ORIGINAL ARTICLE

HOW TO STRENGTHEN THE MONITORING AND EVALUATION SYSTEMS TO IMPROVE COMPASSIONATE, RESPECTFUL, AND CARING SERVICES IN ETHIOPIA: AN IMPLEMENTATION STUDY

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ABSTRACT

Background: *Monitoring and Evaluation (M&E) practices have a key role in encouraging the performance of Compassionate, Respectful and Caring (CRC) initiatives. However, during the last five years, CRC implementation was given less attention, and caused to a lack of integration and oppression. Therefore, this study aimed on assessing how to strengthen the M&E system to improve the CRC.*

Methods: *An implementation study with a qualitative approach was conducted in three regions of Ethiopia (Oromia, SNNP, and Sidama) and FMOH from 01 March to 30, 2021. Twenty-six key informants were interviewed using an interview guide and analyzed using open code version 4.02. Additionally, 15 health institutions were observed. The data were coded, and thematized.*

Result: *The finding of this research indicated that the program didn't have scope, structure, and M&E frame works during the strategy development. Additionally, the program's document didn't have standardized indicators for the M & E plat forms. Besides this, the current M&E systems and current practices different from region to region and facility to facility. The finding also revealed that there are barriers to the M&E systems of the program's implementation. The most affecting barriers are: organizational barrier (absence of standard indicators and lack of resources), behavioral barrier (bad behavior, poor attitudes), and technical barrier (poor knowledge and difficulty in measuring). On the other hand, the finding indicated that there are good opportunities to enhance the M&E of the CRC program, such as good government commitment, availability of systems and materials, and availability of funders.*

Conclusion: *The M&E platforms and practices of the CRC program were not uniform across regions and facilities. Besides, the current reporting and feedback mechanisms are also different from region to region and facility to facility. Therefore, establishing a clear structure, ownership, scope, M&E framework, and standardized indicators of the CRC program is important at the national level. Moreover, preparing working documents and guidelines is also crucial for improving the program.*

Keywords: *CRC, Monitoring and evaluation, Phenomenological, Ethiopia*

INTRODUCTION

Compassionate and Respectful care (CRC) is defined as," A means of serving patients, being ethical, practicing the professional oath, and being a model for young professionals and students" [1]. CRC is also defined as, "Mercy and sympathy actions and cares which are considered as essential principles of patient-centered care"[1, 2]. The role of compassion-based care has become significant to health professionals, and to patients in recent times[3]. Compassion lies at the intersection of empathy (in this case, understanding patients' concerns) and sympathy (feeling patients' emotions). Health professionals' care to their patients without compassion cannot be

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considered as patient-centered care delivery. Similarly, the word respectful care is the kind of care in any setting which supports and promotes patients' respect regardless of any differences[1].

Research evidences suggested that compassionate and respectful care improves the effectiveness of treatment outcomes. For instance, patients who treated by a compassionate caregiver tend to share more information about their symptoms and concerns which helps the care giver for more accurate understanding and diagnoses[4]. In addition, compassionate behavior reduces patient anxiety[6]. On the other hand, anxiety and fear delay healing[5], and As a result, compassionate care can positively affect patients' rate of recovery and probability to be healed. In general, many studies indicated that a patient-centered care approach which involves the delivery of a compassionate, respectful model of care indicates the care deliverers' high quality professional life. This research indication prompted policy-makers to advance this approach. The positive interaction between health care professionals and patients is extremely influential in patient treatment outcomes [7].

Compassionate and Respectful Care (CRC) service is a new program in the Ethiopian health system that was launched in 2015 as one of the four transformational agendas in the health sector transformational plan I (HSTP-I). Following this, all levels of health systems started implementing different CRC initiatives in the last five years. For example, the Establishment of CRC councils in all levels of the health systems, mass clinical and non-clinical staffs' training, preparation of different implementation manuals, guidelines, protocols, incorporation of CRC components in different health disciplines' curriculum, and designing monitoring and evaluation systems are being implemented so far[8, 9].

Even though considerable health gains have been achieved through the implementation of CRC, there are still different challenges. The lack of adequate data on the status of CRC monitoring and evaluation is the most affective challenge that boldly initiated the need for this implementation research to be conducted. The integrated and coordinated CRC implementation approach is one of the priority transformation agendas among the six pillar agendas in the new Health Sector Transformation Plan (HSTP-II) which are planned to be achieved by 2030[8, 10]. To achieve this specific transformation agenda, four major strategic interventions were identified: enhancing ethical competences and practices for health care providers, strengthening policies, systems, and practices for health workforce job satisfaction to increase their, performance, and efficiency, strengthening person-centered care, and strengthening community Stakeholders Engagement. However, we do not have comprehensive evidence on how to achieve these interventions[11].

Monitoring and evaluation practices have key roles in the effective performance of the CRC initiatives [12]. Monitoring is the process of regular and systematically collecting, analyzing, and reporting information about a project's inputs, activities, outputs, outcomes, and impacts. Therefore, monitoring is a way of improving the efficiency and effectiveness of a project by providing the management and stakeholders with project progressive development and achievement of its objectives within the allocated funds[13]. It therefore, keeps the CRC initiatives and the management on the right track.

Evaluation is a means of checking a project's efficiency, effectiveness, and impact. Evaluation involves: looking at what the project intended to achieve, assessing progress towards what was to be

completed and impact on targets, looking at the effectiveness of the project's strategy, looking at the efficient use of resources, opportunity costs, and sustainability of the project, and the implications for the various stakeholders[14, 15].

Monitoring and, some times, evaluation fall under project management's control functions. It provides regular feedback that helps the organization to be on the track on: costs, personnel, implementation time, organizational development, economic and financial results, and it compares plans with actual performance. Effective monitoring and evaluation systems are mainly determined for tracking performance and providing instant information for management decision-making[16, 17]. Although they are very essential in improving performance, they are also very complex, multidisciplinary, and they involve skill-intensive processes. Building effective M&E systems is very important requirement for the growing demand to enhance performance which is also one of the NGOs' and donors' to check the effective use of the donor's funds, impact, and benefits brought by the projects[18]. Hence, there is a need to establish rules and regulations of preparing minimum parameters for monitoring and evaluation tasks that can be used to track progress and effectiveness[19].

Adequate and skilled staff and financial resources are vital ingredients in developing an effective M&E systems. Failure to allocate a reasonable proportion of resources on this aspect of project management impedes internal learning, and it resulted in effective practices of the M&E systems [20, 21].

During the last five years, CRC implementation was given less attention except few trials here and there that lack integration and responsiveness[9, 22]. So, this remains a major challenge in the CRC implementation. Thus, the current study aimed to answer this question on how to strengthen the monitoring evaluation systems to improve the CRC service. It is also important for the improvement of the program.

METHOD

Study setting: The study was conducted in some purposively selected Ethiopian health institutions from 01 to 30 February 2021. Ethiopia is the second populous country in Africa, next to Nigeria with more than one hundred ten million people. It is bordered by Eretria, South Sudan, Sudan, Djibouti, and Somalia (14). Ethiopia is divided into ten geographical regions (Tigray, Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, SNNPR, Gambelia, Harari, and Sidama) and two administrative cities, Addis Ababa and Diredawa. The country has three level health care delivery systems. The first level comprises a district hospitals, health centers, and satellite health posts. District hospitals and health centers focused on curative and preventive health services, while health posts concerned on providing preventive services. The second level in the tier is General Hospitals, and the third is a Specialized Hospitals, both of them exclusively focusing on curative health services (15).

The institutions were selected purposively based on their current CRC implementations. According to the ministry of health report, South Nations Nationalities and Peoples Region and Sidama region were selected for the study due to their relatively better implementation practices. On the contrary, the Oromia region was selected due to the lower current performance of the CRC.

Study design: Implementation research with qualitative design was applied to understand situations in their uniqueness as part of a particular context and

interactions. This design helped the researchers to examine the data closely at the surface and deep levels. It helped to describe the essence of phenomenon by exploring them from those who experienced practically, and it helped to understand the meanings which participants ascribed to that phenomenon.

Study population and sample size: The study participants were selected from FMOH and from all health institutions in the four selected regions such as Amhara, SNNP, Sidama & Oromia RHB. The data were collected from CRC focal persons, M&E directors, quality directors, and heads of all health institutions. Study participants who worked at least for more than six months in a specific position were included in the study. A total of 26 key informants were interviewed using an interview guide. Moreover, a desk review on 15 health institutions was conducted on their M&E processes using guided by observational checklist. The level of information saturation was used to determined the sample size. The information was considered as saturated when the research questions were adequately answered, the information generated redundancy, and when there is no new response given from the participants.

Data collection tools and procedures: A qualitative research data collection tools (Key informant interview, observation, and document review) were used to address all the research questions. Furthermore, document reviews and observation checklists were employed to cross check the information that was collected from study participants. Before executing the practical data collection process, the key informant guide was tested out from health institutions which are not included in the study. Errors or ambiguous wordings were identified and rectified based on the pilot findings. The pilot was conducted in the Amhara regional health bureau. An audio recorder was used for recording the participants' information to avoid potential mistakes during data collection.

The semi-structured interview guide was prepared with multiple probes to get relevant information (Annex-1). Checklists were also prepared for data collection from document reviews and from observations to assess the implementation status of the program(Annex-2) in the included institutions and regions. The data were collected from study subjects using interviews and checklists. The data collection which included audios, photos, and other documents was taken after permission from the head of the organization and written consent of the participants completed using a participant consent note/form which was developed for this purpose. In addition, primary data (textual data) in the form of expanded field notes and transcripts were collected.

Data quality management: The data collectors gave information to the participants about the purpose of the study before they collected the data. Audio data were recorded using an audio recorder, and they were transcribed to the Amharic language verbatim. Besides, expanded field notes were collected during the data collection period to support the audio information. Two teams of data collectors which included two interviewers and two recorders per team recruited to collect the data. The data collectors are mastered with public health science, they are well experienced with qualitative data collection. Two supervisory teams were assigned to control the overall data collection process. The first supervisory team controlled the data collected from the Oromiya region and the health ministry. The second supervisory team also controlled the data collected from the Sidama and SNNP regions. A three-day training was

given to data collectors before the data collection was started. A supervisory checklist was developed to check the quality of the data collection process.

Data analysis: The observed data and the document interviewed data were transcribed into the textual data. Likewise, the interviewed data were also made/ changed into text (field notes and transcripts). The audio recorded interview was firstly transcribed to Amharic language and then translated into English. Codes were given based on original terms used by participants. In the same way, codes were also analytically developed or inductively identified in the data, and they were affixed with sets of notes or transcripts. In addition, they were transformed into categorical labels or themes. Materials were sorted out according to these categories. This sorting included: identifying similar phrases, patterns, relationships, and commonalities or disparities. Besides, sorted out materials were examined to identify meaningful patterns and processes. These identified patterns were evaluated in light of previous research and theories. Finally, a small set of generalizations were established. The transcript and notes were analyzed using open code version 4.02,and the data were qualified and saved in a plain text file form—a descriptive phase of identifying meaning units and assigning codes that were compared and reorganized into tentative categories.

Ethical Consideration: Ethical clearance was given from the Review Board of the University of Gondar using the Ref. No.V/P/RCS/05/676/2021 and on the date of 21 January 2021. Similarly, written permission was given from FMOH and respective RHBs. Informed consent was taken from study facilities and study respondents. All data were categorized based on codes instead of by mentioning the name of the respondents to avoid an indication of any personal characteristics. The data were secured in the University repository, and they were prevented from any access to an unauthorized person.

Data collection procedures were done abiding to the four ethical principles. Participation was entirely on voluntary based. The consent form was given to participants before they proceeded to the interview. They were allowed to read the consent form thoroughly, and to sign on it to ensure their voluntary participation. The interviewees were informed about the purpose of the study, and about the benefit they may get in doing so. Their personal information was kept anonymous, and contextualization to some identifiers was avoided to protect the personal identities of study subjects. The participants have the right to accepted or declined participation. Furthermore, they have the right to cease the participation at any time and stage in the course of the interview whenever they want to stop. The interview avoided any negative effect or reduce inflicting harm on study participants. It was non-maleficence to reduce psychological and emotional fatigue which may result from the participation. Quite places were selected for the interview during data collection to ensure privacy and avoid the discomforts of respondents. The researchers were very honest and genuine to the findings which are found from this research. The result of the study was reported as it was taken from study subjects. Subject involvement was minimized as much as possible during data collection and write-up.

RESULTS

Characteristics of study participants: A total of 26 participants, ten from FMOH, six from RHBs, and ten from primary health workers were participated in

the study. Most of the participants were Male (17), and they were 30 years old and above (23). Likewise, the majority of the participants have second degree and above (17) educational status, and they have ten years and above working experiences (Table1).

Table 1: Characteristics of study participants of M&E system of CRC program in Ethiopia, 2021

Variables		FMOH	RHB and lower level	Total
Sex	Male	7	10	17
	Female	3	6	9
Age	20-30 years	0	3	3
	31-40 years	5	6	11
	41- 50	4	4	8
	Above 50 years	1	3	4
Educational status	First degree	0	8	8
	Second degree	9	8	17
	Third degree	1	0	1
Working experience	Less than 10 years	2	7	9
	10-20 years	5	5	10
	Greater than 20 years	3	4	7

The study participants' responses were analyzed using thematic analysis, and six themes were identified from the collected data. These themes were: the CRC program M& E platform, the Current practice of M&E of CRC program, current reporting and feedback mechanisms of the M&E systems for CRC, barriers and enablers of the M&E systems of CRC program, and the proposed strategies for the M&E systems of CRC.

CRC Program M& E Platform: The respondents' responses to CRC program M&E platforms were analyzed using four subthemes. The subthemes were: the framework of the CRC for the M& E systems, integration of the CRC program to the M&E systems, structure of CRC program, and ownership of the CRC program.

The framework of the CRC for M&E Systems: The monitoring and evaluation framework assists in understanding and analyzing a program, and it helps to develop sound monitoring and evaluation plans. It also helps to improve implementation of monitoring and evaluation activities. Additionally, it can facilitate achieving program's goals and measuring short, medium, and long-term objectives. The respondents explained that there was no any monitoring and evaluation framework during the development of the CRC program. But, most of the study participants agreed that during the development of the strategy, the program didn't have monitoring and evaluation frameworks.

Among the participants, a 44 years old who is Ministry of health staff stated that:

> *"…in the beginning, there was no m& E framework. However, some institutions and managers who accepted the strategy and the issues as it is useful for the community, may reported voluntarily and evaluated their implementations."*

Additionally, a32 years old who is a regional health bureau staff said that:

> *"…. for the last five years, CRC was one of the four transformation agendas. . This transformation agenda was designed to achieve different objectives and goals in different areas. But the program didn't have clear monitoring and evaluation frameworks."*

Integration of CRC program to the M&E systems: The majority of study participants articulated that the CRC program monitoring and evaluation system should be integrated into the main institutional monitoring and evaluation systems. It is essential in helping program managers, planners, implementers, policy-makers, and donors to get the right information, and to make informed decisions about the program's operations. In addition, the participants stated that the monitoring and evaluation systems of the CRC program, and the main institutional monitoring and evaluation systems work differently and independently in all the health systems.

> *"…we tried to invest much effort to integrate it with our systems, but we didn't make it practical. because at the initial phase, the planning of our system and the program of CRC were planned to be done independent. As a result, we didn't have any harmonization or alignment of the programs. The two programs have different priorities and focus areas, and we didn't integrate their monitoring and evaluation systems."*
>
> (A32 years old, Ministry of Health staff*)*

However, In some facilities, the monitoring and evaluation systems of the CRC program were integrated into the facility's main M & E systems. Respondents stated that the CRC program was also integrated with other programs. This was understood when some health facility heads present their plans and activities. But the observational and document review showed no evidence of integration of the CRC program and the M& E system of the facilities.

> *"…we have one system for our hospital to monitor and evaluate our hospital's performances. The CRC program has a focal person, and he/she is part of the management team who are assigned to integrate the CRC with our facility's main monitoring and evaluation. Even though the CRC has no its own indicator, our facility developed an indicator to monitored the program, and it is considered as one of our strategic activities."*
>
> (A31 years old, CRC focal*)*

Structure of CRC program: The study revealed that the structure of the CRC's program implementation is implemented differently. In addition, the structure of the CRC program's national, and regional, institutions has a different composition. The majority of participants stated that the CRC program at the national level is mainly coordinated by the ethics case team. In the same way, some regions followed this structural alignment. For instance, Oromia and SNNP regions followed this structure. In contrary to this, some regions do not follow this structure, but they have already assigned one focal person from the quality of the clinical service directorate.

> *"…at the national level, this transformation agenda was mainly coordinated by the ethics case team. At the same time, some regions may follow this structural alignment, but some other regional's do not follow this structure, and they have already assigned one focal person from the quality of the clinical service directorate. For instance, Oromia and SNNP regions are examples for the first which established one case team for this program. However, some facilities integrate this issue*

with the quality audit and thrive on these achievements."

(A 44 years , Ministry of Health staff*)*

Likewise, most of the facilities and lower-level health institutions whose heads participant stated that running the CRC's program was responsible for one focal person who is also a members of the quality improvement team of the health facilities.

"Generally, the monitoring and evaluation system of the CRC program in our hospital is closely administered by a CRC focal person, CRC committees, and CRC quality improvement team which has four members. The CRC committees round two times per month to identify the gaps, and to give feedback on CRC implementation to each department of the hospital. …."

(A 28 years old who is a Quality improvement focal*)*

Ownership of the CRC program: The finding of this study revealed that the ownership of the program is not clearly stated by the concerned body, and each department and directorate doesn't have defined roles and responsibilities of the tasks. Most of the participants stated that the ownership of the CRC program was not well defined and the department employees have no defined responsibility. In addition, the participants also stated that some default activities like providing the training, and monitoring cascading of training were the responsibilities of the human resource directorate, but other additional program's activities like providing the CRC service which help the community are the duties of the clinical service directorate.

"…to be frank, the ownership of this program is not clearly assigned to a particular section in the department. There is no clearly defined ownership at the regional and facility-level since the CRC focal person does the activities. The assigned focal person considered the CRC program's activities as an additional responsibility, and he doesn't give attention to monitoring the CRC program."

(A 34 years old who is Ministry of Health staff*)*

In contrast, some participants articulated that the ownership of the program is clearly known. It is given to the case team who regularly monitor and evaluate the program, and who are accountable for the program.

"… in our region, we assigned the ownership of the CRC program for specific case teams in the lower level of the health system which was not applicable in the previous structure. We also tried to allocate a particular budget for CRC as much as possible in our region."

(A 38 years old who is a Regional Health Bureau Staff*)*

The current practice of the M&E of CRC program: The current practice of the monitoring and evaluation of CRC program according to the respondents was analyzed using four subthemes. The subthemes were: current planning, monitoring, evaluation, supervision, and mentorship practices. When integrated into the more comprehensive health system, planning efforts can deliver Quality Strategies mandated to the National Health Care in Ethiopia which emphasizes on the need to treat people with dignity and respect.

Planning: The finding of this research indicated that the program's planning of the organizations was one component of the monitoring and evaluation of the program. Having common planning of the institutions helps to make rational decisions by choosing the best possible alternative of the programs. The

majority of the participants stated that the program's CRC program of the M&E was not aligned with the institution's main M& E systems. This indicated poor monitoring and evaluation practices of the program. Furthermore, during the document review of each institution, the researchers confirmed that the plan of the CRC program was not aligned with the main system of the M& E of the institutions.

A 38 years old is a ministry staff described the issues as :

> *"We imputed much effort to align all systems in our ministry, but practically we didn't materialized since at the initial phase, the planning of our system and the CRC program had different and independent plans. We didn't have any plan alignment of the program. The two program plans had different priorities, and they focused on areas of the intervention. When it comes to the regions, the gap of plan alignment severe, and they seemed as if they were tin dependent departments of an institution."*

On the other hand, few participants stated that they had a plan alignment of CRC programs and other different activities in their institution especially in the lower level of the health system. In the same way, they stated that they had a common plan for each activity including the CRC programs within their facilities.

> *"…from the very beginning, we had a strategic plan and yearly plan for our hospital. The yearly plan is divided into quarterly, and our activities are done based on this plan. Hence, each activity's performance is evaluated based on our plan which includes also the CRC service, but there are still budget constraints."*
>
> (A 26 years old who is a CRC focal from HC*)*

Monitoring: Monitoring of the program was found to be an important tool in this study. Even though many participants stated that the CRC program had no standardized indicator to monitor the program's achievements, they all also stated that they follow a common approach to monitoring the program. Additionally, they stated that they frequently monitor the CRC service program's achievements based on their plans.

A regional health bureau staff said that:

> *"…Basically, we didn't have any standardized indicator to monitor the CRC program, but we have a common approach to monitoring the program. The main thing that we follow and monitor is whether the institution or the region has achieved the planned activities or not. Practically, the monitoring may be qualitatively or quantitatively, and it depends on the planned activities. For example, we frequently monitored the community satisfaction level based on the CRC initiatives…."*

On the other side, few participants stated that the CRC program didn't have a standardized indicator, and they do not monitor the program's achievements due to different reasons. They also stated that sometimes in exceptional cases, they monitor and follow the program using the review meeting of the program. Still, this depends on the fund of the program and the follow-up of the higher officials.

A facility health practitioner who is a CRC focal said that:

> *"CRC program has no indicator to monitor the program. Mainly we have monitored the program's achievements using different review meeting programs, and by following other proxy indication of the program's performance. But, the*

budget for conducting the review meeting maters the performance of the program."

Evaluation: The study also indicated that evaluations helped to differentiate what works were well done and what could be to improved in a CRC program or initiatives. The evaluation of the program was conducted by using different supporting tools such as observational checklist, regular report, and participatory review meeting. The majority of the participants stated that the CRC program's evaluation was conducted by observing the institutions' work performances directly using the checklist and checking the regular reports. However, during the document review of the institutions using observational checklist, the researchers assured that the evaluation system of each institution varies from institution to institution.

"The performance of CRC program implementation was regularly evaluated based on the quarterly reports. We have also evaluated the performance of the CRC program implementation by the checklist which we prepared, and by discussing with the communities who get the health services from our health facilities. There is also an observational field checklist to evaluate the program of the CRC implementations…."

(A 42 years old who is a Regional Health Bureau staff*)*

The other way of evaluating the CRC program was a participatory review meeting. During the review meeting of the CRC program, all stakeholders and focal persons of the program participated. According to the majority of the participates' respond, a participatory review meeting of the program was used to evaluate the program's achievement seven though the period of the review meeting and the list of participants were different from institution to institution. The variation of the period was from once a year to twice per a year.

"…the review meeting was conducted at least annually, and the participants were all the regional focal persons, heads, and incubation center delegates."

(A 32 years old who is a Ministry of Health staff)

Similarly, another participant who is 28 years old, and who participated in the study from Oromia regional health bureau also stated that:

"The other way through which we support the region was in the form of participatory review meetings. In this review meeting, the supervisor filed the report, the regular report findings and the feedbacks, and he also presented them. In the review meetings, these issues discussed intensively. The review meeting is conducted at least once per year, or sometimes also twice per year."

Supervision and mentorship: Supervision and mentorship were also important to provide a safe and supportive opportunity for individuals to engage in critical reflections, to raise issues, to explore problems, and to discover new ways of handling the CRC program's general progress and them selves during the study. The finding of this study indicated that the supervision and mentorship program of CRC was conducted through integrated or through program-specific ways. The time and the supervisor of the supervision and mentorship program varied from institution to institution depending on the program's focus. The majority of the participants stated that the CRC program was supervised and mentored by program-specific professionals at least once a year. Likewise, the integrated supportive supervision of the program was also conducted once a year as stated

by the majority of respondents. On the other hand, the observational checklist and the document review result showed that the majority of the observed 12 (15) institutions lack the CRC program's compost in the integrated supportive supervisor checklist.

"The supervision and mentorship program was given in two ways. The one way was given through technical committee composed a team, and who deliver technical support for the region and for the facilities through the integration of technicians from our office and regional experts. The other way is as other activities we give like integrated supportive supervision of SIS in which we participated as a member, and we incorporated our activities in the checklist."

(A 36 years old, who is Ministry of Health staff)

The current reporting and feedback giving mechanisms of the CRC program

Report mechanisms: Participants explained that there is no standardized report format or indicators to trace the activities of the CRC program. However, the health facilities prepared their reports which is reported to the higher officials and stakeholders mainly every quarter or by the end of the year based on their own report format.. Review meetings and creating telegram accounts are also means of reporting mechanisms as underlined by the study participants.

"… Our support and supervisions are conducted in every quarter based on the checklists. We received reports and we crosscheck, whether or not the activities mentioned in the reports are really done on the ground in our field observation. Our feedback mechanism is mainly based on after-the-field supervision and giving it on the spot. The Regional and Federal Ministries of Health also give us feedbacks via report and telegram accounts to integrated with other programs. We have no regular meetings specifically for the CRC program, but there are meetings integrated with other programs held by the Federal Ministry of Health."

(A 55 years old who works in Zone Health Department)

Feedback mechanisms: Participants emphasized that the other transformational agendas have their own indicators, and we can give the feedback based on the indicators. But, there are no indicators for the feedback mechanisms, and they are not uniform across the health facilities. However, field supervision, report, review meeting, observational checklist, and patient group discussions serve as feedback mechanisms. Besides, the feedback is not given for the CRC program independently; instead it is given in collaborative with the other programs.

"… we provided feedback in two mechanisms. First, during the final day of the supervision in which we give oral and informal feedback based on the discussion and action plan agreement forms. After completing all supervision reports and reviewing the activities, we also give comprehensive and written feedback for the supervised institutions and regions by the institutional e-mail to support formal letters."

(A 39 years old ho is a Ministry of Health staff)

Barriers of M& E systems of CRC program

Organizational barriers: This study revealed that one of the monitoring and evaluation barriers for CRC program implementation was the organizational barrier which includes the absence of the standardized indicator, un integrated standardized indicators, lack of human resources, lack of budget, poor infrastructure, and lack of government commitment. A 44

years old man who participated in the study from the Ministry of Health supported this barrier as:

"*…the other point is that things are resource-intensive to implement and to follow the* M&E *frameworks. The major one is also poor collaboration work with other transformation agendas. As a plan, there may be four in one and one into four. But practically, it is not supported with the monitoring and evaluation frameworks."*

Behavioral Barriers: This study also showed that bad behavior of professionals who considered CRC program as a political instrument, and who have bad attitudes towards their profession are other challenging barriers to monitor and evaluate CRC program implementation. A 39 years old man who participated in this study from the Federal Ministry of Health explained this barrier as:

"…now the major problem is related to the attitude of the health professionals who say like, "why not we disrespect because our mothers delivered their child in the home so why we focus on the respect of the service?"" rather than delivering the service accordingly. The measurement by itself is also a challenge which includes the attitude, skill, behavior of the profession, the availability of service, and others."

Technical Barriers: The participants replied that technical barriers such as being unskilled for their professions, not having proper knowledge about their professions, and poor attitude of the professionals are the main identified barriers. A 32 years old man who participated in the study from the Federal Ministry of Health supported this point as:

"…most of the problem is the capacity mostly related to the technical knowledge and skills.It is very difficult to measure, and to prepare an indicator for the attitudes of the health workers regarding the companionate, respectful and caring service. The other challenge is the focus of the program. If the government's focus about the program' evaluation changed, we could develop an indicator in the proxy and direct indicators...."

Enablers of M& E systems of CRC program

Government commitment: Even though many barriers are identified in this study; there are also good opportunities to enhance the monitoring and evaluations of CRC program implementation. These includes: good government commitment such as including CRC program as a transformational agenda, the establishment of national team to develop the CRC program indicators and the establishment of national monitoring and evaluation team which the deputy prime minister leads. A 44 years old man who participated in the study from the Federal Ministry of Health listed these enabler as:

"...For the last five years, CRC has been one of the themes of the transformation agendas. These transformation agendas were designed to achieve different objectives and goals in different sectors. Likewise, inter-professional collaboration to embed the pre-service education stage demands a collaborative attitude among health workers which result in more respectful relationships within health care teams. In the regions, the council isled by the regional president even though most of the councils are not functional, and they are not much strong. However, few regions and institutions have accomplished substantial achievements.

Availability of systems and materials: The stud also publicized the availability of systems and materials such as availability of DHIS2 system, availability of the national monitoring and evaluation system,

the easily accessible CRC program indicators, availability of electronic media records, and availability of trainings are the enablers for monitoring and evaluation of CRC program implementation.

> *"As an opportunity, the availability of electronic medical records and the DHIS2 system are good opportunities. There is also an opportunity to measure the CRC program globally. The commitment of the ministry to make CRC a transformational agenda is also an other enabling opportunity. The availability of capacity-building activities and the platform of integrated supervision can also be mentioned as enabling opportunities."*
>
> (A 39 years old who participated in the study from Federal Ministry of Health)

Availability of funders: The participants assured the availability of funders as another good opportunity for the monitoring and evaluation of CRC program implementations. Since accomplishing all the transformational health agendas only by government is impossible because of budget restriction, there are other alternative good opportunities to the implementation of the programs. A 50 years old woman who participated in the study from the Federal Ministry of Health supported this point as:

> *"… The ministry of health seemed as it is committed to the program in cooperating with funders and stakeholders. In addition, there are also different initiatives such as initiative from the regions to take the ownership of CRC program, at higher institutions the health science students are joining on their own interests, there is initiative of strengthening the ethics education at the lower class, there is initiative of creating the integration with other stakeholders, and others."*

Proposed strategies for the M&E systems of CRC: The finding also identified potential strategies to improve the CRC program monitoring and evaluation systems, and explored using two subthemes: System-level and program-level recommended subthemes.

System-level suggested strategies: The study also discovered a system-level improvement strategy for the better implementation of the M&E systems of the CRC program. The study revealed that the structure, ownership, scope and M&E frameworks, and standardized indicator of the CRC program should be clearly indicated in the HSTP documents. The majority of participants pointed that the CRC program of M&E systems should be started in both at the system and at the national levels. Additionally, they pointed out that the CRC program should have a clear structure, ownership, scope, M&E frameworks, and standardized indicator at a national level. Similarly, they also stated that for the improvement of the program, the program of CRC should be integrated into the main systems of M&E of the institutions'. A 39 years old man who took part in the study from the Federal Ministry of Health supported this idea as:

> *"If CRC is considered as one transformation agenda, it should have an M&E frameworks. However, , till now it doesn't have any responsible person or structure for this activity. If this is guided by the state ministry across different directorates like HRH, quality, clinical service, and other directorates there would be a better result and follow-up of the program."*

Similarly, a 36 years old participant from the woreda health office stated that*:*

> *"Firstly, the top management should be reliable and give a direction for the integration of the program. The other thing is the budget should be pooled and integrated into all programs. Further-*

more, the plan should be aligned and led by a strong committee who review all the team's program activities chaired by the state minister. In addition to this, at a national level, there should be a clear M&E frameworks, ownership, and standardized indicator."

Program level suggested strategies: The study also pointed out the program level improvise of the M& E system of the CRC program. The majority of the participants agreed that there should be a plan alignment of the program and guidelines of working documents at the departments' program level. Additionally, they pointed out that for the better success of the M& E program, there should also bean incentive mechanism and collaborative work with other departments and other stakeholders. A 40 years old participant who was selected from the Federal Ministry of Health supported this finding:

"I have recommended three things. First, the program should be mainstreamed in to all the ministry and other concerned bodies. Second, we should develop standardized measurement tools Thirdly, based on the standardized measurement tool, we have to develop an index and assess the current performance of the CRC program. After that, we can decide and follow the program even the facilities can access their performance like other programs."

Similarly, a 46 years old participant who was selected from SNNP Regional Health Bureau supported the above idea:

"Firstly, the main listed activities should have a standardized indicator to follow, monitor, and do activities accordingly. Otherwise, it is complicated to track and manage them. The possible option may be the four transformation agendas should be lead and coordinated in one indicator. The other option may be specifically for the CRC program to develop an indicator which helps to monitor and follow the activities and prepare guidelines and working documents. The last option is the program level strategy can support to develop an incentive mechanism, and to work collaboratively with other departments."

DISCUSSION

This study indicated that the CRC program hasn't specific scope, ownership, structure, and M&E frameworks during the strategy development. Additionally, the CRC program has no a standardized indicator to monitor and evaluate the program. Besides, different health institutions' performance varies from institution to institution. The CRC program of Ethiopia in general has no M&E frameworks during the strategy development. This hinders the monitoring and evaluation practices. However, the monitoring and evaluation framework assists in understanding and analyzing a program, and it helps to develop sound monitoring and evaluation plans in the implementation of monitoring and evaluation activities. In addition, it can also facilitate program's goals to be achieved. Furthermore it helps to measure short, medium, and long-term objectives. Not only this, the M& E framework also can help to monitor and evaluate the program effectively. This concept is similar with the recent studies which were conducted in different countries[23, 24].

The structure of the CRC program of Ethiopia in different institutions has a different structure. Having a uniform structure is essential in helping program managers, planners, implementers, policy-makers, and donors to get the right information, and to make

informed decisions about program operations. On the other hand, the variability of the program structure affects the performance of the CRC program, and it lacks well defined ownership, responsibility, and accountability of the program performance. This may be because the top managements give less attention during the development of the strategy, and they do not give a direction to have a common practice of the program. This finding is similar to the previous studies which were conducted in different countries and programs[23].

The finding also showed that the CRC program of the M&E of the program of Ethiopia is not aligned with the institutions' main M&E systems. As indicated from different studies, the program's plan is an important input for the implementation of the program and the monitoring and evaluation of the program. However,, for the better success of the program and follow-up of the program's plans, alignment is very crucial issue. Having common planning of the institutions' helps to make rational decisions by choosing the best possible alternative of the programs. This poor monitoring and evaluation of the program and related concepts is similar with the previous studies conducted in different countries of the world[25, 26].

The finding stated that the CRC program has no standardized indicator to monitor the program's achievements, but it simply has a common approach to monitoring and evaluating the program. On the other hand, to monitor the program of each activity, having a standard indicator is mandatory. During the HSTP plan of the sector, the CRC program hadn't a standardized indicator. This may affect the effectiveness of the M&E systems of the program's initiative. This is similar supported by other findings conducted on other programs[27-29].

In addition, the finding indicated that the evaluation system of the CRC program is conducted using different tools: observational checklist, regular report, or participatory review meeting. However, the time of frequency and the method of evaluation is not standardized. This is due to fact that they do not have a common indicator to evaluate the program. Additionally, this variation might be due to the program's difference in structure and ownership across regions and facilities. This finding is parallel with other findings of the previous studies[30].

The finding also pointed out that the supervision and mentorships are also important to provide a safe and supportive opportunity for individuals to engage in critical reflections to explore problems, and discover new ways of handling both for the situation and for their own CRC program during the study. The time of using supervision and mentorship program is varied from institution to institution depending on the program's focus. Hence, the integrated supportive supervision of the program is conducted once a year which is in contrast with the WHO standard that is four times per year. This variation might have occurred due to the difference in focusing on the program and ownership of the program. This finding is also consistent with other studies[31, 32].

Similarly, the study found that the absence of the standardized indicator, un integrated standardized indicators, lack of human resources, lack of budget, poor infrastructure, and lack of government commitment are some barriers to monitoring and evaluating CRC program implementation. An evidence which found from a similar qualitative study conducted, in international development partners supported that the lack of standardized indicators was the main challenge of monitoring and evaluation of health systems [33]. Similarly, a study which was done in Ghana

also supported this finding that weak linkage of indicators, technical barriers like the gap of knowledge, limited resources and budget, and absence of comprehensive national database are some of the major barriers to monitoring and evaluating of projects[34]. Likewise, a similar study found that limited resources and budget, lack of ownership, weak support, and supervision are some barriers to monitoring and evaluating the program[35].

The M&E platform and the current practice of the CRC program are not uniform across regions and facilities. Similarly, the current practice of reporting and feedback mechanisms is also different from region to region and facility to facility. Therefore, establishing a clear structure, ownership, scope, M&E framework, and standardized indicator of the CRC program is important at a national level. Moreover, plan alignment of the programs and preparing working documents and guidelines are also crucial for the improvement of the M&E system of the program.

List of Abbreviations

CRC: Compassionate Respectful and caring (CRC); FMoH: Federal Ministry of Health; Health Sector Transformation Plan; HSTP-1: Health sector transformation plan I, M&E: Monitoring and Evaluation; NGOs: Non-Governmental Organizations; and SNNP: South Nation Nationalities and Peoples:

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