World Health Organization

QUALITY OF CARE IN FRAGILE, CONFLICT-AFFECTED AND VULNERABLE SETTINGS

TAKING ACTION

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Preface

This document outlines a practical approach to taking action for quality of care in settings of fragility, conflict and vulnerability. It provides a starting point for planning and implementing action for quality health services that are effective, safe, people-centred, timely, efficient, equitable and integrated.

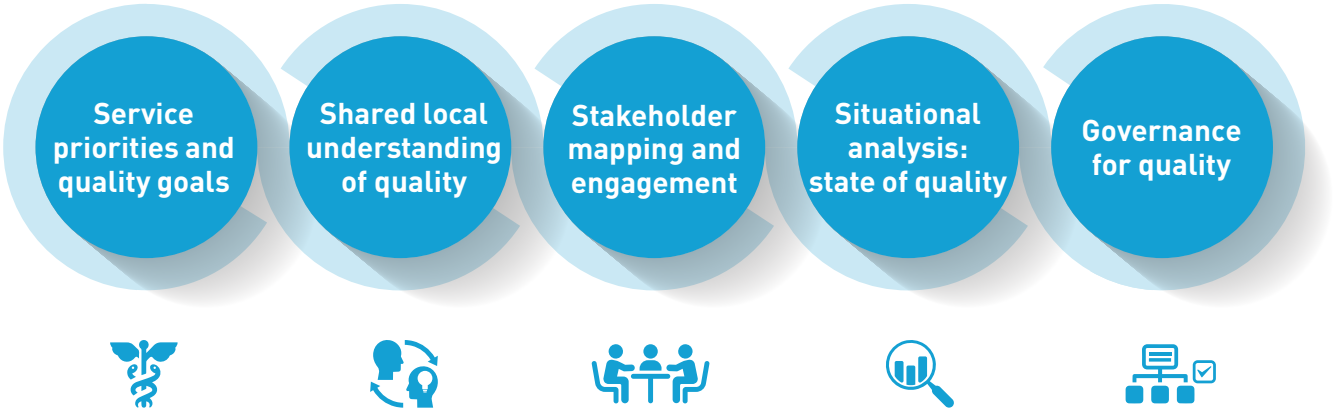
The target audience is organizations involved in planning and delivering health services in fragile, conflict-affected and vulnerable settings, including state and non-state health authorities at the national and subnational levels, humanitarian actors, health cluster coordinators and health-care providers.

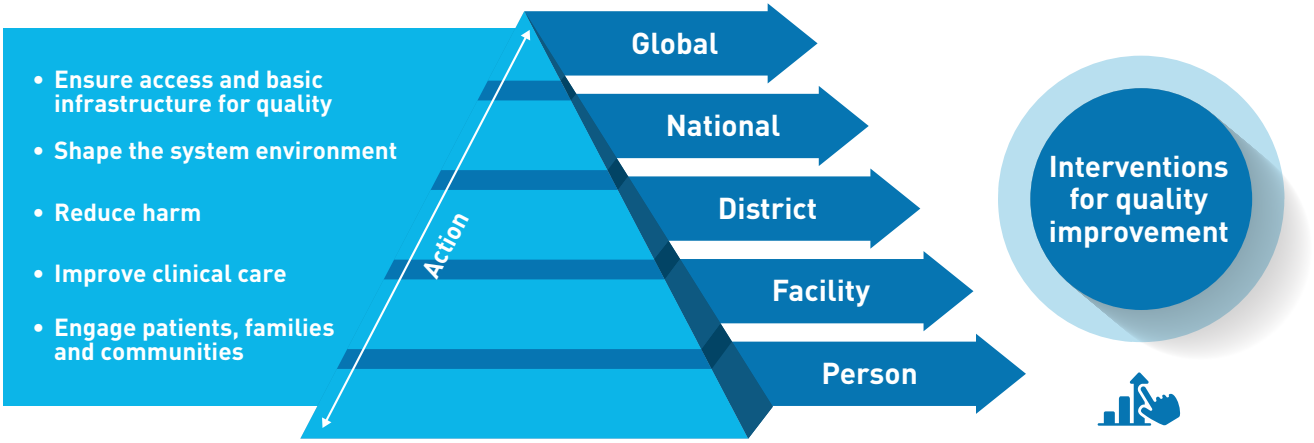
The document is a nonprescriptive process guide to support action planning, including assessment of needs, challenges and assets; establishment of structures for quality; and agreement, implementation and monitoring of a set of interventions for quality improvement.

The challenge of addressing quality is compounded because fragile, conflict-affected and vulnerable settings do not represent a homogenous set of circumstances, but rather a series of unique settings. Key to success will be adaptation of the approach to each particular context, recognising the value of local ownership and wisdom. Indeed, there is much still to learn about what works and in which contexts and how to develop and sustain a culture of quality. A focus on continued learning will be critical.

However, enough is known to make an important start on efforts to improve quality of care in fragile, conflict-affected and vulnerable settings, and that is what this document is intended to support. Lives depend on it.

Eight essential elements of strategic action planning for quality in fragile, conflict-affected and vulnerable settings





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This document was produced under the overall direction of Edward Kelley and Shams Syed from the Integrated Health Services Department, World Health Organization (WHO) headquarters, Geneva, Switzerland. It is the product of foundational technical collaboration between WHO headquarters, the WHO Regional Office for the Eastern Mediterranean and the University of North Carolina, United States of America, aimed at addressing quality in fragile, conflict-affected and vulnerable settings.

The principal writing team consisted of Sheila Leatherman, Matthew Neilson and Shams Syed. The content draws heavily on the WHO *Handbook for national quality policy and strategy* and other relevant WHO technical content related to the emerging work on quality health services.

Substantial content for this document has been adapted, with permission, from a number of published and unpublished papers authored by Sheila Leatherman and a team including Maggie Holly, Dilshad Jaff, Grace Jaworski, Charlotte Lane, Sheila Patel, Jen Stutsman, and Linda Tawfik, and assisted by colleagues at the Gillings School of Global Public Health at the University of North Carolina. The work of the University of North Carolina on quality in extreme adversity has provided the academic foundation for this document.

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A number of people have provided ongoing strategic guidance in the development of WHO work on quality in fragile, conflict-affected and vulnerable settings, including Andre Griekspoor and Dirk Horemans from WHO headquarters, and Linda Doull and Eba Pasha from the Global Health Cluster. Their technical input into the refinement of early versions of the document is noteworthy.

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Executive summary

The Sustainable Development Goals urge all countries to achieve universal health coverage, including financial risk protection and access to quality essential health services. In fragile, conflict-affected and vulnerable settings, delivery of quality health services faces significant challenges, including disruption of routine health service organization and delivery systems, increased health needs, complex and unpredictable resourcing issues, and vulnerability to multiple public health crises. Despite the difficulty of addressing quality in such settings, the need is acute, given the significant health needs of the populations in these environments and the increasing numbers of people for whom these settings are home.

The term 'fragile, conflict-affected and vulnerable settings' describes a range of situations, including humanitarian crises, protracted emergencies and armed conflicts. Poor-quality care accounts for an estimated 15% of all deaths in low- and middle-income countries; this is likely to be worse in fragile, conflict-affected and vulnerable settings. Estimates indicate 60% of preventable maternal deaths, 53% of deaths in children aged under five years, and 45% of neonatal deaths take place in fragile settings where political conflict, displacement or natural disasters prevail. Action to promote high-quality care is arguably even more important in these settings than in more stable settings, given the significant health needs of the populations involved.

This document is a starting point for multi-actor efforts to address quality of care in fragile, conflict-affected and vulnerable settings. It presents contextual information related to quality and outlines a practical approach to action planning and implementation in such settings. Key principles include flexibility and adaptation, pragmatism, urgency of responsiveness, and building on existing foundations. The document builds on the technical foundation from the World Health Organization National Quality Policy and Strategy initiative and draws on an emerging academic and experiential knowledge base.

There are several options for organizing action on quality in fragile, conflict-affected and vulnerable settings, ranging from discrete quality initiatives of individual providers, through to coordinated multistakeholder action. While the scale and scope may vary, this document proposes a common set of considerations to support development of quality action plans. These are presented under eight nonsequential, interrelated action elements:

- *Service priorities and quality goals:* This reflects the need to align with existing health sector priorities to provide quality essential health services that address the public health risks and health needs of the population. Key actions include identifying service priorities and health needs, and setting a small number of quality goals aligned with service priorities and quality challenges.
- *Shared local understanding of quality:* Although developing a consensus definition of quality across the many actors in fragile, conflict-affected and vulnerable settings may not be possible, action on quality will benefit from a shared understanding of high-priority health-care quality issues. Key actions include engaging stakeholders in exploring how quality is meaningfully understood in the local context, and working towards shared language and understanding to support quality action planning.
- *Stakeholder mapping and engagement:* This focuses on continued interaction and collaboration between stakeholders, including efforts to advance a commitment to, and capacity for, improved quality. Key actions include mapping current and potential stakeholder roles, engaging with existing coordination mechanisms, and actively engaging stakeholders in planning and implementing action on quality.

- *Situational analysis* – state of quality: This assessment is an effort to establish a baseline understanding of the quality of health services, including identification of the context-specific needs for better-quality services and challenges to delivering quality care in fragile, conflict-affected and vulnerable settings so that interventions can best be targeted. Key actions include collecting data (from desk review, facility observations and primary data collection) and engaging stakeholders to validate and interpret the findings.
- *Governance for quality:* Arrangements for governance and accountability in fragile, conflict-affected and vulnerable settings are essential for assurance of quality, but they may be suboptimal due to various challenges, including the presence of multiple providers and inconsistency of state oversight. There is a need to ensure effective and collaborative governance to address quality. Key actions include mapping the current governance landscape, and clarifying roles and responsibilities for improving and monitoring quality of health services.
- *Interventions for quality improvement:* The success of any action plan for quality will rely on effective implementation of a pragmatic set of quality interventions. In fragile, conflict-affected and vulnerable settings, interventions can be organized around five areas: ensure access and basic infrastructure; shape the system environment; reduce harm; improve clinical care; and engage patients, families and communities. Key actions include mapping current quality-related activities, selecting a pragmatic set of quality interventions, and developing an operational plan to support implementation.
- *Health information systems and quality assessment:* Health information systems provide data required to drive improvement across the system, but information systems may be disrupted or limited in fragile, conflict-affected and vulnerable settings. Key actions include reviewing current health information system assets and challenges, performing ad hoc assessment of quality health services where necessary, and incorporating critical health information system-strengthening activities within the quality action plan.
- *Quality measurement:* Improvement in quality in fragile, conflict-affected and vulnerable settings should be measured and monitored using a pragmatic set of indicators taking account of the many quality priorities and challenges and being careful not to add undue measurement burden. Key actions include cataloguing and assessing existing quality indicators, reviewing illustrative indicator lists, and selecting a practical, contextualized indicator set to inform improvement efforts.

1. Introduction and background

Quality of care is central to improving population health outcomes and critical to achieving universal health coverage. The success and value of universal health coverage depend on providing quality services to all people everywhere, including in fragile, conflict-affected and vulnerable settings. The challenges in such settings present significant risks to service access and quality that need to be addressed. This document outlines a practical approach to action planning for quality of care in fragile, conflict-affected and vulnerable settings.

Three seminal global publications highlight the importance of quality health services. The World Health Organization (WHO), the World Bank and the Organisation for Economic Co-operation and Development (OECD) *(1)*, the National Academies of Sciences in the United States of America *(2)*, and the Lancet Global Health Commission *(3)* all outlined the centrality of quality to universal health coverage and the Sustainable Development Goals. The number of deaths each year in low- and middle-income countries due to inadequate quality of health care ranges between 4.9–5.2 million *(4)* and 5.7–8.4 million *(2)*, which accounts for up to 15% of overall deaths in these countries *(2)*. Lack of adherence to evidence-based clinical guidelines results in people receiving less than half of the recommended care, even for common needs such as children's health, family planning, antenatal care and childbirth *(2)*. The National Academies of Sciences highlight that quality of health care is likely to be worse in settings of 'extreme adversity', noting, for example, that nearly 23% of quality-related neonatal mortality occurs in fragile states, although such states account for only 8.5% of the population of low- and middle-income countries *(2)*. As summarized by the WHO Director-General, "without quality, universal health coverage remains an empty promise" *(4)*.

Since the publication of these reports, WHO has put greater emphasis on supporting countries to set direction for improving quality in health services and has increased attention to essential health services in fragile, conflict-affected and vulnerable settings through its 13th General Programme of Work, which provides strategic direction until 2023. While action on quality in fragile, conflict-affected and vulnerable settings must address multiple challenges, it also provides an opportunity that is fundamental to improving health systems.

1.1 Purpose of this document

This document is a starting point for multi-actor efforts to address quality of care in fragile, conflict-affected and vulnerable settings. It builds on the technical foundation from the WHO National Quality Policy and Strategy initiative, including *Handbook* for *national quality policy and strategy (5))* and *National quality policy and strategy tools and resources compendium (6)*, and an emerging academic and experiential knowledge base *(7)*. The approach outlined here builds on a long history of relevant humanitarian law and principles (see Box 1). The document outlines key considerations related to quality in fragile, conflict-affected and vulnerable settings; describes a strategic approach to action planning in these settings; and presents a menu of illustrative interventions. The content straddles the strategic and operational in recognition of the practical, context-specific and urgent needs for quality of care in fragile, conflict-affected and vulnerable settings. It is supplemented by a tools compendium for quality in fragile, conflict-affected and vulnerable settings *(8)* that presents resources to support implementation of a pragmatic set of quality interventions.

Box 1.

Guiding principles and human rights in fragile, conflict-affected and vulnerable settings

In any situation it is the responsibility of the state to provide protection and care to its population. Key treaties, which countries may have signed or ratified, guide government, national and international actors as well as non-state armed groups (i.e. those party to a conflict) on how this should be done.

International human rights law is a system of norms designed to protect the human rights of all people, whatever their nationality, place of residence, sex, ethnic origin, colour, religion or any other status. These are international (global) treaties, but regional treaties such as that by the African Union *(9)* may also be formed. The right to health care is specified in the International Covenant on Economic, Social and Cultural Rights *(10).*

International humanitarian law is composed of treaties designed to limit the effects of armed conflict on a population and applies to both international and non-international armed conflict. It aims to respect and protect people who are not, or are no longer, taking part in hostilities. Health care is afforded special attention as attacks, threats or violent obstruction of the work of health-care workers, facilities and medical transport are a violation, interfering with obligations to provide care to wounded and sick people. The right to health care is specified in the four Geneva Conventions, and the First and Second Additional Protocols *(11)*.

International refugee law comprises treaties that protect and assist people who have become refugees, are no longer protected by their own countries, are outside their country of origin, or are at risk of or are survivors of persecution or other forms of serious harm in their country of origin. Assistance includes health care and is described, for example, in the 1951 Convention and 1967 Protocol relating to the Status of Refugees *(12)*.

Where humanitarian assistance is provided in disasters or crises, multiple United Nations General Assembly resolutions exist. United Nations Resolutions 46/182 and 58/114 specify humanitarian principles – assistance must be based on humanity, impartiality, neutrality and independence *(13)*. The United Nations Inter-Agency Standing Committee, under the United Nations Emergency Relief Coordinator/Under-Secretary-General for Humanitarian Affairs, has also produced multiple guidance documents to help ensure quality humanitarian responses are provided *(14)*. Established nongovernmental organizations and humanitarian actors will therefore aim to provide care and assistance by a human rights approach and are guided by these principles. Furthermore, many agencies have made commitments to ensure their own organizations operate to high standards.

The Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations in Disaster Relief is a voluntary code that aims to ensure adherence to fundamental rules and principles concerning ethical conduct in all activities, and to maintain independence and effectiveness in disaster relief *(15)*.

Many nongovernmental organizations and actors have adopted the Core Humanitarian Standard, which places communities and people at the centre of humanitarian action. It outlines policies and practices that an organization needs to achieve to deliver quality assistance, while first being accountable to communities and people affected by a crisis *(16)*. Some nongovernmental organizations have further committed to the Core Humanitarian Standard Verification Scheme, which assesses the extent to which organizations are achieving the Core Humanitarian Standard commitments *(17)*.

In fragile, conflict-affected and vulnerable settings, governments may request international assistance, including through:

- bilateral agreements between governments;
- government preparedness mechanisms for surge capacity deployment through verified emergency medical teams;
- requesting United Nations assistance to help coordinate a large-scale response through the United Nations Inter-Agency Standing Committee Cluster system.

Understanding guiding principles and human rights in fragile, conflict-affected and vulnerable settings alongside existing approaches and commitments that various actors may follow can help leverage efforts to deliver quality health services.

1.2 Fragile, conflict-affected and vulnerable settings

Fragile, conflict-affected and vulnerable settings is a broad term describing situations of crisis induced by a variety of factors (see Box 2).[a] While there is no widely accepted global definition, fragile, conflict-affected and vulnerable settings are generally seen to include those experiencing humanitarian crises, protracted emergencies, prolonged disruption to critical public services or governance (e.g. due to political or economic challenges, conflict or natural disaster), or armed conflict. Other terms variously used to describe such environments include 'settings of extreme adversity', 'humanitarian settings' and 'acute', 'protracted' or 'complex' emergencies.

Box 2.

Spectrum of stability

There will naturally be varied opinions as to how settings are classified. Given the dynamic nature of fragility, conflict and vulnerability, there is not a binary distinction between fragile, conflict-affected and vulnerable settings, and non-fragile, non-conflict-affected and non-vulnerable settings. Rather, there is a spectrum of stability, depending on various contextual factors. At one end lie the clear-cut fragile, conflict-affected and vulnerable settings experiencing severe, complex and often protracted crises. At the other end are settings in long-term states of stability and prosperity. In between are settings that fluctuate between stability and fragility, have particular susceptibility to natural or other catastrophes, or experience varying stability across different subnational geographical areas. Some countries self-identify as fragile, conflict-affected and vulnerable while others resist such classification.

In this document we use the terms 'fragile, conflict-affected and vulnerable settings' and 'stable settings' to describe settings that generally sit on each side of this spectrum.

a In some documents, 'violence' is used in place of 'vulnerable'; the term still relates to similar settings with ongoing protracted crises.

The World Bank refers to "fragility, conflict and violence". It highlights that 2 billion people live in such settings, and by 2030 nearly 50% of poor people worldwide will be living in such situations *(18)*. The World Bank uses the term "fragile" to define countries facing particularly severe development challenges such as weak institutional capacity, poor governance or political instability. As of 2019, an estimated 131.7 million people worldwide are in need of humanitarian aid *(19)*, and 1 in every 70 people around the world is in a crisis situation. The mean duration of crises where there is a humanitarian response plan is nine years *(20)*. For the purposes of delivering and monitoring critical country support, WHO maintains a dynamic list of fragile, conflict-affected and vulnerable countries based on a number of criteria, including the grade of emergency and the Inter-Agency Standing Committee Early Warning, Early Action and Readiness system *(21)*. This document uses a broader, nonprescriptive definition, recognizing that the approach outlined may be suitable in a range of settings experiencing some degree of fragility.

Irrespective of the terminology used, the current global situation points to a large proportion of the global burden of disease being found in countries including such fragile, conflict-affected and vulnerable settings. Estimates indicate that 60% of preventable maternal deaths, 53% of deaths in children aged under 5 years, and 45% of neonatal deaths take place in fragile settings where political conflict, displacement and natural disasters prevail *(22)*. Clearly, attention needs to be given to the availability and quality of health services in these settings.

Due to the diversity of infectious disease outbreaks, this document does not explicitly include settings experiencing such conditions. It is clear, however, that infectious disease outbreaks can place strain on even the best-resourced health systems and can exacerbate existing situations of fragility, conflict and vulnerability. As such, the actions proposed here are not intended as a guide to improving quality in infectious disease outbreaks but are pertinent in fragile, conflict-affected and vulnerable settings affected by such public health emergencies.

There is a multitude of different concepts and definitions related to fragile, conflict-affected and vulnerable settings experiencing health emergencies, crises, conflict and other situations of adversity. While clarity around terminology is important, action on improving quality in such settings should not be hindered by extensive discussion on which definitions to use. Several common factors are normally present in each of these settings that are likely to have an impact on the delivery of quality care. In broad terms, this generally includes the disruption of routine health service organization and delivery systems, increased health needs, complex resourcing landscapes, and vulnerability to further public health crises. For the purposes of this document, what is important is that the actions outlined here provide a starting point to enhance quality of care in the full range of settings experiencing fragility, conflict or vulnerability.

1.3 Service delivery in fragile, conflict-affected and vulnerable settings

Health service delivery looks quite different in health emergencies and fragile, conflict-affected and vulnerable settings compared with stable settings. Health emergencies and fragile, conflict-affected and vulnerable settings often have multiple organizations involved in providing health services, resulting in a far more complex service delivery landscape than seen in stable settings. Provider organizations might include state health services, local private and faith-based providers, national and international military organizations, humanitarian nongovernmental organizations (often working in support of existing providers), national rapid response teams, and international emergency medical teams. There may be a mix of multiple providers, often changing as the crisis progresses through different phases of response and recovery. Arrangements for effective coordination are of variable success, often with insufficient oversight by national and subnational health authorities. While well-prepared, well-resourced health systems may be able to respond to acute health emergencies through routine service delivery mechanisms, this is often not possible in very low-resourced and protracted emergency settings. Regulatory capacity is often eroded in such settings. Box 3 outlines some health service delivery platforms seen in fragile, conflict-affected and vulnerable settings.

Box 3.

Delivery platforms in fragile, conflict-affected and vulnerable settings

Existing public and private providers may include:

- community-based health worker teams, including volunteers (e.g. through integrated community case management);
- community facilities and primary care clinics;
- hospitals;
- private practices;
- traditional practitioners.

Emergency and humanitarian mechanisms may include:

- emergency medical teams;
- mobile clinics;
- military treatment centres;
- newly established permanent or temporary medical installations, including hospitals and primary care centres;
- community-based programming;
- special purpose facilities and services;
- campaigns (e.g. vaccination);
- services and screening at points of entry.

Many factors determine the feasibility of service delivery models in these settings, including:

- functioning national and subnational health authorities with sufficient capacity;
- availability of financial, technical and human resources;
- geographical accessibility and displacement;
- adequacy of infrastructure and supply chains;
- patterns of disease burden and public health risk;
- public acceptability of services;
- presence of conflict, security and perceived safety of access;
- presence, capacity and security of humanitarian organizations;
- perceived severity and anticipated length of a crisis;
- political and economic context, including nongovernment-controlled areas and inaccessible areas.

The presence of several complex challenges complicates the delivery of quality health services in emergencies and fragile, conflict-affected and vulnerable settings. Assessing, assuring and improving quality of care requires an approach that takes account of the challenging context and service delivery mechanisms. The linkages between humanitarian and development approaches must be considered in these settings to increase the efficiency and sustainability of efforts and to improve access to quality essential services (Box 4).

Box 4.

The humanitarian–development nexus

Given the often protracted nature of humanitarian crises, the propensity for these to commonly affect settings where development actors were or already are very active, and the growing focus on addressing vulnerability in global development efforts, there is increasing overlap between the activities of the humanitarian and development sectors. In many fragile, conflict-affected and vulnerable settings, both humanitarian and development actors support the delivery of health services. Consequently, there is a pressing need for close coordination and planning across the humanitarian–development nexus. Recognizing this, key stakeholders have committed to the so-called 'new way of working' *(23)*, with the following key features:

- An agreement of collective outcome, ensuring combined efforts have a commonly agreed, measurable impact.
- A focus on identifying and maximizing comparative advantage of each actor in contributing their unique capacity and expertise to the broader humanitarian and development effort.
- The placement of efforts within a multi-year timeframe that allows cumulative action to meet context-specific and often dynamic targets, promoting sustainability and efficiency.

Efforts to address quality should be planned and implemented with these principles in mind, recognizing that activities will likely span the humanitarian–development nexus. Making use of existing coordination mechanisms, some predetermined outcomes for quality of care should be agreed, likely aligning with broader shared agendas on primary health care, universal health coverage and resilience. There needs to be clear understanding, with new quality initiatives, of the service delivery landscape, ensuring efforts add value to the work already under way. Timeframes for implementation should encompass immediate action on improvement priorities and longer-term strategic planning to ensure quality is embedded as health systems recover and build for the future.

Features common to fragile, conflict-affected and vulnerable settings are often seen in health emergencies. A critical concept in such settings is the disaster risk management cycle of prevention, preparedness, response and recovery (Fig. 1).

Figure 1. The disaster risk management cycle

This cycle outlines the various stages involved in addressing potential and actual health emergency situations and can be a useful planning tool across multiple sectors:

- 'Prevention and risk management' encompasses measures that can be taken to reduce the likelihood of health emergencies, such as vaccination, health literacy or biosecurity activities.
- 'Preparedness' relates to actions that can be taken in advance of an emergency to ready the system for effective response, such as strengthening health services to better detect infectious disease outbreaks and safely manage increased health needs.
- 'Response' incorporates the actions required to address and contain the emergency, along with efforts to prevent disruption or maintain essential health services and address increased needs.
- 'Recovery' describes the process of rebuilding systems and infrastructure capable of supporting critical public services and state-building.

The individual phases are interrelated. For example, recovery efforts should start during the response phase to support optimal service provision, and efforts for prevention and preparedness should be central in response efforts and recovery planning. Clearly, there are implications for service delivery, and hence quality care, through the whole cycle that need careful consideration.

1.4 Quality of care in fragile, conflict-affected and vulnerable settings

While the case for addressing health care quality in fragile, conflict-affected and vulnerable settings is clear, and some important foundations have been established, experiences in many settings suggest the quality agenda is often relegated to the status of 'not now', with priority being given to simply providing access to care. This approach is misguided. Access to care that is unsafe, ineffective and not trusted by the communities it serves risks significantly worsening health outcomes and increasing vulnerability to further public health emergencies, and is a missed opportunity to build back better. Additionally, it represents a poor use of limited health funding. Action to promote high-quality care is arguably even more important in fragile, conflict-affected and vulnerable settings than in more stable settings, given the significant health needs of the target populations. There is a clear need to understand how countries and humanitarian and development stakeholders can best be supported to assess, assure and improve the quality of care provided.

Over the past 25 years, several important technical resources have been developed to support different aspects of quality service delivery in fragile, conflict-affected and vulnerable settings, such as the *Sphere handbook (24)*; *Classification and minimum standards for foreign medical teams in sudden-onset disasters* ('blue book') *(25)*; the development of a large body of clinical guidelines adapted to humanitarian contexts, standards and functions for coordination; and information management standards with indicators for monitoring health status, service availability, clinical outputs and outcomes. There are also increasing examples, particularly among individual nongovernmental and provider organizations, of attempts to introduce quality improvement interventions within health service delivery programmes in the most challenging environments.

There are many constantly changing and diverse challenges that might be faced in such efforts. For example, multiple actors are often involved in delivering health services, often relying on a foreign humanitarian workforce, and services might be delivered using non-standard mechanisms such as mobile or temporary clinics. This, combined with differences in presence and role of authorities, often results in difficulties coordinating and regulating services, and in the monitoring of and accountability for quality of care. The movement of populations in such settings – for example, internally displaced people and refugees – brings challenges in planning services and meeting their needs and can impact upon the needs of and services provided to local host populations. There may also be damaged infrastructure, which can threaten the safety of health workers and limit their ability to provide care.

Fragile, conflict-affected and vulnerable settings may also be more at risk of major public health emergencies that put further demand on services, such as infectious disease outbreaks and natural disasters. Over 80% of major infectious disease epidemics occur in fragile, conflict-affected and vulnerable settings *(26)*.

There will likely be significant financial and resourcing constraints that have an impact on the quality of care within the health sector. The presence of an adequate workforce, in both numbers and necessary skills, is a commonly faced challenge. Populations living in fragile, conflict-affected and vulnerable settings are likely to experience an increased burden of ill health, reflecting the difficulty of providing even routine care in such settings, and the additional health risks posed by damaged infrastructure, physical and psychological trauma and challenging living and economic conditions.

Addressing these challenges is not simple. This difficulty is compounded by the fact that fragile, conflict-affected and vulnerable settings do not represent a homogeneous group but rather a series of unique settings with their own sociopolitical contexts, service delivery mechanisms and health needs. Services within these settings may be provided by humanitarian and development agencies, with significant donor funding. It is likely that increasing donor attention will be given to assuring the quality of services. It is incumbent upon the global health and humanitarian sectors to meet this challenge.

1.5 Defining quality

International organizations have agreed on a basic definition of quality of health care. The Institute of Medicine defined quality in 1990 as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" *(27)*. WHO adapted the definition to be "the extent to which health care services provided to individuals and patient populations improve desired health outcomes" *(28)*. While there is no single universally accepted definition of 'quality' health care, there is a commonly shared understanding of basic concepts and defining dimensions (Box 5).

Box 5.

Quality domains

Quality health care can be defined in many ways, but there is growing acknowledgement that quality health services across the world should have the following attributes:

- Effective: provides evidence-based health care services to people who need them.
- Safe: avoids harm to the people for whom the care is intended and for the people providing care.
- People-centred: provides care that responds to individual preferences, needs and values.

To realize the benefits of quality health care, health services must have the following attributes:

- Timely: reduces waiting times and sometimes harmful delays for the people who receive and the people who give care.
- Equitable: provides care that does not vary in quality on account of age, sex, gender, race, ethnicity, geographical location, religion, socioeconomic status, linguistics or political affiliation.
- Integrated: provides care that is coordinated across levels and providers and makes available the full range of health services throughout the life course.
- Efficient: maximizes the benefit of available resources and avoiding waste.

Source: adapted from *Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care*. Geneva: World Health Organization; 2018 *(5)*.

These definitions can be broadly applied to many contexts, but quality may be understood and addressed differently by key stakeholders in fragile, conflict-affected and vulnerable settings where there are constraints due to the breakdown in health systems, lack of safety and security, and a scarcity of requisite resources. There remains, however, a need for attention to the full spectrum of quality domains, with a clear or increased case for action across each domain in such settings:

- Effective care is central to achieving health outcomes across all settings, but the changing health needs often seen in fragile, conflict-affected and vulnerable settings may require different skills, resources and guidelines to those required in more stable settings, and provider capacity to meet evidence-based standards of care may be more limited.
- Fragile, conflict-affected and vulnerable settings may experience particular difficulty in ensuring the foundations for safe care, such as water, sanitation and hygiene and infection prevention and control. Risks of harm to the people receiving and providing care may be increased due to a multitude of reasons.
- The needs and preferences of communities may differ in challenging fragile, conflict-affected and vulnerable settings, and services may be delivered by new providers without existing community relationships, potentially raising issues related to trust, respect and dignity that affect service use. A sustained effort is required to understand community needs and provide people-centred services.
- It is likely that urgent and emergency care needs will be increased, particularly in areas of conflict or settings where services have been disrupted, highlighting the necessity for timely care with the right skills and supplies.
- Access difficulties for some communities may be exacerbated by logistical, geographical, social, cultural or financial barriers, the marginalization of certain populations and attacks on civilians, requiring a strong focus on promoting equity of access to health care among affected populations and between displaced and host populations.
- Multiple and new providers and a rapidly shifting local health system environment provide challenges to provision of integrated care.
- In fragile, conflict-affected and vulnerable settings, domestic resources are often scarce and health service delivery may rely upon multiple donors needing to demonstrate maximum return on their investment, further emphasizing the need for efficient services that avoid waste.

1.6 A culture of quality

A culture of quality is a recurrent challenge in stable settings. Without a focus on culture, however, even well-intentioned quality initiatives are unlikely to succeed and be sustained. This becomes a key consideration in fragile, conflict-affected and vulnerable settings given the enormous challenges that these settings face. There is no single definition of what a culture of quality entails, but in terms of health service providers it has been described as "a working environment which is open and participative, where ideas and good practices are shared, where education and research are valued and where blame is used exceptionally" *(29)*. Box 6 outlines the key features. The challenges of health service delivery in fragile, conflict-affected and vulnerable settings may make achieving a culture of quality seem unachievable. For example, processes for learning, accountability and improvement, inherent to a culture of quality, rely on data and governance systems that are likely to be disrupted. Furthermore, personnel may be working in conditions that undermine morale and limit efforts on organizational culture.

Box 6.

A culture of quality: key features

- strong leadership for quality at all levels;
- openness, transparency and accountability;
- emphasis on teamwork;
- systematic learning and feedback for improvement;
- meaningful engagement of workforce, service users and communities;
- empowerment of individuals while recognizing complex systems;
- alignment of professional and organizational values;
- fostering pride in care;
- valuing compassionate care;
- coherence of quality efforts with service organization and planning.

It is important to recognize that health services in fragile, conflict-affected and vulnerable settings may have several important assets and opportunities to build the foundations for a culture of quality. Health workers who have chosen to remain, or those actively contributing to humanitarian efforts, are likely to have motivations consistent with providing quality care. External organizations may bring experience and expertise to support a culture of quality. Different service delivery organizations operating in the context of adversity might be united by common goals focused on compassionate care that fosters a sense of shared purpose. Where systems are damaged or have limited capacity, rebuilding efforts provide an opportunity to plan strategically for institutionalizing a quality culture. While the evidence base on shaping a culture of quality is scarce, pragmatic first steps in fragile, conflict-affected and vulnerable settings need to be considered carefully.

1.7 What is needed to improve quality globally?

Challenges to quality exist around the world. Many of these challenges are similar in high-income countries, low- and middle-income countries, and fragile, conflict-affected and vulnerable settings. Common barriers attributable to human behaviour include a general lack of knowledge (e.g. providers do not know the right thing to do), lack of compliance to guidelines and standards, human error (e.g. wrong diagnoses, medication errors), failures in communication between providers or with patients, and situations where patients and families have difficulty following a treatment plan for a range of reasons (e.g. financial). Some common barriers due to system issues include governance or lack of accountability for quality of care, unstable resourcing, safety deficits, information deficits from deficient health management information systems, and lack of integrated care across levels causing poor referrals and a lack of follow-up care.

While these are common barriers seen in all contexts, fragile, conflict-affected and vulnerable settings have unique compounding factors that will often exacerbate them. At the heart of efforts to improve quality, regardless of the setting, is the need to understand and overcome these human and system factors through a multimodal approach that encompasses strategic direction and improvement activities across all health system levels.

The 2018 WHO, World Bank and OECD report *Delivering quality health services: a global imperative for universal health coverage (1)* outlines several recommendations for governments, health systems, citizens, patients and health workers as they address quality (Box 7). Most of these recommendations have clear applicability to fragile, conflict-affected and vulnerable settings, but adaptation is required for many of them, for example to account for settings that do not have a functioning national government or suitable governance structures, or areas not under government control. As such, although the recommendation for all governments to develop a national quality policy and strategy may not always be a nationally led process, the principles of the WHO approach to national quality policy and strategy remain pertinent.

Box 7.

High-level actions by key constituencies for quality in health care

All governments should:

- have a national quality policy and strategy;
- demonstrate accountability for delivering a safe high-quality service;
- ensure reforms driven by the goal of universal health coverage build quality into the foundation of care systems;
- ensure health systems have an infrastructure of information and information technology capable of measuring and reporting quality of care;
- close the gap between actual and achievable performance in quality;
- strengthen partnerships between health providers and health users that drive quality in care;
- establish and sustain a health professional workforce with the capacity and capability to meet the demands and needs of the population for high-quality care;
- purchase, fund and commission based on the principle of value;
- finance quality improvement research.

All health systems should:

- implement evidence-based interventions that demonstrate improvement;
- benchmark against similar systems delivering best performance;
- ensure all people living with chronic disease are enabled to minimize the impact on their quality of life;
- promote culture systems and practices that reduce harm;
- build resilience to enable prevention and detection of and response to health security threats through focused attention on quality;
- put in place infrastructure for learning;
- provide technical assistance and knowledge management for improvement.

All citizens and patients should:

- be empowered to actively engage in care to optimize their health status;
- play a leading role in the design of new models of care to meet the needs of the local community;
- be informed that it is their right to have access to care that meets achievable modern standards of quality;
- receive support, information and skills to manage their own long-term conditions.

All health workers should:

- participate in quality measurement and improvement with their patients;
- embrace a practice philosophy of teamwork;
- see patients as partners in the delivery of care;
- commit to providing and using data to demonstrate the effectiveness and safety of care.

Source: Adapted from *Delivering quality health services: a global imperative for universal health coverage*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development, and Word Bank; 2018 *(1)*.

1.8 Setting directions for quality of care: organizing for impact

WHO, the World Bank and OECD have called on countries to improve quality of care across the health system through a clearly articulated national direction on quality *(1)*. The development, refinement and execution of a national quality policy and strategy is a priority for countries as they look to systematically improve the performance of their health systems. A national quality policy and strategy is an organized effort by a country to promote and plan for improved quality of care. An effective strategic direction for quality can create a culture shift and support providers to deliver, and users to demand, quality care; bring together multiple quality initiatives under a systematic and organized effort to improve quality of care across the health system; secure high-level commitment to quality through stakeholder engagement and consensus-building; and clarify structures for accountability and monitoring of systemwide quality efforts.

The WHO *Handbook for national quality policy and strategy* proposes an organizing framework of eight essential elements for developing strategic direction for quality *(5)*. These interrelated elements represent the common building blocks to be considered by countries as they set national direction on quality (Fig. 2). The elements provide an important starting point for addressing quality comprehensively as a long-term endeavour.

Figure 2. Eight elements of national quality policy and strategy

Although nationally led solutions are not likely to be the starting point in fragile, conflict-affected and vulnerable settings, the eight elements can provide an important context-specific approach to action planning for quality of care in such settings.

Another key foundational document is the WHO *Quality health services: a planning guide (30)*, which builds on the national quality policy and strategy approach and outlines a series of key activities and foundational requirements for quality health services across different health system levels, emphasizing the interrelatedness of facility improvement activities, subnational support and national direction.

The approach outlined in the *Handbook for national quality policy and strategy* was co-developed with numerous countries. Some of these countries were experiencing fragility, conflict or vulnerability, so although the approach was designed to be generic and adaptable to different contexts, there has been a degree of validation in its usefulness to organize strategic action planning in fragile, conflict-affected and vulnerable settings. Further refinement is required to better reflect the variety of challenges and service delivery contexts in such settings and the need for a flexible, action-focused approach.

Using the eight elements as a validated starting point, and based on a literature review, engagement of experts and implementation experience from fragile, conflict-affected and vulnerable settings, the following interdependent elements make up a strategic approach to quality action planning and are described in more detail later in this document. These elements align with those outlined in the *Handbook for national quality policy and strategy* but have been tailored to the specificities of the fragile, conflict-affected and vulnerable context:

- *Service priorities and quality goals:* This element reflects the need to align with existing health-sector priorities, which may be national or relate to the particular setting. The emphasis is on identifying the conditions and populations requiring particular focus in order to provide quality essential health services that address the public health risks and health needs of the population.
- *Shared local understanding of quality:* While developing a consensus definition of quality across the many actors in fragile, conflict-affected and vulnerable settings may not be possible or even necessary, organizations taking action on quality (state and non-state) should try to develop a shared understanding as the basis for improvement efforts.
- *Stakeholder mapping and engagement:* This element focuses on continued interaction and collaboration between stakeholders, including efforts to advance a commitment to, and capacity for, improved quality. Quality initiatives should align with and strengthen, where necessary – coordination mechanisms at different levels of the health system.
- *Situational analysis – state of quality:* This activity gathers data to describe specific dimensions of quality, such as the accessibility, effectiveness and safety of health care being provided. Context-specific challenges to delivering quality care are identified so that appropriate interventions can be implemented. Recognizing that many improvement actions may already be taking place, current activities can be mapped for strengthening and gaps identified.
- *Governance for quality:* Arrangements for governance and accountability in fragile, conflict-affected and vulnerable settings are essential for assurance of quality but may be suboptimal due to many challenges, including the presence of multiple providers and inconsistency of state oversight. Any strategic effort to improve quality should, at a minimum, map and understand the governance landscape and, where possible, clarify and optimize systems and organizational structures. There is also a need to ensure effective and collaborative governance of any joint effort to address quality, where relevant using the health cluster system.
- *Interventions for quality improvement:* The success of any action plan for quality will rely on judicious selection and effective implementation of a pragmatic set of quality interventions. In fragile, conflict-affected and vulnerable settings, interventions can be organized around five areas: ensure access and basic infrastructure; shape the system environment; reduce harm; improve clinical care; and engage patients, families and communities. Particular attention should be paid to prioritizing interventions with maximal impact, building on existing foundations, and meeting identified priorities for quality improvement.
- *Health information systems and quality assessment:* Health information systems provide the data required to drive improvement across the system. In fragile, conflict-affected and vulnerable settings, where routine systems may not be established or have been disrupted, there is a need for focused attention on strengthening the health information system to support delivery of quality care and, where necessary, performing discrete quality assessments to inform the implementation of improvement activities.
- *Quality measurement:* Improvement in quality in fragile, conflict-affected and vulnerable settings should be measured and monitored using a pragmatic set of indicators, taking account of the many priorities and challenges in such settings. Significant caution is required to not add an undue measurement burden.

2. Development of quality action plans for fragile, conflict-affected and vulnerable settings

2.1 The need for strategic quality action plans in fragile, conflict-affected and vulnerable settings

There are multiple and complex challenges to delivering quality health services in fragile, conflict-affected and vulnerable settings. Intact health systems with reliable funding, resourcing, governance and accountability are unlikely to exist. Low-quality care may lead to substantial morbidity, mortality, human suffering and the wasting of resources.

There is increasing evidence and experience globally of what works to address quality of care. Effective, sustainable efforts require a focus on immediate improvement priorities at the point of care supported by strategic oversight and planning. There is a need for careful consideration of how this can best be achieved in different fragile, conflict-affected and vulnerable settings – there is no 'one-size-fits-all' solution. The approach for developing quality action plans in fragile, conflict-affected and vulnerable settings is based on the eight elements outlined in Section 1. The development of a quality action plan is intended to:

- provide a shared understanding of major quality-of-care challenges and priorities for action;
- enable the rapid introduction of a prioritized set of improvement interventions that complement each other and are appropriate to the setting;
- ensure coherence with existing domestic, humanitarian and development efforts considering the humanitarian–development nexus 'new way of working' (see Box 4);
- support systematic consideration of quality within evolving health systems through all phases of crisis response and recovery;
- encourage political and financial support for addressing quality of care in fragile, conflict-affected and vulnerable settings.

This document and the quality action plans it supports take a broad view of quality of care and the actions needed to improve it, noting that quality care is supported by a wide range of structures

and systems. In fragile, conflict-affected and vulnerable settings, there is unlikely to be an explicit coordinated quality strategy at the onset of the crisis; instead, activities, programmes and interventions will be undertaken by multiple actors, including governments, humanitarian and development nongovernmental organizations, military and private providers, and community and civil society-based organizations and donors. The approach described here can be adapted and refined based on the specific needs of particular crises and the organizations taking action.

Addressing quality of care can be complex and challenging even in stable settings, and even more so in fragile, conflict-affected and vulnerable settings. It is important that those taking action on quality have realistic expectations of success. Success may be incremental and modest and must be viewed in the context of the challenges faced and resources available. Even modest successes in such environments may provide real and meaningful benefits for the people receiving better care and important foundations to support further, larger-scale improvement.

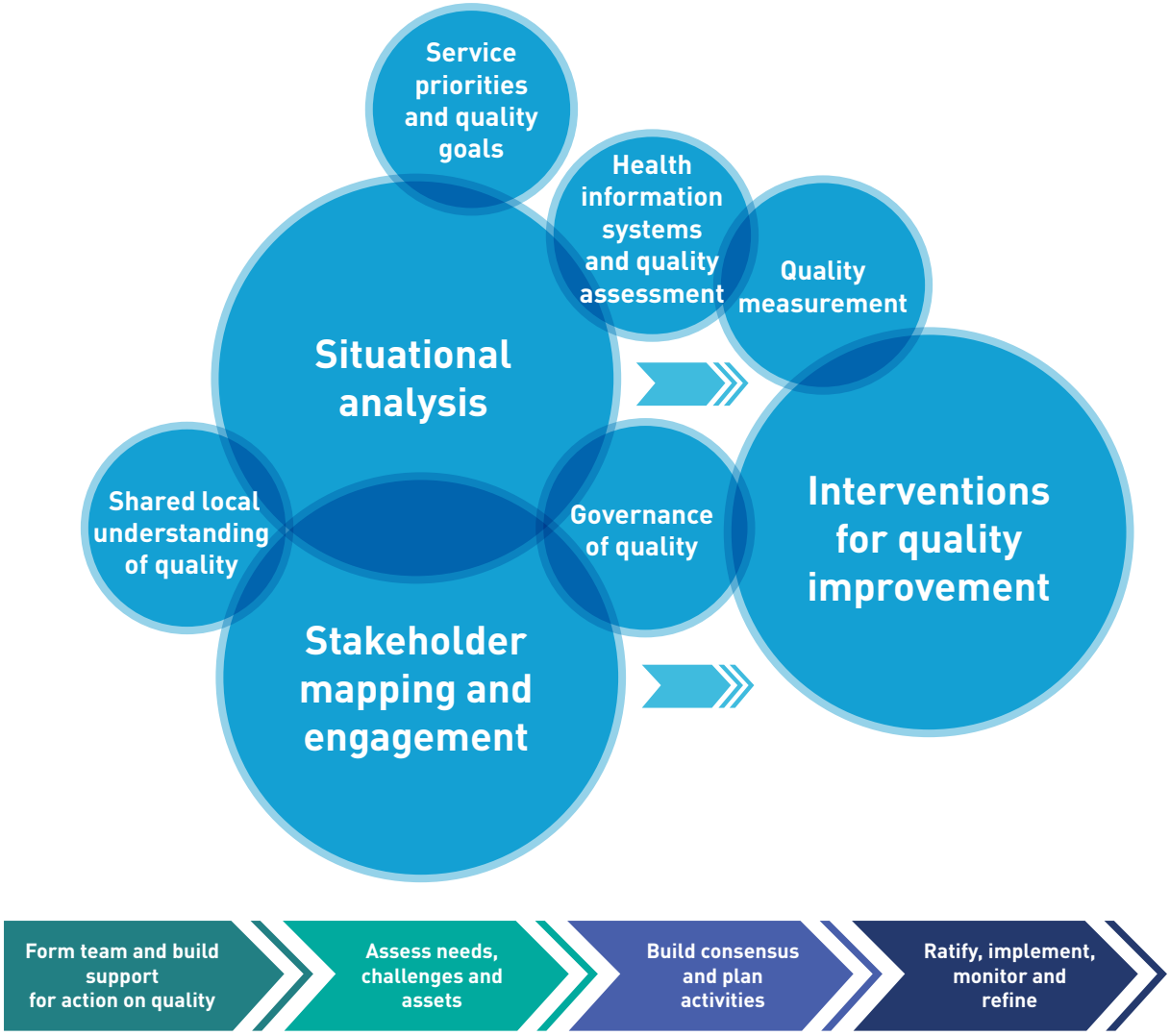
2.2 Making the case for quality

In many fragile, conflict-affected and vulnerable settings, quality of care may not be an explicit priority of national authorities or other key actors. For efforts to be sustainable and effective, buy-in from key stakeholders in the planning, resourcing and delivering of health services focused on quality is crucial. This must be adequately prioritized and funded. Even in stable environments, quality is often seen as a secondary consideration to other components of health service delivery; this may be more pronounced in fragile, conflict-affected and vulnerable settings. Foundational efforts may be required to build the case for quality among key stakeholders with focused attention on multiple fronts, including data on the state of quality and its impact on mortality and morbidity; building the quality management knowledge and capacity of key stakeholders; reviewing existing service packages to identify entry points for quality improvement; and fostering support among political, humanitarian and donor organizations. Linking universal health coverage-focused efforts with quality health services in these unique settings will be central to making the case at the national and global levels.

2.3 Overview of the process

Key considerations for development are outlined below. These eight elements describe interconnected components (Fig. 3) that should be addressed during development of the action plan. The development process will look different in every setting, depending on which organization or group is developing the plan, the proposed scope and scale, the resources and expertise available, and contextual factors such as the stage and severity of the crisis. Local expertise and experience are critical in adapting the approach. Planning for action on quality may be integrated with broader health service planning processes, or it may be a standalone, discrete initiative to improve quality of care by, for example, a particular state or non-state organization.

Figure 3. **Flexible action planning process incorporating the eight essential elements**



2.3.1 Models and options

Several different options exist for the scope and content of quality action plans for fragile, conflict-affected and vulnerable settings. In many settings, the process of developing the action plan may be as important as the resultant document, as the process is an opportunity to build support and systems for action on quality. Given the diversity of fragile, conflict-affected and vulnerable settings, this document cannot describe all possible pathways for systematically addressing quality of care. Regardless of the setting, however, the same eight elements should be addressed. Options include the following:

- *Quality action plan developed by an individual nongovernmental organization or humanitarian partner for the services they provide:* This can be taken forward by any organization involved in the delivery of health care in the setting, including nongovernmental organizations, provider organizations, disease or population programmes, and funding organizations. This is likely to be the most common option, given the complexity faced in fragile, conflict-affected and vulnerable settings and the multiplicity of providers. In some settings, providers may see value in developing quality action plans specifically for the services they plan and deliver; it is still important to reach out to other stakeholders to understand the broader system environment and to support coordinated delivery of services. In some cases, the action plan is developed at the central or corporate level of an organization and then interpreted and operationalized locally. In other cases, the project or a local nongovernmental organization leads the development and operationalization of the plan. The quality plan may cover multiple service delivery units and programmes or a single site such as a hospital.

- *Multistakeholder quality action plan:* In some settings, multiple stakeholders combine efforts to address quality of care. Many interventions can be strengthened through collaborative and systemwide action. Such an approach can maximize efficiencies in implementation and has greater potential to improve health and development outcomes across the local system. In humanitarian settings there will already be a humanitarian response plan, health cluster or sector coordination mechanism, and coordinated set of interventions, and so there is a foundation for collaborative action that should be leveraged. Where applicable, existing humanitarian coordination mechanisms should consider adopting responsibility for the development and implementation of a quality action plan. While conceptually multistakeholder action plans may be preferable to separate plans for individual actors, the planning and delivery of such coordinated action is complex and may be logistically challenging. Action on quality should not be delayed while awaiting the consensus of all stakeholders. Multistakeholder action may be of particular relevance where usual governmental structures for governance and accountability are not functioning. It may also be more achievable within defined geographical areas, such as camps hosting displaced people or distinct subnational areas.
- *Nationally owned quality strategy or action plan:* In some fragile, conflict-affected and vulnerable settings, a viable national health authority with the capacity to develop and implement a quality action plan remains, although it may not have control over the planning and delivery of services in all territories. Where a functioning national authority exists, the plan may encompass immediate improvement priorities and longer-term planning for the systems needed to sustain delivery. National authorities should aim to engage a broad range of actors to direct multistakeholder action on quality across the whole health system. For such settings, the additional considerations outlined in the *Handbook for national quality policy and strategy (5)* will be of use.
- *Subnational quality action plan within national quality policy and strategy:* In countries where one or more subnational areas are experiencing fragility, conflict or vulnerability, there may be an opportunity to develop a quality action plan in these areas, complementing the broader national quality policy and strategy where this exists, although in many cases this may be unsuitable due to the prevailing political situation. While aspects of this process will need to be tailored for the needs of the setting, integrating with the national process can maximize efficiencies in delivery of interventions, bring prominence to quality issues among the stakeholders in the area, and secure linkages to longer-term national quality directions. Even where no national quality direction has been set, subnational authorities may have key roles in planning, coordination and delivery of services and can provide leadership in planning action on quality across the local health sector.

2.3.2 Developing the quality action plan

To initiate the action planning, the organization or group leading the process should identify the team that will work on developing the plan. The team should have a suitable mandate, ability to manage resources, and influence to initiate change across the services that fall under the remit of the plan. It may be helpful to draft a brief roadmap, outlining the roles and responsibilities of the different actors, with clarity on current structures. It is also helpful to agree how progress will be monitored, and to clarify procedures for the validation and ratification of the action plan by key stakeholders.

The elements described below do not represent a linear process but provide a series of considerations that should be brought together in a process that will vary between settings, depending on context and existing structures and activities. Broadly, the process will consist of an initial situational analysis exercise, which may also provide an early opportunity for stakeholder engagement, further collaboration with stakeholders to foster a shared understanding of quality and agree on a set of quality interventions, drafting of the quality action plan, and following the required process to secure leadership support and validation.

The output will be an explicit statement of a locally appropriate action plan to create the conditions for quality care to be delivered, optimize governance functions, and implement a pragmatic set of quality interventions. Given the dynamic nature of many fragile, conflict-affected and vulnerable settings, planning for action on quality will be an ongoing activity and there will be a need for regular reappraisal and refinement of the action plan throughout different phases of the prevailing crisis.

2.4 Essential elements for action planning for quality in fragile, conflict-affected and vulnerable settings

2.4.1 Service priorities and quality goals

An important early step is to identify and understand local health service priorities. It is not the role of a quality action plan to define the package of services to be delivered; rather, this element of the process is focused on understanding the local health needs and service delivery context so that interventions focused on quality can be most effective.

Many settings have an agreed health services package outlining a set of health services that address local needs and provide an entry point for integrated action on quality. The development process for this package is likely to have taken account of the particular needs and priorities of the setting, and common or universal considerations around essential service provision. There are well-elaborated processes for establishing such packages in fragile, conflict-affected and vulnerable settings *(31)*, and the development and implementation of packages may provide an opportunity to integrate key actions that address quality of care.

Where local health service delivery priorities are already well understood, aligning quality initiatives with these local priorities can promote greater efficiency of efforts and build political and financial support. For example, a large-scale infectious disease outbreak may be an important, high-profile priority that also provides an opportunity to build support for action on quality of care.

Box 8.

Guiding questions to understand local service priorities and linkages to improve quality

- What are the current health service delivery priorities in the setting?
- Are these appropriate, given the prevailing context?
- What is known about the public health risks and health needs of the population?
- Are any population groups disproportionately underserved or at risk?
- How can the work on quality best align with existing service priorities?
- What opportunities exist to influence service priorities?

Identifying service priorities requires consideration of conditions, populations and any significant gaps that require particular and urgent consideration. While there are many commonalities between different fragile, conflict-affected and vulnerable settings, service priorities vary significantly depending on the stage and type of crisis and differ across geographical areas facing different challenges. For example, acute and violent crises have increased trauma and emergency care needs, while post-crisis settings may have a need to provide more comprehensive services for mental health and rehabilitative care.

When identifying local service priorities, there may already be explicit statements to draw upon, such as those contained in national or subnational health strategies, humanitarian response plans, or the missions, contracts and strategies of existing service providers. Further considerations in identifying priorities include current and projected health needs; risks such as mental health disorders, malnutrition or infectious disease outbreaks; health needs arising from disruption to supplies and services, such as loss of access to long-term medication for chronic diseases; gaps in current service provision; existing guidance on required services in fragile, conflict-affected and vulnerable settings *(24,32)*; and the views of communities and providers. These may be examined as part of the situational analysis and stakeholder engagement to help build a picture of service priorities that can inform the emerging work to improve quality of care in the near and longer term. Box 8 provides a set of guiding questions that those developing quality action plans can use to explore local service priorities and the linkages to improve quality.

It may also be useful to consider the list of priorities for delivering health services in fragile, conflict-affected and vulnerable settings presented in Table 1. This is a dynamic list largely representative of usual service priorities. It is not exhaustive and does not include outbreaks, and it needs to be specifically adapted in every setting to be unique to the local context.

Table 1. Listing priorities for health services: clinical conditions and target populations

Medical needs and clinical conditions	Target populations
Trauma- and violence-related injuries Noncommunicable diseases ▪ Cardiovascular diseases, diabetes, cancer, chronic obstructive pulmonary disease Communicable diseases ▪ Health care-associated infections ▪ Respiratory diseases (TB, pneumonia) ▪ Malaria ▪ HIV Mental health Malnutrition Interpersonal, sexual and gender-based violence Palliative and end-of-life care	Women ▪ Reproductive, maternal Neonates and infants Children ▪ Preventive and curative Adolescents People with disabilities Older people Health-care professionals

In fragile, conflict-affected and vulnerable settings the risk of gender-based violence is acute. The health sector has an important role to play in addressing such violence and its significant health consequences. While this is not covered in detail in this document, action on gender-based violence supports delivery of quality care; further information is available from the Global Health Cluster *(32)* and WHO *(33,34)*.

When developing a quality action plan in a fragile, conflict-affected and vulnerable setting, it is helpful to set a small number of quality goals that contribute to the local health service priorities and are appropriate to the setting. Goals are usually general aspirations or targets that set the course for future activities, based on the results of the situational analysis and in agreement with key stakeholders. They should be clear and meet a particular need. They should also be timebound, with a means to assess progress and achievements. They may be broad goals relevant to service provision as a whole, or they may be targeted to certain existing service priorities. The quality action plan should contain a goal statement with three to five quality goals, feasible under the purview of the organization or group responsible for developing the plan. It may also be helpful to define regular (e.g. quarterly) milestones to help track progress of the initial implementation phase.

Key actions - Service priorities and quality goals

- Identify stated service priorities, current and potential health needs, and gaps in provision.
- Consider opportunities for the quality action plan to address service priorities.
- Identify three to five quality goals that meet service priorities and address current quality problems.

2.4.2 Shared local understanding of quality

The concept of quality may be understood differently by different stakeholders in fragile, conflict-affected and vulnerable settings. During development of the quality action plan, it will be useful to present a definition of quality that can foster a shared understanding in language relevant to the local context. The exercise of developing local understanding of quality is useful in itself to the action planning process as it can open a dialogue about the importance of quality, build understanding among key stakeholders, and show how interventions might be targeted to meet local priorities.

The process of fostering shared understanding of quality should be integrated into other aspects of the action planning process and need not be burdensome. The intention is to build sufficient shared understanding of quality early in the process as a foundation for collaborative improvement efforts. For a plan developed and implemented by a single organization, it may be appropriate to use the organization's existing quality definition. In this instance, there would still be value in engaging stakeholders at different levels of the organization, and from the population being served, so the definition is relevant and accepted. If there is a multi-actor plan, developed, for example, as part of the coordinated activities of the relevant health cluster, then a broader consultative process may help to foster a common language and grounding in key concepts. In situations where national authorities are leading the process, there is an opportunity to develop an agreed, systemwide definition that can underpin longer-term improvement efforts. The *National quality policy and strategy tools and resources compendium* provides tools and further guidance on the process of developing a local definition, and examples of local definitions produced in several countries *(6)*.

In general, the process is likely to involve the following steps:

- Engage stakeholders in discussion about the local understanding of quality.
- Share and discuss global definitions, definitions from key stakeholders, quality concepts and existing relevant commitments of key stakeholders (e.g. humanitarian principles).
- Build consensus around how quality is understood locally (e.g. in relation to local quality challenges) and essential local features.
- Where an explicit agreed definition is considered desirable, adopt/develop a draft definition and present to stakeholders for agreement.

The quality definition needs to consider the specific challenges of individual fragile, conflict-affected and vulnerable contexts. Table 2 outlines a set of questions that can be used by stakeholders to explore each of the quality domains in fragile, conflict-affected and vulnerable settings. These questions can guide discussions around local understanding of quality in the fragile, conflict-affected and vulnerable context and can be used as part of a broader stakeholder discussion.

Table 2. Framing questions to examine quality in fragile, conflict-affected and vulnerable settings

Quality domain	Framing questions to examine quality in fragile, conflict-affected and vulnerable settings
Effective	▪ What information is available on whether care for common conditions meets required standards? ▪ Are quality improvement methods regularly applied to improve the effectiveness of care? ▪ Are health workers and facilities ready to provide effective care with the changing health needs in this setting (e.g. possible increase in conflict-related injuries or infectious diseases)? ▪ Are appropriate clinical standards, guidelines and protocols in place?
Safe	▪ Do health services have protocols and resources to prevent harm? ▪ Do health services have policies and mechanisms for protection of occupational health and safety of the workforce? ▪ Do facilities have adequate provisions for water, sanitation and hygiene, and infection prevention and control? ▪ Do communities feel they can reach health-care facilities safely? ▪ Do communities trust they will be safe if they attend health services? ▪ Are health facilities and providers known to be at risk from attack?
People-centred	▪ How have the health needs of people and communities changed since the onset of fragility, conflict or vulnerability? ▪ Are data collected on the experience of care from patients' and families' perspectives? ▪ Are data collected from communities to understand their perceptions of health needs and the quality of care provided? ▪ Are communities involved in the planning and management of health services, including those provided by nongovernmental organizations and the humanitarian sector? ▪ Are health services provided in a compassionate manner sensitive to age, gender, physical ability and culture, and to people living with conditions associated with stigma?
Timely	▪ What factors are preventing people from receiving care without potentially harmful delay? ▪ Does timeliness incorporate access to the right setting and set of skills at the right time? ▪ What is the capacity for health workers to respond to peaks in demand in a timely manner? ▪ For health emergencies such as outbreaks, are systems in place to ensure a rapid response where required?
Equitable	▪ What barriers exist that prevent certain people from accessing the services they need? ▪ Are there certain population groups or geographical areas that lack access to services? ▪ Are services equally available to populations on all sides of the conflict or political divide, and to all those injured in conflict?

Quality domain	Framing questions to examine quality in fragile, conflict-affected and vulnerable settings
Integrated	▪ Are mechanisms in place to facilitate coordination among all health providers? ▪ Is provision made for care across the continuum of promotive, preventive, curative, rehabilitative and palliative services? ▪ What is needed for effective referral and transfer of patients? ▪ Are mechanisms in place to facilitate coordination between different sectors (e.g. child protection, nutrition, shelter)?
Efficient	▪ Is the provision of services driven by medical need without under- or overuse? ▪ Are mechanisms in place for funding organizations (domestic, donor) to assess value for money on their health-service investments? ▪ Do organizations delivering health care work together to maximize synergies and minimize waste?

Key actions - Shared local understanding of quality

- Identify existing national definitions and definitions used by key stakeholders.
- Explore how quality is understood in the context of local health service delivery.
- Work towards a shared understanding among key stakeholders and, where necessary, agree on a working definition for use in a quality action plan.

2.4.3 Stakeholder mapping and engagement

Coordinating action

In efforts to improve quality of care in fragile, conflict-affected and vulnerable settings, there are two broad considerations in relation to the coordination of action. First, coordination of the overall health response is needed, as a key activity in itself, to support quality of care. Second, for many discrete initiatives, to improve quality it will be important to align with, build on and optimize the coordination structures already in place. It is important to reiterate that the realities faced in these settings may be far from the optimal, coordinated approach, thus making initial stakeholder mapping and engagement even more critical.

In humanitarian settings, coordination can be understood as "the systematic use of policy instruments to deliver humanitarian assistance in a cohesive and effective manner. Such instruments include strategic planning, gathering data and managing information, mobilizing resources and ensuring accountability, orchestrating a functional division of labour, negotiating and maintaining a serviceable framework with host political authorities and providing leadership" *(36)*. Coordination is a recognized principle or mechanism for the delivery of quality services in such humanitarian settings *(24)*.

A key approach to promoting effective coordination in fragile, conflict-affected and vulnerable settings is the cluster system. This system is initiated at the request of the host government when United Nations assistance is needed to help coordinate an effective humanitarian response with multiple sectors and agencies. The rationale for such a system is that it should make the humanitarian response more predictable, timely, accountable and effective, and facilitate partnership between key agencies. Within this system there are 11 global clusters reflecting different sectors, such as water, sanitation and hygiene, shelter and protection. WHO is the lead agency for health. At the global level, the Global Health Cluster has an alliance of over 60 partners and supports health clusters activated in 30 countries, and over 600 partners are involved in the health response to crises. At the country level, the different clusters activated may not always correspond to the same 11 global groupings. This is dependent on the specific needs of the setting – for example, health and nutrition may be combined at the country level. In general, WHO leads the health cluster supporting ministries of health, which may also co-lead the response effort.

Countries may have existing health partner coordination structures that function well to coordinate the health response during times of crises. Where practical, it is preferable that these are used and built upon rather than replaced with different mechanisms. Within fragile, conflict-affected and vulnerable settings, the cluster approach is in widespread use. Although there is relatively little peer-reviewed evidence around the impact of the approach, the evidence that does exist suggests that clusters improve coordination and quality of services *(37)*. The *Health cluster guide* is a key publication outlining how the cluster lead agency, coordinator and partners can work together to improve health outcomes *(38)*.

Many stakeholders working on quality of care in fragile, conflict-affected and vulnerable settings will be very familiar with the prevailing health and humanitarian coordination mechanisms. It is important that any organization implementing efforts to improve quality of care in fragile, conflict-affected and vulnerable settings engages early and leverages existing coordination mechanisms.

Some stakeholders may be able to assess and improve coordination mechanisms as part of the quality action plan, if it is felt that aspects could be optimized to improve delivery of care. For example, reviewing coordination mechanisms through a quality lens may identify issues around community involvement or quality oversight mechanisms that have been overlooked.

Clarifying stakeholder roles

Fragile, conflict-affected and vulnerable settings are almost always characterized by a multiplicity and diversity of external and domestic organizations providing services to vulnerable populations. It is important to clarify roles and responsibilities, ensure critical population needs are being reliably met, reduce duplication of efforts, and realize the broader benefits of collective responsibility and action. The United Nations cluster approach has a focus on understanding the 'four Ws' of who does what, where and when.

As part of the stakeholder engagement process, teams developing quality action plans should consider a clarification of roles and responsibilities, as illustrated in Table 3. Coordination and allocation of roles and responsibilities vary between settings, depending on the stakeholder and service delivery landscape and the respective capacities and resources of different actors. It is important to build on any existing quality-related work being led by stakeholders across the system, drawing implementation experience into development of the proposed interventions and broader action plan. Where multiple partners are involved in quality action planning, varied opinions on how to proceed are a natural part of the process and should be used as an opportunity to discuss local priorities, develop shared goals, and define where different actors can add value.

It may be helpful to analyse the scope and influence of various stakeholders. Various tools are available to support such efforts, as outlined in *National quality policy and strategy tools and resources compendium (6)*.

Action on quality in fragile, conflict-affected and vulnerable settings will vary across a spectrum of ambition, resource and scale. Often activities are driven by one organization and concentrated on certain facilities, geographical areas, populations or medical needs. In other cases, there may be the scope and appetite for coordinated multistakeholder action or leadership from national authorities. Action in such settings should not wait for consensus or widespread buy-in but should begin at whatever scale is achievable. Even when starting small, however, it is important that there is engagement with coordination mechanisms to avoid fragmentation of different efforts.

Regardless of the scope of the quality action plan, an early activity is often to host a multistakeholder meeting to build support and facilitate engagement in various aspects of the process. This meeting may include selecting priorities, developing a quality definition, undertaking a situational analysis, and selecting a set of quality interventions. Similar events may be held as the action plan is developed and implemented, fostering a shared quality agenda, continuing to facilitate meaningful engagement at all stages, and promoting transparency and accountability.

Table 3. Illustrative roles in fragile, conflict-affected and vulnerable settings

Actor	Role
Government (national) and district health management teams	▪ Defining a package of services ▪ Setting standards for clinical care ▪ Contracting with nongovernmental organizations for service delivery ▪ Coordinating efforts of multiple partners and providers
Health insurance organizations	▪ Strategic commissioning and purchasing services ▪ Performance management and benchmarking ▪ Collecting and sharing data on performance
Health-care providers (nongovernmental, governmental private)	▪ Peer review – adherence to clinical standards and guidelines ▪ Building joint capacity for quality improvement
Health facility management teams	▪ Infection prevention and control ▪ Reporting adverse events and medical errors ▪ Occupational health and safety [a]
Civil society and communities	▪ Monitoring performance and promoting transparency ▪ Continual engagement and building trust throughout planning and implementation process ▪ Promoting appropriate use of health services

Actor	Role
Patients and families	▪ Using available self-management tools ▪ Providing feedback on needs and user experiences
United Nations agencies and health clusters	▪ Validating capabilities and capacity ▪ Negotiating with and coordinating actors ▪ Quasi-governmental functions where the ministry of health is unable to provide these (e.g. standard-setting)
Development partners and donors	▪ Standardizing basic accountability mechanisms ▪ Contracting nongovernmental organizations for service delivery ▪ Demanding adherence to standards ▪ Advocating for action on quality and joint commitment

[a] Safety of the health workforce is a critical consideration for health services delivery in fragile, conflict-affected and vulnerable settings. For further information, see *Occupational safety and health in public health emergencies: a manual for protecting health workers and responders*. Geneva: World Health Organization and the International Labour Organization; 2018 *(39)*.

Key actions - Stakeholder mapping and engagement

- Map the roles of key stakeholders in development and implementation of the quality action plan and related activities.
- Engage early with humanitarian and health-sector coordination mechanisms in the setting, ensuring their engagement in planning for improved quality.
- Continue to engage a broad set of stakeholders throughout the process and through to implementation.

2.4.4 Situational analysis– state of quality

Conducting a baseline situational analysis is an early essential activity in the development of any quality action plan in fragile, conflict-affected and vulnerable settings. A situational analysis can improve understanding of the existing state of quality, the anticipated barriers and facilitators for action plan development and implementation, the major challenges and priorities, and the current status of important contextual factors such as infrastructure, capacity and political climate. The situational analysis can be used to guide the approach taken by the team developing and implementing the quality action plan and should be shared with key stakeholders to facilitate their engagement.

The size and scope of the situational analysis will vary significantly depending on available resources, practical constraints, and whether the plan is being led by one organization, a group of organizations or a national government. At a minimum, the aim is to gather enough information to inform sensible decisions on where to focus initial efforts to address quality. The situational analysis should start with an outline to guide the data collection and analysis process (Box 9).

Box 9.

Example outline: situational analysis on quality

Context of service delivery:

- existing service priorities;
- key stakeholders and their roles;
- current provider landscape and services or programmes offered;
- cross-cutting contextual challenges to the delivery of quality health services;
- existing quality-related policies, plans and programmes;
- asset mapping.

State of quality:

- qualitative and quantitative overview of existent data relating to the current status of service delivery across all quality domains.

Health system levers and linkages with quality:

- consideration of health system levers (e.g. financing, workforce, supplies, commodities, technologies, infrastructure, health information systems, data availability) in the local context and key linkages with quality of care.

Assets and challenges to enhancing quality:

- ensuring access and basic infrastructure for quality;
- system environment;
- reducing harm;
- improving frontline clinical care;
- engaging and empowering patients, families and communities.

The situational analysis should be grounded in the local context. It should focus on a systematic collection of a comprehensive range of information. It may be focused on one or more facilities, providers or geographical areas (e.g. camps for displaced people), or it may assess a broader health system. Review of the questions presented in Table 2 may be helpful to determine the key contextual issues to be examined. The final situational analysis outline should be a short document listing the broad categories of information that would be desirable to present. This can be used to plan for how to collect the required data, usually incorporating the subsequent stages described below.

Desk review

Much of the required data for the situational analysis can be gathered through a review of existing documentation and data sources. This is likely to include national health policies and strategic plans; defined service packages; guidelines and protocols used by providers; health worker training documentation; nongovernmental organizations' and humanitarian partners' plans, periodic monitoring reports and evaluation reports; humanitarian response plans; related health-sector situational analyses and planning documents; and government documents such as quality-related legislation, regulation and statutes.

The desk review should aim to gather existing performance data about the current state of quality in the overall health system through routinely collected data from the health management information system, health information and reports of individual providers and humanitarian partners, ad hoc surveys or self-assessments of facility and system performance, and programme reports from disease- and population-specific programmes. Where possible, data should be presented on existing quality-sensitive indicators, incorporating data on structures and inputs, the process of care and outcomes. Data should be disaggregated to a level relevant to the action plan, and should be presented for high-priority conditions and populations.

It is helpful to report on the availability of data on quality, the existence of suitable sources, and the current state of the routine health information system. Data that can be accessed may be highly specific or timebound rather than generalizable – for example, coming from individual projects, facilities or descriptive programme reports. Following the desk review, and in the absence of adequate data on the state of quality, a more formal process of systematic collection of data on health-sector performance and quality of care focused on the target providers and populations covered by the plan may be needed, in addition to the less formal steps outlined below.

More information on health information systems and quality assessment is available in Section 2.4.7.

Stakeholder interviews

To supplement the desk review, interviews should be performed with a range of key stakeholders, such as those listed in Table 3. This can elicit useful perspectives on the understanding of quality, critical contextual challenges, relevant existing initiatives, resources, and factors that could determine the success of the action plan. A question guide can be developed based on the scope of the proposed action plan, the findings of the desk review, and a review of relevant situational analysis tools. The process of interviewing stakeholders may also help to engage them in the broader effort to improve quality. The stakeholders interviewed will vary, depending on the scope of the action plan. For large-scale national plans, the stakeholder list may be extensive *(6)*. Even for smaller initiatives focused on a limited set of facilities or providers, it can be helpful to speak to stakeholders to determine how best the current initiative can align with existing work, overcome challenges and add value.

Observation

If the team performing the situational analysis is not familiar with the realities of service delivery in the setting where the action plan will be implemented, it may be useful to conduct a series of visits to health-care settings. This allows direct observation of practice and an opportunity to engage health workers directly. Ad hoc visits to health facilities will not necessarily provide a representative impression of quality and service delivery, but they may help to clarify and validate findings from other parts of the assessment. Observations may enhance visibility of the quality action planning work and identify key areas requiring further examination.

Stakeholder review and validation

As a final step in the situational analysis, it may be helpful to collate initial findings and present these to the stakeholder group for further validation. This may be done as part of the stakeholder engagement process, using the opportunity to develop a shared understanding of the state of quality and develop consensus regarding priorities for action.

Review of quality challenges common in fragile, conflict-affected and vulnerable settings

As part of the situational analysis there should be a concerted exercise to systematically identify, understand and share challenges to quality of care in that particular setting. Table 4 presents a list of challenges common in fragile, conflict-affected and vulnerable settings. There will be variability in strengths, intractability and other attributes. Many of these challenges are related to the availability of essential services; others may be more sensitive to interventions proposed under the quality action plan. It is important to be aware of all challenge types to enable the selection of a set of interventions that fully embrace the local context.

Table 4. Common challenges to delivering quality care in fragile, conflict-affected and vulnerable settings

Domain	Challenges
Cross-cutting	▪ Uncertain or unstable financing and funding mechanisms ▪ Poor or eroding infrastructure and facilities ▪ Inadequate or maldistributed resources ▪ Insufficient personnel with appropriate skills and qualifications ▪ Disruption or lack of systems to ensure knowledge and skills of health professionals ▪ Reduced availability or quality of formal education or professional development ▪ Insufficient adherence to existing care standards ▪ Ineffective oversight or governance of health providers ▪ Instability of government systems or policies ▪ Lack of understanding about health-care quality concepts and methods
Effective	▪ Lack of knowledge and skills among providers to manage changing health-care needs (e.g. injuries from conflict or previously rare infectious diseases) ▪ Lack of availability of context-adapted clinical standards, guidelines and protocols ▪ Lack of capacity among providers to implement quality-improvement methods ▪ Disrupted or lack of health information and performance measurement systems
Safe	▪ Limited systems available to identify and address errors ▪ Culture of safety not prioritized in favour of meeting immediate needs ▪ Direct safety of health facilities threatened by conflict ▪ Unsafe environments posing harm and risks to patients and health-care workers ▪ Limited provision of infection prevention and control ▪ Lack of or damaged water, sanitation and hygiene infrastructure
People-centred	▪ Lack of systems to engage patients, families and communities ▪ New providers may not have the trust of communities ▪ Service design may not be informed adequately by local community context ▪ Challenges in accessibility ▪ Linguistic or cultural challenges among international provider organizations
Timely	▪ Inadequate attention to timely emergency care services, such as ambulance and referral services ▪ Reduced service availability due to lack of resources or damaged infrastructure ▪ Increased health needs overwhelming services with limited human resource capacity ▪ Lead time for establishing functioning services

Domain	Challenges
Equitable	▪ Logistical constraints to providing services in hard-to-reach areas ▪ Increased barriers to access for marginalized groups (e.g. women, children) ▪ Reduced capacity to pay for services and medicines due to income disruption ▪ Challenges in ensuring all sides in a conflict receive similar levels of care ▪ Discrepancies between displaced populations and local host communities ▪ Enhanced stigma and violence towards marginalized populations
Integrated	▪ Breakdown of primary care and referral networks ▪ Lack of follow-up and continuity of care ▪ Lack of coordination between multiple providers, many of which are new to the setting ▪ Limited knowledge among providers of local systems ▪ Disrupted communication and health information systems
Efficient	▪ Difficulties in tracking expenditure and measuring impact ▪ Multiple funding streams, donors and providers, leading to difficulties in coordination, redundancy in service delivery, and disruption to health labour markets ▪ Mismatch between population needs and priorities and programmes of donors and providers ▪ Constraints in efficient procurement and monitoring of use of essential supplies ▪ Increased opportunities for corruption

A variety of tools have been developed by WHO and other organizations to support situational analyses for quality, including those with relevance to fragile, conflict-affected and vulnerable settings. A selection of these are presented in the *National quality policy and strategy tools and resources compendium (6)*.

key actions - Situational analysis

- Develop a context-specific outline for the final situational analysis report.
- Perform baseline situational analysis incorporating desk review, facility observations and primary data collection, where necessary.
- Engage stakeholders to discuss challenges to quality service provision, develop a shared understanding of the situation, and validate the findings of the situational analysis.

2.4.5 Governance for quality

In relation to quality of care, governance can be understood as "the stewardship and capacity to transparently and responsively direct health systems resources, performance, and stakeholder participation, towards delivering quality health care" *(40)*. Governance activities in fragile, conflict-affected and vulnerable settings may include organized efforts to set and monitor the achievement of minimum standards, including the package of services to be delivered; develop accountability mechanisms between administrators and the population, providers and health professionals; ensure an adequately trained and supervised workforce; and provide leadership and oversight of health services delivery and regulatory authority.

For the team or organization developing the quality action plan, there are four critical governance considerations:

- Understand the current governance landscape and the influence of this on efforts to improve quality in the specific setting.
- Agree how to engage with existing governance mechanisms without hampering progress.
- Determine how to leverage and strengthen governance mechanisms.
- Advance accountability and transparency.

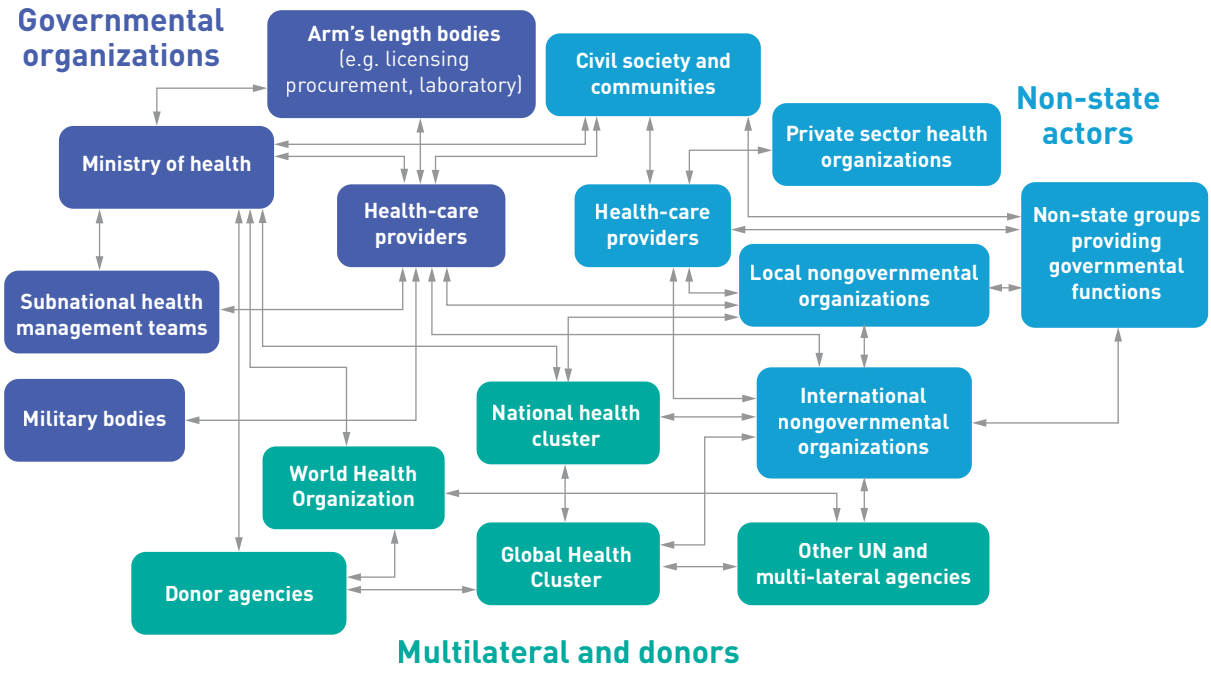
In many stable settings, governance functions may be synonymous with state-run mechanisms for planning, regulating, monitoring, accountability and quality assurance. In fragile, conflict-affected and vulnerable settings, such mechanisms may be disrupted or deprioritized or may simply not exist. Services may be provided by a range of providers. Capacity for monitoring, management and oversight will be limited by the context and changes in government stewardship. Systems normally in place to ensure adequacy of health workers may be more difficult to implement during crises or may not explicitly relate to nongovernmental or private providers. Processes to assure the quality of essential medicines and medical supplies may be disrupted. Standards of care developed for non-crisis settings may not be wholly relevant, and local capacity for monitoring and governing improvement efforts may not exist. Where service capacity is strained, there may be reluctance to introduce regulatory mechanisms that would discourage recruitment or limit the input of international providers.

Figure 4 presents an illustrative map of health-sector governance relationships in fragile, conflict-affected and vulnerable settings, highlighting the complexity likely to be present. Despite these challenges, governance functions in these settings remain critical to improving quality of care. New and innovative approaches may be needed to optimize structures, support adequate leadership throughout the system, build in meaningful accountability for the delivery of quality care, and foster productive relationships between communities, health workers, providers and regulatory mechanisms. The potential for involvement of communities themselves in quality governance is of particular note (see Box 10).

The importance of the government or state role and functions in a specific setting depends on the context and is defined by three main characteristics: its responsibility and willingness to serve the affected populations; its capacity for action; and stability, security and access to affected populations *(41)*. In addition, the standing of the government within the locality, in terms of trust and authority, will always be a key consideration.

The approach taken to address governance will depend on the current governance landscape and scope of the proposed work on quality of care. Where there are functioning national and subnational government institutions, organizations providing services should be aware of existing governance mechanisms and look to align with and strengthen these. This may include ensuring all stakeholders are aware of relevant legislation, all health workers are registered with local regulatory bodies, facilities comply with existing standards and licensing requirements, and data on performance are shared through the national health information system.

Figure 4. **Health-sector governance relationships in illustrative map of fragile, conflict-affected and vulnerable settings**



Box 10.

Accountability to the people: the role of communities in governance in fragile, conflict-affected and vulnerable settings

There is increasing recognition of the need for patients, families and communities to be formally engaged in the planning and delivery of health services in fragile, conflict-affected and vulnerable settings. A series of crises have provided stark examples of the dangers of failing to engage, with widespread evidence of distrust in formal health services, leading to delayed presentation and low use of health services.

Fragile, conflict-affected and vulnerable settings provide several challenges to engagement, such as disruption to existing engagement platforms, influx of providers with no established community relationship, and increased strain on health services pushing engagement down the list of priorities.

Ultimately, health service providers should be accountable to the populations they serve. Quality services cannot be provided without attention to the needs, preferences and experiences of patients and communities. Efforts should be made to formally engage communities in governance and accountability mechanisms. As stakeholders address governance in the development of the quality action plan, they should consider what mechanisms can be used to engage and empower communities in the development of the plan, the implementation and monitoring of quality interventions, and the planning and delivery of health services. Aligned with the actions presented in Section 2.4.3, this is likely to involve the identification of patient, community and civil society groups or structures that can provide a trusted link between providers and people; the involvement of such groups in planning mechanisms and formal governance structures; and focused efforts to gather and act upon the views of the people receiving services. While community engagement will be critical to ground quality action planning in what matters most to the population, it is important to ensure the burden and responsibility for improving quality of services do not fall on the community.

Further information on how to engage communities is presented in Section 2.4.6 and the accompanying tools compendium *(8)*.

In the quality action planning process, any critical governance gaps in the existing system can be identified and plans made to address these with specific providers, programmes or populations, or across the system where feasible. The following questions may help to plan the actions required and can be incorporated into the situational analysis:

- What structures exist to regulate, monitor and improve performance of services and health workers?
- How has quality been applied to packages of services, and is it appropriate to the local context?
- What standards of care appropriate to the local context and disease burden are available?
- To whom are providers accountable for their performance?
- What mechanisms and processes exist to reduce medical harm and avoid medical error?
- What actions are required to satisfy organizational leadership, donors and communities that standards are being complied with?
- What systems are in place to ensure health workers are adequately qualified for the roles they are performing, and their skills and knowledge are up to date?
- What mechanisms are in place to ensure accountability to health workers for the provision of appropriate working conditions and support for training and professional development?
- Are mechanisms in place for external review of provider performance?
- What opportunities exist to specify appropriate quality measures in contracting and collaborating with providers?
- What processes are in place to ensure accountability in addressing deficiencies in the performance of facilities, providers and health workers?
- What legislation is in place to regulate performance and processes in the health sector?
- How are communities involved in planning, setting expectations and reviewing data about performance?

In some circumstances there may be opportunities for multistakeholder efforts to meet critical governance gaps, for example by establishing shared mechanisms to regulate providers and implement unified standards and processes. This could encompass formal systems being overseen by existing coordination mechanisms, such as a national health cluster or sector, and be applicable to a range of partners; or it may comprise ad hoc voluntary arrangements, for example for peer review, sharing or development of standards, or developing community-based scorecards.

WHO, as a multilateral organization, or as the health cluster lead agency (if this exists within a country), will have a key role in coordinating any multistakeholder efforts to facilitate the required governance and oversight where local systems are not adequate Specific considerations related to the WHO role in governance of emergency medical teams are presented in Box 11.

The quality action planning process may provide opportunities to open discussions among stakeholders about how best to work together to address governance gaps. In settings with existing humanitarian coordination mechanisms, such bodies should consider adopting responsibility for the development and implementation of a multistakeholder quality action plan. Governance of this effort may involve focused advocacy and resource mobilization efforts; identification of a core technical team to drive progress on action planning; and creation of a working group or oversight committee to provide strategic direction, monitor and transparently report on progress in addressing quality, and seek connection with national quality efforts, where relevant.

Box 11.

Certification of emergency medical teams

Emergency medical teams are specialized self-sufficient groups of health professionals mostly deployed by international organizations to meet critical health-care needs in emergency and disaster situations. WHO has developed a global verification system to ensure emergency medical teams meet required standards and are competent to meet the needs in the situation to which they are deployed. WHO has published guidance on classification and minimum standards for foreign medical teams in sudden-onset disasters, and maintains a list of emergency medical teams, from a range of organizations, certified as compliant with these standards. This regulatory and accountability mechanism provides a useful example of how global cooperation and coordination mechanisms can be used to assure quality, especially when a country's own systems cannot fulfil such functions owing to a situation of prevailing urgency and fragility.

Key actions - Governance for quality

- Map current governance landscape and identify existing processes with which current quality efforts should align.
- Identify critical governance gaps and address these where feasible, ensuring the present governance structure has the necessary authority to regulate quality of care measures.
- Clarify structures, plans and processes for governance of the quality action plan development and implementation, under the existing humanitarian or emergency response coordination structures, linked with national quality programming where appropriate.

2.4.6 Interventions for quality improvement

Quality interventions are actions that can be taken across a health system to improve the quality of care. Defining a set of interventions lies at the heart of quality action plans in fragile, conflict-affected and vulnerable settings. The intention is to address the identified quality challenges and achieve the stated quality goals. The proposed interventions should include change-oriented actions, be both system- and people-focused, and come together to make up a coherent and pragmatic framework for action. The process of selection, and the set of interventions itself, will vary depending on the scope of the quality action plan and the organization leading its development. In general it will involve the following steps:

- Review contextual challenges, service priorities and quality goals, integrated with the other relevant elements of action planning (notably situational analysis and stakeholder engagement).
- Map quality-related activities already being implemented and identification of gaps.
- Review evidence and implementation experience to understand which interventions might be most appropriate to the context.
- Consider the need for wide-ranging action focused on quality across five areas: ensuring access and basic infrastructure; shaping the system environment; reducing harm; improving clinical care; and engaging patients, families and communities.
- Consider the need for action across each level of the health system (national, state, regional, district, facility, community, individual), through the engagement of a range of relevant stakeholders.
- Consider the need for action and engagement across each type of health provider (e.g. ministry of health, nongovernmental organization, private, military).
- Consider the available levers for change, including policies, processes, management actions, governance and accountability, resource allocation, clinical care practices and human behavioural change, across multiple stakeholders.
- Review illustrative quality interventions lists to assess suitability in the local context; the list provided within this document provides a useful starting point (see Table 5).
- Select and prioritize an initial set of interventions, supported by stakeholder consultation.
- Begin operational planning for implementation.

Selecting interventions: evidence for impact

Addressing quality in fragile, conflict-affected and vulnerable contexts represents a nascent field of study. Evaluation and research in the quality field historically have not used rigorous methods of causal evaluation, and attribution of impact effects is almost impossible when so many factors are at play. Although it is difficult to access a robust and coherent body of reliable evidence, expansive evidence scans, field interviews and expert consultation have brought to light a set of illustrative interventions likely to be of value across a range of fragile, conflict-affected and vulnerable settings *(5,42)*. These interventions are presented in Table 5; expanded descriptions are provided in Annex 2.

The WHO, World Bank and OECD report on quality describes a number of evidence-based illustrative interventions that can be used to improve quality of care through a focus on four common areas: shaping the system environment; reducing harm to patients and populations; improving frontline clinical care; and engaging and empowering patients, families and communities *(1)*. This provides a useful starting point for identifying quality improvement interventions, but not all the suggested interventions might be suitable for improving quality in the context of fragile, conflict-affected and vulnerable settings; for example, many interventions rely on the existence of functioning national systems, which may not be present in such settings.

Based on further research to support development of this document and related work on quality in fragile, conflict-affected and vulnerable settings, a fifth area was added – ensure access and basic infrastructure – to recognize that the breakdown in infrastructure and scarcity of essential resources is characteristic of many settings. Actions to improve those conditions are paramount and indeed central to achieving quality health services. The five intervention areas are:

- Ensure access and basic infrastructure for quality: Access and quality are inextricably linked. The existence of well-functioning service delivery platforms and the ability of affected people to

equitably access and use services are clear prerequisites for any effort to improve care in fragile, conflict-affected and vulnerable settings. Access relies on multiple issues – geographical, financial, and security and safety of users and the workforce. The interventions in this category must support critical foundations for quality related to physical infrastructure (e.g. water, sanitation, hygiene, reliable electricity supply), which cannot be assumed to be existent and adequate.

- Shape the system environment: Quality care depends on interventions focused on care processes and service delivery and on efforts to create the supportive conditions, governance processes and culture necessary to enable providers to meet the desired levels of care. This includes a strong focus on the capacity of the health workforce to deliver quality care, and accountability mechanisms linked to assessment against defined quality standards.
- Reduce harm to patients and populations: These interventions focus on key activities to uphold the foundational principle of causing no avoidable harm to the people receiving health services. Achieving this requires multimodal and multidisciplinary action to implement a range of practical tools, while concurrently addressing the behavioural and cultural changes required to build a sustainable, safe environment.
- Improve frontline clinical care: These interventions focus on processes and tools to increase the effectiveness of clinical care. This incorporates collaborative, supportive, quality-focused processes to monitor and improve health worker practice and practical resources to support diagnosis and management at the point of care.
- Engage and empower patients, families and communities: These interventions describe a series of practical steps to promote engagement of patients, families and communities in planning, delivery and evaluation of quality health services. Engagement requires attention to language and health literacy challenges to facilitate 'giving voice' and developing appropriate communication, health education, and self-care programmes and technologies.

Although these interventions are listed separately, many will be implemented concurrently and in an integrated manner. Further detail on the interventions outlined below is presented in Annex 2.

The interventions in Table 5 are described in broad terms. Within any given setting, selection and implementation will require further analysis of the intervention to understand its component parts and the activities and tools required for operationalization. As an example, in Box 12 the 'reducing harm' intervention area is broken down.

Table 5. Quality of care: illustrative interventions

Area	Illustrative interventions
Ensure access and basic infrastructure for quality	▪ Ensure structural capacity and essential inputs ▪ Negotiate terms for care provision and safe access ▪ Provide access to mobile services ▪ Contract out services ▪ Strengthen health information systems for quality and performance ▪ Optimize procurement and supply chain systems
Shape the system environment	▪ Link quality action planning to a defined package of health services ▪ Recruit and retain workforce with a focus on quality of care ▪ Pre-verify qualifications of health teams for deployment ▪ Strengthen quality accountability mechanisms ▪ Strengthen performance reporting for quality ▪ Use performance-based contracting and commissioning ▪ Implement financing methods to enhance quality based on context ▪ Oversee quality of private-sector care provision ▪ Assess facility capacity for delivery of quality services
Reduce avoidable harm	▪ Strengthen infection prevention and control ▪ Implement high-priority patient safety processes at the point of care ▪ Provide hands-on patient safety training to health-care workers ▪ Use a context-specific patient safety risk management tool
Improve frontline clinical care	▪ Use context-appropriate guidelines, standards and protocols ▪ Routinely use quality monitoring and improvement processes ▪ Provide training with supportive supervision and performance feedback to the health workforce ▪ Strengthen primary care and referral networks to deliver quality services ▪ Use clinical decision support tools ▪ Use electronic and digital health technologies and programmes
Engage and empower patients, families and communities	▪ Establish patients' rights and complaints programmes ▪ Formally engage and empower communities ▪ Educate patients, families and communities ▪ Provide peer support and counselling ▪ Measure patients' experiences of care for service improvement ▪ Use patient self-management tools

Box 12.

Unpacking interventions for planning and implementation: reducing avoidable harm

The interventions below have been elaborated to highlight a non-exhaustive selection of more granular components that might inform their selection, planning and implementation.

Strengthen infection prevention and control:

- Ensure infection prevention and control minimum requirements are in place *(42)*.
- Train and support infection prevention and control focal points within provider organizations.
- Perform infection prevention and control self-assessments.
- Train and educate the health workforce in infection prevention and control.
- Monitor infection prevention and control indicators (e.g. hand hygiene compliance) and perform hospital-acquired infection surveillance where practical.

Implement high-priority patient safety processes at the point of care:

- Identify and address common safety challenges in communication and coordination (e.g. use of abbreviations, verbal and telephone orders, handover of patients).
- Ensure standard procedures for patient identification.
- Implement key actions for medication safety, blood safety, injection safety and radiation safety.
- Use safety protocols and tools, such as the *WHO surgical safety checklist (44)*, the *WHO safe childbirth checklist (45)*, the *WHO trauma care checklist (46)* and the *WHO medical emergency checklist (47)*.

Provide hands-on patient safety training to health-care workers. Such training promotes safer care processes and supports implementation of many of the other interventions listed here. Delivery might incorporate:

- bedside/clinical tutorials;
- simulation methods.

Use a context-specific patient safety risk management tool. This may include action to:

- establish morbidity and mortality meetings;
- apply workplace organizational methods;
- use mistake-proofing methods to design safer processes;
- conduct routine clinical audits;
- implement a context-specific system for adverse or sentinel event reporting and learning.

In most fragile, conflict-affected and vulnerable settings, some of the proposed interventions outlined in Table 5 – particularly those on infrastructure, financing and service packages – will be implemented as routine operations and functions of existing health sector, humanitarian and development actors. They are mentioned here as they are foundational to quality of care and need to be considered when planning for quality or operationally addressed if deficient.

For example, issues of retaining and recruiting the workforce, ensuring basic infrastructure, and managing procurement and supply chains are all basic functions and competencies routinely conducted by governments and humanitarian and development organizations. Interventions such as the use of safety tools and protocols, routinely monitoring for adherence to standards and protocols, and assessing patients' experiences of care are not usual and widespread practices in many settings. While the foundational interventions may not be under the purview of the quality action plan, it is still important to consider the full range of interventions required to assure and improve quality, as many of these are interrelated and the action planning process may provide an opportunity to identify gaps, advocate for further action, or address gaps in some of the fundamental actions. Careful selection

and prioritization of interventions is critical in any setting, but particularly in fragile, conflict-affected and vulnerable settings. Human and financial resources are severely limited in such settings, and any decision to implement a particular quality intervention comes with a significant opportunity cost.

When selecting and prioritizing interventions, it is important to understand the quality challenges and priorities. The selection process should draw on the situational analysis. This may seem obvious, but in many instances the selection of interventions is not based on the challenges and quality priorities of the setting but is influenced by preconceived notions of the utility of specific interventions and implementation experience from vastly different contexts.

Selecting interventions necessarily considers various entry points for change, from multilateral organizations to national, regional, district, facility, provider and patient levels. It is important to plan stakeholder engagement involving those most likely to understand the challenges and assets relevant to implementation. When selecting interventions, it is important to review what is already taking place to ascertain where the action plan can add value, again making use of the situational analysis. The prioritization and phasing of interventions will also vary depending on the context – for example, whether there are armed conflicts, or whether the government is functionally controlling and managing health facilities.

The selection of a pragmatic set of quality interventions can be supported through the application of a range of criteria (Box 13). The criteria should be agreed among the team leading the action plan development and other key stakeholders with knowledge of the local context. Principal among the criteria is the feasibility of successfully implementing the intervention. If for any reason it is believed the intervention is not feasible, for example due to security and access issues, significant challenges to sustainability, prohibitive cost, or incompatibility with local norms and systems, then there is little value in considering the intervention further.

Box 13.

Criteria to aid selection of quality interventions

- feasibility;
- expected impact on quality goals and challenges;
- relevance to service priorities;
- value (greatest impact for least cost and effort);
- acceptability (to patients, providers and communities);
- relative ease of implementation.

Such an exercise may form part of broader activities on stakeholder engagement and can be performed in a number of ways, depending on the scope of the action plan and process of development. Options include facilitated group work to discuss each intervention against the criteria, to rapidly agree on priorities, use of Delphi methodology to establish consensus among a broad stakeholder group, or independent scoring using multicriteria decision analysis. The process may be useful for prioritization and for the identification of challenges or opportunities that should be considered in the implementation phase.

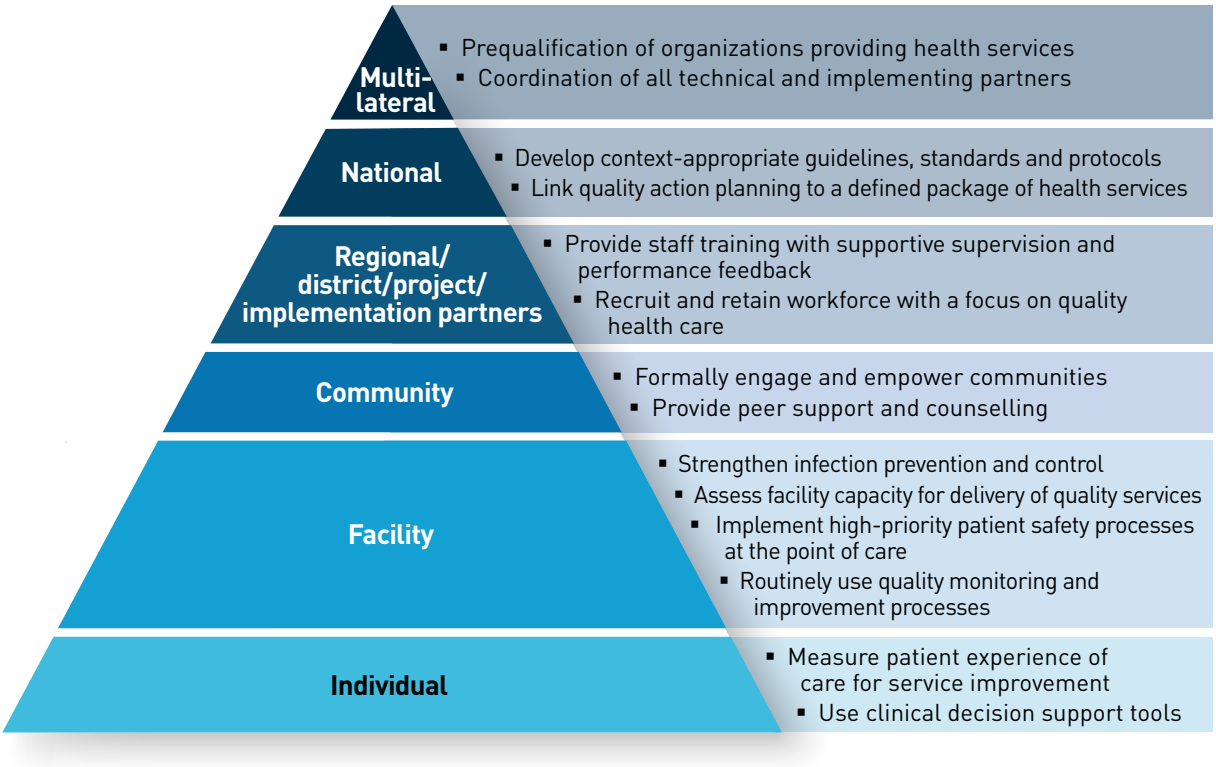
The output of the process might be a list that then forms the basis of detailed discussions on operational planning, a ranking of all presented interventions to inform the decisions of leadership, and a stepwise roadmap outlining short-, medium- and longer-term priorities. It is important to recognize that this selection and prioritization process is dynamic and flexible, to be revisited during implementation of the quality action plan, and then revised based on emerging evidence and experience. As the set of interventions is defined, it is helpful to keep in mind there are no guarantees or fail-safe solutions, and that a combination of integrated interventions is needed for quality improvement.

Levels for action

Quality interventions do not exist as discrete actions. Given the nature of health service delivery and the multiplicity of providers, donors and other actors present in an emergency or humanitarian crisis, it is inevitable that there will be multiple programmes, approaches, methods and levers for change. To effect and sustain meaningful improvements on quality, there needs to be recognition and coordinated action at all levels. Previous publications have included a pyramid to map coordinated quality actions at multiple levels of a health-care system, such as national, region/state/district, facility, community and individual.

Fig. 5 shows an adapted model that can be used to define multilevel systemic activity needed in fragile, conflict-affected and vulnerable settings. Note the crossover and interdependency of action at each level. When considering multi-level action, there is a key role for primary health care that is explored further in Box 14. Another critical level that should be included is the international or multilateral level, with defined actions for international donor and multilateral institutions. The rationale is that humanitarian settings are defined by the need for major entities beyond the country to intervene, sometimes in acute and short-term circumstances, but increasingly in sustained or protracted engagements. This calls for an explicit delineation of roles and responsibilities. In fragile, conflict-affected and vulnerable settings, the additions at the multilateral or international level are activities such as situational analysis, resourcing, coordination of humanitarian and development organizations, validation of nongovernmental organization capabilities to provide emergency services, and provision of quasi-governmental responsibilities in the absence of functioning national governments. Such functions may include establishing common governance, accountability and reporting requirements, and overseeing system level interventions such as development of the services package and setting of standards.

Figure 5. Coordinated capacity for quality improvement at all levels: sample interventions



The development of a pragmatic set of prioritized quality improvement interventions should be followed by the development of an operational plan that outlines the responsibilities, timelines and resources required, and takes account of relevant activities already in progress. Each selected intervention should be unpacked to understand the practicalities of how implementation will take place, the need and process for building the required implementation capacity, and the opportunities to maximize synergies and efficiencies across the set of interventions. Operational planning may also take account of the processes required to monitor and refine interventions as they are implemented.

As with the action plan, operational planning may take various forms, for example being done at the level of an individual provider or a coordinated group of stakeholders or integrated within existing operational planning processes. Further information on operational planning is available in the *Handbook for national quality policy and strategy (5)* and the *National quality policy and strategy tools and resources compendium (6)*.

Action to improve care should not be delayed to allow detailed planning; however, it is important that the selected set of interventions is seen in the context of the broader quality action plan that addresses the supporting governance, measurement and coordination mechanisms, and that considers the conditions required to build a sustainable approach for health systems recovery and long-term planning. The operational planning phase may also require focused attention on the costing of activities and resource mobilization.

Also of importance in this context are the linkages between quality directions in subnational fragile, conflict-affected and vulnerable settings and the quality directions within the country as a whole. Where feasible and politically acceptable, organizing for quality in subnational settings should consider and be aligned with overall quality directions across the entire country.

Box 14

Primary health care and quality in fragile, conflict-affected and vulnerable settings

In any setting, efforts to improve quality of care may gravitate disproportionately towards secondary and tertiary services and facility-based care. In fragile, conflict-affected and vulnerable settings, it is important to consider how the set of quality interventions can focus on using the primary health care approach to enhance population health.

The 2018 Declaration of Astana reaffirmed the need for an increased focus on primary health care as countries look for cost-effective, people-centred means to deliver universal health coverage, This is highly pertinent in fragile, conflict-affected and vulnerable settings, where a focus on primary health care can deliver an improved response to the crisis situation and there is an opportunity to equitably and efficiently deliver quality services as the health system is rebuilt. There is a key role here to strongly advocate for a continued focus on strengthening primary health care.

Primary health care is a whole-of-government and whole-of-society approach to health that combines multisectoral policy and action, empowered people and communities, and high-quality primary care with a public health approach. As primary health-care systems are planned and implemented in fragile, conflict-affected and vulnerable settings, there is an opportunity to take action to build quality into the design *(48)*. This is particularly important given the driving force of primary health care in universal health coverage-driven reform processes that are being emphasized at national and global levels. Strong primary health-care systems can play a critical role in crisis situations *(49)*, necessary for effective prevention, detection and response functions for emerging health threats and acting as a foundation for resilient health systems. Primary health-care-oriented health systems can also provide a strong and sustainable link to the communities affected by crisis, facilitating the proactive communication and engagement that form a cornerstone of quality service provision.

key actions - Interventions for quality improvement

- Review quality challenges, priorities and goals; map current activities; and review context-appropriate evidence of success.
- Taking into account relevant contextual issues, select a pragmatic set of quality interventions.
- Develop an operational plan to support implementation of the set of quality interventions as part of the broader quality action plan.

2.4.7 Health information systems and quality assessment

Improving quality relies on the presence of clear and accurate performance data, whether at the level of the practitioner, provider or population. In fragile, conflict-affected and vulnerable settings, data on quality of care have several important uses, including:

- identifying critical improvement needs across the system;
- supporting clinical and managerial decision-making;
- facilitating the selection and implementation of quality interventions;
- monitoring and transparently reporting progress for feedback and accountability.

Any quality action plan – whether its scope is an individual health facility or a broader health-care system – must address the health information system. In stable settings, data on quality may be collected through a variety of means, including routine national health management information systems; regular or ad hoc population surveys; facility assessments; disease- and population-specific programmes; and regulatory mechanisms such as external evaluation.

The multiple challenges faced in fragile, conflict-affected and vulnerable settings may cause significant disruption to many of these data collection opportunities. For example, routine health management information systems may be disrupted, and the capacity of health workers to collect and share data may be stretched. Security situations may make facility surveys and other data-collection activities more challenging, and there may be a lack of trained data specialists. Of note is the need for health information systems in fragile, conflict-affected and vulnerable settings to provide data on the direct health burden from any specific crisis and on wider impacts on population health and the functionality of the health system.

Tailored approaches are required. Using and enhancing existing data collection and reporting systems is necessary to reduce data burden.

People developing quality action plans in fragile, conflict-affected and vulnerable settings cannot fix the entire health information system. The focus is on how to get enough data to drive key improvement activities and on actions that can strengthen the measurement of quality systematically and routinely. This usually involves assessing the current health information landscape to understand what data sources are available; planning any required ad hoc data collection exercise to support the emerging quality initiative; and identifying necessary health information system strengthening interventions within the purview of the organizations implementing the action plan. Generating and sharing learning on quality of care also merits consideration, as outlined in Box 16.

Assessing the health information systems landscape

It is useful to consider which data are collected and through which sources as part of the situational analysis. In addition to (or more often in place of) those used in more stable settings, organizations providing health services in fragile, conflict-affected and vulnerable settings may use data collection tools tailored to the context. An example is the Health Resources Availability Monitoring System tool *(50)*. The multiplicity of donors and organizations providing services may mean several different systems are in use in one setting. Box 15 highlights examples of health information sources in fragile, conflict-affected and vulnerable settings.

The extensiveness of the assessment of the health information system will vary significantly, depending on the scope of the quality action plan. At any scale it will be useful to understand whether the current system produces the data that health workers need to improve the care they provide to patients. Further detail on examination of the quality implications of health information systems is provided in the *Handbook for national quality policy and strategy (5)* and *National quality policy and strategy tools and resources compendium (6)*. Many other health information system assessment tools are publicly available.[b]

b For a list of such tools, see https://www.measureevaluation.org/his-strengthening-resource-center/his-assessment-tools/index.html/histoolssearch.

Box 15.

Examples of health information sources in fragile, conflict-affected and vulnerable settings

- needs assessment;
- epidemiological surveillance;
- routine health management information system;
- health emergencies information tools (e.g. Health Resources Availability Monitoring System);
- reporting systems from individual providers;
- disease and population programme systems;
- household surveys;
- disease registries;
- death registration;
- modelling, estimates and projections.

Ad hoc collection of data on quality of care

Even in settings with well-functioning health information systems, there will often be few data elements related directly to quality of care. Where existing health information systems do not provide the required data to support the quality action plan, it may be necessary to perform one or more discrete data collection exercises. These may consist of external assessment, internal assessment, self-assessment or a mixture of different approaches, and will often involve facility observation, interviews with key respondents, focus group discussions and surveys.

Several tools for such exercises exist, a selection of which are available in the tools compendium accompanying this document *(8)*, but many are not tailored to fragile, conflict-affected and vulnerable settings. Of note, WHO and the Global Health Cluster have developed a tool specifically for the collection of data to monitor performance and drive improvement in health services in fragile, conflict-affected and vulnerable settings *(39)*.

Adapting and refining the approach to ad hoc collection of data on quality of care to meet the specific contextual needs and priorities for the action plan is essential.

Strengthening the health information system

The quality action plan cannot solve every challenge with the health information system, but it may provide an opportunity to take action on areas of critical need to support improvements in care. The focus should be on strengthening areas that are critical to implementation of the priority interventions, and to overcoming any information system deficiencies that could prevent the delivery of quality care or increase risk and harm to patients and communities. Any planned action to improve the health information system should take account of local evidence and implementation experience and should aim to be pragmatic and achievable.

Box 16.

Learning systems for quality in fragile, conflict-affected and vulnerable settings

There is a critical role for the collecting and sharing of learning between providers and facilities in fragile, conflict-affected and vulnerable settings, particularly in the absence of strong information systems, context-appropriate benchmarks and standards, and evidence of impact and effectiveness. Key in such efforts will be starting with what is achievable. Often this simply means connecting the relevant stakeholders, demonstrating the value in sharing learning, and encouraging transparency over sharing data to spur improvement.

Actions may include:

- using technological and digital solutions for the collection, analysis and sharing of data;
- strengthening community engagement mechanisms to enable meaningful participation in planning and performance evaluation;
- implementing arrangements to share data between facilities and providers for benchmarking and learning;
- identifying and addressing any process constraints that interfere with transfer of knowledge and information;
- initiating a regular programme of facility assessment surveys using context-specific tools;
- liaising with providers and technical programmes to leverage expertise and resources from across the system;
- collecting simple data from patients and communities to understand their needs, preferences and experiences of health services.

Key actions - Health information systems and quality assessment

- Review the current local health information system landscape, identifying data sources, challenges and gaps in availability of data to drive improvement.
- Where required, plan and perform an ad hoc assessment of quality health service delivery.
- Incorporate any critical actions to strengthen the health information system in support of the planned improvement activities in the quality action plan.

2.4.8 Quality measurement

Closely linked to the need for attention on health information systems to address quality in fragile, conflict-affected and vulnerable settings is the value of defining a set of practical quality measures. The indicators related to quality of care in fragile, conflict-affected and vulnerable settings might differ from those suitable to more stable settings, owing to the practicalities of data collection, differences in local burden and susceptibilities, differences in how services are delivered, and differing improvement priorities and timescales. There is currently no widely used measurement framework for quality and performance in fragile, conflict-affected and vulnerable settings.

Box 17.

Uses of quality measures

High-quality data on quality measures have many uses, including:

- monitoring for adherence against standards and guidelines;
- providing feedback to providers on quality improvement activities;
- providing transparency and accountability to the public and funders;
- benchmarking to understand comparative performance and efficiency;
- helping with strategic or value-based purchasing and contracting;
- monitoring quality interventions.

Further information on the development of a quality measurement framework is provided in the *Handbook for national quality policy and strategy (5)*. Key suggested steps for development and implementation include review of expert illustrative and global indicator lists; cataloguing and assessing existing quality indicators and potential sources; and using a conceptual framework to guide the selection of an indicator set that provides a holistic overview of quality. Indicator frameworks should be closely linked to the goals, priorities and interventions identified during action planning, allowing measurement efforts to be relevant to the broader improvement activities. It is important to consider how indicators can best reflect what matters most to those using services.

The aim should be to develop a pragmatic rather than perfect set of indicators that can feasibly be measured without undue measurement burden and that provide a foundation for later development. This is likely to mean no more than 10–15 indicators, balanced across structure (input), process and outcome measures. Consideration should be paid to how frequently the indicators should be measured and how the data can best be shared and used for benchmarking, and guiding and informing improvement (see Box 17 for further detail on quality measures) . Where new data collection will be required to report on certain indicators, the added value should be weighed against the resources and efforts required to report.

A useful source of illustrative service delivery indicators tailored to fragile, conflict-affected and vulnerable settings is the *Sphere handbook (24)*. Many of these indicators are of clear relevance to quality and can be adapted for the context of specific settings. Illustrative benchmark values are also provided for many indicators to guide understanding of what an acceptable level might be, given the challenging environment. Other indicator sources include those signposted in the *Handbook for national quality policy and strategy (5)* and *National quality policy and strategy tools and resources compendium (6),* and the broader work of WHO on health statistics and information systems *(51)*. It may also be possible to derive useful indicators from some of the quality assessment tools in use or proposed as part of the action plan. A list of illustrative indicators relevant to quality in fragile, conflict-affected and vulnerable settings, adapted from existing lists, assessment tools and conceptual frameworks, is presented in Table 6.

Table 6. Illustrative indicators for quality in fragile, conflict-affected and vulnerable settings

Ensure access and basic infrastructure
Service utilization rates against locally defined standards (disaggregated per population group)
Percentage of facilities with adequate supply of electricity and clean water
Average number of days per month when essential medicines are not available (disaggregated by facility)
Shape the system environment
Health worker to patient ratio
Percentage of births attended by skilled personnel (doctors, nurses, midwives)
Percentage of facilities that have been externally assessed by a competent authority as meeting minimum quality standards
Percentage of health-care facilities that deliver agreed package of health services
Percentage of health centres with standardized treatment protocols for selected high-priority or high-burden conditions
Improve frontline clinical care
Mortality rates for priority conditions or populations (disaggregated per population group)
Percentage of people managed according to evidence-based and context-specific guidelines (for selected high-priority conditions)
Contraceptive prevalence
Percentage of children aged 12 months who have had 3 doses of diphtheria, pertussis and tetanus vaccine
Percentage of people previously on selected long-term medication (e.g. antiretroviral therapy, cardiovascular disease secondary prevention) who continue to receive such medicines
Percentage of facilities with functioning triage or pre-screening of patients
Reduce harm to patients and populations
Percentage of facilities with suitable supplies for rapid immediate response to epidemics and all hazards, including infection prevention and control supplies and personal protective equipment
Postsurgical infection rate
Percentage of facilities with adequate observed hand hygiene compliance
Medication error rate
Engage and empower patients, families and communities
Percentage of facilities that have formal community or patient participation on management or oversight committees and structures
Percentage of patients reporting being treated with dignity during last interaction
Percentage of patients reporting having been involved in decisions about care or treatment by any doctor
Percentage of facilities with suitable arrangements for ensuring privacy during medical examinations

Table 6 is not an exhaustive list but provides an illustrative sample of the indicators that might be collected to support quality improvement in fragile, conflict-affected and vulnerable settings. There is significant overlap between the categories. Many indicators have been stated on a multifacility or multiprovider scale (e.g. percentage of facilities with a particular characteristic) but could be reframed for action plans for a smaller-scale initiative. This list should be seen as a supportive tool to guide indicator selection and should be supplemented by context-specific indicators that account for particular challenges and needs. Where feasible, indicators should be disaggregated to better explore equity of service use.

Key actions Quality measurement

- Catalogue and assess existing quality indicators.
- Review illustrative and sample lists suitable for fragile, conflict-affected and vulnerable settings.
- Select a practical indicator set that is feasible and contextualized and can support the improvement efforts set out in the quality action plan.
- Begin collection of data even if incomplete, as data reliability usually improves once monitoring starts.
- Provide data feedback routinely to the health workforce and health-sector management.

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Annex 1
Supplementary tools and resources

Tools and resources for each quality intervention category have been collated into a compendium that accompanies this document *(8)*. The *Quality of care in fragile, conflict-affected and vulnerable settings: Tools and resources compendium* represents a curated, pragmatic, nonprescriptive collection of tools and resources to support the implementation of interventions to improve quality of care in fragile, conflict-affected and vulnerable contexts. Relevant tools and resources are listed under five areas: ensuring access and basic infrastructure for quality; shaping the system environment; reducing harm; improving clinical care; and engaging and empowering patients, families and communities. Cross-cutting products are also signposted. This compendium complements, and can be considered in tandem with, the WHO *National quality policy and strategy tools and resources compendium (6)*, which provides tools focused on the process of developing national quality policy and strategy.

Who is the compendium for?

The compendium is aimed at a range of stakeholders working in fragile, conflict-affected and vulnerable settings, including humanitarian agencies and their coordination bodies (e.g. the national health cluster), ministry of health personnel at the national and district levels, public and private health-care provider organizations, nongovernmental organizations, managers, system leaders and practitioners, as they work towards improving quality of care.

Why was the compendium developed?

The compendium is a companion to this document. The compendium signposts further resources to support practical action around implementation of quality-related interventions.

How was the compendium developed?

Development involved a process of several rounds of scoping searches, tools identification and refinement by the WHO national quality policy and strategy team; collaboration and co-development with technical and humanitarian partners; and focus on meeting priority, context-specific and practical needs. Tools and resources have been sought based primarily on their use in supporting implementation of evidence-based interventions for improving quality in fragile, conflict-affected and vulnerable settings.

How should the compendium be used?

The compendium is intended for use alongside other knowledge products such as this document, the *National quality policy and strategy handbook* and the *National quality policy and strategy tools and resources compendium*.

Annex 2
Expanded descriptions of interventions

The following are descriptive statements on each of the quality interventions presented in Section 2.4.6 of this document. The illustrative interventions have been selected based on an extensive literature review of global evidence and experience of what works to improve access to quality essential health services in fragile, conflict-affected and vulnerable settings, conducted by a team at Gillings School of Global Public Health at the University of North Carolina, United States of America. Evidence summaries are available.[c]

Ensure access and basic infrastructure for quality

Ensure structural capacity and essential inputs

Delivery of quality essential health services in fragile, conflict-affected and vulnerable settings relies on availability of health facilities with the infrastructure, equipment and workforce to function. This includes a reliable supply of safe water, sufficient electricity (including backup supply), laboratory capacity to support diagnosis and monitoring, and physical space to assess and manage patients. In many settings, work is required to understand how this basic capacity can be built, maintained and equitably distributed.

Negotiate terms for care provision and safe access

This intervention encompasses the negotiation process that should take place to uphold the core tenet of humanitarian practice that people who provide or use health services should be able to do so without being subject to attacks or threats. Health facilities and patient transport should not be targeted. Emphasis should also be placed on the safety of health workers. The reality is that risks may be present. Negotiation may have to take place at multiple and different levels, for example between providers and the state or non-state authorities, or between international organizations such as the United Nations and all sides involved in a conflict to maintain quality essential health services.

Provide access to mobile services

Mobile surgical teams, medical teams and care units can be deployed to ensure access to quality health services during crises and when health-care systems are not in place or are destroyed or fragmented. Mobile health services and transport improve access to health care for people living in fragile, conflict-affected and vulnerable settings, offering flexible options for treating isolated and vulnerable groups and newly displaced populations. This may include scheduled visits, clinics or emergency services (e.g. emergency obstetric care) and access to ambulance and health facility transfers. Such services can be deployed on foot, bicycle, motorcycle, boat or vehicle (e.g. van-based clinics). These modalities become critical for people living in remote, fragile or conflict affected settings who may be cut off from access to health services and for whom mobile services may be their only source of health care *(1)*.

Contract out services

In some fragile, conflict-affected and vulnerable settings, federal government, regional or district actors do not have sufficient capacity to provide quality essential health services. In such contexts,

c See: https://sph.unc.edu/files/2020/07/Healthcare-quality-in-Extreme-adversity-and-FCV-settings-globally-evidence-scans.pdf.

some services can be contracted with non-state service providers such as national or international nongovernmental organizations and humanitarian agencies to provide the required quality care. These accords should be legally binding to provide the highest degree of reliability and accountability possible, while remaining practical.

Strengthen health information systems for quality and performance

A health information system collects health data at all levels and converts them into information for health-related decision-making and actions. In addition to being essential for monitoring and evaluation, a health information system serves broader ends, such as validating data accuracy, providing alerts and early warning capabilities, facilitating effective surveillance and communicable disease control, enabling patient and health facility management, and supporting global reporting. In fragile, conflict-affected and vulnerable settings, challenges with access and security may limit the collection, storing and transfer of data on the availability and quality of health services, which limits decision-making and strategic planning.

Optimize the procurement and supply chain systems

Health facilities require a consistent and reliable stock of medicines, equipment and supplies to deliver quality of care. A reliable and efficient system to acquire such goods is essential. In fragile, conflict-affected and vulnerable settings, facilities may lack essential supplies for normal function, especially when increased demand occurs. Dependable mechanisms for delivering and obtaining supplies are fundamental to quality of care, requiring action at multiple health system levels to ensure demand is understood and barriers to supply are removed.

Shape the system environment

Link quality action planning to a defined package of health services

Maintaining and, if necessary, restoring access to a package of health services is a central consideration in fragile, conflict-affected and vulnerable settings. Agreeing on a package of services, and linking the quality action plan to this, is an important step to accelerate progress towards universal health coverage. The Global Health Cluster defines essential packages of health services as "detailed lists of interventions/services (preventive, promotive, curative, rehabilitative and palliative) across different levels of care, endorsed by the government at the national level, or agreed to by a substantial group of actors when services are to be provided in areas outside of government control. These interventions should be available to all, safe, people-centred, and of assured quality to be effective. They should be funded by the government, with or without donor support, and to the extent possible be provided without user fees at the service delivery point during the emergency" *(2)*.

Recruit and retain workforce with a focus on quality of care

Developing and maintaining an effective workforce in fragile, conflict-affected and vulnerable settings is an essential foundation for delivery of quality health care. This intervention reflects the need for coordinated action to understand the workforce needs and implement appropriate strategies so the right mix of adequately trained health workers is recruited, distributed and retained. For example, this may require attention to training needs, working conditions, safety and security concerns, and financial and non-financial incentives. Community health workers often have a critical role in providing quality essential health services and maintaining engagement with communities in fragile, conflict-affected and vulnerable settings.

Pre-verification of qualifications of health teams for deployment

Health teams are groups of health workers, such as doctors, nurses and paramedics, that may be deployed by governments, militaries, nongovernmental organizations and other organizations to manage patients in some fragile, conflict-affected and vulnerable settings, in particular those affected

by an emergency or disaster. Given the acute nature of such emergencies, and the lack of sufficient governance systems in some settings, there is a risk that teams may operate without being suitably qualified, or that assuring their adherence to minimum standards may delay their response. Systems to ensure qualification of such teams before deployment can be important. Pre-verification can happen at many levels; a well-known example is the WHO Global Emergency Medical Team Registry *(3)*.

Strengthen quality accountability mechanisms

Accountability mechanisms describe a range of potential actions focused on the relationships between different actors in the health system, commonly involving requirements for reporting performance (in processes and outcomes of care), or compliance with standards and guidelines. Accountability implies consequences for meeting or not meeting expectations or obligations. Often this involves health facilities and health workers being accountable for the care they provide, and managers and funders being accountable for their contribution to the conditions that support quality care. Within fragile, conflict-affected and vulnerable settings this might include systems to make services accountable to the communities they serve, and contractual, regulatory and performance management mechanisms.

Strengthen performance reporting for quality

Performance reporting is a broad term for a process used to increase transparency and accountability on issues of quality by providing systematic information on how health services are being delivered in the local context. It includes a range of approaches with a focus on consistent assessment against defined quality standards and a defined set of quality indicators. Of note is the increasing use of balanced scorecard approaches to measure, report and manage performance in the delivery of a package of health services.

Use performance-based contracting and commissioning

Performance-based contracting and commissioning is a broad term for remuneration and resourcing provided to health-care providers and health facilities based on the quality of health services provided. Payment can be allocated at the level of the individual, group or institution. Often the amount that is dependent on performance is a subcomponent of the full payment. Application of this approach shows varied results across different settings and warrants careful understanding of contextual factors that affect its success.

Implement financing methods to enhance quality based on context

There is a need for careful consideration of how the quality of health services is affected by the way they are funded. In fragile, conflict-affected and vulnerable settings, a variety of funding mechanisms may be in place across different providers, and government resources may be very limited. User fees are commonly in place. A range of locally adapted financing methods have been used to enhance the quality of health services in fragile, conflict-affected and vulnerable settings, including performance-based financing and direct cash transfers to populations. The experiences and success of these approaches are highly context-sensitive and depend on the specifics of the financing methods used.

Oversee quality of private-sector provision of care

Since the private sector often provides a significant proportion of health services in fragile, conflict-affected and vulnerable settings, oversight of the quality of services warrants specific attention. In this context, the private sector refers to all non-state actors involved in health – profit and not-for-profit, formal and informal, domestic and international *(4)*.

Assess facility capacity for delivery of quality services

The basic capacity of the facility to deliver quality care can be examined through external and self-assessment tools. These facility- and service-level assessments are considered a central quality intervention and involve various formal methods, including assessment of individual and organizational

performance. Health-care providers and managers, technical partners and funders can conduct an organized process to compare themselves against defined standards of care and explicit criteria with a view to defining their basic capacity and readiness for delivering quality care.

Reduce harm to patients and populations

Strengthen infection prevention and control

Infection prevention and control is "a practical, evidence-based approach which prevents patients and health workers from being harmed by avoidable infections" *(5)*. Strengthening infection prevention and control in fragile, conflict-affected and vulnerable settings may involve ensuring minimum requirements are in place *(6)*; training and supporting a focal point within provider organizations; performing self-assessments; training and educating the health workforce in infection prevention and control; and monitoring infection prevention and control indicators such as hand hygiene compliance and performing health-care-associated infection surveillance where practical.

Implement high-priority patient safety processes at the point of care

Many instances of harm can be avoided through improved practices at the point of care. Actions to support this include identifying and addressing common safety challenges in communication and coordination (e.g. use of abbreviations, verbal and telephone orders, handover of patients); ensuring standard procedures for patient identification; implementing key actions for medication safety, blood safety, injections safety and radiation safety; and using safety protocols and tools, such as those for safe surgery and safe childbirth.

Provide hands-on patient safety training to health-care workers

Hands-on patient safety training incorporates teaching methods such as bedside and clinical tutorials and use of simulation methods. Such training promotes safer care processes and supports implementation of many of the other interventions listed here.

Use a context-specific patient safety risk management tool

"Clinical risk management specifically is concerned with improving the quality and safety of healthcare services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks" *(7)*. In fragile, conflict-affected and vulnerable settings, this may include action to establish morbidity and mortality meetings; promote clinical team rounds; apply workplace organizational methods; conduct routine clinical audits; and implement a context-specific system for reporting and learning from adverse and sentinel events.

Improve frontline clinical care

Use context-appropriate guidelines, standards and protocols

Clinical guidelines, pathways and protocols are tools to guide evidence-based health care. These tools enable a standardized approach to care for people with specific health conditions or clinical presentations. They may serve as an important source of reference and can strengthen the clinical skills, confidence and performance of health workers. People using the guidelines should be actively involved in training to support adherence and reduce unjustified variations in standards of care.

Routinely use quality monitoring and improvement processes

Quality can be improved by processes that assess care against accepted standards of best practice. Examples include peer review and clinical audit which couple quality monitoring with actionable feedback. A common usage worldwide is to foster implementation of clinical practice guidelines,

specifically to identify unjustified variation and increase guideline adherence. The goal is to improve the process of delivering care to effect better patient outcomes and optimize use of resources. Noted challenges to successful implementation include provider buy-in and leadership support for the process, the accuracy of information in clinical records, the effectiveness of continuing feedback mechanisms, and resource availability for guideline adherence.

Provide training with supportive supervision and performance feedback to the health workforce

Training and supportive supervision of the health workforce are among the most common interventions implemented to improve quality in low- and middle-income countries. Appropriate training and education should ensure health workers possess correct knowledge, skills and attitudes to meet the needs of the populations they serve. Supportive supervision promotes mentorship and open communication, and supervisory visits should provide an opportunity for performance feedback and monitoring, shared learning and problem-solving between supervisors and supervisees. These methods require adequate human and financial resourcing. Providing workforce training and ongoing supportive supervision simultaneously can be more effective than either method used alone but requires careful adaptation to fragile, conflict-affected and vulnerable settings.

Strengthen primary care and referral networks to deliver quality services

Formal collaboration between different primary care providers and facilities in fragile, conflict-affected and vulnerable settings may enhance the ability of services to provide access to quality essential health services. Of critical importance are more timely and reliable linkages to specialty care at secondary and tertiary levels. Such networks might encompass shared accountability to provide services to a defined population; efforts to bring care closer to communities; gatekeeping functions to enable primary health care as a hub of coordination for health care; and pragmatic referral systems including referral to secondary and tertiary care. There are several approaches and tools to support networked delivery, such as electronic systems and geospatial techniques.

Use clinical decision support tools

Clinical decision support is the provision of knowledge and patient-specific information presented at appropriate times to enhance frontline health-care delivery. This encompasses a variety of tools such as triage systems, condition-specific order sets, computerized alerts and reminders, documentation templates and diagnostic support. Clinical decision support tools can be automated (embedded within electronic health records or mobile devices) or paper-based. There is a need to balance use of clinical decision support for standardization of care with clinicians' autonomy to make decisions based on context, clinical expertise and unique patient needs.

Use electronic or digital health technologies and programmes

Digital health is a broad term for the use of information and communications technology to address health needs. It encompasses electronic (eHealth) and mobile health (mHealth) technologies. Examples include telemedicine networks, digital medical records, mobile or computer-based diagnostic tools, research and supply delivery, and patient support and education using mobile phones. These technologies have the potential to support health service delivery in hard-to-access areas. The relative ease of access to mobile phones worldwide means that mHealth technologies can be useful in providing patient education information and support in a variety of settings. Mobile-based applications for health workers can support learning, knowledge and clinical decision-making in fragile, conflict-affected and vulnerable environments.

Engage and empower patients, families and communities

Establish patients' rights and complaints programmes

The establishment of patients' rights aims to institutionalize a culture in which patients' needs and preferences and right to health are central to delivery of health care. Programmes encompass rights related to access to medical services, sufficient nutrition, respectful care, a clean environment and healthy working conditions, all of which can be challenging in fragile, conflict-affected and vulnerable settings. Establishing complaints programmes acknowledges patients' rights to file complaints and grievances with an organization due to dissatisfaction with the treatment received. Tracking and monitoring trends can highlight performance problems and promote accountability for improvement.

Formally engage and empower communities

Formalized community engagement and empowerment refers to the active and intentional contribution of community members to their own health and to the performance of the health delivery system. Community involvement in health has multiple objectives, including adoption of behaviours to prevent and treat diseases; effective participation in disease control activities; contribution to the design, implementation and monitoring of health programmes; and involvement in resource allocation. Participation in and input to health systems can occur through various means, such as needs analysis, high-level priority-setting or participation on governing boards. Each of these requires action to build engagement capacity, deploy appropriate tools, and ensure sustainability and follow-up.

Educate patients, families and communities

This encompasses educational activities to prevent and manage disease, reduce health risks, and improve health outcomes and impact. Patients, families and communities should be supported to make informed decisions about their own health through provision of appropriate health information. Various forms include home-based education, peer education and support, expert patient groups, use of digital or electronic educational strategies, health promotion campaigns, and community mobilization.

Provide peer support and counselling

Peer support groups link people with similar clinical conditions to share knowledge and experiences. The approach complements and enhances other health-care services by creating the emotional, social and practical support necessary for managing health problems and staying as healthy as possible. Peer support projects, including use of peer educators and counsellors, have shown success in positively changing health behaviours and enhancing health literacy and health outcomes. Given the severe human resource challenges in fragile, conflict-affected and vulnerable settings, specifically the shortage of trained health-care providers, peer support groups and peer counsellors can play a significant and larger role in improving care and patient outcomes.

Measure patient experience of care for service improvement

Patients' feedback on their experience of care is a strategy to better understand and improve health service quality. In higher-income countries, there is a growing body of evidence that self-reported experience correlates with objective measures of clinical quality. Recording, analysing and acting on patient feedback is critical to understanding health service use and improving the quality of care provided.

Use patient self-management tools

Patient self-management tools are technologies and techniques used by patients and families to manage their health issues outside formal medical institutions. Examples include tools that allow patient self-monitoring and management of chronic diseases, or support people to identify symptoms of acute illness that require medical assessment or intervention. Challenges to widespread implementation of these tools – which are likely to be felt even more acutely in fragile, conflict-affected and vulnerable settings – include geographical and financial access, trained human resources, and access to education.

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7. Patient safety curriculum guide: multi-professional edition. Geneva: World Health Organization; 2011 (https://www.who.int/patientsafety/education/curriculum/who_mc_topic-6.pdf, accessed 14 August 2020).

Annex 3
Glossaries of key terms related to quality in fragile, conflict-affected and vulnerable settings

Handbook for national quality policy and strategy (part III) (https://www.who.int/servicedeliverysafety/areas/qhc/nqps_handbook/en/, accessed 14 August 2020).

Health systems strengthening glossary (https://www.who.int/healthsystems/hss_glossary/en/, accessed 14 August 2020).

Global health cluster guide (https://www.who.int/hac/global_health_cluster/guide_glossary_of_key_terms/en/, accessed 14 August 2020).

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