to the Health Facility Development Committee or Hospital Board.

Clinical Governance

1. Support clinical staff in carrying out audit projects. This includes giving advice on audit design, developing data collection tools, and analyzing and presenting data collected.

2. Project-manage clinical audit projects, including planning, design and facilitation.

3. Collect data for clinical audit projects using a variety of research methods, including retrospective case note reviews, patient interviews, and observational studies.

4. Co-ordinate, collect and submit data for clinical audit projects required in accordance with monthly and quarterly deadlines.

5. Plan and coordinate a number of corporate clinical audit projects documentation, regular audits of deteriorating patients, and an ongoing program of nursing audits.

6. Facilitate the change process resulting from clinical audit, to ensure maximum benefit to patient care.

7. Assist in the follow-,up of clinical audit topics, ensuring that conclusions, outcomes, and action plans are recorded and progressed.

8. Ensure the wide dissemination of clinical audit project results and conclusions.

9. Support clinicians by submitting clinical audit projects for publication through appropriate media (journals, posters and presentations).

Supply Chain

1. Ensuring Central Medical store, drug depots, and warehouses have enough stock.
2. Overseeing the ordering and packaging processes of medicines and medical supplies.
3. Monitoring stock levels.
4. Provide leadership to supply chain team to ensure safe working practices, promoting safety awareness.
5. Ensure Supply Chain related processes are functioning effectively to support the provision of quality and safe care in health facilities/hospitals.
6. Develop competencies/skillsets/leadership of QMTs. Provide them with objectives, tools, and information necessary to execute their task competently.
7. Supervise and motivate the team members to achieve continuous improvement.

People-Centered Care

1. To contribute to the development and delivery of patient experience capability and capacity across the health system.
2. To gather patient experience feedback on health care services through an extensive outreach program.
3. To support people to share their experiences with healthcare providers and to support the operational teams to develop skills, knowledge and experience to do this within their own areas.
4. To identify engagement opportunities across facilities/hospitals to collect patient feedback and liaise with relevant partners as appropriate.
5. To develop and maintain robust systems for collating and analyzing patient feedback, including maintaining relevant databases and designing relevant reports and graphics.

6. To share, interpret, and present the results of the patient experiences collected.

7. To produce bi-annually and annual patient experience reports for Liberia.

8. To train, support and supervise volunteers to participate in the collection of patient experiences.

To work with colleagues to identify local trends in health care and gaps in need.

Annex 2: Terms of Reference (TOR) for Quality Management Teams (QMTs)

1. National Quality Management Team (NQMT)

The roles and responsibilities of the NQMT shall include:

a. Develop national standards and guidelines for QoC across the country.

b. Support the dissemination and implementation of the national quality guidelines, strategies, and SOPs at the national and sub national levels.

c. Coordinate the planning, resource mobilization, monitoring and evaluation of quality interventions within the health sector.

d. Facilitate the institutionalization/mainstreaming of quality and safety across all national healthcare programs and interventions.

e. Collaborate with training institutions to develop and implement the national healthcare quality training curriculum and training manual.

f. Create opportunities for capacity building among healthcare providers through Continuous Professional Development (CPD) programs including training, mentorship and coaching.

g. Coordinate integrated supportive supervision at all levels of the health system with emphasis on improving healthcare quality and enhancing patient and provider safety.

h. Harness best practices and document lessons learnt from quality improvement and patient safety interventions implemented across the country.

i. Promote learning on healthcare quality and safety by organizing monthly in-person or virtual technical sessions to share knowledge and engage meaningfully with national and sub-national level stakeholders.

j. Identify and recognize excellence in the provision of quality health services by promoting a culture of recognition and appreciation (award ceremonies, appreciation messages, tokens of incentive, etc.)

k. Provide technical support to CQMTs, DQMTs and HFQMTs to identify QI priorities in health facilities and present work plans to the NHQAB for discussion and recommendations.

l. Adapt and develop technical tools for assessing, monitoring & evaluation, mentorship of healthcare workers in healthcare quality and safety at all levels of the health system.

m. Consolidate and submit quality performance reports/updates to the NHQAB on a quarterly basis.

Membership

a. National Healthcare Quality Manager (Director, HQMU)
b. National IPC Coordinator (Secretary)
c. National Diagnostic Coordinator
d. Clinical & Patient Safety Coordinator (co-lead)
e. Supply Chain Coordinator
f. Quality Assurance Coordinator
g. Policy & Stander Coordinator
h. Data Manager (Coordinator)
i. Community Health representative
j. AMR focal person/representative
k. M&E Officer (HMIS representative)
l. FH
m. PBF
n. Partners
o. WASH/DEOH

Governance
The NQMT reports to the NHQAB. The NQMT will provide updates and recommendations for key quality issues in the country and propose interventions for approval by the NHQAB.

The NQMT will oversee the activities on quality and patient/provider safety for the entire country and provide technical support to ensure the goals and objectives of the national roadmap/work plan for healthcare quality and safety are met.

The team will be chaired by the director of the HQMU and co-chaired by the National Clinical and Patient Safety Coordinator. The chairs may designate any representative from the HQMU to act on their behalf in the case of absence. The National IPC Coordinator will serve as the secretary during all NQMT meetings.

NQMT meeting frequency
The NQMT will meet monthly at the HQMU office at a time that will be communicated at least one (1) week before the meeting date. A quorum of more than 50% of the statutory members will be considered sufficient to act and make recommendations on behalf of the committee.

The agenda for the NQMT meetings shall be developed by the chair/co-chair and circulated to members by the secretariat at least one (1) week prior to the meeting.

Meetings will be open to the members of the team or their designated representatives from within the team. Guests may be invited as non-voting members with the permission of the Chair, depending on the agenda to be discussed.

Approval & review
The NQMT shall review this ToR annually, or as need arise based on emerging health issues affecting the country. It will produce annual reports that will include a summary of activities related to QoC and patient & provider safety in the 15 counties, and recommendations to the NHQAB.

2. County Quality management Team (CQMT)

The CQMT shall:

a. Coordinate all QI activities at the district and health facility level.

b. Develop county QI plans biannually, in alignment with the national work plan.

c. Conduct quarterly Joint Integrated Supportive Supervision (JISS) activities in selected 3districts and health facilities in the county.

d. Monitor and evaluate QI activities in the county referral hospitals.

e. Organize trainings, coaching and mentorship on QI (IPC, AMR, WASH) and patient safety for district, facility and community stakeholders.

f. Conduct regular integrated monthly QI meetings.

g. Provide technical support to QMTs at the district and health facility levels.

h. Review and ensure clinical services are provided in line with the EPHS to comply with national quality standards and benchmarks.

i. Submit monthly reports to the HQMU, MoH, on QoC and patient safety indicators in the county.

j. Make a presentation on the state of quality and patient safety in the county during county Quarterly Review Meetings.

k. Support partners in the planning, implementation, and evaluation of QI and patient safety activities in health facilities in the county.

Membership

a. The CQMT will comprise the following members:
b. County Clinical Supervisor (lead)
c. County Health Officer (CHO)
d. Community Health Department Director (CHDD)
e. County IPC focal person – co-lead

f. County Reproductive Health focal person
g. County M&E officer
h. County Environmental Health Technician
i. County Diagnostic Officer
j. County Pharmacist
k. County Surveillance Officer
l. County Health Services Administrator
m. Community Health focal person
n. Partners

Governance
The CQMT reports to the HQMU of the MoH. The CQMT will provide updates and recommendations for key quality issues in the county and propose interventions for approval by the national team.

The CQMT will oversee the activities of the health facility and district QMTs and provide technical support to ensure the goals and objectives of the programs are met.

The team will be chaired by the county Clinical Supervisor and co-chaired by the county IPC focal person. The chairs may designate any representative from the CHT to act on their behalf in the case of absence. The county pharmacist will serve as the secretary during all CQMT meetings.

CQMT meeting frequency
The CQMT will meet monthly at a venue and time that will be communicated at least two (2) before the meeting date. A quorum of 51% of the statutory members will be considered sufficient to act and make recommendations on behalf of the committee.

The agenda for the CQMT meetings shall be developed by the chair/co-chair and circulated to members by the secretariat at least one (1) week prior to the meeting.

Meetings will be open to the members of the team or their designated representatives. Guests may be invited as non-voting members with the permission of the Chair, depending on the agenda to be discussed.

Approval & review
The CQMT shall review this ToR annually, or as need arise based on emerging health issues affecting the county. It will provide an annual report that includes a summary of activities related to quality of care and patient & provider safety, and recommendations to the national QMT.

3. District Quality Management Team (DQMT)

The NHQS has been developed to improve the capacity of the health system, provide quality health services, and restore the public's trust. The aim is to provide robust services through improved leadership, governance, accountability and community engagement.

Quality management is about delivering effective care in an environment that is safe for patients, staff and the public. It also ensures that health care teams are accountable for the quality, safety and satisfaction of patients in the care they have delivered. County and district health teams play critical supervisory roles, while the health care facility is responsible for the provisions of routine health services with the highest quality standard. These terms of reference (ToR) will provide the guidance for DQMTs.

Purpose of DQMT
To provide leadership direction and accountability for health care quality and safety at the district level. Members of DQMT are assigned to carry out specific quality management tasks and should see those tasks as part of their routine responsibilities rather than extra duties.

Roles and Responsibilities
The DQMT ensures health care quality and patient safety within the health district. A DQMT is a multidisciplinary team whose role is to develop, adapt, and implement health care quality activities (quality planning, improving, and control) at the district and health facility levels, in consultation with the district and county health teams.

Specific roles and responsibilities
The DQMT will:

a. Lead and coordinate district health quality management activities in collaboration with key stakeholders and CQMT.

b. Develop a yearly DQMT work plan.

c. Ensure that quality management activities align with county and national health strategies and priorities.

d. Facilitate the implementation of QI projects/interventions at health facility and community levels.

e. Review and monitor the effectiveness of quality and safety process and interventions at the district and HF levels of the health system to improve clinical care and patient outcomes.

f. Support capacity building for frontline health workers in quality and patient safety through training and mentorship.

g. Oversee the implementation of the monthly JISS tool and provide hands-on mentorship and feedback.

h. Promote participation of district and HF focal points on the monthly teleconference (TC) platform to share quality improvement projects and lessons learnt to help inform best practices on quality and patient safety.

i. Enhance documentation and reporting on healthcare quality indicators from the health facilities, consolidate and transmit reports to the CHT.

j. Develop QI plans for health care facilities within the district.

k. Organize QI and patient safety meetings with HFQMTs to discuss key issues affecting healthcare quality and patient/provider safety.

l. Support regular quality rounds to review and analyze root causes for adverse events in facilities and, along with HFQMTs, identify system deficiencies and feasible strategies to address them; and

m. Follow up action plans along with HFQMTs generated from JISS supervisions conducted for prompt redress and improvement along with the CQMT.

Expected deliverables

a. Monthly JISS conducted and reports submitted to county level and feedback provided to facility level.

b. JISS Scorecard and Action Plan developed and posted at HFs.

c. Participation of facility and district level focal points on the monthly QoC TC improved.

d. Reporting on QoC and patient safety indicators accurate and timely; and

e. District work plan for quality and patient safety developed and aligned.

Membership and Governance

The DQMT will comprise of the following members:

a. District Health Officer (lead)
b. District Environmental Technician
c. District RH focal person
d. District EPI/Child Survival focal person
e. District Surveillance Officer
f. District Mental Health Officer
g. District Data clerk
h. District Health Promotion/IPC focal person (co-chair)
i. Representative from MIA.

Governance

The DQMT reports to the CQMT. The DQMT will provide updates and recommendations for key quality issues in the district and propose interventions for approval by the national team.

The DQMT will oversee the activities of the HFQMTs and provide technical support to ensure the goals and objectives of the programs are met.

The team will be chaired by the District Health Officer (DHO) and co-chaired by the district IPC focal person. The chairs may designate any

representative from the DHT to act on their behalf in the case of absence. The District EHT will serve as the secretary during all DQMT meetings.

DQMT meeting frequency

The DQMT will meet monthly at a venue and time that will be communicated at least two (2) days before the meeting date. A quorum of more than 50% of the statutory members will be considered sufficient to act and make recommendations on behalf of the committee.

The agenda for the DQMT meetings shall be developed by the chair/co-chair and circulated to members by the secretariat at least one (1) week prior to the meeting.

Meetings will be open to the members of the team or their designated representatives from within the team. Guests may be invited as non-voting members with the permission of the Chair, depending on the agenda to be discussed.

Approval & review

The DQMT shall review this ToR annually, or as need arises based on emerging health issues affecting the district. It will provide an annual report that includes a summary of activities related to QoC and patient & provider safety, and recommendations to the CQMT.

Annex 3: Definition of terms

Accreditation: A formal process by which a recognized body, assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable and are designed to encourage continuous improvement efforts within accredited organizations. An accreditation decision about a specific health care organization is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years. Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation.

Licensing: This describes a government-endorsed regulatory process to grant permission and specify scope for the healthcare practice of an individual or organization usually preceding accreditation.

Licensure: Licensure is a process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession. Licensure regulations are generally established to ensure that an organization or individual meets minimum standards to protect public health and safety. Licensure to individuals is usually granted after some form of examination or proof of education and may be renewed periodically through payment of a fee or proof of continuing education or professional competence. Organizational licensure is granted following an on-site inspection to determine if minimum health and safety standards have been met.

Certification: This provides recognition from state, private or non-governmental bodies- for organizations, people, processes or objects that meet defined conditions developed for the certification process.

Quality: The degree to which health services for individuals and population increases the likelihood of desired health outcomes and is consistent with current professional knowledge. Seven dimensions of healthcare define its quality namely: safety, timeliness, effectiveness, efficiency, equity, patient centered care, and integrated.

Quality Assurance: All the planned and systematic activities implemented within the quality system, and demonstrated as needed to provide adequate confidence that an entity will fulfil requirements for quality.

Quality Control: Operational techniques and activities that are used to fulfil requirements for quality.

Quality Improvement: "An organizational strategy that formally involves the analysis of process and outcomes data and the application of systematic efforts to improve performance."

Quality Management: All activities of the overall management function that determine the quality policy, objectives, and responsibilities, and implement them by means such as quality planning, quality control, and quality improvement within the quality system.

Quality Planning: Activities that establish the objectives and requirements for quality and for the application of quality system elements.

Regulation: The imposition of external constraints upon the behavior of an individual or an organization to force a change from preferred or spontaneous behavior.

Standard: An established, accepted and evidence-based technical specification or basis for comparison.

Service user: This is a person or organization that could or does receive a service that is intended for or required by this person or organization.

Stakeholder: A person or organization that can affect, be affected by, or perceive itself to be affected by a decision or activity. For the purpose of this NHQS, they included MoH, NGOs, and not-for-profit sector; community groups and CSOs; UN agencies (including the WHO), health professions associations, regulatory bodies; patients, families, caregivers, and other health service users.

Healthcare-Associated Infections: Infection that occurs during the provision of care or during hospitalization that was not present at the time of admission.

Just culture: Atmosphere of trust in which healthcare workers are supported and treated fairly when something goes wrong with patient care.

"The reprint of the National Healthcare Quality Strategy -2024-2028 is made possible by the generous support (funding) of the United States Government through The Meeting Targets and Maintaining Epidemic Control (EpiC) project. The contents do not necessarily reflect the views of the United States Government. EpiC is a global cooperative agreement (7200AA19CA00002) led by FHI 360 with core partners Right to Care, Palladium International, and Population Services International (PSI)."