

Quality, Equity, Dignity

The network to improve quality of care
for maternal, newborn and child health

STRATEGIC OBJECTIVES



Quality, equity, dignity: the network to improve quality of care for maternal, newborn and child health – strategic objectives

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EXECUTIVE SUMMARY

The past two decades have been marked by substantive progress in reducing maternal and child deaths. Yet progress has often been slow to reach those who need it most. Provision of quality care is uneven, and often fails to respect the rights and dignity of those who seek it.

Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Tanzania and Uganda, supported by the World Health Organization, the H6 partnership and partners from all stakeholder groups, have brought together the Network for Improving Quality of Care for Maternal, Newborn and Child Health, ('the QoC Network'). Inspired by the Sustainable Development Goals and the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health, countries in the QoC Network have agreed on a vision that every pregnant woman and newborn receives good-quality care throughout pregnancy, childbirth and the postnatal period. The vision is underpinned by the core values of quality, equity and dignity.

As a step towards ending preventable maternal, newborn and child deaths and achieving universal health coverage, countries in the QoC Network will work together to halve maternal and newborn deaths and stillbirths in participating health facilities in a five-year period.

This document sets out the four strategic objectives of the QoC Network: leadership, action, learning, and accountability. The strategic objectives are underpinned by the importance of community engagement in improving the quality of care. They were reached by consensus among the QoC Network countries and partners present at the Network launch meeting in Lilongwe, Malawi, in February 2017.

The strategic objectives and their related outputs and key deliverables will inform implementation of quality improvement in a way that is scalable and sustainable. They also provide a basis for development of monitoring frameworks which will enable tracking of progress towards the goals and targets of the QoC Network.

Lastly, the document describes the mechanisms for supporting the QoC Network. The leaders of the QoC Network are the countries participating, who will share information on successes and challenges through a national and global learning network. WHO will provide technical and managerial secretariat to the QoC Network while task-oriented working groups will support countries by providing guidance and tools to support the implementation of improvements in quality of care, supporting quality of care monitoring, catalysing stakeholders to take part in country implementation, and promoting the QoC Network as an implementing platform of the wider Quality Equity Dignity campaign for every woman and every child.

Although the QoC Network is initially focusing its efforts on mothers and newborns, it will quickly expand to include child health and aims to gradually cover the full continuum of care. It is also expected that the number of countries that join the QoC Network increases as the learnings from implementation grow.

INTRODUCTION

1. The UN Sustainable Development Goals (SDGs) have set ambitious health-related targets for mothers, newborns and children, which countries have committed to achieving by 2030.¹ Working towards these will mean progress is made on universal health coverage (UHC) and on achieving the goals of the Global Strategy for Women's, Children's and Adolescents' Health ('the Global Strategy')² as well as the goals of the Every Woman Every Child movement.ⁱ The Global Strategy, with the goals SURVIVE, THRIVE and TRANSFORM, is aligned with the SDGs and was launched by the UN Secretary-General and world leaders in September 2015. Achieving these goals is a key priority for WHO Member States, as reflected in the World Health Assembly resolutions on UHC (WHA64.9) and the implementation of the Global Strategy (WHA69.2).
2. Globally, the rate of skilled birth attendance during childbirth has increased from 58% in 1990 to 73% in 2013,³ mostly due to increases in facility-based births. Evidence shows, however, that giving birth in a health facility with a skilled attendant is not sufficient to reduce maternal and newborn deaths and severe morbidity.⁴ Many women and their babies die as a result of poor care, even after reaching a health facility. If we want to accelerate reductions in maternal and newborn mortality and morbidity, improving the quality of care and patient safety is critical.
3. WHO envisions a world in which "every pregnant woman and newborn receives quality care throughout pregnancy, childbirth and the postnatal period".⁵ This vision is supported by two complementary global action agendas conceptualized by WHO and partners in 2013–2014: Strategies towards Ending Preventable Maternal Mortality (EPMM)⁶ and the Every Newborn Action Plan (ENAP).⁷
4. In this context, nine countries – supported by WHO, the H6 partnership (WHO, UNAIDS, UNFPA, UNICEF, UN Women, and the World Bank) and partners from all stakeholder groups – have launched the Network for Improving Quality of Care for Maternal, Newborn and Child Health ('the QoC Network'). In the nine participating countries, the QoC Network aims to halve the rates of maternal and newborn deaths and stillbirths in targeted health-care facilities within five years.
5. The QoC Network believes that coordinated actions to implement effective, scalable and sustainable improvements in quality of care can make a huge difference and, with the right investment and focus, could support the QoC Network to achieve its ambitious goal.

ⁱ More information about the movement is available at <http://www.everywomaneverychild.org/about>.

THE CHALLENGE

6. While, thanks to focused advocacy and investment, the rate of skilled birth attendance has increased in many high-burden countries, there are still many women and babies who, even after reaching a health facility, die or develop lifelong disabilities due to poor quality of care. WHO estimates that 303 000 mothers and 2.7 million newborn infants die around the time of childbirth annually,⁸ and that many more are affected by preventable illness. Some 2.6 million babies are stillborn each year.⁹
7. Health facilities often struggle to provide the rapid emergency care needed to manage maternal complications and to care for small and sick newborns. Common causes include inadequate or unhygienic infrastructure, lack of competent, motivated staff, lack of availability or poor quality of medicines and other resources, poor compliance with evidence-based clinical interventions and practices, and poor documentation and use of information. As a consequence, mothers and newborns continue to die from preventable causes, such as blood loss, high blood pressure, obstructed labour, complications of preterm birth, asphyxia and infection, even when they are in the care of health services.
8. Poor quality of care also increases the risk of illness and lifelong disability. Mothers may develop pelvic infection, fistulas, uterine prolapse, fatigue and depression. Babies may be at risk of infection, or go through asphyxia or trauma during labour, which can lead to neurodevelopmental impairment and disabilities. Being born too soon presents a hugely increased risk of death and complications in settings where nursing care for small and sick babies is weak.
9. Poor quality of care is an affront to human rights. Large differences in the death rates of mothers and their newborn infants reveal inequities between rich and poor countries, and between rich and poor communities within countries. On average, the lifetime risk of maternal death in high-income countries is 1 in 3300, compared with 1 in 41 in low-income countries.¹⁰
10. The challenge is not limited to the medical aspects of care. A growing body of research on women's experiences around the world paints a disturbing picture of disrespectful, abusive or neglectful treatment during childbirth in some facilities.¹¹ This constitutes a violation of trust between women and their health-care providers, and can be a powerful disincentive for women to seek and use maternal health-care services. Disrespectful and abusive treatment may of course occur at any time during pregnancy, childbirth and the postpartum period, but women are particularly vulnerable during labour, when stress can increase the risk of complications.
11. Good quality of care requires effective communication – a woman or, as relevant, her family or other people who care for her, should be able to expect an understanding of what is happening to her and her baby, and to know what to expect, and her rights. Both a woman and her baby should receive care with respect and dignity, and a woman and her family should have access to the social and emotional support of their choice.

12. Against this, a recent survey of midwives in low- and middle-income countries showed that significant social and cultural, economic, and professional barriers could prevent quality midwifery care from being provided – three barriers that were found to arise from gender inequality linked to negative institutional hierarchies.^{12,13} A key finding was that 37% of all midwifery personnel globally had experienced harassment in the workplace. Childbirth is often a time of stress and anxiety, and creating a supportive and safe environment for midwifery personnel, and working to remove the structural barriers to the provision of quality midwifery care will protect staff as well as users of services.
13. Community engagement is also central to improving the quality of care. The perspectives of women, their families and communities on the quality of services influence decisions to seek care. Engagement by service providers at facilities of the communities they serve allows them to learn what users' expectations are, build trust, and involve people in the process of delivery; this is an essential component for improving quality of care and access to maternal and newborn services.
14. Patient safety and quality of care are critical dimensions of UHC. Patient safety is a challenge everywhere: evidence suggests that as many as 1 in 10 patients are harmed while receiving hospital care in high-income countries, and that complication rates are high in low-income countries.¹⁴ The harm can be caused by a range of errors or adverse events. Of every 100 hospitalized patients at any given time, 7 in high-income and 10 in low- and middle-income countries will acquire health care-associated infections (HAIs).^{15,16} Hundreds of millions of patients are affected worldwide each year. Simple and low-cost measures of infection prevention and control, such as appropriate hand hygiene, can greatly reduce the frequency of HAIs, especially for mothers and newborns. Antibiotic resistance is also an increasing threat to mothers and newborns in hospitals.
15. Improving the quality of care and patient safety is therefore critical to ending preventable maternal and newborn deaths, and achieving the SDGs by 2030 as well as the Global Strategy goal, SURVIVE. SDG targets 3.1 and 3.2 are to cut global deaths of mothers to less than 70 per 100 000 births, to reduce neonatal mortality in all countries to 12 or less per 1000 live births and to reduce stillbirths to 12 or less per 1000 total births.^{17,18} The global rates are currently as follows: maternal mortality is 216 per 100 000 births, global newborn mortality is 19 per 1000 live births, and stillbirths are 18 per 1000 total births – and there are large inequities between and within countries.^{19,20}

OUR VISION, THEORY OF CHANGE AND GOALS

Vision

16. The vision of the QoC Network is that every pregnant woman and newborn infant receives good-quality care throughout pregnancy, childbirth and the postnatal period.²¹ The vision is underpinned by the core values of quality, equity and dignity, which we have emphasized in the title of the QoC Network:

- **Quality** – many morbidities, disabilities and deaths of mothers and infants could be prevented by effective, scalable and sustainable improvements in the quality of care.
- **Equity** – receiving quality care is a basic human right. Such care addresses the needs of the mother and the newborn in a holistic manner, and minimizes inequities between those who are rich and those who are poor, marginalized or otherwise disadvantaged. For the most disadvantaged families and communities, quality of care needs to be complemented with specific policies to increase access to care.
- **Dignity** – any area of health care should be expected to provide dignity and not to see this as a luxury add-on. There is particular relevance for women in childbirth because dignity reduces stress, and many studies have shown that stress and isolation impair the progress of labour and increase the risk of complications. Conversely, social support, the presence of a companion in labour, a friendly, supportive midwife and a calm, welcoming environment can all make a huge difference to mothers' experiences of care and also reduce their risks of complications.

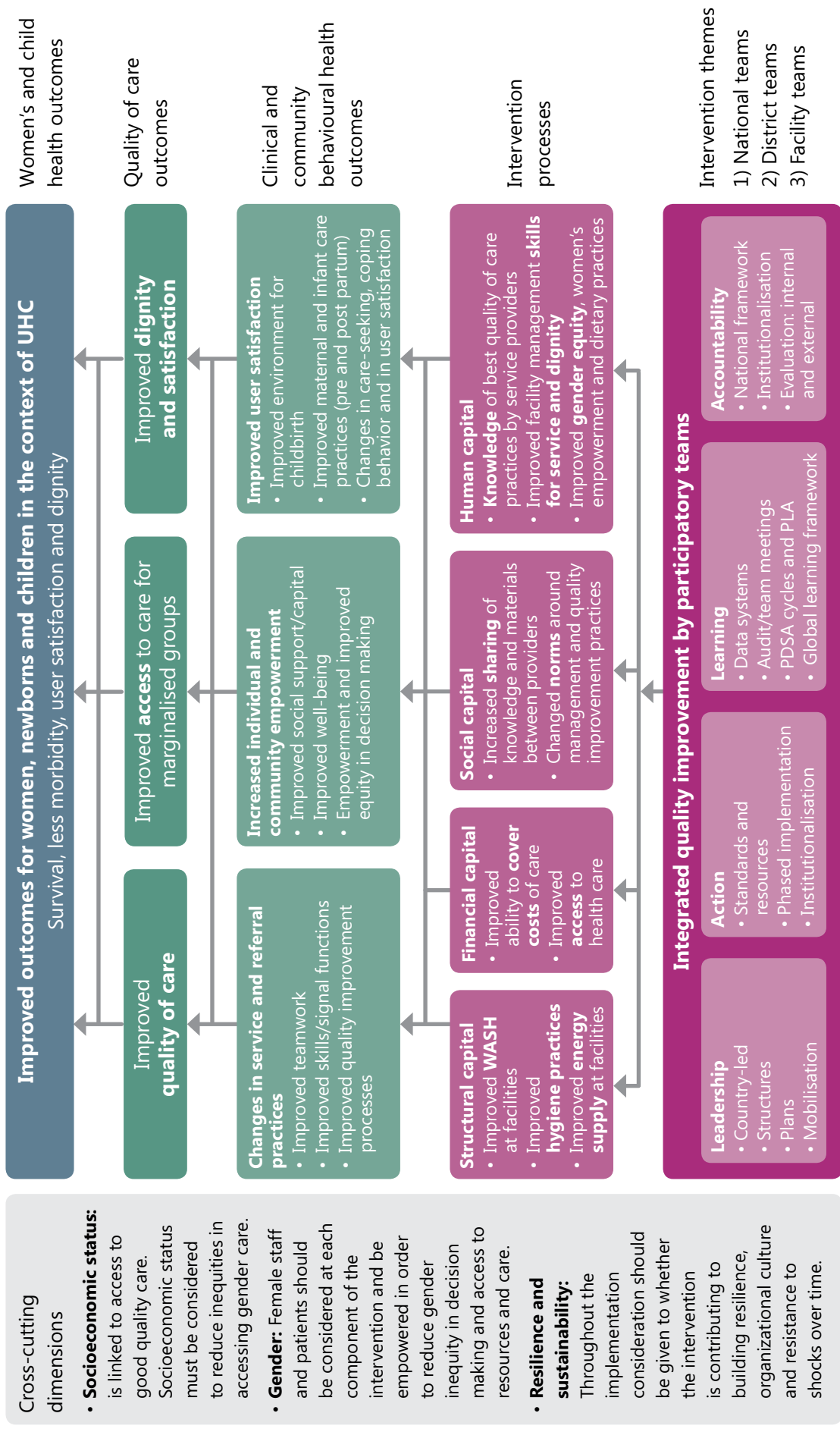
If the QoC Network is successful, its beneficiaries will include:

- the millions of women and their newborn infants who endure unnecessary and preventable risks in childbirth;
- health workers who face enormous challenges in resource-poor settings;
- nations that consider investment in healthy women and children as the bedrock of economic and social development; and
- global partners who wish to see rapid progress towards the SDGs and the targets of the Global Strategy for Women's, Children's and Adolescent's Health.

While the QoC Network in the first phase focuses its efforts on mothers and newborns, it will quickly expand to include child health and aims to gradually cover the full continuum of care.

Theory of change and logical framework

Figure 1. A theory of change for improving QoC for women, newborns and children



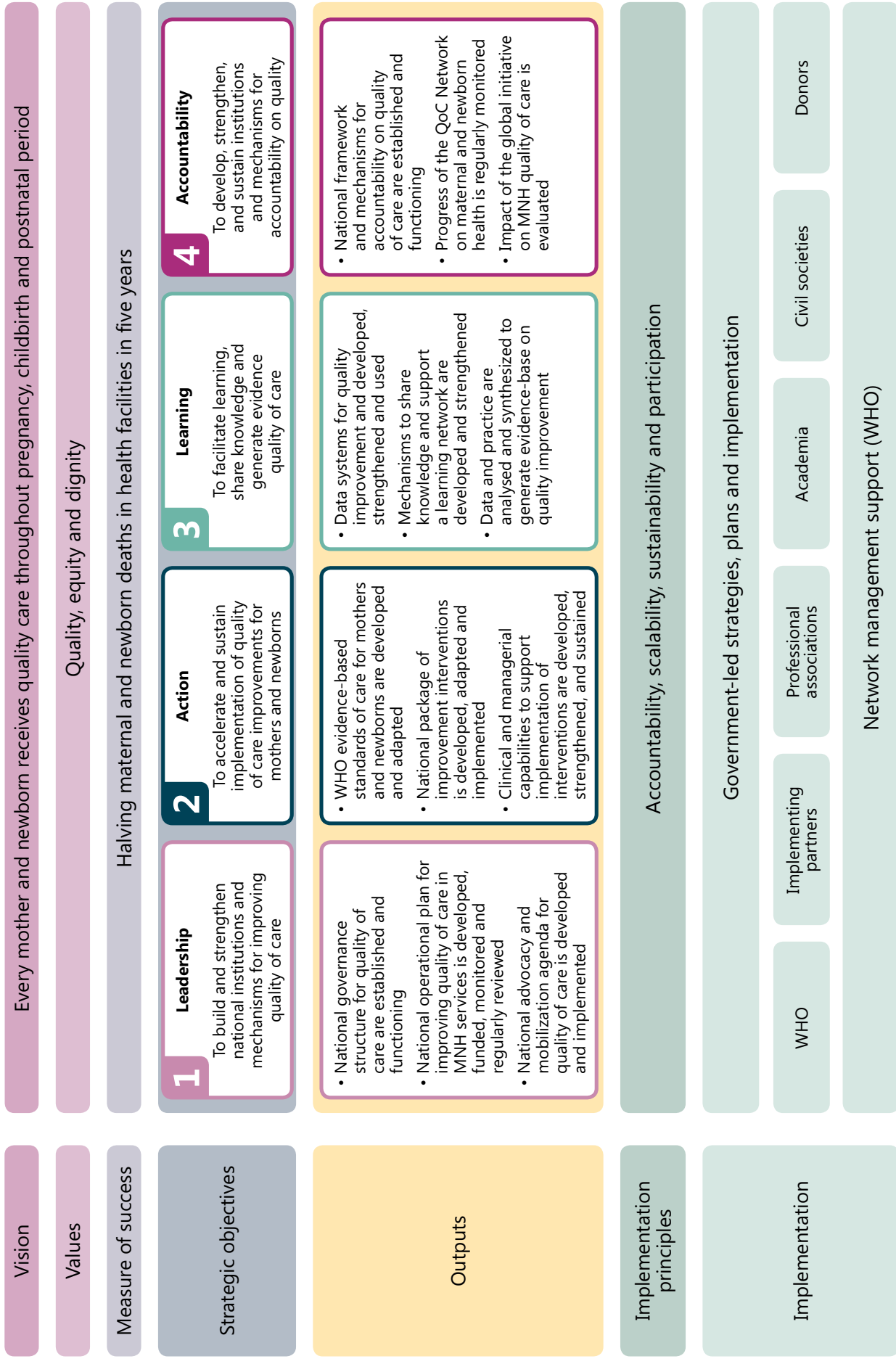
17. Figure 1 outlines a theory of change for improving the quality, access and dignity of care for maternal, newborn and child health within the context of UHC. The model responds to the Global Strategy, and provides a broad framework for work on quality of care. Despite substantial investments to date to improve this quality of care in high-burden countries, especially for mothers and newborns, efforts have often been fragmented. This support is frequently project-based and not institutionalized within government systems. In contrast, the current discourse around UHC is increasingly focusing on quality of care as being integral to financial protection. Building on this movement, it is encouraging that an increasing number of countries have developed or are intending to develop governance structures and national strategies to improve the quality of care in health services.
18. The QoC Network will build on this movement with a particular focus on care for pregnant women and newborns, with a gradual expansion to the full continuum of care. It will bring global and regional coordination to quality of care, share best practice from countries achieving successes, and help to catalyse, through coordinated evidence-based action and joint learning, progress in the poorest countries with the most fragile health systems.
19. The QoC Network will build on the leadership of governments and health professionals. It will embrace the work of implementing partners, funding agencies, and H6 agencies. Figure 2 outlines the overall logical framework of the work of the QoC Network.

Goals

20. If we are successful in realizing the vision set out above, we hope to achieve the following goals:
 - **Reduce maternal and newborn mortality** – reduce maternal and newborn deaths and stillbirths in participating health facilities by 50% over five years.
 - **Improve the experience of care** – enable measurable improvements in user satisfaction with the care received.

Figure 2. Overall logical framework of the QoC Network, for mothers and newborns

The Network to Improve Quality of Care for Mothers and Newborns



STRATEGIC OBJECTIVES

21. Our approach to improving quality of care for mothers and newborns (and in due course for infants and children) is structured around four strategic objectives, summarized by the key words of leadership, action, learning and accountability. The strategic objectives, and associated outputs, describe what needs to happen at the country level, in order for improvements in quality of care to be realized. Each of the objectives is discussed in turn below.

Strategic objective 1: Leadership

Build and strengthen national institutions and mechanisms for improving quality of care in the health sector

22. Some countries have made great strides in setting up institutional mechanisms and channelling investments towards improving quality of care; others less so. While expert advice has its purpose, the best way for countries to adopt new thinking and practices is often through peer learning from colleagues in countries facing similar challenges.

Output 1: National and sub-national governance structures for quality of care are strengthened (or established) and are functioning

23. Success in implementing quality of care depends on strong leadership and championing of quality by ministries of health. This leadership can be strengthened by a national multi-sectoral Steering Group on quality, coordinated by the government as part of a directorate or unit for quality of care. The Steering group will bring together the broad range of stakeholders involved in development, implementation and monitoring of the national quality strategy for health services. To focus on maternal, newborn and child health, the creation of a Technical Working Group is also recommended, specifically for developing the instruments for improving quality of care for pregnant women and children, guiding implementation, and for monitoring progress at regular intervals. The governance structure should span the national, sub-national and health-facility levels, with district-level quality of care committees working hand-in-hand with quality teams in health facilities.

Key deliverables for this output:

1. A national leadership structure for quality of care in health services established or strengthened;
2. A ministerial, multi-stakeholder steering group for quality improvement in maternal and newborn health services established or strengthened;
3. Quality of care committees in district health management teams established and functioning (with representatives from the community and women's associations being included);
4. Quality of care committees in hospitals and quality improvement teams in health facilities established or integrated into existing structures, and functioning (with representatives from the community and from women's associations being included); and

5. A liaison mechanism on quality issues established and functioning, set up between groups at the three levels – national, district and health facility.

Output 2: National vision, strategy and costed operational plan for improving quality of care in maternal and newborn health services is developed, funded, monitored and regularly reviewed

24. While many countries do have comprehensive policies, fewer have a written plan specifically to address how to bring about improvements for mothers and newborns, including doing so in disadvantaged and hard-to-reach populations. WHO and partners will provide technical support for the development of a national strategy and of an operational plan for improving such quality of care for pregnant women and newborns. National quality strategies should guide the development of the operational plan for quality of care, which will unify investments, guide implementation and monitor and review progress. These plans should propose a national package of interventions and set targets for improvement in maternal and newborn health. They will also need to be costed, funded and provide for the regular review of progress against the targets. Furthermore, partners will need to align activities and resources in support of the operational plan. For its successful implementation, roles and responsibilities should be agreed, and adequate human, material and financial resources will need to be committed at both the national and district level.

Key deliverables for this output:

1. National vision, strategy and operational plan have been developed (with targets) for improving quality of care in maternal and newborn health services;
2. Partners are aligned and resources have been mobilized for the implementation of the national operational plan;
3. Implementation of the national operational plan has been costed, with funding from the budget allocated;
4. Human resources for implementation of the national plan have been committed, and roles and responsibilities of different stakeholders have been agreed;
5. Regular reviews of progress against targets are in place and the national plan is ready to be adjusted as required.

Output 3: National advocacy and mobilization strategy for quality of care is developed and implemented

25. The advocacy and involvement of civil society groups is critical to success. Mobilizing communities, political leaders, health professionals and other stakeholders through media, specific campaigns, and the involvement of high profile women and of local champions and community groups is all vital for success. To facilitate the process, the QoC Network will support the development and implementation of national advocacy and mobilization strategies, and play a key role in sharing successes and making stories available in the public domain.

Key deliverables for this output:

1. Professional associations, academics, civil society and the private sector have been brought together and mobilized to champion the QoC Network and support implementation; and
2. A national advocacy and mobilization strategy has been developed with the involvement of a broad range of stakeholders, and is implemented and monitored.

Strategic objective 2: Action

Accelerate and sustain implementation of quality of care improvements for mothers and newborns

Output 1: WHO evidence-based standards of care for mothers and newborns are adapted and disseminated

26. National standards for quality of care are the backbone of efforts to make improvements. WHO has published *Standards for improving quality of maternal and newborn care in health facilities*.²² Countries will be supported by the QoC Network to review and update national standards and protocols against these WHO standards, and to translate the updates into tools for national practice. To ensure that updated guidance reaches end-users, the QoC Network will provide support for dissemination of the updated products across national, district and facility levels.

Key deliverables under this output:

1. National standards and protocols for maternal and newborn quality of care have been compiled and reviewed;
2. National standards and protocols have been adapted and updated to follow WHO standards;
3. National standards and protocols have been incorporated into national practice tools; and
4. Updated national standards and protocols plus their practice tools have been disseminated to all relevant stakeholders and are in use.

Output 2: National package of improvement interventions is adapted (or developed) and disseminated

27. WHO guidance on quality improvement interventions²³ identifies key strategies for implementing quality of care. For countries to develop their own national package of quality improvement interventions, support will be provided by the QoC Network to develop this package, furthering any current quality improvement interventions in the country and basing the support on the development of existing capacities and best practices.

Key deliverables under this output:

1. Quality improvement interventions in the country have been compiled and reviewed, and best practice identified;

2. The quality of care situation has been assessed, with gaps in quality identified based on the national standards of care; and
3. National package of quality improvement interventions to address identified quality gaps is developed and disseminated, drawing on the WHO quality improvement interventions.

Output 3: Clinical and managerial capabilities to support quality improvement are developed, strengthened and sustained

28. Obstetricians, paediatricians, other doctors, midwives, nurses and managers need user-friendly quality improvement and management support to set up a quality improvement process that is sustained and effective. To aid the development of clinical and managerial capabilities in quality improvement, WHO and partners will support countries to establish national resource centres that can function as hubs for training and enable continued support for capability-building. The QoC Network will support governments in identifying and training national and district quality improvement experts to be available for facilitating and supporting local teams. Quality improvement teams will use a participatory learning approach, which is important for social change; the QoC Network will therefore support countries in adapting manuals for participatory learning and action (PLA). Support will also be provided to document meetings using standard templates for schedules, alongside other materials.

Key deliverables for this output:

1. A national resource centre, with tools to improve capabilities of health-care providers and managers is established and functioning;
2. National and district pools of experts in quality improvement (including PLA) are identified and trained;
3. National manuals for quality improvement and PLA for national, district and facility levels, and community groups and committees have been developed and are in use; and
4. Monthly meetings for participatory learning on quality improvement at district, facility and community levels have been scheduled and take place.

Output 4: Quality improvement interventions for maternal and newborn health are implemented

29. The first step for countries will be to identify learning sites where the national package of interventions will be implemented. This will require a baseline assessment to be made, and the national change package to be contextualized to the district context. The QoC Network will provide resources and technical support to adapt and implement the package at the selected sites. To assess progress and to identify effective and scalable quality improvement interventions, learning sites will be reviewed and assessed regularly. This will lead to a refined change package that can be expanded beyond the selected demonstration sites.

Key deliverables for this output:

1. Learning sites have been identified and established to implement a national package of improvement interventions for quality of care in maternal and newborn health services;
2. A change package has been adapted to the district context;
3. Resources and technical support to implement the change package in the districts has been provided;
4. Success of learning sites is reviewed and assessed regularly;
5. A refined package of effective and scalable quality improvement interventions is identified from learning sites; and
6. The implementation of a refined package of interventions has been expanded into new districts and health facilities.

Strategic objective 3: Learning

Facilitate learning, share knowledge and generate evidence on quality of care

Output 1: Data systems are developed or strengthened to integrate and use quality of care data for improved care

30. Many countries lack the data they need to improve care. Data reflect the performance of the system and are essential for informing leaders, planners, managers and healthcare providers about resources, performance, process and impact. WHO and partners will define a core set of maternal and newborn health quality indicators to be adapted by countries. The QoC Network will provide support to countries in their development and implementation of a systematic process for including quality of care indicators in national health information systems. It will be important not to develop parallel data systems but to strengthen existing systems for the integration of quality of care monitoring. The QoC Network will have a key role in building capabilities for data collection, synthesis and use, particularly for decision-making, prioritization and planning.

Key deliverables under this output:

1. A national core set of quality of care indicators for maternal and newborn health have been agreed and validated, and is aligned with the core global indicators;
2. A process to add a core set of maternal and newborn quality of care indicators into the national health information system has been established and is supported;
3. Data collection, synthesis and reporting are standardized, and data quality is monitored and assessed;
4. Capabilities in data collection, synthesis and use at health facility, district and national levels have been strengthened;
5. A system for collection and reporting of case histories, stories from the field, and testimonials has been developed and is in use; and

6. Key data are shared with health-facility staff, district health teams and community groups to inform user decision-making, prioritization and planning.

Output 2: Mechanisms to facilitate learning and to share knowledge through a learning network are developed and strengthened

31. Individual countries and the global community have much experience of what does and does not work, but each country will need to adapt good ideas to its local context. A learning network will allow the transfer of information and knowledge freely between and within all countries interested in improving maternal and newborn care. It will act as an information hub that both transfers and receives knowledge to and from national planners, district and facility managers and health-care workers – as well as to and from global partners. The design of the network will incorporate both virtual and face-to-face components that will:

- build excitement and motivation by sharing progress and challenges within and between countries
- provide a repository of technical knowledge, implementation ideas and tools
- offer a growing inventory of tested ideas to help communities engaged in similar activities
- establish communities of practice and learning collaboratives at global, national and district levels
- make process and outcome data transparent, comparable, available and easily accessible.

32. To facilitate learning, WHO will work with countries to co-develop national learning networks, anchored in a website on global quality of care in maternal and newborn health that will function as a resource for quality improvement. The QoC Network will also support the establishment of national quality of care resource management centres in managing online networks and supporting communities of practice and learning collaboratives, including facilitating link ups between them.

Key deliverables under this output:

1. National and international resources on quality of care are accessible through a dedicated QoC website;
2. Virtual and face-to-face learning networks and communities of practice have been established and are supported at the global, national and district levels;
3. Learning collaboratives between health facilities and districts have been established and are supported; and
4. A government focal point and national institution has been established to coordinate and sustain a national learning network.

Output 3: Data and practice are analysed and synthesized for an evidence base on quality improvement

33. Most countries collect a huge amount of data that are not analysed, or are analysed but not presented in a policy-friendly and useful format to guide reviews and action. The QoC Network will support countries to improve their capacity to regularly

collect accurate data and to synthesize and disseminate data through workshops, online learning and direct technical support. Through the regular use of data, best practices and variations will be identified and shared within and between countries.

Key deliverables under this output:

1. Data are analysed and synthesized regularly to identify successful interventions; and
2. Best practices and variations are identified and disseminated within and between countries.

Strategic objective 4: Accountability

Develop, strengthen and sustain institutions and mechanisms for accountability for quality of care

Output 1: National framework and mechanisms for quality of care accountability are established and functioning

34. Accountability of and to governments, district authorities, facilities, health leaders (including health care professional associations) and communities is often hampered by a lack of data, weak information systems, and lack of independent review mechanisms. Countries need clear guidance on how to achieve good accountability for quality of care in maternal and newborn health. WHO and partners will assist countries to develop quality indicator dashboards with analytics appropriate to facility, district and national levels. Countries will be encouraged to use these regularly to track performance, publish results and create internal accountability in the health system. The regular progress review against targets in the operational plan will be made public and discussed in national forums, including at multi-stakeholder forums. To complement regular reporting, there will be periodic independent assessments of progress to validate routinely collected results. It is expected that this information will be used by and inform the accountability mechanisms managed by local communities – to generate community-based case studies, tools and best practices. This will also enable community engagement in evidence-based budget advocacy and accountability to be scaled up.

Key deliverables under this output:

1. Quality indicator dashboards have been developed, with appropriate analytics to track progress at facility, district and national levels, and they are regularly updated and published;
2. Inputs and outputs in the national operational plan for quality of care are tracked and regularly reported, and reports are disseminated to stakeholders and discussed in national and sub-national forums;
3. Regular multi-stakeholder dialogue takes place to monitor progress;
4. Resources have been committed and action is taken to resolve issues; and
5. Periodic independent assessments of progress are in place to validate routinely reported results.

Output 2: Progress of the QoC Network on maternal and newborn health is regularly monitored

35. The QoC Network will regularly monitor its own progress in all four strategic areas, as well against overall outcomes. It will publish progress in annual reports, and key findings will guide the review and revision of the QoC Network's work plan. Learning will be made available in the public domain and discussed at regional and global forums, particularly for policy dialogue.

Key deliverables under this output:

1. An annual progress report on the QoC Network is published;
2. The QoC Network plan is reviewed, revised and shared;
3. There is an annual review and planning meeting of the QoC Network; and
4. Implementation learning at global and national levels is summarized and made available in the public domain (peer-reviewed publications included).

Output 3: Impact of the global initiative on quality of care for maternal and newborn health is evaluated

36. This initiative has defined ambitious outcomes intentionally: we believe that we can accelerate cuts in death rates for mothers and newborns, and, specifically, halve deaths in targeted facilities over a five-year period. We believe an ambitious target with a foreseeable timeframe will galvanize attention, improve the collection of baseline data, accelerate action and attract investment resources.

37. Many global and country initiatives do not have a clear evaluation plan. This initiative will be accompanied by an internal and external evaluation plan. The internal evaluation will be linked closely to the knowledge and learning that is generated in the country learning platforms. Through an external evaluation (in a limited number of countries and districts), we shall also measure in detail how the work has reduced morbidity, improved the experience of care, and triggered valuable spin-off benefits for other areas of care. A range of methods and designs will be used to measure impact and to collect quantitative and qualitative process information and economic data. The evaluation plan will be open and transparent. The results of both the internal and external evaluations will inform continuous improvements to the implementation guidance and learning platform.

38. The QoC Network will be a broad-based partnership of committed governments, funding and implementation partners.

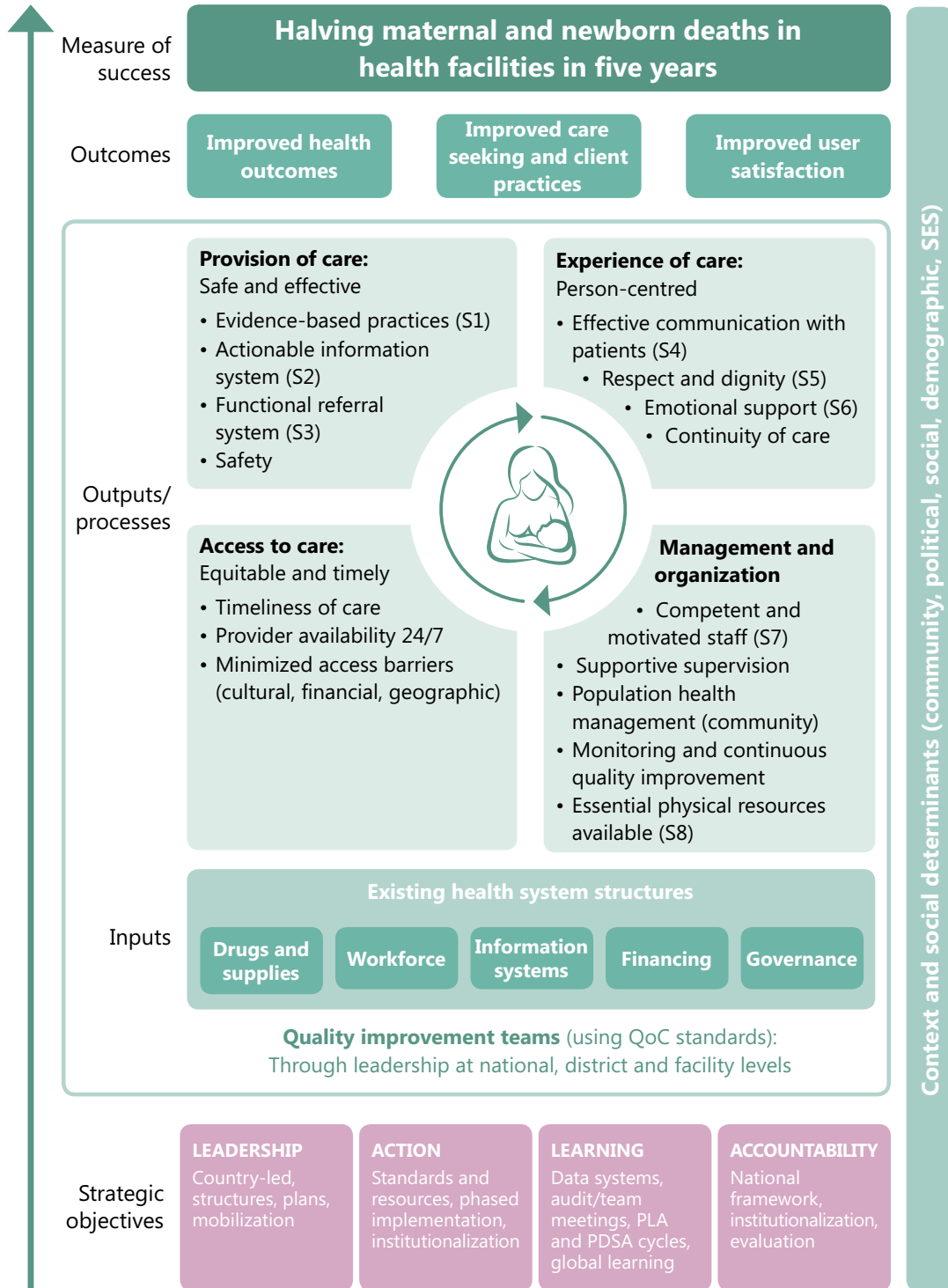
Key deliverables under this output:

1. Country-specific evaluation designs have been developed and agreed;
2. Pre-intervention qualitative and quantitative data collection has been established and is implemented;
3. An interim impact analysis has been performed and is used to inform programme implementation; and
4. A final impact analysis has been performed and disseminated.

MONITORING AND EVALUATION FRAMEWORK

39. Using the existing monitoring and reporting systems, all participating countries will attempt to capture a small, standardized core set of indicators at the national and subnational level to monitor progress towards the goals and targets of the QoC Network.
40. Building on each country's monitoring system, countries will monitor and report indicators from each of the four central elements in the logic model shown in Figure 3. These are: 1) provision of care, 2) experience of care, 3) management and organization, and 4) access to care.
41. With the exception of the core measures, the indicators, measurement methods and data sources of the QoC Network will vary according to each country's monitoring framework and the indicators prioritized within each monitoring component. Some measures, such as indicators of QoC Network implementation milestones, will require interviews with stakeholders and the review of relevant documents. Other indicators, such as quality of care measures, will need to be extracted from routine data sources such as, depending on the specific indicator, the national health management information system (HMIS), facilities' monthly reporting forms, or facilities' registers and/or patient records. Periodic client interviews, community focus groups, and/or exit questionnaires will likely be needed to assess women's and families' experiences of care.
42. As part of each country's monitoring framework, stakeholders will need to define priority quality measures for routine tracking at national, regional, district and facility level. While some quality measures will be tracked and analysed routinely, other measures will be monitored by a quality improvement team for a finite period while the team works to improve a specific process of care (improved management of newborn asphyxia, for example). Not all such measures will need to be incorporated into routine national or local information systems.
43. The QoC Network will help to support countries to build information systems, and capabilities of health workers for monitoring quality of care through several mechanisms, including a user-friendly web-based platform of key resources such as tools and methods for data collection. While goals are often guided by the SMART criteria – Specific, Measurable, Ambitious, Relevant and Time-bound – it is important to consider the existing availability, sources, collection and analytical methodology for data as well as the quality. While reviewing needs and monitoring frameworks, countries can leverage extensive lists of standardized indicators, and data collection methods, tools and methodologies. Leveraging these validated tools and methods can save time and resources.
44. The QoC Network will act as a repository for tools, methods, and lists of standardized indicators for countries to review. With a few topics currently receiving relatively limited guidance – such as experiential quality and patient satisfaction – the QoC Network will be able to update countries on new tools or methods being developed. More importantly, countries are encouraged to identify and communicate information gaps, to help push researchers to develop methods of common interest.

Figure 3: Monitoring logic model: unpacking the links between the strategic objectives and the outcomes of the QoC Network



THE QoC NETWORK AND ITS WORKING MECHANISMS

45. The QoC Network will be a broad-based partnership of committed governments, implementation partners and funding agencies. In the first phase, nine countries will be included in the network so that partnerships can form across these countries and learning can then be taken up rapidly by further countries. The QoC Network supports the objectives of the Global Strategy for Women's, Children's and Adolescents' Health, and contributes to its implementation. The QoC Network will have a light-touch governance structure to facilitate and coordinate its work, to which WHO will provide the management support.
46. The leaders of the QoC Network are the countries participating and they will exercise their leadership in a 'hub and spokes' model through routine conference calls and at least one face-to-face meeting at the highest level (health service director-general or health minister), organized around periodic events such as the World Health Assembly. Each country will identify and communicate a focal person for implementation, coordination and monitoring, and identify alternatives to ensure flawless communication about the agenda and decision-making of the QoC Network.
47. The agenda of the QoC Network will further be developed through task-orientated working groups:
- **Implementation methods and knowledge management group** – this will provide guidance and tools to support the implementation of improvements in quality of care at the country level. Also, it will assist with establishment of the knowledge network within and across countries, support capability development of learning hubs in countries, regions and sub-regions. The group will work closely with the working group on monitoring.
 - **Monitoring group** – this will support quality of care monitoring in countries, and coordinate with other monitoring platforms and working groups as relevant.
 - **Advocacy group** – this will catalyse stakeholders in quality, equity and dignity (QED) to take part in country implementation, and will promote the QoC Network as an implementing platform of the wider QED campaign, which also has a dedicated advocacy working group coordinated by the Partnership for Maternal, Newborn & Child Health.ⁱⁱ The activities of the QoC Network's advocacy working group will be coordinated and supported by the QED working group.ⁱⁱⁱ
48. Based on needs, other priority issues such as evaluation and community involvement will be addressed through relevant groups as the agenda evolves. All working groups will have work plans, which will be used to execute joint tasks and to monitor progress.
49. First-phase countries committed to join the QoC Network are **Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Tanzania** and **Uganda**. These

ⁱⁱ More information about the partnership is available at <http://www.who.int/pmnch/about>.

ⁱⁱⁱ This QED working group drives the campaign for UHC and equitable access to essential interventions for women's, children's and adolescents' health, including stillbirth prevention. QED is the focus of broad-based partnering efforts to implement the Every Woman Every Child's *Global strategy for women's, children's and adolescents' health* in support of the SDGs.

countries are engaged on the basis of being well-positioned to make rapid progress, as evidenced by a high degree of political will and commitment to support and resource maternal and newborn health services from their governments and, from funding and technical partners, strong, funded commitment and support. More countries have expressed interest to join the QoC Network. It is expected that as the learnings from the implementation of the QoC Network Strategic Objectives increases and we learn more about quality improvement, the number of countries that would be supported through the QoC Network will increase too.

50. Different members of the QoC Network (both the countries and the partners) will undertake a breadth of activities to support each of the strategic objectives. At a high level, the roles and responsibilities of the QoC Network members are as follows:
- **Countries** – participating governments are committed to improving quality of care and will: adopt the strategic objectives and proposed working mechanisms of the QoC Network; provide national leadership and governance structures to facilitate quality improvement; and share information on successes and challenges – data, case histories, field reports and testimonials – through the national and global learning network.
 - **Partners** – at the country level, partners will support the QoC Network’s strategic objectives; harmonize their investment with the national operational plan; work in a coordinated fashion to build national capabilities for strengthening national and district quality improvement processes; and support the sharing of information, best practices and lessons learned through the national and global learning framework and via evaluation of the QoC Network activities. It is envisaged that the H6 partnership (WHO, UNAIDS, UNFPA, UNICEF, UN Women, and the World Bank) will play a very important role in catalysing and harmonizing actions, and so providing support for the implementation of better quality of care for maternal, newborn and child health.
 - **Management** – WHO, in close collaboration with UNICEF, UNFPA, countries and partners, will provide the management support to the QoC Network.
51. The work of the QoC Network will build on domestic resources and structures for quality of care. Countries will be supported in their efforts to improve quality of care, but country leadership will be key to success. The network members will each commit to aligning resources and technical assistance to achieve the common goal of the QoC Network.
52. Countries will become part of the QoC Network by, as mentioned above with regard to their roles, committing national leadership to improving quality of care, participating in the learning framework, and providing managerial, technical and financial support for quality improvement action, within the constraints of their national planning cycle and budget. Supporting partners will enter the network based on their commitment, potential to align with the strategic objectives, and ability to collaborate.
53. Finally, the theory of change and the strategic objectives of leadership, action, learning and accountability within our logical framework will guide efforts in each country.

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