

Improving the quality of care for maternal, newborn and child health

Implementation guide for national, district and facility levels



World Health
Organization

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Improving the quality of care for maternal, newborn and child health: implementation guide for national, district and facility levels

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Foreword

Despite significant increases in access and coverage of health services for mothers and children, a staggering number of women and newborns still face sickness and death during and after childbirth. We now know that having access to health services is on its own not enough to reach the Sustainable Development Goal targets of reducing maternal and newborn deaths. We also know that most maternal and newborn deaths and stillbirths can be prevented with good-quality care. The quality aspect is also a key component for addressing health system inequities and inefficiencies, improving accountability, and providing dignified and respectful service delivery.

In 2019, the United Nations General Assembly adopted the United Nations Resolution on Universal Health Coverage, which addresses the urgent need for action for universal health coverage (UHC) *with* quality care. However, we know quality of care does not occur spontaneously. The challenge to deliver quality care is faced at all levels – national and district, as well as at the level of health facilities. Health system performance and health outcomes rest on all stakeholders. More investment is needed to consolidate the foundations of health systems, improve the engagement of communities to define and deliver quality care for mothers and newborns, and cultivate a quality culture within and among health managers and the broader health workforce.

This implementation guide contains practical guidance for policy-makers, programme managers, health practitioners and other actors working to establish and implement quality of care (QoC) programmes for maternal, newborn and child health (MNCH) at national, district and facility levels. It is intended to help anyone, throughout the health system, who wants to take action to improve the QoC for MNCH.

By working together to improve the quality of health care for women and children through all levels of the health-care system, from national level down to community level, we can help build a healthier, safer and more equitable world for all.

Anshu Banerjee,
Director, Department of Maternal, Newborn, Child and Adolescent Health and Ageing

Acknowledgements

This implementation guide is a “living document” that builds on previous iterations and incorporates the rich implementation experience emerging from the 10 countries in the Quality of Care Network for improving quality of care (QoC) for maternal, newborn and child health (MNCH).

The guide was developed by the Department of Maternal, Newborn, Child and Adolescent Health of the World Health Organization (WHO), under the overarching leadership of Anshu Banerjee and Anthony Costello. The conceptualization and writing team was led by Blerta Maliqi and composed of Bénédicte Walter, Martin Dohlsten, Moise Muzigaba, Nuhu Yaqub and Zainab Naimy, with Nigel Livesley and Sonali Vaid as the lead writers. Anayda Portela, Assumpta Muriithi, Bernadette Daelmans, Joanne Ashton, Jorge Hermida, Kathleen Hill, Pierre Barker and Wilson Were are acknowledged for their contributions on the conceptualization and peer review of the document throughout its development.

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Abbreviations

CSO	civil society organization
DHMT	District Health Management Team
HMIS	health management information system
LALA	Leadership, Action, Learning and Accountability
MNCH	maternal, newborn and child health
MPDSR	maternal and perinatal death and response
NGO	nongovernmental organization
NQPS	national quality policy and strategy
QI	quality improvement
QoC	quality of care
TWG	Technical Working Group
UHC	universal health coverage
WHO	World Health Organization



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How to use this implementation guide

What is the purpose of this implementation guide?

This implementation guide provides practical guidance for policy-makers, programme managers, health practitioners and other actors working to establish and implement quality of care (QoC) programmes for maternal, newborn and child health (MNCH) at national, district and facility levels.

Who is this implementation guide for?

This guide is intended to help anyone, throughout the health system, who wants to take action to improve the QoC for MNCH.

This can include, but is not limited to:

- national policy-makers and legislators;
- programme managers and technical staff at national, district and facility levels;
- health-care practitioners working in MNCH;
- other actors working to establish and implement QoC programmes for MNCH at national, district and facility levels.

How was this implementation guide developed?

The guide was co-produced with the countries and partners of the Network to Improve Quality of Care for Maternal, Newborn and Child Health (Box 1). It takes into account their experiences in delivering health care for MNCH and is the result of a great deal of collaboration, consultation and reflection among leading experts in the fields of quality improvement and MNCH. The guide also facilitates the implementation of the existing body of work on quality of health care such as the WHO Handbook for National Quality Policy and Strategy (1), WHO QoC MNCH standards (2,3,4), quality tools and approaches.

Box 1. The Network for Improving Quality of Care for Maternal, Newborn and Child Health

In February 2017, 10 countries – Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Sierra Leone, Uganda and the United Republic of Tanzania – together with WHO and supported by a coalition of technical and implementing partners, established the Network for Improving Quality of Care for Maternal, Newborn and Child Health. The Network was established to accelerate achievement of universal health coverage (UHC) goals with a focus on quality. Driven by the values of equity and dignity, all countries in the Network committed to halving maternal and newborn deaths and stillbirths and to improving the experience of care for pregnant women, mothers and their babies by the end of 2022 (5).

To achieve these targets, the Network agreed to pursue four strategic objectives: Leadership, Action, Learning and Accountability (LALA), as a framework for implementation of its activities and the key ingredients for impact. The strategic objectives, and associated outputs, describe what needs to happen at the country level for improvements in QoC to be realized (6).

- **Leadership:** Build and strengthen national institutions and mechanisms for improving QoC in the health sector.
- **Action:** Accelerate and sustain implementation of QoC improvements for mothers and newborns.
- **Learning:** Facilitate learning, share knowledge and generate evidence on QoC.
- **Accountability:** Develop, strengthen and sustain institutions and mechanisms for accountability of QoC.

How is this implementation guide structured?

This guide is organized into three sections (A, B, C), which detail the actions required to facilitate implementation of QoC for MNCH at the national, district and facility levels, respectively. The three sections of this guidance can be used independently and are not dependent on each other. A midwife working in a health-care facility might only be interested in using the parts relating to improving QoC at facility level, while a ministry of health official at national level may have to start with the national-level section.

Section A targets national health professionals and decision-makers, and describes strategic activities to create policy and an enabling environment for QoC implementation. National-level commitment and leadership is a precondition to improve, scale up and sustain QoC.

Section B targets district (subnational) health managers, decision-makers and practitioners, and describes activities to create and maintain an enabling environment to facilitate implementation of QoC at district level. In this document, the term “district” is used to denote the subnational level, a clearly defined administrative area, where local government and administrative structures are in charge of organizing and delivering health services, including organization of referral.

Section C targets health managers and practitioners at facility level, working with MNCH at a hospital or health centre in charge of organizing and delivering care at facility level and engaging in quality improvement (QI) activities.

Activities at each level are divided into *start-up activities* and *ongoing activities*. The start-up activities are efforts needed to set up a working environment to facilitate improvement of QoC. Ongoing activities are efforts needed to ensure sustainability and to optimize QI results as quality initiatives progress.

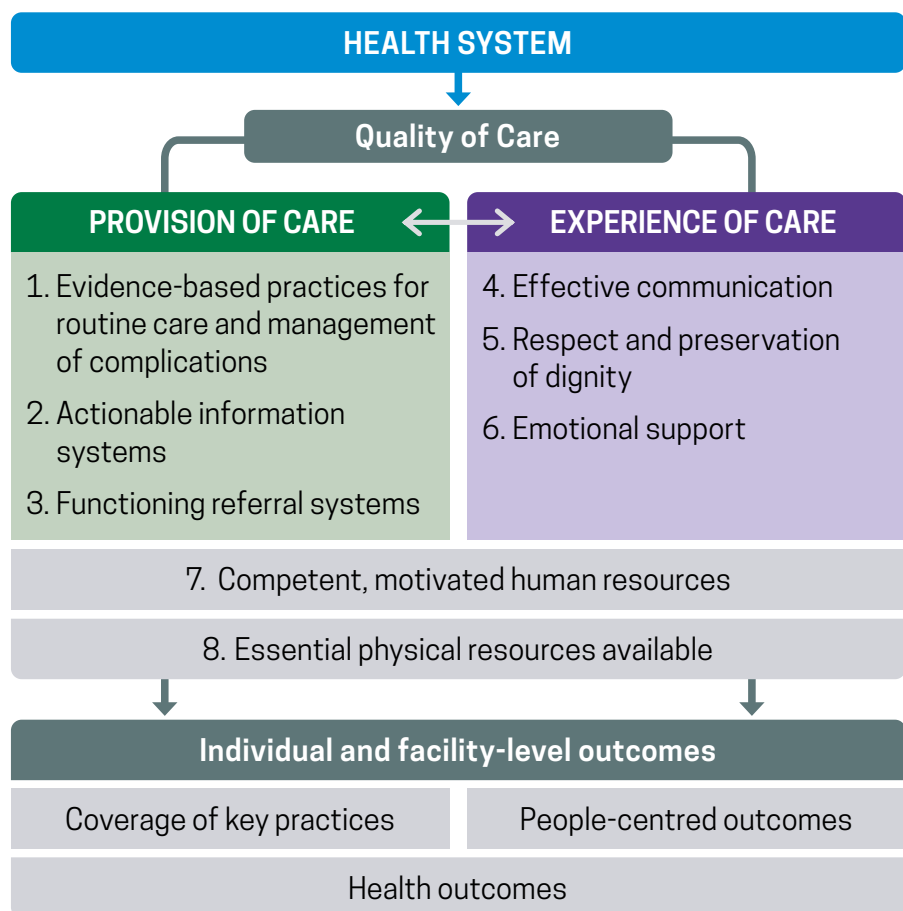
Understanding quality of care

Why quality of care?

It is estimated that between 5.7 and 8.4 million deaths are attributed to poor-quality care each year in low- and middle-income countries, which accounts for up to 15% of overall deaths in these countries (7). The occurrence of adverse events, resulting from unsafe care, is considered to be one of the 10 leading causes of death and disability worldwide. Improving access to health services must go hand in hand with improving the quality and safety of these services. Poor quality and experience of care may also lead to loss of confidence in the formal health sector and adversely impact future health-seeking behaviour (8).

WHO, in collaboration with partners, has developed the MNCH QoC standards conceptual framework (Fig. 1), encompassing the provision and the experience of care, and comprising eight domains of quality that should be assessed, improved and monitored within the context of the health system (2,3,4).

Fig. 1. WHO QoC standards conceptual framework



Interrelated functions for quality health services

The WHO national quality policy and strategy (NQPS) guidance provides implementers with the framework for conceptualizing and developing national QoC strategic directions (1). The implementation of these strategic directions is facilitated by five interrelated functions that support delivery of QoC and enable its sustainability (Box 2).

Box 2. A systemic approach to supporting QoC



1. ON-SITE SUPPORT

To ensure that care remains of good quality, health workers, managers and their teams must apply QI to address gaps and reward good performance. The development of capacity for QI requires structured support across all levels of service delivery. This support includes continuous coaching to build and sustain QI skills of health workers at the front line (on-site support) (9). On-site support needs to be carefully planned and executed from the point of care or facility to the district and national levels. Specific attention is required to develop and sustain QI coaching mechanisms at the facility and district levels, including embedding QI on-site support within existing mechanisms such as supportive supervision and periodic reviews.



2. SHARING AND LEARNING

Sharing and learning good practices and failures is fundamental to improving quality. A learning system among health workers and managers enables routine sharing of their experiences and can lead to the adaptation and scale-up of best practices. Learning should be facilitated within and between health teams, facilities and districts up to the national level. At the team and facility level (micro level), learning influences adaptation and use of best practices, enabling organizational problems to be addressed. At the district or subnational levels (meso level), adaptation of learning as an active mechanism for reflection and action allows for sharing of best practices and lessons among teams and facilities, both within the same district and across districts. It also facilitates development of targeted management responses to address gaps identified by the facilities, including clinical skills and capacity-building for health workers. At the national level (macro level), it is important to recognize successful interventions and share them with a larger audience. Additional support provided by academic and research institutions for the documentation of best practices is needed to build the local evidence base. Well-documented implementation experiences can be used to influence management decisions and inform policy dialogue to support scaling up of successful practices and interventions within and across countries.



3. MEASUREMENT

Data are needed to find out whether QI activities are indeed implemented and if targeted MNCH outcomes are being reached. Routine health management information systems (HMIS) should be strengthened to report on agreed QoC MNCH indicators. Additional flexible systems and tools to monitor progress in implementing QoC MNCH standards need to be adapted to country context and continuously updated to reflect QoC priorities.



4. STAKEHOLDER AND COMMUNITY ENGAGEMENT

Community and stakeholder engagement are critical to ensure accountability for QoC and help identify gaps, prioritize concerns, monitor performance and provide solutions to improving QoC. Community feedback is also valuable in guiding the most strategic use of resources to improve services. QoC programmes benefit from making intentional and systematic efforts to engage community representatives, including women representatives and patients, to participate in the programme. When community engagement mechanisms are in place, they provide a powerful avenue to ensuring accountability for results. Examples such as community scorecards or guidance for community dialogue are useful platforms that allow for meaningful participation of communities in improving QoC.



5. PROGRAMME MANAGEMENT

Effective programme management is vital and required at all levels to support QoC implementation. It is therefore crucial to invest in strengthening the capacities of managers and service providers across the system. Programme management is vital for ensuring that activities to improve quality are carried out and supported by adequate resources, and that upstream planning and review are in place to enhance management of quality programmes at national, district and facility levels. District management and leadership, through the programme management function, facilitate and ensure that QoC activities are prioritized, supported and delivered at the point of care. Programme management for quality should also include advocating and promoting a culture of quality within the health system, starting with the management and leadership. The programme management function is responsible for linking QoC efforts with the broader health system functions, including health planning, financing, service delivery, commodities and supply chain management, measurement, etc., in order for the health system to respond to QoC needs in an effective and timely fashion.

The first two of the above functions – *on-site support* and *sharing and learning* – serve primarily to build the knowledge, skills and motivation of front-line workers, managers and teams, and to enable them to share their experiences of improving QoC through all levels of the health system and how these informed practice, management and policy changes. Together, the other three functions: *measurement*; *stakeholder and community engagement* and *programme management* aim to improve the accountability, governance and management of efforts to improve the QoC.

Taking action

Guiding principles for implementers

Efforts to improve quality are underpinned by a few guiding principles. These will help implementers to get started quickly, set the tone for their efforts, and hopefully foster a positive culture of QoC improvement efforts.

START FAST, SMALL AND KEEP IT SIMPLE

Many health managers and implementers have prior experience with improving QoC for MNCH and can build on that to avoid spending excessive time planning or developing new documentation. It is recommended that changes start small and that implementers learn and adapt from the initial experience.

FOCUS ON HEALTH OUTCOMES AND PATIENT EXPERIENCE

All efforts to improve service delivery need to be directed towards improving health outcomes and the experience of care of the patient. It is recommended that activities directly impacting patients be prioritized.

BUILD ON EXISTING STRUCTURES AND FUNCTIONS

Multiple departments – not only those set up specifically for quality purposes – have a role to play to improve QoC. Wherever possible, QoC activities need to be housed within existing structures and coordination ensured across all actors. This will support the sustainability of the QoC improvement activities.

CHANGE SYSTEMS TO SUPPORT HEALTH WORKERS

Poor organization management systems – such as health-care organization rules and information flows – could prevent health workers from carrying out their tasks successfully. The focus must not be on punishing individuals for providing poor care in such conditions, but on bringing multiple sectors and departments together to improve systems and support health workers. Leaders, managers and practitioners must avoid creating a culture of blame and instead motivate their staff by looking for examples of good work and being quick to show appreciation for it.

LEARN, ADAPT AND SHARE

Evidence from implementation needs to be shared to build and expand the knowledge on how to improve, scale up and sustain QoC. To enable this sharing and learning, managers and leaders must nurture a culture of openness that celebrates and encourages successful QI.

Engaging stakeholders

Creating enabling environments to improve the QoC for MNCH requires the participation of different people and organizations. All relevant stakeholders need to join the conversation. These include organizations from many different parts of government, as well as civil society, professional associations, academia, implementation partners and funding partners. Stakeholders who have not traditionally been part of the dialogue – such as faith-based organizations and the private sector – could also play a part in the work. Working with local authorities and community members early on helps to tailor interventions to their context and to give people a sense of ownership.

Useful resources*

[Quality health services: a planning guide.](#)

[Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care.](#)

[Standards for improving quality of maternal and newborn care in health facilities.](#)

[Standards for improving the quality of care for children and young adolescents in health facilities.](#)

[Standards for improving quality of care for small and sick newborns in health facilities.](#)

[Quality of care for maternal and newborn health: a monitoring framework for Network countries.](#)

[The Network to Improve Quality of Care for Maternal, Newborn and Child Health: strategic objectives.](#)

[Improving the quality of care for mothers and newborns in health facilities: POCQI: point of care quality improvement. Coaching manual.](#)

[Every Mother Every Newborn \(EMEN\) quality improvement guide for health facility staff.](#)

[Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health.](#)

* The useful resource box provides hyperlinks to the documents listed. Full reference of these documents can be found in the list of references and Annex 3 of this guide.



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SECTION A.

Improving maternal, newborn and child health quality of care at national level

Using this section

This section describes activities for national-level health managers, decision-makers and practitioners to enable implementation of QoC efforts across all levels of the health system. It provides detailed guidance for implementing start-up and ongoing activities to improve MNCH QoC at all levels. The start-up activities are efforts needed to set up a working environment to facilitate improvement of QoC. The ongoing activities are efforts needed to ensure sustainability and optimize QI results as quality initiatives progress. At the end of this section, a table lists some of the common challenges in implementing national-level activities, as well as possible solutions.

Before starting, it is recommended that users consult the previous chapter on “How to Use this Implementation Guide”, which explains in more detail the purpose of the guide, who it is for, why QoC is important, and the guiding principles to get started.

The need for national-level activities to support quality of care

National-level commitment and leadership are a precondition to improve, scale up and sustain QoC. Such efforts can take several forms, including:

- the government makes an official commitment to improve QoC for MNCH;
- the ministry of health and partners commit the resources required for this improvement; and
- the ministry of health commits to giving regular updates on the progress to improve MNCH QoC.

At the national level, QoC will be rooted in directions set by the NQPS. This implementation guide looks at how to operationalize the QoC policy and strategy directions at all levels of the health system and how QoC for MNCH activities can be implemented even if national policies and strategies are not yet fully developed.

Overview of national-level activities

National-level activities to support the improvement of quality of care for maternal, newborn and child health

Start-up activities

- 1 Establish or strengthen the MNCH QoC Technical Working Group (TWG)
- 2 Develop a roadmap based on a review of existing MNCH QoC activities, partners and resources
- 3 Develop a national operational plan to learn how to improve and sustain MNCH QoC at scale
- 4 Orient learning districts and facilities to QoC activities

Ongoing activities

- 1 Foster a positive environment for improving QoC
- 2 Address MNCH programmatic and health system constraints for improving QoC
- 3 Address district implementation gaps and needs for improving QoC
- 4 Strengthen the monitoring and measurement of QoC, and use QoC data for decision-making
- 5 Use learning to strengthen implementation and inform scale-up of MNCH QoC
- 6 Use periodic review mechanisms to ensure accountability and response

Start-up activities at national level

The start-up activities are efforts needed to prepare the environment for the QoC implementation. Start-up activities at the national level are designed to build commitment and enthusiasm across government and partners, align MNCH QoC objectives and targets with national strategies and priorities, design the implementation path, and allocate resources needed to support implementation. The start-up phase establishes the basis for the development of the QoC interrelated systems and lines up engagement of districts, implementers and other stakeholders to the QoC goals.



1 Establish or strengthen the maternal, newborn and child health quality of care Technical Working Group

The MNCH QoC leaders at the national level will facilitate the establishment or strengthening of a national TWG for MNCH QoC, which will support the government leadership in managing MNCH QoC efforts. The composition of the TWG is described in Box 3. The TWG is responsible for:

- supporting the national executive leadership in MNCH QoC efforts;
- guiding and coordinating efforts to improve MNCH QoC;
- developing a roadmap to guide MNCH QoC improvement;
- developing and overseeing implementation of the operational plan for MNCH QoC;
- aligning technical support for improving MNCH QoC;
- advocating QoC in MNCH in the country;
- facilitating contributions to global learning on how to improve MNCH QoC;
- conducting periodic reviews of the operational plan based on learning from implementation.

Box 3. Composition of the Technical Working Group

Multiple sections and departments within the ministry of health need to be engaged, work together, have defined roles and support a unified effort to improve MNCH QoC. Representatives from the following areas are recommended to be included in the TWG:

- Ministry of health; MNCH departments; development partners; improvement experts; implementing and funding partners; civil society and community-based organizations; faith-based organizations; professional organizations; academic institutions; private sector representatives; and other stakeholders.
- Department representatives from key health system players, such as health-care workforce, health information, essential medicines, finance, gender, social welfare. These groups will be essential for removing health systems constraints to providing quality care.
- Key groups that are working in QoC and those with influence over the quality agenda.
- National structures, units and departments for health-care quality and safety.

TWG members decide upon its working norms, such as frequency of meetings, roles and timelines. In addition to this MNCH QoC TWG, countries may have other working groups for MNCH or for QoC with members from other ministries and sectors. It is important that the MNCH QoC TWG is part of and works in synergy with such groups.



2 Conduct the maternal, newborn and child health quality of care landscape synthesis

The first activity of the TWG is to undertake a situation analysis of the QoC for MNCH, which will serve as a basis for developing the roadmap to improving MNCH QoC at scale and its related operational plan. The MNCH QoC landscape synthesis tool (see Annex 1) could be used for this exercise.

The MNCH QoC landscape synthesis helps users to:

- Bring together and analyse the status of QoC for MNCH and key factors that contribute to poor QoC.
- Bring together existing strategies and policies specific to QoC or related to QOC for MNCH.
- Map existing interventions to improve quality of MNCH across provision and experience of care, including what and where these are, their scope, resources available, activities and actors.
- Assess status of development and implementation of QoC for MNCH standards and those related to QoC interventions.
- Map and analyse capacities required for implementation of the five interrelated functions for QoC: on-site QI support, sharing and learning for QoC, measurement of QoC, stakeholder and community engagement, and programme management for QoC.
- Agree on the indicators that will track improvement in the QoC for MNCH and the programme milestones to track implementation.
- Identify QoC capacity-building areas at all levels of the health system.

The landscape synthesis identifies the strengths, capacities, resources and good practices that can be used to determine and prioritize strategic gaps, and to identify partners and stakeholders working in MNCH QoC. This information can ultimately aid in coordinating activities to avoid duplication.

The MNCH QoC landscape synthesis must be completed through a participatory and collaborative process. The TWG leads this effort and engages with all stakeholders involved in MNCH QoC to provide the information and to complete the situation analysis of QoC for MNCH. The landscape synthesis summarizes and analyses existing information. While it is possible that the information documented may not be complete or up-to-date, these gaps should not stop the finalization of the analysis. Instead, addressing these gaps can be part of the activities to be prioritized as part of the roadmap and its related operational plan.

It is estimated that the landscape synthesis can be completed within four to eight weeks.

Useful resources:

The MNCH QoC landscape synthesis tool (Annex 1).

WHO MNCH QoC related resources (Annex 4).



3 Develop the maternal, newborn and child health quality of care roadmap based on the review of existing related activities, partners and resources

A roadmap for MNCH QoC provides guidance on how the country can meet its goals for MNCH QoC. It occupies a niche within the NQPS directions and is based on analysis of the current situation of MNCH QoC in the country, existing activities, and available technical and financial resources.

The roadmap must be connected and contribute to the national strategic directions on quality and address at least three aspects of MNCH QoC implementation: introduction and implementation of the MNCH QoC standards; QoC measurement; and stakeholders and community engagement in QoC MNCH (Box 4).

The roadmap will identify MNCH quality interventions that will guide the efforts to improve QoC in the country. Boxes 5 and 6 provide examples of MNCH-specific interventions.

Based on the situation analysis and country context documented through the landscape synthesis, the roadmap identifies and sets the QoC goals, targets and national quality aims. These goals and targets must be aligned with the national MNCH goals and targets and assist in their achievement.

Box 4. Useful resources to support development of the maternal, newborn and child health quality of care roadmap

WHO QoC standards for MNCH

The WHO QoC standards (2,3,4) provide guidance on the organization, planning and delivery of MNCH health services in facilities, and can also help when preparing evidence-based national standards and protocols. The standards are based on WHO guidelines and can be used to inform the assessment, improvement and monitoring of MNCH care in health facilities and the organization of services within the broader health system.

The QoC standards are organized into eight domains that cover provision and experience of care. Each QoC domain represents a standard of care and each standard includes a set of quality statements and measures that can be used as benchmarks for QoC improvement.

Introducing and implementing the MNCH QoC standards provides an opportunity to develop benchmarks for national health facility assessments, audits, accreditation and performance reward.

The standards will guide the identification of components of care and resource inputs that are required to provide quality health services and will help in tracking QI and monitoring performance in care or service delivery. They also guide the identification of MNCH and systems interventions needed to support improvements at scale.

The standards need to be reviewed, adopted and adapted to the specific country context. It is important to brief district and facility teams on the updated national standards and assess the standard implementation at the district level as this will help identify district-specific improvement aims based on standard implementation.

Useful resources:

[Standards for improving quality of maternal and newborn care in health facilities.](#)

[Standards for improving the quality of care for children and young adolescents in health facilities.](#)

[Standards for improving quality of care for small and sick newborns in health facilities.](#)

[Quality of care for maternal and newborn health: A monitoring framework for network countries.](#)

[Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health.](#)

QoC MNCH measurement

A monitoring framework for QoC MNH developed for the QoC Network countries includes 15 common MNCH indicators that cover input, process, output, outcome and impact aspects of provision and experience of care (10). Some of these indicators can be generated through the national routine HMIS.

Data are also needed to find out whether QI activities are indeed implemented and if targeted MNCH outcomes are being reached. The monitoring framework establishes links between the MNCH QoC standards quality statements and measures, as well as the associated QoC assessment tools that can be used to measure QI results.

Stakeholder and community engagement in QoC MNCH

WHO guidance on *Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health* can serve as a starting point for planning and implementation (11). The guidance serves as an entry point to identify activities countries can engage in to increase stakeholder and community engagement at national, district and facility levels. Examples include community scorecards and guidance for community dialogue, etc., which are useful platforms that allow for meaningful participation of communities in improving QoC.

Box 5. Quality interventions for maternal, newborn and child health

Quality interventions can be broadly categorized as serving the following purposes:

- *Improving system environment* – Enabling an environment that supports QoC (e.g. MNCH QoC standards, training, professional regulation, quality assurance, accreditation, public reporting, benchmarking, performance-based financing, regulation of medicines).
- *Reducing harm and improving clinical interventions and patient care* – Improving facility-level clinical care and reducing harm (e.g. maternal and perinatal death surveillance and response, MNCH QoC checklists, pathways, protocols, adverse event reporting systems, clinical decision-support tools, audit and feedback, morbidity and mortality reviews, QI cycles).
- *Patient, family and community engagement* – Empowering and engaging patients, families and communities (e.g. health literacy, peer support, shared decision-making, self-management programmes).

Some of these quality interventions are interrelated and can thus have greater impact when implemented in combination with each other.

The roadmap also identifies and recommends the MNCH quality interventions that will be used to achieve the agreed targets. The quality interventions need to be relevant to the selected aims and applicable at district and facility levels.

Developing a MNCH QoC roadmap is a participatory and collaborative process, usually achieved through a consultative workshop. The TWG leads this effort and uses the opportunity to seek the engagement of various stakeholders involved in MNCH QoC. It is important for the development of the roadmap to be done in a time-sensitive manner so as not to delay activities to improve MNCH QoC. The length of the roadmap development workshop could be up to two days. It is recommended that the roadmap be finalized no later than two weeks after the end of the workshop.



4 Develop a national operational plan to guide implementation of maternal, newborn and child health quality of care improvements

The MNCH QoC national operational plan operationalizes the implementation of the roadmap. The operational plan is a practical document that describes how the activities will be implemented by identifying the processes, resources and actions needed to support implementation of QoC. The operational plan pays special attention to the districts in which MNCH QoC improvement activities will take place and where these activities will be thoroughly documented for learning and adaptation. For the purposes of this guide, these districts are called “learning districts” (Box 6).

The operational plan should include:

- identification of the **selected learning districts** in which MNCH QoC improvement activities will be thoroughly documented;
- **improvement aims**ⁱ that the learning districts should start with;
- the **quality interventions** to be used to reach the improvement aims in the selected districts;

ⁱ While the MNCH QoC roadmap sets the larger goals for improving QoC, the operational plan to improve MNCH QoC focuses on selected aims that are relevant to the learning districts and to patient outcomes (clinical outcomes and experience of care), allow for implementation of the WHO QoC MNCH standards, and are aligned with national priorities. The district improvement aims need to be specific to the district context; therefore, they have to be discussed and decided together with the district staff and other relevant stakeholders.

- the organization and resources needed to support the implementation of the **interrelated functions for QoC services**ⁱⁱ at the national, district and facility levels, with special attention towards the learning districts. These functions are:
 - **On-site support:** Resources, tools and processes needed to support facility staff to implement the quality interventions, including QI coaches, clinical mentors, etc.
 - **Sharing and learning:** Resources, tools and processes required to support sharing and learning among implementers across the facility, district and national levels.
 - **Monitoring and measurement:** Resources, tools and processes to monitor and measure the implementation and results of quality interventions, to learn whether QoC is improving or not.
 - **Stakeholder and community engagement:** Resources, tools and processes to facilitate engagement of stakeholders and communities in QoC efforts.
 - **Programme management:** Resources, tools and processes to ensure that at national, district and facility levels, activities to improve quality are supported, that planning and review processes take into consideration findings, learning and recommendations of the QI processes, and that responses required to address gaps in implementation are adequately supported and implemented.

The operational plan includes a timeline, agreed-upon roles and responsibilities for national and district-level staff and stakeholders, and the periodic progress review time frame to ensure accountability and follow-up. The ministry of health and the TWG oversee the implementation of the operational plan and update the roadmap for MNCH QoC based on lessons learned from the implementation.

ii. Further detail on each of the interrelated functions can be found in the chapter on “How to Use this Implementation Guide”.

Box 6. Learning districts

MNCH QoC activities should be implemented across the whole country. However, it is recommended that a few districts be selected for learning purposes, to serve as “laboratories” to test ideas, develop contextualized models of implementation and inform the scaling up of QI at national level. These are referred to as *learning districts*. The number of learning districts depends on the level of diversity among districts in the country. It is recommended that each country select at least three to five learning districts, and as many as necessary to represent the diversity of the country.

Criteria to select learning districts:

The TWG decides on the criteria for selecting learning districts. Some suggested criteria include:

- The district management team in the learning district is committed to learning and making changes to improve MNCH QoC.
- The learning districts are representative of others in the country. They are neither the best nor the worst performing in terms of MNCH QoC and in resources available for MNCH QoC. (Learning from the best-resourced districts may not be applicable to other districts, while the poorly resourced districts may struggle to dedicate time and effort to learning.)
- The district has an adequate caseload to generate learning quickly. (If learning districts have a very low caseload, it will take time to learn whether the changes being made are leading to better care or not.)
- The selected districts include a variety of facilities – large and small; public, faith-based and private-for-profit; rural and urban.

Because gaps in referral systems can be a major cause of poor QoC, selecting districts that have a referral hospital can help in understanding and solving problems related to referral systems.



Orient the learning districts to quality of care activities

Once the operational plan has been developed and learning districts identified, the next steps should be orientation of the learning districts and relevant stakeholders. The orientation of the learning districts will help to:

- Ensure commitment and participation of the district staff and stakeholders. If a selected district is not interested or unable to participate fully in the orientation, then another district can be selected in its place.
- Orient district management and stakeholders on the purpose of the MNCH QoC roadmap, and orient the staff on selected MNCH QoC standards, QoC interventions, and related measurements.
- Clarify the role of the interrelated functions for QoC – on-site support, sharing and learning, measurement, stakeholder and community engagement, and programme management.
- Agree on district-level aims and identify the facilities that will be engaged upfront.
- Initiate the development of the district operational plan, including the plan for training of district staff on QoC standards, interventions, assessment, measurement, etc., as needed.
- Clarify how the national-level and district partners will provide support to the district in this work.

The orientation workshop is organized by the team responsible for implementing the QoC activities for the MNCH programme at the national level in close collaboration with the District Health Management Team (DHMT). Recommended participants for this workshop are facilities, partners and community representatives at the district level. The use of the district landscape synthesis tool facilitates the identification of strengths, capacities, resources and partners working in MNCH QoC at the district level.

Ongoing activities at national level

The ongoing activities are efforts needed to ensure sustainability and optimize QoC results. Ongoing activities at the national level are designed to ensure that QoC systems are functioning, activities are sustained and the operational plan to improve MNCH QoC is continually revised with feedback from the implementation experience.

Countries have different combinations of actors leading the implementation of QoC. While recognizing this diversity, it is envisaged that the TWG must play a leadership role and ensure that the QoC interrelated functions are resourced and supported by structures that have clear roles and responsibilities, and work in coordination with each other across all levels.



Foster a positive environment for improving quality of care

Culture changes are not one-off activities but will need constant reinforcement. A QoC-driven environment requires management to encourage staff to identify gaps and take action, and to actively look for and celebrate successes in implementing QI and improving QoC (see Box 7).



Address maternal, newborn and child health programmatic and health system constraints for improving quality of care

The function of the national level is to solve programmatic and health system constraints that have to be addressed at this level. This may include introducing new MNCH guidelines and practice tools, updating national QoC for MNCH standards, implementing MNCH QoC assessments periodically, redesigning MNCH service delivery, developing MNCH QoC bundles and models of care that respond to the national and district-specific context, strengthening workforce availability and competencies, improving commodities and supply chain management, and enhancing infrastructure and financing, etc.

The TWG and the ministry of health MNCH-related departments must play a critical role in addressing the MNCH QoC programmatic issues while determining which structures are most appropriate for addressing other identified health system gaps.

Box 7. Strategies to develop and maintain a positive environment and build motivation to improve quality of care

- Recognize and reward efforts to improve QoC. This could take the form of recognition, professional incentives, and opportunities for QI teams and facilities to present their work in meetings, conferences and other sharing platforms.
- Actively identify and celebrate successes – big and small – achieved by the participating districts and facilities.
- Identify and promote champions of quality, who can share their experiences and motivate colleagues and staff.
- Respond actively to solve challenges in managing the QoC activities. Avoid punishing individuals or teams who report problems. Instead, leaders and managers need to be supportive and available to help with problem-solving.

3

Address district implementation gaps and needs for improving quality of care

The national level ensures that QoC interventions are supported in the learning districts. A main role of the national level is to solve problems that districts cannot address on their own. The type of support that the national level can provide varies, from providing additional resources, organizing and supporting capacity-building activities, to supplying commodities and mobilizing partners. The national level also serves as an interface with other relevant ministries, departments and organizations to respond to gaps that require intersectoral action.

The TWG must make sure that the identified gaps are addressed by the appropriate structures.

4

Strengthen the monitoring and measurement of quality of care, and use quality of care data for decision-making

Monitoring and reporting of QoC MNCH indicators that cover provision and experience of care are key to demonstrating progress and addressing challenges in QoC MNCH improvement efforts. Some of these indicators can be generated through the national routine HMIS. Many QoC-related measures are specific to the QI aims. These measures show whether QI activities are indeed implemented and if targeted MNCH outcomes are being reached. However, most of these measures cannot be generated by the HMIS; therefore, it is necessary to develop simple and flexible tools that facilitate the QI data collection and use.

To facilitate data collection and use, the QoC monitoring focal points must be identified and supported across all levels. The QoC monitoring focal points will coordinate MNCH QoC measurement activities – including the HMIS readiness assessment for MNCH QoC measurement and continuous data collection, reporting and analysis – and support the DHMT and facilities to use the data for QI.

5

Use learning to strengthen implementation and inform scale-up of maternal, newborn and child health quality of care

The successes achieved and challenges faced by the learning districts and facilities will provide invaluable learning that can be used, ranging from updating standard implementation practices, to resource allocation, service organization and policy change.

Facilitated sharing and learning of both successes and failures within and across districts and facilities can show how well MNCH quality interventions improve QoC, what changes in the MNCH quality interventions may be needed, and how to adapt the existing systems to implement these quality interventions at scale.

Learning generated from the implementation and support of the QoC interrelated functions across the learning districts and facilities will inform scaling-up of these functions and related structures across the country.

Countries will have to establish learning mechanisms (platforms) to facilitate sharing and learning across all levels of the system (see the section on “sharing and learning” in the chapter on “How to Use this Implementation Guide”). Academic institutions can support the development and implementation of the national learning platform, including facilitation of exchanges among practitioners, learning districts, decision-makers and academics, among others.

These institutions can also facilitate the documentation of QoC implementation experiences and undertake implementation research to inform policy change and scaling-up of interventions. They can directly contribute to the coordination and alignment of the work of stakeholders responsible for evidence generation, policy-making and the day-to-day implementation of programmes. These learning mechanisms have to be institutionalized and funded.

While establishing full-fledged learning platforms may take time, their absence should not prevent the sharing of emerging learning between districts and facilities. Use of digital technology or social media can be a quick way to bring together practitioners to share experience and learning. Annual national quality forums also provide countries with an effective mechanism for sharing learning.

Useful resource:

Guidance on developing national learning health-care systems to sustain and scale up delivery of quality maternal, newborn and child health care.



6 Use periodic review mechanisms to ensure accountability and response

The MNCH QoC updates need to be included in the ministry of health's periodic reviews. Regular reviews of the implementation by the national TWG would help as a way to actively respond to and address implementation needs, as well as to feed into strategic processes such as the NQPS review, the QoC for MNCH roadmap, and other related policies, strategies, investments.

Useful resource:

Developing and updating the National Maternal and Newborn Health Quality of Care Roadmap (Annex 2).



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Section B.

Improving maternal, newborn and child health quality of care at district level

Using this section

This section describes activities for district health managers and health workers to enable implementation of QoC efforts in a district. The term “district” is used in this document to denote a clearly defined administrative area where there are local government and administrative structures that take over many of the responsibilities from the national government and where there is a general hospital for referral. This section provides detailed guidance for implementing start-up and ongoing activities to improve MNCH QoC. The start-up activities are efforts needed to set up a working environment to facilitate improvement of QoC. The ongoing activities are efforts needed to ensure sustainability and optimize QI results as quality initiatives progress.

Before starting, it is recommended that users consult the chapter on “How to Use this Implementation Guide”, which explains in more detail the purpose of this guide, who it is for, why QoC is important and the guiding principles to get started.

The need for district-level activities to support quality of care

This section of the implementation guide describes how to initiate and support QoC MNCH activities at district level. The DHMT is responsible for implementation of activities at the district level. The DHMT’s commitment and leadership is a precondition to implementing, improving and sustaining QoC. At the district level, QoC activities have to be rooted in the district management processes. The DHMT is responsible for organizing services to respond to community QoC needs, allocating resources to support implementation of QoC in facilities and beyond, organizing the QI on-site support and the district QoC learning system, monitoring and measuring performance, and feeding the QoC data and lessons learned into the quarterly and other review processes and practices. The DHMT engages with the community to ensure that the QoC needs are addressed and accountability is maintained. It mobilizes district stakeholders to align their support to QoC activities and provides feedback to the national level on implementation of the QoC roadmap, national QoC policy directions, MNCH guidelines and standards implementation, etc.

Overview of district-level activities

District-level activities to support the improvement of quality of care for maternal, newborn and child health

Start-up activities

- 1 Introduce the MNCH QoC programme to districts, facilities and stakeholders
- 2 Review and map existing QoC activities, partners and resources
- 3 Develop a district operational plan for improving MNCH QoC
- 4 Mobilize capacity for QI coaching at district and facility levels
- 5 Orient the learning facilities on QoC activities
- 6 Provide early support to learning facility staff

Ongoing activities

- 1 Foster a positive environment for improving QoC
- 2 Build capacity and identify gaps at district and facility levels
- 3 Respond to facility needs in reaching selected improvement aims
- 4 Ensure functionality of the interrelated functions to improve QoC
- 5 Use learning to improve the district operational plans and activities
- 6 Maintain engagement with national level

Start-up activities at district level

The start-up activities are efforts needed to prepare the environment for the QoC implementation. Start-up activities at the district level are designed to build commitment and enthusiasm across partners, facilities and communities, and facilitate the implementation path (see Box 8). The start-up phase establishes the basis for the development of the QoC interrelated systems and lines up engagement of districts, implementers and other stakeholders.



1 Introduce the maternal, newborn and child health quality of care programme to districts, facilities and stakeholders

The DHMT will facilitate and introduce the programme to the:

- health workers at district and facility levels;
- communities served by the districts and facilities; and
- stakeholders who can potentially support the programme, such as local authorities, civil society organizations (CSOs), nongovernmental organizations (NGOs) and other sectors (e.g. education, community development).

The introduction to QoC MNCH provides overall practical information that includes:

- an orientation on QoC, national and district-specific QoC aims;
- how the QoC activities fit in with other ongoing activities at the district and facilities;
- what support the district can provide to facilities and communities (QI on-site support, learning opportunities, etc.); and
- how stakeholders can align and facilitate the improvement of the MNCH QoC programme in the district.

Box 8. How to ensure quality of care activities are a district priority

- Make sure district, facility, community leaders and government authorities are actively engaged in the orientation.
- Be clear on the practical aspects of the work (who does what).
- Invite feedback and input into the current plans from the people who will be most affected – this will include beneficiaries of care and staff from the health-care facilities. They also need to be involved in the ongoing planning and management of the overall programme.



Review and map existing quality of care activities, partners and resources

Many districts already have designated resources and ongoing activities focusing on improving QoC. Mapping these resources and activities is a useful way to identify funding or implementation gaps, to learn what current activities are or are not working, and to avoid duplication. This mapping exercise needs to seek engagement with the various entities involved in MNCH QoC in the district. The MNCH QoC landscape synthesis tool (Annex 1) could be used for this exercise. This tool helps users to:

- Bring together and analyse the QoC for MNCH status and key factors that contribute to poor QoC.
- Map existing interventions to improve quality for MNCH across provision and experience of care: what, where, scope, resources available, activities and actors.
- Assess status of development and implementation of QoC for MNCH standards and related QoC interventions.
- Map and analyse capacities required for implementation of the five interrelated functions for QoC – on-site quality improvement support, sharing and learning for QoC, measurement for QoC, stakeholder and community engagement, programme management for QoC.
- Identify QoC capacity-building areas at all levels of the health system.

The district landscape synthesis tool identifies the strengths, capacities, resources and good practices that can be used to determine and prioritize strategic gaps, identify partners and stakeholders working in MNCH QoC, and ultimately coordinate activities to avoid duplication.

The MNCH QoC district landscape synthesis tool must be completed through a participatory and collaborative process. This can be done with support from the national level, and needs to engage with all stakeholders involved in MNCH QoC to complete the information and the QoC for MNCH situation analysis. The landscape synthesis summarizes and analyses existing information. It is possible that the information documented may not be complete or up to date, but these gaps should not stop the finalization of the analysis.

It is estimated that the landscape synthesis exercise can be completed within four to eight weeks.

During the mapping exercise, it is useful to gather information around existing QI activities that can facilitate the organization of the on-site support. For example, these activities can be related to improving facility-level clinical care and reducing harm, enabling an environment that supports QoC, and patient, family and community engagement and empowerment. It would also be useful to collect information on existing structures and requirements that can be used to enable the development of the QoC learning system, measurement, and stakeholder and community engagement.

Useful resource:

The MNCH QoC landscape synthesis tool (Annex 1)



Develop a district operational plan for improving maternal, newborn and child health quality of care

The DHMT uses the information from the MNCH QoC district landscape analysis to develop an operational plan to improve MNCH QoC.

The district operational plan is a practical document that describes how the activities will be implemented. It identifies the processes, resources and actions needed to support implementation of QoC activities. It also needs to be aligned with the national operational plan for MNCH QoC. The operational plan pays special attention to the facilities in which MNCH QoC improvement activities will take place and where these activities will be thoroughly documented for learning and adaptation. For the purposes of this guide, these facilities are called “learning facilities” (Box 9).

Box 9. Learning facilities

It is recommended that the process begin with a focus on a limited number of facilities – referred to as learning facilities. Their experience shapes the district and national understanding on how to manage a functional QoC programme and can inform the expansion of QoC activities to other facilities.

Each district needs to decide on a feasible number of learning facilities. Too few learning facilities will not generate much learning among themselves, which will make it hard to use peer-to-peer learning to support facility staff to improve care. Too many facilities will require more resources being put into doing the work rather than learning how to best run a QoC programme.

Criteria for selecting learning facilities

Suggested criteria to consider when selecting the learning facilities include:

- The facility leadership is interested and committed to learning and making changes to improve MNCH QoC.
- The facilities are representative of others in the district. They are neither the best nor the worst performing in terms of MNCH QoC and in resources available for MNCH QoC.
- The facilities have an adequate caseload to generate learning quickly. If learning facilities have a very low caseload, it will take more time to learn whether the introduced improvements are leading to better care or not.
- The initial learning facilities need to be representative of a variety of facilities – large and small; public, faith-based and private-for-profit; rural and urban. The learning generated from such a selection of sites is more likely to be generalizable. Additionally, including facilities at different levels of the health system can provide learning on how to improve linkages and referrals.
- The facility is accessible for QI coaches to provide on-site support.

The operational plan should include:

- Identification of the **selected learning facilities** in which MNCH QoC improvement activities will be thoroughly documented.

- **Improvement aims** that the learning facilities start with, which need be specific to the context and should therefore be discussed and decided on together with the facility staff and community representatives (see Box 10).
- The **quality interventions** to be used to reach the aims in the selected facilities.
- The organization and resources needed to support implementation of the **interrelated functions for QoC services**,ⁱⁱⁱ with specific attention paid to supporting MNCH QoC activities in the learning facilities and between the national level and the districts (see Box 11).

Box 11. Select appropriate quality interventions

Quality interventions can be broadly categorized as serving the following purposes:

- to improve facility-level clinical care and reduce harm (e.g. MNCH QoC checklists, pathways, protocols, adverse event reporting systems, clinical decision-support tools, audit and feedback, morbidity and mortality reviews, QI cycles);
- to enable an environment that supports QoC (e.g. MNCH QoC standards, training, professional regulation, quality assurance, accreditation, public reporting, benchmarking, performance-based financing, regulation of medicines); or
- to empower and engage patients, families and communities (e.g. health literacy, peer support, shared decision-making, self-management programmes).

Some of these quality interventions are interrelated and can thus have greater impact when implemented in combination with each other.

Useful resources to inform the QoC work at district and facility levels are available in Annex 4.

To facilitate implementation of QoC activities at the district and facility levels, it is necessary to review and strengthen the critical systems related to information, sharing knowledge and learning, programme management and community engagement. These systems are critical for supporting the implementation of the five interrelated functions required for optimal delivery of QoC programmes.

Useful resource:

[Five functions to improve quality of care for maternal newborn and child health.](#)

Box 10. Agree on improvement aims

The operational plan to improve MNCH QoC focuses on selected aims that are relevant to the district and to patient outcomes (clinical outcomes and experience of care), allow for implementation of the WHO QoC MNCH standards, and are aligned with national priorities.

Aims can be selected using a variety of information sources (existing data from routine HMIS, QoC assessments, user experience assessments, periodic reviews, or any other data that the district or facilities may have collected). They also have to be guided and informed by the experience of health workers and communities.

Some considerations to take into account when selecting improvement aims to start and motivate the health workers and QI teams include:

- Select aims that impact patient outcomes and experience of care.
- Aims should address problems that health workers feel motivated to solve.
- Choose problems that are under the DHMT's control.
- The aims should be easy to measure – data for the selected aim must be easily available at the health-care facility and not take too much effort to gather or analyse.

iii. Further detail on each of the interrelated functions can be found in the chapter on "How to Use This Implementation Guide".



Mobilize capacity for quality improvement coaching at district and facility levels

The development of capacity for QI at district and facility levels is key and requires structured support across all levels of service delivery. Specific attention is required to develop and sustain QI coaching mechanisms at the district and facility levels, including embedding QI on-site support within existing mechanisms such as supportive supervision and periodic reviews.

In district settings where QI initiatives are already in place, mobilizing and engaging with existing QI coaches is recommended to accelerate the start-up of the initiative. In other settings, it might be necessary to build new QI coaching capacities to ensure support to facilities.



Orient the learning facilities on quality of care activities

Once the learning facilities have been identified, the next step is to orient the facilities and community representatives. The orientation will help to:

- ensure commitment and participation of the facility staff and community representatives (if a selected facility is not interested or unable to participate fully in the orientation, then another facility can be selected in its place);
- explain the purpose of the MNCH QoC activities – orient the staff on selected MNCH QoC standards, QoC interventions and related measurement;
- facilitate agreement on facility-level aims;
- orient the staff on selected quality interventions and plan for training of facility staff on quality interventions as needed; and
- clarify how the national level and district partners will provide support to the facility in this work.

The orientation workshop is organized by the DHMT with support from the national level. Recommended participants for this workshop are management teams from learning facilities, and partners and community representatives at the district level.



Early support to learning facility staff

Immediately after the orientation, the DHMT must ensure that learning facility staff are debriefed on the QoC, oriented on the district QoC programme and supported with capacity-building on QI. The orientation session may include, but not be limited to:

- training on QI methods
- data collection on specific aims
- stakeholder and community engagement in QoC
- refresher training on standards and guidelines relevant to the selected improvement aim, as needed.

QI coaches should be identified and assigned to specific learning facilities and plan the initiation of the QI on-site support. QoC learning among facilities and within the district should also be planned and can be organized within already existing forums and meetings. It is also important to have structures in place to streamline feedback and lessons learned from the learning facilities and districts to the national-level management.

Ongoing activities at district level

The ongoing activities are efforts needed to ensure sustainability and optimize QoC results. Ongoing activities at district level are designed to ensure that the systems set up to improve QoC continue to function, start-up activities are sustained, and the district operational plan to improve MNCH QoC is continually revised based on implementation experience.

1

Foster a positive environment for improving quality of care

Cultural changes are not one-off activities but will need constant reinforcement. A QoC-driven environment requires management to encourage staff to identify improvement areas and take action, and to actively look for and celebrate successes in implementing QI and improving QoC (Box 12).

2

Build capacity and identify gaps at district and facility levels

The development of capacity for QI at district and facility levels is key and requires structured support across all levels of health service delivery. The support includes continuous coaching to build and sustain QI skills of health workers at the front lines (on-site support). Specific attention is required to develop and sustain QI coaching mechanisms at the district and facility levels, including embedding QI on-site support within existing mechanisms such as supportive supervision and periodic reviews.

Useful resource:

[Point of Care Quality Improvement: Setting up and managing a quality improvement programme at district level programme management guide.](#)

Box 12. Fostering a positive environment for improving quality of care

To foster a positive environment for improving QoC, the DHMT can:

- Recognize and reward efforts to improve QoC. This could take the form of recognition, professional incentives, opportunities for QI teams and facilities to present their work in meetings, conferences and other sharing platforms, etc.
- Actively identify and celebrate successes – big and small – achieved by the learning facilities.
- Identify and promote champions of quality, who can share their experiences and motivate colleagues and staff.
- Respond actively to solve challenges in managing the QoC activities. Avoid punishing individuals or teams who report problems. Instead, leaders and managers need to be supportive and available to help with problem-solving.



Respond to facility needs in reaching selected improvement aims

The DHMT needs to use data and information from QI coaches and facility staff to understand what progress has been made towards the agreed improvement aims. One of the main roles of the DHMT is to solve problems that facilities cannot address on their own; hence, if the facility identifies a need that it cannot address, it must be brought to the attention of the DHMT. The type of support needed from the district level can vary, from supplying medicines and equipment, supervision and mentorship, helping the facility with inventory forecasting, to generating demand for the facility's services.



Ensure support to the interrelated functions to improve quality of care

The DHMT needs to help ensure functionality of the interrelated functions to support QoC. This might require additional support from the national level; hence, the DHMT needs to initiate linkages to address this. Below are examples of relevant aspects the DHMT needs to consider in order to provide support for functionality of the interrelated functions of QoC.

On-site support for QoC

Ensure there are enough coaches, with dedicated time, permission and resources to support the learning facilities. It is also important that the coaches are given opportunities to develop their own skills.

Sharing and learning for QoC

The DHMT is responsible for creating opportunities to share learning within its own district and with other districts. This can be done more informally, through social media platforms – such as setting up WhatsApp groups, etc. – but it can also be done through district collaboratives, which gather the learning facilities together and enable sharing and learning among them. The learning from the facilities can also inform the district review process. If needed, these types of activities can also be done with support from the national level.

Measurement for QoC

The DHMT needs to support the review of four types of measures from the learning facilities: patient outcome measures, patient process measures, facility input measures and programme performance measures.

- Data on patient outcomes and processes of care will enable the DHMT to understand learning facilities' progress in reaching the selected improvement aims. This will help them identify facilities that are doing well and have lessons that can be shared with other facilities, as well as facilities that need additional support.
- Programme performance measures will help the DHMT to see whether the support systems for QoC are functional and whether facilities have the necessary resources to provide QoC.

Stakeholder and community engagement

Stakeholder and community engagement are critical to ensuring accountability for QoC. Their involvement can help identify gaps, prioritize concerns, monitor performance and provide solutions to improving QoC. It is important for the DHMT to plan out how to include stakeholders and communities in the QoC efforts. Examples such as community scorecards or guidance for community dialogue are useful platforms that allow for meaningful participation of communities in improving QoC.

Programme management for QoC

The DHMT, through the programme management function, needs to facilitate and ensure that QoC activities are prioritized, supported and delivered at the point of care. The programme management function is responsible for linking QoC efforts with the broader health system functions in the district, including health planning, financing, service delivery, commodities and supply chain management, measurement, etc.

The DHMT can use the programme performance measures (10) as support for understanding whether the structures and system for QoC are working. These data include information on:

- frequency and adequacy of QI on-site support visits/support and clinical mentorship;
- whether QoC data are being adequately collected and shared between the facility and the district;
- whether peer-to-peer learning opportunities are being organized in the district and are conducted in ways that foster openness and sharing; and
- whether problems are being solved at the facility level and coaches and the DHMT are actively involved in providing external support.

**5 Use learning to improve the district operational plans and activities**

The successes and challenges experienced by the learning facilities will provide invaluable input and can help to inform ways to adapt the operational plan and activities. Facilitation of sharing of learning (successes and failures) within and across districts and facilities can show:

- how well MNCH quality interventions improve QoC;
- what changes in the MNCH quality interventions may be needed; and
- how to adapt the existing systems to implement these quality interventions at scale.

Any successful changes can help inform the national level and lead to integration into policies, strategies, financing mechanisms and relevant implementation tools.

Useful resource:

Guidance on developing national learning health care systems to sustain and scale up delivery of quality maternal, newborn and child health care.



Maintain engagement with national level

The DHMT needs to interact regularly with the national level to convey progress. This will include sharing data on progress, identifying specific problems for which the district needs help, and sharing any key lessons learned about how best to organize such an effort at the district level.



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SECTION C.

Improving maternal, newborn and child health quality of care at facility level

Using this section

This section provides detailed guidance for implementing start-up and ongoing activities to improve MNCH QoC at the facility level. The start-up activities are efforts needed to set up a working environment to facilitate improvement of QoC. The ongoing activities are efforts needed to ensure sustainability and optimize QoC results as quality initiatives progress.

This section describes activities needed to support delivery of QoC by staff in health facilities. QoC will improve only if health facility management and leadership and all health staff are involved in QI. To simplify communication, activities for this section are grouped under two themes: activities to be undertaken by the health facility management and leadership, and activities to be undertaken by all staff organized in QI teams.

Before starting, it is recommended that users consult the chapter on “How to Use this Implementation Guide”, which explains in more detail the purpose of this guide, who it is for, why QoC is important, the systems required to support implementation of QoC, and implementation guiding principles.

Quality of care facility leadership team

The QoC facility leadership team is composed of the health facility management team and the QI team lead(s). The facility leadership team identifies the overall QI facility aims and targets, and oversees the QI implementation. The facility leadership’s commitment is a precondition to implementing, improving and sustaining QoC at the facility. The team ensures that QI teams receive on-site support and sufficient resources from the health facility and the DHMT to attain their QI initiative aims.

Quality improvement team

QI teams are composed of staff who work together to implement QI interventions and achieve the improvement aims agreed upon by the health facility. The QI team needs to be multifaceted and include a broad range of staff who are involved in efforts to improve QoC at the facility, which can include physicians, nurses, clinic officers, data clerks, pharmacists, auxiliary staff, etc. The inclusion of a broad range of expertise brings together the skills, experiences and insights of different viewpoints, which can contribute to the identification of QI gaps and solutions. Each QI team needs a team leader who is responsible for coordinating and leading the work and who will be part of the QoC leadership team at the facility.

Overview of facility-level activities

QoC leadership team activities to support the improvement of quality of care for maternal, newborn and child health

QI team activities to support the improvement of quality of care for maternal, newborn and child health

Start-up activities

- 1 Introduce the QoC activities to facility, community and other stakeholders
- 2 Establish the facility QI team(s)
- 3 Identify improvement aims for the facility
- 4 Facilitate initiation of QI activities

- 1 Set up a QI team
- 2 Decide on improvement aim(s)
- 3 Define aim-related measures and set up a process for data collection and use
- 4 Analyse gaps and identify actions for reaching selected aim(s)

Ongoing activities

- 1 Foster a positive environment for improving QoC
- 2 Support QI processes and QI capacity-building
- 3 Support QoC measurement
- 4 Respond to facility needs in reaching selected improvement aims
- 5 Facilitate sharing of information and learning
- 6 Engage with the communities and stakeholders
- 7 Ensure use of QI findings in the facility and district review and appraisal processes

- 1 Continue improvement activities
- 2 Review data to determine effective actions and progress
- 3 Apply effective actions to the routine work
- 4 Maintain effective communication with the facility leadership team
- 5 Share learning and results
- 6 Engage in accountability activities

Start-up activities – Facility leadership team

The start-up activities are efforts needed to prepare the staff for the QoC implementation. Start-up activities at the facility level are designed to build commitment and enthusiasm within the facility teams. The facility leadership team plays a pivotal role in ensuring that QoC improvement is a priority and is adequately supported.



1 Introduce the QoC activities to facility, community and other stakeholders

The facility leadership team, with the support of the DHMT, will introduce and orient all the staff at the facility, communities served by the facility and local stakeholders on QoC for MNCH (see Box 13).

The orientation should include overall practical information such as:

- what QoC is and why it is important;
- the roles the facility, community and stakeholders play in QoC;
- how the QoC activities in the facility contribute to the district and national QoC agenda;
- the district and facility QI aim(s) and the potential benefits for the patients and the community;
- how the QoC activities fit in with other ongoing activities at the facility; and
- what support the facility can expect from the district and national levels (QI on-site support, learning opportunities, etc.).



2 Establish quality improvement team(s)

The facility leadership team leads the initiation of QI team(s). Smaller facilities may have one QI team that works on different MNCH QI aims and larger facilities may have multiple QI teams (Box 14). Teamwork and communication among all staff – clinical and nonclinical – are essential to improving QoC.

Box 13. Considerations for a successful orientation

- Make sure facility staff and community leaders play a prominent role in the orientation.
- Be clear on the practical aspects of the work (who does what).
- Invite feedback and input into the current plans from the people who will be affected by QoC activities (facility staff and community members) and involve the people who will be most affected by the programme in ongoing planning and management.

Box 14. Considerations for the composition of the quality improvement team

The composition of QI teams is not fixed and will depend on the selected aim at the facility level. However, they need to include:

- representatives from all staff cadres involved in the selected component of care, including staff who:
 - provide care for the patient
 - know the practical enablers at the facility to providing quality care
 - can fix administrative problems
 - are good at communicating with other staff members outside the team
 - know how to present and use data.
- community representatives, such as users of the facility, local government representatives, health committee members, community leaders, etc.
- nonclinical staff – such as auxiliary staff, data managers, transport staff, administrative staff, technicians – who are often integral to improving services.



3 Identify improvement aim(s) for the facility

The facility leadership team will facilitate the identification and definition of the specific aim(s) that the facility wants to achieve. Aims can be selected using a variety of information sources, such as existing data, routine HMIS, or any other data that the facility may have collected; they can also be guided by the experience of health workers and communities. Improvement aims can be selected in different ways:

- a common aim can be chosen for them by the district, or
- they can select their own aim, depending on what they want to improve – it is also encouraged that community members be included in this process.

Facility improvement aims need to be aligned with the district and national QI aims but are more specific and are grounded in the data from that facility and have a defined target and time frame (Box 15).

Useful resource:

[Improving the quality of care for mothers, newborns and children in health facilities. POCQI: point of care quality improvement. Facilitator manual.](#)



4 Facilitate initiation of quality improvement activities

The facility leadership team needs to organize the support of the QI implementation in their facility. In collaboration with the DHMT, the facility leadership team will identify QI coaches and plan for the first coaching visit. The facility leadership team and staff, supported by the QI coach, will identify the QI aim, establish the QI team, develop the QI implementation plan – including data collection, frequency of QI team meetings, reporting mechanisms – and plan the follow-up coaching visits.

Once the start-up activities have been initiated, the QI teams will implement their QI project. Continuous support from the facility leadership team will be needed to ensure that challenges and gaps are addressed and that efforts are sustained. The next section will present the ongoing activities to support the QI implementation.

Box 15. Agree on facility improvement aims

Facility improvement aims need to be relevant to the facility and to patient outcomes, and should be aligned with district priorities. Aims can be selected using a variety of information sources, such as existing data from routine HMIS, QoC assessments, user experience assessments, periodic reviews, or any other data that the facility or the district may have collected. They also need to be guided and informed by the experience of staff and community.

Some aspects to consider when selecting improvement aims include:

- The aims should impact patient outcomes and experience of care.
- Aims should relate to problems that health workers will be motivated to solve.
- Choose aims that are under the control of the QoC leadership team.
- Data for the selected aim must be easily available at the facility and not take too much effort to gather or analyse.

Ongoing activities – Facility leadership team

Once the start-up activities have been implemented and the QI teams have started to work on QI projects, efforts are needed to ensure sustainability and to optimize QI results as quality initiatives progress. The ongoing activities are designed to ensure that the systems set up to improve QoC continue to function and that QI activities are sustained. QI teams need continuous guidance from the facility leadership team and capacity-building to ensure that staff are motivated and supported to continue with the efforts to improve the QoC.

1 Foster a positive environment for improving quality of care

Culture changes are not one-off activities but will need constant reinforcement. A QoC-driven environment requires management to encourage staff to identify improvement areas and take action. It also requires the facility leadership team to actively look for and celebrate successes in improving QoC. Supportive visits from the DHMT can also be opportunities to create positive environments for QI (Box 16). Supervision and coaching visits can be a venue to leverage the QI work and support the identification of QI champions and reward QI teams.

2 Support quality improvement processes and capacity-building

Capacity for QI at facility level requires structured support, including continuous coaching, to build and sustain QI skills for the leadership team and staff. The members of a QI team need ongoing support from the facility leadership team and district level to build and sustain their QI capacities and identify QI gaps. This can be done through QI coaching mechanisms or supportive supervision that embraces QI. The facility leadership team needs to engage with the district and national levels to ensure that QI support is available to the facility.

3 Support quality of care measurement

The facility leadership team must ensure that the QI teams are able to collect, interpret and report on QI initiatives data. The facility leadership team must provide the QI teams with access to the existing facility data systems and adequate support to develop data collection analysis and reporting forms that may be required to document the QI project. QI teams need to have the capacity to collect, report and analyse QI data. The facility leadership team must continuously create opportunities for building capacity of staff on QoC measurement. This may require additional support from district and national levels.

Data are key to understanding if the QI efforts are having the desired impact or not. Data will also help to identify promising QI initiatives that can be shared with other facilities and provide support to make sure the QI team(s) can improve care and reach the selected improvement aims. Information from QI projects will also feed into the periodic reviews of the facility and district levels, which can be useful to help understand successes, challenges and gaps. QI data from the facility can be reported as dashboards or using other simple visualizations that can be shared with the communities to demonstrate accountability and keep them informed of the QoC improvements.

Box 16. How to create a positive environment for improving quality of care

- Give time, permission and encouragement to the QI team members to improve QoC.
- Actively identify and celebrate successes – big and small – achieved by the QI team(s).
- Identify and promote champions of quality, who can share their experiences and motivate colleagues and staff.
- Respond actively to solve challenges in managing the QoC activities.
- Avoid punishing individuals or teams who report problems.
- Be supportive and available to help with problem-solving.

4

Respond to facility needs in reaching selected improvement aims

The findings and learning from the QI work in facilities will help to uncover bottlenecks and gaps to improve QoC. The facility leadership team needs to make sure the QI findings from the facility are shared and discussed with the facility staff and the DHMT, and incorporated into the facility improvement processes.

The facility leadership team is often responsible for addressing challenges and gaps identified by QI teams. These may include resource gaps, organizational design, roles and responsibilities, clinical or technical capacities of staff, etc. The facility leadership team can provide support to solving QI problems that are within the facility's control. For problems outside the facility's control the facility management must enlist the attention of the DHMT or other stakeholders. They can provide support by addressing issues related to staffing levels, supervision and mentorship, supplies and equipment, and engage with communities to generate demand for the facility's services, etc.

The information gained from the QI projects in the facilities could be used to inform reviews, priorities, resource allocation and performance appraisal processes at facility and district levels.

5

Facilitate sharing of information and learning

The facility leadership team must encourage QI teams to regularly share what they are learning. Sharing can be done by incorporating discussions in routine facility meetings or by organizing separate meetings to discuss efforts to improve QoC. It is important that these meetings foster a culture of problem-solving and learning.

The facility leadership team must enable facility staff, who are working to improve QoC, to participate in national and district-level events where they can share with and learn from other facilities. The DHMT are usually responsible for creating opportunities to share learning within its own district and with other districts. It is important that the facility leadership team support the QI teams in the documentation and dissemination of QI initiatives that can be useful to share beyond the facility.

Useful resource:

Guidance on developing national learning health care systems to sustain and scale up delivery of quality maternal, newborn and child health care.

6

Engage with the communities and stakeholders

The facility leadership team is responsible for initiating and building trusting relationships with community representatives. Stakeholder and community engagement is critical to ensure accountability for QoC and supports identification of gaps, prioritization of concerns, monitoring of performance and development of solutions to improve QoC. Community representatives bring the user perspective into consideration and must be involved in the facility QI work. Examples such as community scorecards or guidance for community dialogue are useful platforms that allow for meaningful participation of communities in improving QoC.

Useful resource:

[Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health.](#)

Start-up activities – Quality improvement teams

The start-up activities are efforts needed to prepare the facility staff for QI implementation. These activities are designed to build commitment and enthusiasm within the facility staff to ensure that QI is taking place and is a priority.



Set up a quality improvement team

The first step when setting up a new QI team is to agree on the roles, norms and functions of the team. This will enable members to get a better understanding of the work that lies ahead (Box 17).

Box 17. Setting up the quality improvement team

Roles and responsibilities:

The roles and responsibilities of the team members need to be clearly articulated and agreed upon. It is important to select a team leader who is responsible for the QI project. Others may be tasked to coordinate data collection and analysis, maintain records for the team, communicate with other staff, etc. The team leader will be part of the facility leadership team.

Frequency of meetings:

It is important for the team to meet regularly, especially in the early stages, to make sure the QI project is progressing as planned and that challenges can be addressed.

Engaging with the facility leadership team:

Regular communication among QI and facility leadership teams enables QI information sharing and facilitates enlisting support for solving QoC problems. Reporting on QI activities can be included within existing meetings at the facility.



Decide on improvement aim(s)

The QI team needs to identify and define the specific aim(s) that they want to achieve. Aims can be selected using a variety of information sources such as existing data, routine HMIS, or any other data that the district or facilities may have collected. QI aims can be guided by the experience of health workers and community representatives. The QI aim(s) should reflect the overall facility improvement aim(s). The involvement of the facility leadership team in defining the team QI aim(s) could facilitate this alignment.

Early success in improving care can motivate facility staff. Some factors to consider when selecting an improvement aim are highlighted in Box 18. These are especially important for new QI teams. As the teams gain more experience in improving care, they can choose more complex aims.



Define quality improvement aim-related measures and set up processes for data collection and use

QI teams need to use local data to know whether they are making progress or not. Most aims will require data to be frequently analysed (daily, weekly, etc.). QI teams must measure frequently the processes and outcomes of their actions to find out if their QI initiative is resulting in positive changes.

The QI teams may collect two types of data:

- Indicators related to the improvement aim(s):
 - if the QI team is working on aims decided by the DHMT, they will be provided the indicators to use for these aims;
 - if the QI team is working on an aim they selected themselves, they will need to define the indicator(s); this can be done with support from the facility leadership team or the DHMT.
- Additional data on other QoC indicators related to inputs, processes, outputs and outcomes that may have been defined by the district or national levels.

It is best if the QoC data are already available in the existing facility data information systems, for instance, through registers, individual patient charts, or other facility data collection tools. If the QoC data are not readily available in the existing facility systems, the QI teams may need to adjust documentation to collect them. The analysis, interpretation and use of data can be done with support from the facility leadership team or the DHMT.

Box 18. Factors to consider when selecting an improvement aim

Some factors to consider are:

- The impact on improving patient outcomes or experience of care – specifically:
 - How much does the selected process or outcome contribute to maternal and newborn care morbidity and mortality?
 - How many women or babies will experience the outcome or receive the process of care?
- The interest of the QI team members – they will be more motivated to solve problems:
 - that are under the control of the QI team;
 - if the improvement areas selected can be managed by the team members and the facility;
 - that are achievable within a short time and without use of outside resources;
 - that are possible to measure (data for the selected aim must be available at the health-care facility or possible to gather and analyse within the capacities of the facility).



Analyse gaps and identify actions for reaching selected aim(s)

After the QI team has defined an improvement aim, they need to analyse the gaps and identify the main barriers to reaching the improvement aim. Gaps and barriers may include:

- infrastructure, human and financial resources, supplies, etc.
- clinical knowledge and skills
- organization of care
- staff motivation.

It is often easier to identify gaps in resources and clinical skills. However, QI teams should also try to identify issues related to the process of organization of care, roles and responsibilities, optimal use of existing tools and systems, etc. Improving processes of care can improve efficiency and effectiveness and make work easier for staff.

The QI team needs to determine the approaches and actions that are most appropriate for solving particular problems (Box 19). Often, more than one factor needs to be addressed for progress to take place. In many cases, additional support from the facility leadership team or the DHMT might be needed. It is recommended that the QI actions start on a small scale so that their feasibility and potential impact can be better understood.

Useful resources:

[Maternal and perinatal death surveillance and response: materials to support implementation.](#)

[Improving the quality of paediatric care: an operational guide for facility-based audit and review of paediatric mortality.](#)

[Improving the quality of care for mothers, newborns and children in health facilities. POCQI: point of care quality improvement. Learner manual.](#)

Box 19. Examples of methods, approaches and tools to analyse gaps in quality of care

- MNCH QoC standards, based on WHO QoC standards (2,3,4), can help to identify QI aims and serve as a basis for comparing care offered against the desired standards.
- Maternal and perinatal death and response (MPDSR) (12) is a continuous cycle of identification, notification and review of maternal and perinatal deaths followed by actions to improve QoC and prevent future deaths. MPDSR can help uncover QoC deficits and inspire local solutions to address avoidable death factors.

Similarly, child death audits (13) can help uncover QoC gaps, to which the QI teams can respond.

- Checklists, flowcharts, cause-and-effect tools, fishbone analyses, surveys, etc., can also help during analysis to increase understanding on how care is currently being delivered.

Ongoing activities – Quality improvement teams

Once the start-up activities have been implemented and the QI teams have started to work on QI projects, efforts are needed to ensure that the work is sustained and that successful QI initiatives are used to transform the work of the facility. The ongoing activities are designed to ensure that the systems set up to improve QoC continue to function and that QI activities are sustained and institutionalized.



Continue improvement activities

After getting started, the QI team will continue improvement activities. Once an aim has been achieved, the QI team will select new improvement aims. These new aims need to be discussed with the facility leadership team and sometimes the DHMT, to make sure that they are aligned with the facility and district priorities.

It is important that QI activities continue even if team members leave the facility or move to another department. To ensure this, new staff in the facility must be oriented on the QoC efforts and encouraged to be involved in the QI work. The QI team leader or other experienced team members can update new team members about the progress of the QI work and actively engage them in the QI team.



Review data to determine effective actions and progress

The QI team needs to continually collect and analyse data on its selected aim. This will help determine which of the actions and/or solutions are reaching the aim, and which are not. Data clerks or health information managers can help the QI team access QoC data. However, all QI team members must be involved in data analysis and interpretation. Whenever necessary, the QI team can seek support from the facility leadership team or QI coaches.



Apply effective actions to the routine work

Some of the solutions the QI teams identify will lead to improvements and will be feasible for implementation in the facility. These solutions can be integrated into the routine work of the facility. The feasibility of integration should be discussed and analysed with the facility leadership team. Successful QI projects can result in new facility policies and protocols that incorporate new ways of working.



Maintain effective communication with the facility leadership team

The facility leadership team is not always part of the QI team; therefore, the QI team leader must ensure that the facility leadership team is updated on the QI team progress. If the QI team faces problems that cannot be fixed by the team, the facility leadership team should be approached to find a solution. If the problem is beyond the capacity of the facility leadership team, the DHMT needs to be involved to address the issue.



Share learning and results

The QI team needs to identify, document and share the challenges and the results of their QoC improvement efforts. These experiences need to be shared with other departments, facilities and communities. Sharing can take place during peer-to-peer meetings, exchange visits, online webinars, and other virtual or in-person forums. The facility leadership team and the DHMT are usually responsible for creating opportunities to share facility learning and results within and across other districts. Inter-district sharing can be in-person, through meetings and visits arranged by the DMHT, or can be through virtual platforms such as WhatsApp groups, webinars or online forums.

Useful resource:

Guidance on developing national learning health care systems to sustain and scale up delivery of quality maternal, newborn and child health care.



Continuous engagement with the communities

QI initiatives benefit from engagement with community representatives – including women representatives and patients – who can participate in the QI projects. When community engagement mechanisms are in place, they provide a powerful avenue to ensuring accountability for results. QI teams should plan for stakeholder and community involvement at an early stage when setting up QI efforts.

Useful resource:

[Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health.](#)

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Annex 1.

The MNCH QoC landscape synthesis tool - National level

#	Components	Suggested examples and actions	Strengths	Weaknesses or gaps to address	Opportunities
1	National commitment to improve MNCH expressed and demonstrated	1.1 There is a high-level government official (e.g. Minister of Health) who makes an official commitment to improve quality of care for MNCH			
		1.2 Ministry commits to specific MNCH QoC goals linked to existing national priorities (e.g. ENAP, EPMM, SDGs, UHC, etc.)			
		1.3 Ministry of Health develops an action plan to improve QoC, which address MNCH QoC needs (including SSNB)			
		1.4 Plans being implemented and tracked to address system level issues related to resources, supplies, equipment, clinical skills etc for MNCH			
		1.5 Ministry and partners commit to provide regular public updates on progress in improving MNCH QoC e.g through a platform			
2	National leadership and governance structures for QoC are strengthened (or established) and functioning	2.1 Strengthen or develop a National Quality Policy and Strategy to support efforts to improve quality of care in the health sector			
		2.2 Strengthen or establish a government-led, multi-stakeholder steering group (government, MNCH QoC technical and implementing partners, civil society, professional groups, donors) for guiding and coordinating efforts to improve quality of care in MNH services. (Technical Working Group, TWG)			
3	National maternal, newborn, child health quality of care standards adapted	3.1 Review and adapt national standards using WHO standards as a reference			
		3.2 QoC for MNCH standards are integrated in existing QoC assessment and measurement mechanisms (e.g. accreditation systems, results based financing, etc.)			
		3.3 Conduct or update the situation analysis and baseline assessment of QoC MNCH			
4	Institutionalizing QoC for mother, newborn and children (including for small and sick newborns)	4.1 Stakeholders at national, district and community level oriented on MNCAH QoC (including small and sick newborn)			
		4.3 QoC indicators assessing QoC for mothers, newborn and children developed and included in HMIS system (including small and sick newborn)			
		4.4. National MNCH strategy reviewed to include specific actions on improving QoC for mothers and children (including small and sick newborn)			
5	Package of quality interventions for MNCH agreed upon to support implementation of the MNCH QoC standards	5.1 Systems interventions that create a supportive environment for MNCH QoC (e.g. health workforce needs and competencies; training, professional regulation, accreditation, PBF, medication regulations) included in package (including small and sick newborn)			
		5.2 Facility-level quality interventions to reduce harm and improve clinical care for MNCH, including small and sick newborn (e.g. interventions such as KMC; supporting tools and job aids such checklists; MPDSR, paediatric death audit; QoC MNCH assessments, quality improvement cycles) included in package			
		5.3 Patient, family and community interventions (e.g. health literacy, peer-support, shared decision making, self-management programs) included in package			

Action / solution (what could be done to address the gap)	Priority (1 - 4) 1 is low priority and 4 is highest priority	Timeframe	Lead Govt/ National institute	Civil Society Organization Role	Professional Organization Role	Partners (H6 and others)	TA Required? (If Yes outline)

#	Components	Suggested examples and actions	Strengths	Weaknesses or gaps to address	Opportunities
6	Systems to support implementation of quality interventions included in package	6.1 On-site support for quality improvement methods (e.g. coaching)	6.1.1 At the national level, there is agreed upon guidance for how to provide on-site QI support (e.g. frequency of support, how to help teams solve problems etc)		
			6.1.2 There are existing activities (e.g. programmes, projects or partners) providing on-site support to facility-level teams to use QI methods, and can support training		
			6.1.3 There are staff within the health system whose role and responsibility is to provide on-site support to facility-level teams to use QI methods		
		6.2 Learning system	6.2.1 System to capture and document: 1) what people did to improve care, 2) how they did it, 3) what results they achieved (at facility, district, national level) that encourages learning as a mechanism to improve QoC for MNCH		
			6.2.2 Systems and mechanisms (e.g. peer-to-peer learning meetings, exchange visits, online forums) to share lessons within the same level (e.g. facility to facility or district to district) and between different levels		
		6.3 Measurement system	6.3.1 The national health information system has QoC indicators that are regularly reported to appropriate level – and the source of data and tools are clear and available respectively		
			6.3.1.a Input, process, outcome for patient level clinical information (e.g. mortality, ENC, infection control)		
			6.3.1.b District performance measures (e.g. percentage of on-site support visits, learning meetings happening)		
		6.4 Community engagement system	6.3.2 There is a plan to collect and use relevant QoC information outside the routine health information system (e.g. facility based assessments, patient satisfaction, community surveys, insurance or accreditation programmes)		
			6.3.3 There are systems and mechanisms for sharing, reviewing and improving QoC data and information at all levels		
			6.4.1 Community and patient representatives to participate in the leadership groups involved in QoC at national, district and facility levels		
		6.5 Programme management system	6.4.2 Communities and patient groups regularly receive and provide feedback on QoC data and information		
6.4.3 Specific feedback/platform strengthened or established to provide communities and patient groups opportunities to provide feedback on experience of care					
6.5 Programme management system	6.5.2 Existing management structures at national, district, facility levels create national forums and platforms to discuss and QoC progress including the voice of patients and communities, and health providers				
	6.5.3 Existing management structures to monitor how ministry of health is supporting implementation of the quality interventions and measure results, and support health care workers and facilities				

Action / solution (what could be done to address the gap)	Priority (1 - 4) 1 is low priority and 4 is highest priority	Timeframe	Lead Govt/ National institute	Civil Society Organization Role	Professional Organization Role	Partners (H6 and others)	TA Required? (If Yes outline)

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The MNCH QoC landscape synthesis tool - District level

#	Components	Suggested examples and actions	Strengths	Weaknesses or gaps to address	Opportunities
1	National commitment to improve MNCH expressed and demonstrated	1.1 There is a high level government official (e.g. minister of health) makes an official commitment to improve quality of care for MNCH			
		1.2 Ministry commits to specific MNCH QoC goals linked to existing national priorities (e.g. ENAP, EPMM, SDGs, UHC, etc.)			
		1.3 Ministry of Health develops an action plan to improve QOC, which address MNCH QOC needs (including SSNB)			
		1.4 Plans being implemented and tracked to address system level issues related to resources, supplies, equipment, clinical skills etc for MNCH			
		1.5 Ministry and partners commit to provide regular public updates on progress in improving MNCH QoC, e.g. through a platform			
2	National leadership and governance structures for QoC are strengthened (or established) and functioning	2.1 Strengthen or develop a National Quality Policy and Strategy to support efforts to improve quality of care in the health sector			
		2.2 Strengthen or establish a government-led, multi-stakeholder steering group (government, MNCH QoC technical and implementing partners, civil society, professional groups, donors) for guiding and coordinating efforts to improve quality of care in MNH services (Technical Working Group, TWG)			
3	National maternal, newborn, child health quality of care standards adapted	3.1 Review and adapt national standards using WHO standards as a reference			
		3.2 QOC for MNCH standards are integrated in existing QoC assessment and measurement mechanisms (e.g. accreditation systems, results based financing, etc.)			
		3.3 Conduct or update the situation analysis and baseline assessment of QOC MNCH			
4	Institutionalizing QoC for mother, newborn and children (including for small and sick newborns)	4.1 Stakeholders at national, district and community level oriented on MNCAH QoC (including small and sick newborn)			
		4.3 QoC indicators assessing QoC for mothers, newborn and children developed and included in HMIS system (including small and sick newborn)			
		4.4. National MNCH strategy reviewed to include specific actions on improving QoC for mothers and children (including small and sick newborn)			
5	Package of quality interventions for MNCH agreed upon to support implementation of the MNCH QOC standards	5.1 Systems interventions that create a supportive environment for MNCH QoC (e.g. health workforce needs and competencies; training, professional regulation, accreditation, PBF, medication regulations) included in package (including small and sick newborn)			
		5.2 Facility-level quality interventions to reduce harm and improve clinical care for MNCH including small and sick newborn (e.g. interventions such as KMC; supporting tools and job aids such checklists; MPDSR, paediatric death audit; QoC MNCH assessments, quality improvement cycles) included in package			
		5.3 Patient, family and community interventions (e.g. health literacy, peer-support, shared decision making, self-management programmes) included in package			

Action / solution (what could be done to address the gap)	Priority (1 - 4) 1 is low priority and 4 is highest priority	Timeframe	Lead Govt/ National institute	Civil Society Organization Role	Professional Organization Role	Partners (H6 and others)	TA Required? (If Yes outline)

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#	Components	Suggested examples and actions	Strengths	Weaknesses or gaps to address	Opportunities	
6	Systems to support implementation of quality interventions included in package	6.1 On-site support for quality improvement methods (e.g. coaching)	6.1.1 At the national level, there is agreed upon guidance for how to provide on-site QI support (e.g. frequency of support, how to help teams solve problems etc)			
			6.1.2 There are existing activities (e.g. programmes, projects or partners) providing on-site support to facility-level teams to use QI methods, and can support training			
			6.1.3 There are staff within the health system whose role and responsibility is to provide on-site support to facility-level teams to use QI methods			
		6.2 Learning system	6.2.1 System to capture and document: 1) what people did to improve care, 2) how they did it, 3) what results they achieved (at facility, district, national level) that encourages learning as a mechanism to improve QoC for MNCH			
			6.2.2 Systems and mechanisms (e.g. peer-to-peer learning meetings, exchange visits, online forums) to share lessons within the same level (e.g. facility to facility or district to district) and between different levels			
		6.3 Measurement system	6.3.1 The national health information system has quality of care indicators that are regularly reported to appropriate level – and the source of data and tools are clear and available respectively 6.3.1.a Input, process, outcome for patient level clinical information (e.g. mortality, ENC, infection control) 6.3.1.b District performance measures (e.g. percentage on-site support visits, learning meetings happening)			
				6.3.2 There is a plan to collect and use relevant QoC information outside the routine health information system (e.g. facility based assessments, patient satisfaction, community surveys, insurance or accreditation programs)		
				6.3.3 There are systems and mechanisms for sharing, reviewing and improving QoC data and information at all levels		
			6.4 Community engagement system	6.4.1 Community and patient representatives to participate in the leadership groups involved in QoC at national, district and facility levels		
			6.4.2 Communities and patient groups regularly receive and provide feedback on QoC data and information			
			6.4.3 Specific feedback/platform strengthened or established to provide communities and patient groups opportunities to provide feedback on experience of care			
		6.5 Programme management system	6.5.2 Existing management structures at national, district, facility levels create national forums and platforms to discuss and QoC progress including the voice of patients and communities, and health providers			
			6.5.3 Existing management structures to monitor how ministry of health is supporting implementation of the quality interventions and measure results, and support health care workers and facilities			

Action / solution (what could be done to address the gap)	Priority (1 - 4) 1 is low priority and 4 is highest priority	Timeframe	Lead Govt/ National institute	Civil Society Organization Role	Professional Organization Role	Partners (H6 and others)	TA Required? (If Yes outline)

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The MNCH QoC landscape synthesis tool - Facility level

#	Components	Suggested actions	Strengths	Weaknesses or gaps to address
1	MNCH QoC programme is introduced to facilities and community stakeholders	1.1 Facility leadership commits to improve quality of care for MNCH and participates actively in required QoC activities		
		1.2 Orientation carried out in the facilities. The orientation includes: 1.2.a Information about which quality interventions the facility should use and available support to facility staff in using these interventions 1.2.b Information about building on-site support, data, learning, community engagement and program management systems to support staff to improve the QoC		
2	QI teams at facilities are formed and are active	2.1 The hospital has a QI team that has been trained on QI techniques and methods		
		2.2 QI team consists of representatives from all staff cadres involved in the component of care selected as the improvement aim, and also the community representatives in the team		
		2.3 The quality improvement team is using a structured quality intervention such as quality improvement cycles or MPDSR		
		2.4 QI teams are working on a specific improvement aim (aligned with district and national aims) – QI team is analysing the gaps in care related to the improvement aim, testing actions to improve care, uses local data, sharing their experiences and learning with peers		
3	Supportive environment for improving MNCH QoC created in the facility	3.1 The health facility staff in the paediatric, maternity, neonatology sections have been oriented/trained on the key MNCH QoC and QI packages, approaches and tools		
		3.2 Facility assessment to identify key QoC issues carried out (or recently carried out)		
		3.3 Leadership addresses system level issues related to resources, supplies, equipment, clinical skills, etc.		
		3.4 Gives time, permission and encouragement to the QI team members to improve QoC		

Opportunities	Action / solution (what could be done to address the gap)	Priority (1 - 4) 1 is low priority and 4 is highest priority	Timeframe	Lead Govt/ National institute	Partners

#	Components	Suggested actions	Strengths	Weaknesses or gaps to address
4	4.1 On-site support for quality improvement methods (e.g. coaching)	4.1 Facility QI team receives regular on-site QI support based upon agreed upon frequency and plan		
		4.1.2 On-site support is helping teams solve problems and improve QoC		
		4.1.3 Mechanism for addressing process issues that affect MNCH QoC is available in the facility		
	4.2 Learning system	4.2.1 There is a system at the facility to capture and document: 1) what people did to improve care, 2) how they did it, 3) what results they achieved		
		4.2.2 QI team and facility leadership participate in mechanisms (e.g. peer-to-peer learning meetings, exchange visits, online forums) to share lessons within the same level (e.g. facility to facility or district to district)		
		4.2.3 QI team and facility leadership participate in mechanisms to share lessons across different levels (e.g. facility to district or district to national)		
	4.3 Measurement system	4.3.1 QI team is able to collect, analyse and use data related to the selected improvement aim		
		4.3.2 Facility is able to collect, use and report selected data on: 4.3.2.a Input, process, outcome for patient level clinical information (e.g. mortality, ENC, infection control) 4.3.2.b Programme management data (e.g. percentage of on-site support visits, number of learning meetings)		
		4.3.3 QI team is able to collect and use relevant QoC information outside the routine health information system (e.g. facility based assessments, patient satisfaction, community surveys etc.)		
		4.3.4 There are mechanisms for sharing and reviewing QoC data and information among QI team members, with facility leadership and with the district level		
		4.3.5 There are mechanisms in the facility to review and improve quality of data		
	4.4 Community engagement system	4.4.1 Mechanisms allow for sharing QoC data and improvement efforts with the community		
		4.4.2 Mechanisms for communities and patients to regularly provide feedback to the facility on QoC data and information		
		4.4.3 Mechanisms to incorporate input from communities and patients to improve QoC at the facility		
		4.4.4 Community and patient representatives participate in the planning process and they are partners in implementing the operational plan for MNCH QoC		
	4.5 Programme management system	4.5.1 There is explicit communication that QoC is an integral responsibility of facility management		
		4.5.2 Facility leadership demonstrates accountability for QoC results (e.g. they are judged based on leading improvements in QoC)		
		4.5.3 Facility leadership is required to implement the quality interventions and measure results		
		4.5.4 Facility leadership is required to facilitate learning and adapt based on what is being learned		
		4.5.5 Facility leadership is empowered to adapt management systems (e.g. HR, financing, commodities, information etc.) to deliver good QoC		
		4.5.6 Facility leadership is able to work with stakeholders outside the health sector to improve QoC (e.g. work with Ministry of Education to reduce anaemia)		
4.5.7 Facility leadership is quickly able to solve problems in response to requests from QI team, facility staff and the community (e.g. supply issues, HR, training, etc.)				

Opportunities	Action / solution (what could be done to address the gap)	Priority (1 - 4) 1 is low priority and 4 is highest priority	Timeframe	Lead Govt/ National institute	Partners

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Annex 2.

Developing and updating the National Maternal and Newborn Health Quality of Care Roadmap

Background

The WHO-led initiative to improve QoC for MNCH envisions a future where “Every mother and newborn receives quality care throughout pregnancy, childbirth and postnatal period”. This vision brings together efforts to achieve the goals of the Global Strategy for Women’s, Children’s and Adolescents’ Health 2030, UHC and the Sustainable Development Goals.

In 2017, the Network to Improve Quality of Care for Mothers, Newborns and Children was launched, with Bangladesh, Côte d’Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Sierra Leone, Uganda and the United Republic of Tanzania comprising the first wave of countries. The Network is a broad-based partnership of committed governments, implementation partners and funding development partners, coordinated by WHO to support efforts to improve QoC for MNCH. It aims to deliver a vision of quality that is underpinned by the core values of quality, equity and dignity, and targets to halve institutional maternal and newborn deaths in five years. The Network is country-led and builds on national structures for QoC.

Since the launch of the Network, most of the Network countries have developed institutional mechanisms and strategies that target improvements in the quality of maternal and newborn care at scale. One key activity for countries has been the finalization of the MNCH QoC roadmap. This has been done under the leadership of the ministry of health, and through consultative processes with the national TWG to guide the adaption and implementation of QoC standards as an integral part of the national strategic direction for QoC.

However, since the start of the Network, the implementing context and priorities in many countries have changed, especially with the impact of the coronavirus disease 2019 (COVID-19) pandemic. Hence, there is a need to update the national MNCH QoC roadmap, to make sure its implementation is feasible, considering a changing landscape, and that it is also aligned with current country priorities.

Updating the MNCH QoC roadmap is an opportunity to ensure updated alignment by relevant partners and ministry of health directorates engaged in QoC activities. This requires a consultative process with the TWG to make sure the updated roadmap is validated and reflects input from various stakeholders.

Objectives

The main objectives of updating the MNCH QoC roadmap are the following:

- To review and refine prioritized actions and needs under each strategic objective.
- To update landscape synthesis analysis based on national plans and MNCH targets.
- To update mapping of partners’ activities and identify possible gaps and opportunities.
- To refine partners’ responsibility in the indicative work plan.
- To align the MNCH QoC roadmap to other investments currently supporting the QoC MNCH agenda.

Suggested participants

- Relevant representatives from ministry of health directorates (clinical services, MNCH, health extension and primary health services, planning department, health infrastructure directorate/information technology team, policy and planning, etc.)
- Subnational/district representatives (DHMTs)
- Representatives from learning districts and facilities
- Partner organizations: United Nations agencies, development partners and funders of MNCH QoC programmes
- Professional societies of various cadres of health workers (nurses and midwives)
- Representatives from learning districts, CSOs and community representatives
- Academia.

Expected outcomes

- Updated landscape synthesis analysis based on national plans and MNCH targets.
- Completed mapping of partners' activities with outlined gaps and opportunities and a refined partners' responsibility in the indicative work plan.
- Updated alignment of the MNCH QoC roadmap to other investments currently supporting the QoC MNCH agenda.

Suggested preparatory actions to be taken in advance

- Partner mapping tool completed ahead of the update.
- Revision of current version of the roadmap narrative document, indicative work plan, and summary of costing done in advance.
- Setting up of working groups done in advance, with a mix of relevant representatives, for revision of specific parts of the roadmap.

Annex 3.

WHO MNCH QoC related interventions

WHO MNCH QoC related interventions	Maternal Care	Newborn Care	Child care	
System environment	Handbook for National Quality Policy and Strategy			
	Improving QoC for MNCH: Implementation guide for facility, district and national levels			
	Interagency list of medical devices for essential interventions for reproductive health and MNCH			
	Strengthening of midwifery toolkit			
Reducing harm	Maternal death surveillance and response (MDSR): technical guidance information for action to prevent maternal death	Making every baby count: Audit and review of stillbirths and neonatal deaths	Improving the quality of paediatric care: an operational guide for facility-based audit and review of paediatric mortality	
	Maternal and Perinatal Death Surveillance and Response: Materials to Support Implementation			
	WHO Safe Childbirth Checklist		Integrated management of childhood illness (IMCI). Chart booklet	
Improving clinical interventions		ENCC Annual implementation review; KMC assessment		
	Standards for improving quality of maternal and newborn care in health facilities			
		Standard for improving the quality of care for small and sick newborns in health facilities	Standards for improving the quality of care for children and young adolescents in health facilities	
	Quality of care for maternal and newborn health: A monitoring framework for network countries		Measurement Framework for Paediatric QoC Indicators (in development)	
	Every Mother Every Newborn (EMEN) quality improvement guide for health facility staff.			
	The Quality of care in contraceptive information and services based on human rights standards: A checklist for health care providers		Oxygen therapy for children: a manual for health workers	
	Counselling for maternal and newborn health care: A handbook for building skills WHO labour care guide: user's manual		Paediatric emergency triage, assessment and treatment: care of critically-ill children	
	Improving the quality of care for mothers, newborn and children in health facilities. POCQI: Point of Care Quality Improvement. Facilitator and learner manuals.			
	Improving the quality of care for mothers, newborn and children in health facilities. POCQI: Point of Care Quality Improvement. Coaching manual.			
	Point of Care Quality Improvement: Setting up and managing a quality improvement programme at district level programme management guide.			
	Managing complications in pregnancy and childbirth: A guide for midwives and doctors - 2 Edition	WHO recommendations on newborn health: guidelines approved by the WHO Guidelines Review Committee	WHO recommendations on child health: guidelines approved by the WHO Guidelines Review Committee	
	Patient, family and community engagement	Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health		
		Recommendations on home-based records for maternal, newborn and child health		
Programme reporting standards for sexual, reproductive, maternal, newborn, child and adolescent health				



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Annex 4.

WHO MNCH QoC related resources

Resource	Life Course Area	Quality category	Source	Link to publication
<i>Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care</i>	Policy level for MNCH	System (national) level policy guidance	WHO	https://apps.who.int/iris/handle/10665/272357
<i>Improving quality of care for maternal, newborn and child health: implementation guide for facility, district and national levels</i>	Policy level for MNCH	System (national) level policy guidance	WHO	
<i>Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health</i>	Policy level for MNCH	System (national) level policy guidance	WHO	https://apps.who.int/iris/handle/10665/333922
<i>Making pregnancy safer: tool for assessing the performance of the health system in improving maternal, newborn, child and adolescent health</i> [in English and Russian]	Policy level for MNCH	System (national) level policy guidance	WHO Regional Office for Europe	https://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/publications/2009/making-pregnancy-safer-tool-for-assessing-the-performance-of-the-health-system-in-improving-maternal,-newborn,-child-and-adolescent-health
<i>Improving the quality of care for reproductive, maternal, neonatal, child and adolescent health in the WHO European Region</i> [in English and Russian]	Policy level for reproductive health and MNCH	System (national) level policy guidance	WHO Regional Office for Europe	https://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2017/improving-the-quality-of-care-for-reproductive,-maternal,-neonatal,-child-and-adolescent-health-in-the-who-european-region-2017
<i>Quality of care in contraceptive information and services, based on human rights standards – a checklist for health care providers</i>	Maternal health	Clinical decision support tools	WHO	https://www.who.int/reproductivehealth/publications/qoc-contraceptive-services/en/
<i>Counselling for maternal and newborn health care: a handbook for building skills</i>	Maternal health	Training	WHO	https://apps.who.int/iris/bitstream/handle/10665/44016/9789241547628_eng.pdf
<i>WHO labour care guide: user's manual</i>	Maternal health	Training	WHO	https://www.who.int/publications/i/item/9789240017566
<i>Before birth: WHO safe childbirth checklist</i>	Maternal health	Clinical decision support tools	WHO	https://apps.who.int/iris/handle/10665/199179
<i>Maternal death surveillance and response (MDSR): technical guidance</i>	Maternal health	Clinical audits	WHO	https://www.who.int/publications/i/item/9789241506083
<i>WHO recommendations: intrapartum care for a positive childbirth experience</i>	Maternal health	On-site support	WHO	https://www.who.int/publications/i/item/9789241550215
<i>WHO recommendations: non-clinical interventions to reduce unnecessary caesarean sections</i>	Maternal health	On-site support	WHO	https://www.who.int/publications/i/item/9789241550338
<i>WHO recommendations on drug treatment for non-severe hypertension in pregnancy</i>	Maternal health	On-site support	WHO	https://www.who.int/publications/i/item/9789240008793
<i>WHO recommendations: drug treatment for severe hypertension in pregnancy</i>	Maternal health	On-site support	WHO	https://apps.who.int/iris/bitstream/handle/10665/277234/9789241550437-eng.pdf
<i>WHO recommendations: Induction of labour at or beyond term</i>	Maternal health	On-site support	WHO	https://apps.who.int/iris/bitstream/handle/10665/277233/9789241550413-eng.pdf
<i>WHO recommendations: policy of interventionist versus expectant management of severe pre-eclampsia before term</i>	Maternal health	On-site support	WHO	https://apps.who.int/iris/bitstream/handle/10665/277236/9789241550444-eng.pdf
<i>WHO recommendations: uterotonics for the prevention of postpartum haemorrhage</i>	Maternal health	On-site support	WHO	https://apps.who.int/iris/bitstream/handle/10665/277276/9789241550420-eng.pdf
<i>Standards for improving quality of maternal and newborn care in health facilities</i>	Maternal and newborn health	Quality of care standards	WHO	https://cdn.who.int/media/docs/default-source/mca-documents/advisory-groups/quality-of-care/standards-for-improving-quality-of-maternal-and-newborn-care-in-health-facilities.pdf
<i>Quality of care for maternal and newborn health: a monitoring framework for network countries</i>	Maternal and newborn health	Improving measurement systems for QoC MNCH	WHO	https://www.who.int/docs/default-source/mca-documents/advisory-groups/quality-of-care/quality-of-care-for-maternal-and-newborn-health-a-monitoring-framework-for-network-countries.pdf
<i>Managing complications in pregnancy and childbirth: a guide for midwives and doctors – 2nd edition</i>	Maternal and newborn health	On-site support	WHO	https://www.who.int/publications/i/item/9789241565493
<i>Making every baby count: audit and review of stillbirths and neonatal deaths</i>	Newborn health	Clinical audits	WHO	https://www.who.int/publications/i/item/9789241511223

Resource	Life Course Area	Quality category	Source	Link to publication
<i>Standard for improving the quality of care for small and sick newborns in health facilities</i>	Newborn health	Quality of care standards	WHO	https://www.who.int/publications/i/item/9789240010765
<i>Introducing and sustaining EENC in hospitals: routine childbirth and newborn care</i>	Newborn health	On-site support	WHO Regional Office for the Western Pacific	https://iris.wpro.who.int/bitstream/handle/10665.1/13409/9789290617808-eng.pdf
<i>Introducing and sustaining EENC in hospitals: Kangaroo Mother Care for preterm and low-birthweight infants</i>	Newborn health	On-site support	WHO Regional Office for the Western Pacific	https://apps.who.int/iris/bitstream/handle/10665/273625/9789290618584-eng.pdf
<i>Standards for improving the quality of care for children and young adolescents in health facilities</i>	Child health	Quality of care standards	WHO	https://www.who.int/publications/i/item/9789241565554
<i>Measurement framework for paediatric quality of care indicators [in development]</i>	Child health	Improving measurement systems for QoC MNCH	WHO	
<i>Improving the quality of paediatric care: an operational guide for facility-based audit and review of paediatric mortality</i>	Child health	Clinical audits	WHO	https://apps.who.int/iris/handle/10665/279755
<i>Handbook: ICM integrated management of childhood illness</i>	Child health	Clinical decision support tools	WHO	https://apps.who.int/iris/bitstream/handle/10665/42939/9241546441.pdf
<i>Oxygen therapy for children: a manual for health workers</i>	Child health	Clinical decision support tools	WHO	https://apps.who.int/iris/bitstream/handle/10665/204584/9789241549554_eng.pdf
<i>Oxygen therapy for children: a manual for health workers [in Russian]</i>	Child health	Clinical decision support tools	WHO Regional Office for Europe	https://apps.who.int/iris/handle/10665/332854
<i>Paediatric emergency triage, assessment and treatment: care of critically ill children</i>	Child health	Training	WHO	https://apps.who.int/iris/bitstream/handle/10665/204463/9789241510219_eng.pdf
<i>Pocket book of hospital care for children: second edition – guidelines for the management of common childhood illnesses</i>	Child Health	On-site Support	WHO	https://www.who.int/publications/i/item/978-92-4-154837-3
<i>Managing possible serious bacterial infection in young infants when referral is not feasible</i>	Child health	Clinical decision support tools	WHO	https://apps.who.int/iris/bitstream/handle/10665/181426/9789241509268_eng.pdf
<i>Manual on paediatric HIV care and treatment for district hospitals: addendum to the Pocket book of hospital care of children</i>	Child health	On-site support	WHO	https://apps.who.int/iris/bitstream/handle/10665/44511/9789241501026_eng.pdf
<i>Hospital care for children: quality assessment and improvement tool [in English and Russian]</i>	Child health	Clinical audits	WHO Regional Office for Europe	https://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2015/hospital-care-for-children-quality-assessment-and-improvement-tool-2015
<i>Children's rights in hospital – rapid-assessment checklists</i>	Child health	Child rights standards in care	WHO Regional Office for Europe	https://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2017/childrens-rights-in-hospital-rapid-assessment-checklists-2017
<i>Children's rights in primary health care series</i>	Child health	Child rights standards in care	WHO Regional Office for Europe	https://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2015/childrens-rights-in-primary-health-care-series
WHO Children at Hospital app [includes Russian and Kyrgyz versions]	Child health	On-site support	WHO Regional Office for Europe	https://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/children-and-adolescents-in-the-who-european-region/who-children-at-hospital-app
<i>Improving the quality of care for mothers, newborn and children in health facilities. POCQ: Point of care quality improvement, facilitator and learner manuals</i>	MNCH	On-site support	WHO Regional Office for South-East Asia	https://www.qualityofcarenetwork.org/knowledge-library/improving-quality-care-mothers-and-newborns-health-facilities-point-care-quality
<i>Maternal and perinatal death surveillance and response: materials to support implementation</i>	MNCH	Clinical audits	WHO	https://www.who.int/publications/i/item/9789240036666
<i>Hospital care for mothers and newborn babies: quality assessment and improvement tool [in English and Russian]</i>	MNCH	Clinical audits	WHO Regional Office for Europe	https://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/publications/2014/hospital-care-for-mothers-and-newborn-babies-quality-assessment-and-improvement-tool
<i>Assessment tool for the quality of outpatient antepartum and postpartum care for women and newborns [in English and Russian]</i>	MNCH	Clinical audits	WHO Regional Office for Europe	https://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/publications/2013/assessment-tool-for-the-quality-of-outpatient-antepartum-and-postpartum-care-for-women-and-newborns
<i>Manual on supportive supervision in MNCH services [pending publication]</i>	MNCH	Guidance and support materials	WHO Regional Office for Europe	

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