NATIONAL REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, ADOLESCENT, ELDERLY HEALTH PLUS NUTRITION (RMNCAEH+N) QUALITY OF CARE MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL) PLAN 2022-2027

DEPARTMENT OF FAMILY HEALTH,

FEDERAL MINISTRY OF HEALTH, ABUJA

NOVEMBER 2021

FEDERAL GOVERNMENT OF NIGERIA

NATIONAL REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, ADOLESCENT, ELDERLY HEALTH PLUS NUTRITION (RMNCAEH+N)

QUALITY OF CARE MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL)

PLAN 2022-2027

Foreword

Available reflections on quality of care data systems and measurements indicate the increased demand for quality data for decision making across all sectors, increased efforts towards transition to electronic systems, investments for strengthening of health information systems and opportunities to tap into support on measurement, emphasis on capacity strengthening on quality improvement data management, analysis and use for states and facilities, demand for impact evaluations to identify packages of interventions that have or have not led to significant impact for the purpose of scale up and sustainability.

In furtherance of the Federal Government of Nigeria's stewardship of improving the quality of care data systems of the Nation, the first and maiden edition of National Reproductive, Maternal, Newborn, Child, Adolescent, Elderly plus Nutrition (RMNCAEH+N) Health Quality of Care Monitoring, Evaluation, Accountability and Learning (MEAL) Plan 2022-2027 was developed to strengthen the quality of care monitoring components which are the core indicators, quality improvement indicators, sub-national performance indicators and implementation milestones.

The National RMNCAEH+N QoC MEAL plan lays out a vision to establish a coordinated and effective national system for tracking and management of strategic information on RMNCAEH+N QoC. Also, track National RMNCAEH+N QoC progress in line with the global monitoring framework that aligns with the WHO Standards for improving maternal & newborn care in facilities and the Network for Improving Quality of Care for Maternal, Newborn & Child Health. Also, to have quality data and direct specific interventions to achieve the overall goal (s) of RMNCAEH+N quality of care; to reduce maternal and newborn mortality, preventable deaths, stillbirths and improve elderly health plus nationwide nutrition improvement from 2022 to 2027 by 50% and to improve the access to affordable care and enable measurable improvement in patient satisfaction with the healthcare services.

Rolling out and implementing this MEAL plan will be at the primary, secondary, and tertiary levels of care to ensure alignment, synergy and reduced duplication of efforts on Quality of Care by the National, State and LGA levels. We count on the partnership, buy-in and continuous support of all stakeholders in the public and private sectors, including development and implementing partners, non-government and civil society organisations, professional associations, regulatory bodies, academia, research institutions, traditional and religious institutions, and media for successful improving quality of care for maternal, newborn and child health.

The plan is comprised of six (6) chapters that provide an understanding for the establishment of one M &E system that entails the collective responsibility of all stakeholders in implementing the RMNCAEH+N agenda. Implementation of the plan is therefore the role of all stakeholders whereas the overall coordination and ensuring establishment of the system remains the responsibility of the Department of Family Health.

As the Chair of the national inter-ministerial-level QoC Steering Committee, I call on all Stakeholders at all levels in implementing this RMNCAEH+N QoC MEAL Plan 2022-2027 through the National Quality of Care Technical Working Group.

Dr. Osagie E Ehanire, MD, FWACS
Honorable Minister of Health
October 2021

Acknowledgment

The National RMNCAEH+N Quality of Care MEAL plan is a product of a highly consultative process of the National Quality of Care technical working group. The Federal Ministry of Health (FMOH) appreciates the specific and collective inputs. This RMNCAEH+N QoC MEAL plan 2022-2027 will not be implemented as a standalone but as part and parcel of the National Strategic Health Development Plan II (NSHDP II)

We are particularly grateful to the Dr. Anthony Adoghe, Lead of the M&E subcommittee of the National RMNCAEH+N QOC TWG, members of the monitoring and evaluation subcommittee and States Ministries of Health. Also, sincere appreciation for the guidance provided by the WHO's monitoring and evaluation team supporting Quality, Equity, Dignity (QED) network countries; the document also draw from elements of the monitoring and evaluation plan for the National Strategic Health Development Plan II NSHDP II.

WHO Country office, Nigeria is highly appreciated for the technical and financial support provided all through until the final product of the RMNCAEH+N QoC MEAL plan. Also, appreciation goes to United States Agency for international Development (USAID Mission), Clinton Health Access Initiative (CHAI), Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO), Integrated Health Program (USAID/IHP), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), White Ribbon Alliance Nigeria (WRAN) and PATHFINDER International whose technical officers provided technical support and specific inputs into the MEAL plan.

The coordination of the development of the RMNCAEH+N QoC MEAL plan 2022-2027 under the leadership of Dr Amina Mohammed, Head, Coordinating Unit, Family Health Department, her team and the Quality of Care desk led by Dr. Kennedy Abiahu are well recognized. Their hard work, commitment, and dedication towards moving Quality of Care programme in Nigeria to the next level are highly appreciated.

Dr. Salma Ibrahim Anas, MBBS, MWACP, FMCPH
Director, Family Health Department
October 2021.

Executive Summary

According to the Network for Improving Quality of Care for Maternal, Newborn and Child Health EVOLUTION, IMPLEMENTATION AND PROGRESS. 2017–2020 REPORT, the Network was purposefully established as a platform to facilitate the formation of alliances around maternal, newborn and child health quality of care, and to enable the sharing of learnings around quality of care implementation among countries and partners.

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 the World Health Organization (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). The Network was established to accelerate achievement of universal health coverage goals with a focus on quality.

The Network's country implementation approach builds on principles of government leadership and multi-stakeholder partnerships. The approach is driven by the development of a common maternal and newborn health quality of care implementation agenda and a commitment to using learning and data to guide the implementation and foster accountability. The implementation approach calls for a broad coalition of partners and resources to work with the Federal Ministry of Health to develop national policies, strategies, and structures for quality of care in health services. Together, this partnership supports implementation through facilitating quality improvement activities such as onsite support, learning, quality of care measurement, community and stakeholder engagement and programme management.

Although the Covid-19 pandemic has slowed down quality of care implementation activities and impacted the collection of quality of care data, it has also tested the relevance of the collaboration and learning functions of the Network. Throughout the 2020 Covid-19 pandemic period, the learning and sharing of experiences in response to the pandemic has intensified and expanded to engage partners. New approaches were used by key stakeholders to maintain QOC implementation and experience sharing including use of virtual platforms.

Along with the successes, however, there are still persistent challenges, notably those related to quality of care measurement and monitoring to demonstrate impact. In Nigeria, this is mainly due to insufficient resources to support service delivery, gaps in quality of care data and data systems, lack of a critical mass of health managers and practitioners with the requisite skills in quality improvements methods, and continuous dependency of countries on donors' technical assistance and financial investments. In the past 3 years of implementation of MNH quality of care, reporting from Facility to state and to

national level has been inconsistent where it exists, while National level coordination body has no data from implementation in some states. As Government begin the deliberate steps to expand and scale up implementation of RMNCAEH+N Quality of care, have a strong data system for QOC has become very important.

Moving forward, Nigeria will invest more in quality of care, including strengthening their health information systems to improve the overall quality of the data they produce, including maternal, newborn and child health quality of care data. There is a need to strengthen accountability mechanisms and the systematic involvement of communities to improve quality of care. The involvement of academic institutions will be critical to support the development and implementation of a national learning platform for quality of care.

The development of the RMNCAEH+N QoC MEAL plan 2022-2027 was born out of the need to address the implementation milestones on Learning (**LGA learning network established**), Measurement (**Common core indicators are collected and used for LGA and state level learning meetings and reported upwards**), Learning and community engagement (**Identification/agreement with academic /research institution to facilitate documentation and Mechanism for community participation integrated into QoC planning in learning district).**

The plan is comprised of xx sections that provide an understanding for the establishment of one M &E system that entails the collective responsibility of all stakeholders in implementing the RMNCAEH+N agenda. It gives information on the indicators to be monitored, how to set up one M&E system for the QOC in line with existing HMIS and this plan do not seek to establish a stand-alone M&E system. RMNCAEH+N QoC MEAL plan 2022-2027 is considered a "living" document that will be regularly updated based on adaptations of standards, learning in Network countries, and using other quality improvement measurement methods to help improve care.

Acronyms

AOP – Annual Operational Plan

BHCPF – Basic Healthcare Provision Fund.

CEmONC – Comprehensive Emergency Obstetric and Newborn Care

Covid-19 – coronavirus disease

DQA – Data quality assessment

DHIS-2 – District Health information system

ENAP - Every Newborn Action Plan

EPMM - Ending preventable maternal mortality

FMOH - Federal Ministry of Health

HF- Health facility

HIS – Health information system

HMIS – Health Management Information System

HPCC - Health Partners Coordination Committee

ICD-MM - International Classification of Diseases—Maternal Mortality

ICD-PM - - International Classification of Diseases – Perinatal Mortality

IHP - Integrated Health Program

ISS – Integrated supportive supervision

JAR – Joint Annual Review

JHPIEGO - Johns Hopkins Program for International Education in Gynecology and Obstetrics

KMC – Kangaroo Mother care

LGA – Local Government Area

LMIS - Logistics management information systems

MDAs – Ministries Department and Agencies

MDG - Millennium Development Goals

MEAL - Monitoring, Evaluation, Accountability and Learning

M&E – Monitoring and evaluation

MNH – Maternal and newborn health

MNCH – Maternal newborn and child health

MOH – Ministry of Health

MPD-4-QED – MATERNAL PERINATAL DATABASE FOR QUALITY, EQUITY AND DIGNITY

MPDSR – Maternal and Perinatal Death Surveillance and Response

NDR – National Data Repository

NPHCDA – National Primary Healthcare Development Agency

NSHDP II - National Strategic Health Development Plan II

OIC – Officer in charge

PDSA - plan, Do, Study, Act

PHC – Primary Healthcare

PPH- Postpartum haemorrhage

QED - Quality, Equity, Dignity

QI – Quality improvement

QoC – Quality of Care

RMNCAEH+N - Reproductive, Maternal, Newborn, Child, Adolescent, Elderly Health plus Nutrition

SMOH – State Ministry of Health

TWG – Technical Working Group

UHC - Universal Health Coverage

UNICEF - United Nations Children's Fund

UNFPA - United Nations Population Fund

USAID - United States Agency for international Development

U5 – Under 5

WASH- Water, Sanitation and Hygiene.

WHO – World Health Organisation

WRAN - White Ribbon Alliance Nigeria

VFM- Value-for-money

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CHAPTER 1

INTRODUCTION

1.0 BACKGROUND

The Federal Government of Nigeria's commitment to achieve Universal Health Coverage and Sustainable Development Goals (especially Targets 3 and 5) by 2030, lead to the adoption of the Reproductive, Maternal, Newborn, Child Adolescent and Elderly Health Plus Nutrition (RMNCAEH+N) multi-stakeholder partnership coordination platform on Monday, 12th October 2020. The key aims of the RMNCAEH+N platform are to reduce preventable death and improve the health and well-being of mothers, newborn, and children.

Nigeria is currently responsible for about 20% of all global maternal deaths with the maternal mortality ratio currently estimated at 512/100,000 live births,[2] while the childhood mortality with neonatal death rate of 38/1,000 live births, infant mortality rate at 67/1,000 live births and under-five mortality rate of 132/1,000 live births.[2]

Furthermore, major factors identified to be associated with the poor RMNCAEH+N indices in the country include poor Quality of Care (QoC), and poor progress in Nigeria's RMNCAEH+N indicators during the Millennium Development Goals (MDG) period.

The World Health Organization (WHO) defines Quality Care as one which is 'safe, effective, people-centered, timely, efficient, equitable and integrated.'[4] It proposed a QoC framework with two inter-linked elements – **the provision of care**, and **the experience of care**, which together, consists of eight domains, that should be the focus of the assessment, improvement and monitoring of care within the health system for improved outcomes in RMNCAEH+N. Three of the proposed domains relate to "provision of care" – (i) Evidence based practices for routine and emergency care; (ii) Actionable information systems, and (iii) Functional referral systems; while another three domains relate to "experience of care" – (iv) Effective communication, (v) Respect, protection, and dignity, and (vi) Psychosocial and emotional support. The last two domains are cross-cutting and include – (vii) Competent and motivated and empathetic human resources; and (viii) Essential physical resources.

In February 2017, Nigeria and 9 other countries supported by a coalition of technical and implementing partners, established the Global QoC Network to accelerate the achievement of Universal Health Coverage (UHC) goals with a focus on quality of care. This network agreed to pursue four strategic objectives: Leadership, Action, Learning, and Accountability. Nigeria committed to the adoption of the Network strategies including the **Monitoring Framework** (Table 1) which aligns with the Network goals,

strategic objectives, implementation framework and the WHO standards for improving maternal and newborn care in health facilities.

Consequently, the RMNCAEH+N strategic Plan has been developed, and this adjoining monitoring and evaluation Plan is developed to serve the monitoring needs of the implementation of QoC at Federal, State and Local Government levels. The monitoring and evaluation Plan for QoC, which encompasses monitoring, evaluation, and research, is critical to ensuring the impactful implementation of Nigeria's RMNCAEH+N QoC agenda. It will ensure that quality data is regularly collected, synthesized, and analyzed to inform programmatic and policy decisions on the implementation of the QoC strategy. The Research component will provide further support by generating evidence that will strengthen programme implementation and decision-making by stakeholders. Overall, this 5-year document lays out a framework to monitor and evaluate the RMNCAEH+N QoC strategy.

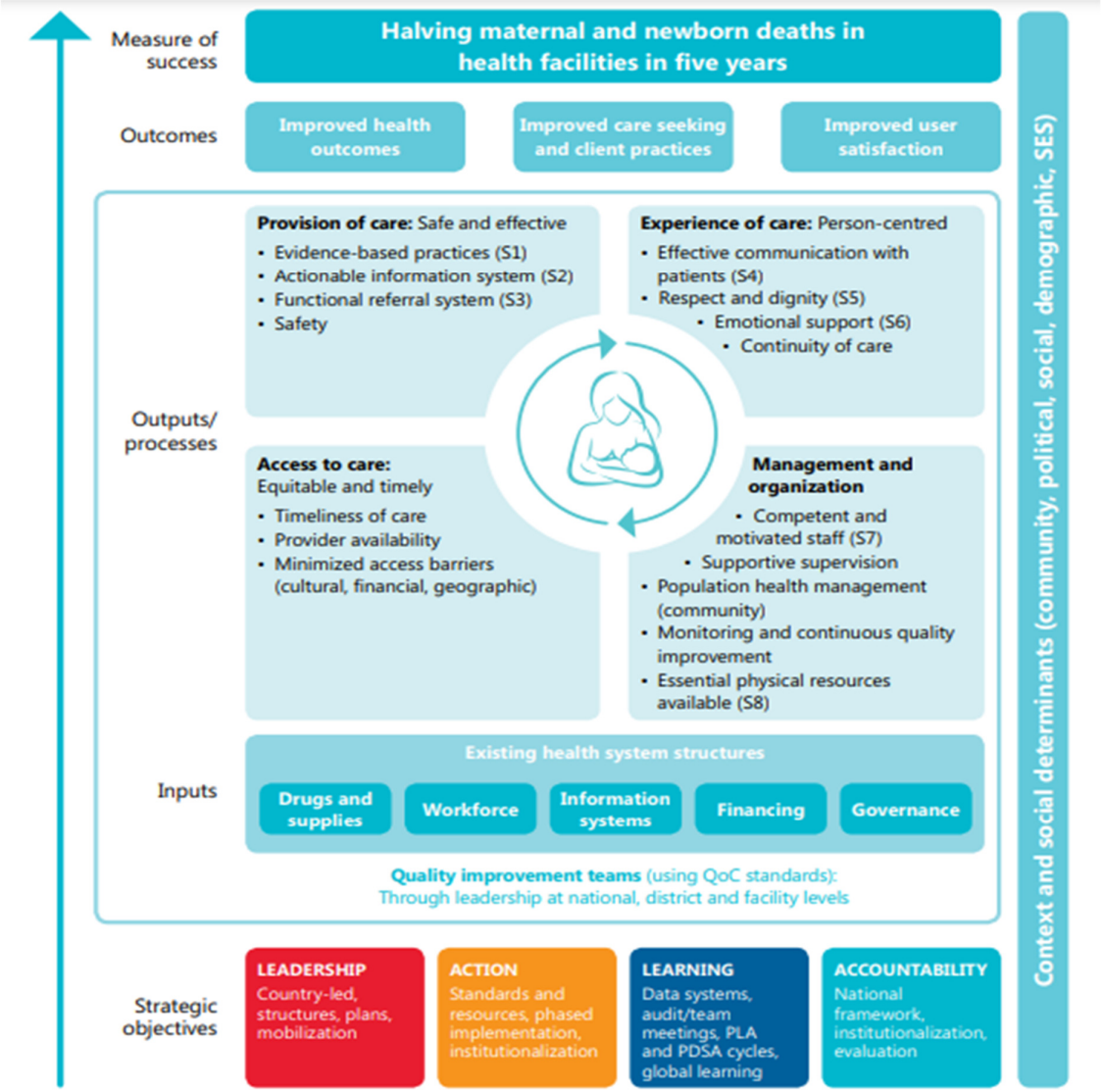


Table 1: Monitoring Logic Model: Unpacking the Links Between the Strategic Objectives and the Outcomes of the Network

1.1 RMNCAEH+N QUALITY OF CARE GOALS

The overall goal (s) of RMNCAEH+N quality of care

1. To reduce maternal and newborn mortality, preventable deaths, stillbirths and improve elderly health plus nationwide nutrition improvement from 2022 to 2027 by 50%.

2. To improve the access to affordable care and enable measurable improvement in patient satisfaction with the healthcare services.

1.2 RMNCAEH+N QUALITY OF CARE TARGETS

To achieve the goals, the targets relating to mortality, avoidable morbidity, and experience of care over a five-year period are as follows:

1. Reduction in the level of maternal deaths in health facilities
2. Reduction in the level of newborn deaths in health facilities
3. Reduction in intrapartum stillbirths
4. Reduction in the incidence of preventable causes of maternal Mortality
5. Reduction in the incidence of neonatal sepsis
6. Reduction in the proportion of women of reproductive age who report negative attitude of health workers as barriers to healthcare services by half (Respectful Maternity Care)
7. Increase in the proportion of women who deliver in a health facility and satisfied with their experience of care during childbirth
8. Increase the number of functional health facilities providing quality of care across all levels

1.3 PURPOSE OF THE M&E PLAN FOR RMNCAEH+N QoC

1.3.1 Approach on development of the national MEAL plan

The 2021 First Quarter meeting of the National Technical Working Group (TWG) on QoC was held from 21st to 23rd April 2021 with one of the objectives focusing on the development of a 2-year Operational Plan with States & Stakeholders. At the TWG meeting, the session continued with a clear overview of the group work to develop a 2-year operational plan. Each group was assigned to each of the 5 sections of the AOP organized according to the QoC strategic objectives – Leadership & Coordination, Action, Learning, and Accountability & Community Engagement.

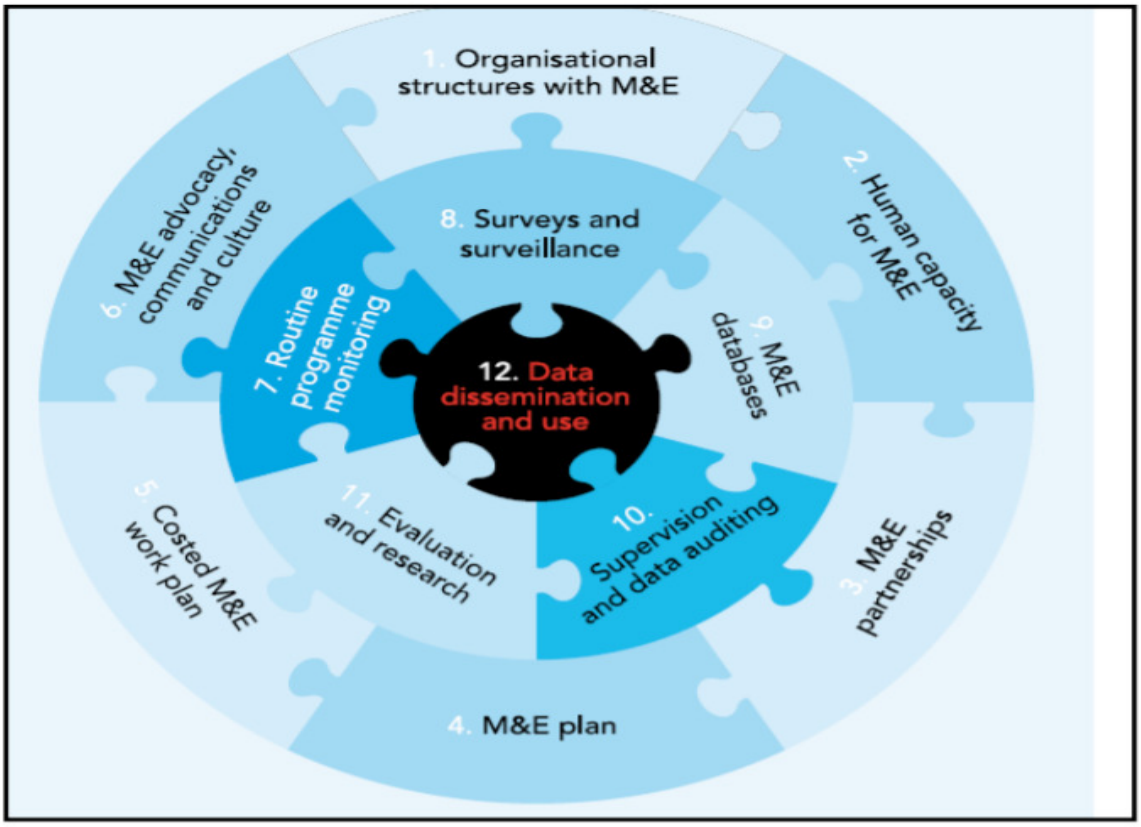
Furthermore, a 3-day subcommittee meeting on the Monitoring and Evaluation for QoC was held from the 23rd to 25th June 2021, to chart mechanisms for strengthening monitoring, evaluation and learning on QoC implementation and how to capture operational activities on the operational plan to address this front burner issue, meeting was supported by WHO. A draft M&E plan was developed at the meeting which will represent the Monitoring and Evaluation Plan for RMNCAEH+N QoC at all levels of care in Nigeria.

Following the development of the draft M&E plan for RMNCAEH+N QoC, a small group initially reviewed the draft M&E plan on 30th July 2021 at the 6th Floor Conference Room, Federal Ministry of Health with participation from Department of Family Health, Department of Planning Research and Statictics, WHO, UNICEF, USAID/IHP with an objective to discuss finalization and validation, RMNCAEH+N QoC Dashboard and strengthening RMNCAEH+N M&E for tertiary level of care.

This led to a small group reviewing the draft M&E plan from 14th to 15th September 2021 at the UN House, Abuja. It was further agreed to expand scope from M&E plan to MEAL plan with participation of Department of Family Health, Department of Planning Research and Statistics, National Institute for Pharmaceutical Research and Development (NIPRD), WHO, UNFPA and CHAI. The aim of the small group was to reorganize the flow and develop the group work guide for the finalization meeting.

The monitoring and evaluation subcommittee meeting held from 29th to 30th September in Nasarawa State with aim of finalizing the draft Monitoring, Evaluation, Accountability and Learning (MEAL) Plan for RMNCAEH+N Quality of Care. This was validated at the Third Quarter RMNCAEH+N QoC National Technical Working Group Meeting with States and Partners.

A post validation of the RMNCAEH+N QoC MEAL plan was further reviewed by the Global M&E team of the QED secretariat. The validated RMNCAEH+N QoC MEAL plan 2022-2027 is for a timeline of 5years.



Box 1: 12 Components Monitoring & Evaluation System Assessment adopted for RMNCAEH+N QoC MEAL Plan

1.3.2 Structure of the M&E Plan

The 12 components in table 2 are not twelve implementation steps. They are not intended to be implemented sequentially; however, they should all be present and working to an acceptable standard for the national RMNCAEH+N QoC MEAL system to function effectively. Depending on resource availability, the M&E Subcommittee via the National RMNCAEH+N QoC TWG Quality of Care may need to focus on a few of the components at the outset and phase-in M&E investments over time to get all the system components operational. It is also important to build on what systems and capacity already exist and to address the issues of human resources/capacity and functioning partnerships to support the collection of good quality data. Most importantly, it is crucial not to lose sight of the ultimate purpose of M&E: using data for decision-making. It is a waste of valuable resources to collect data that are not used.

This RMNCAEH+N QoC MEAL plan also provides guidance to effectively approach the 12 components for strengthening the M&E systems in Nigeria.

1. Organizational Structures with RMNCAEH+N QoC Functions:

a. There is an M&E unit/Division/ Directorate within the FMOH/SMOH/LGA
b. The number of full-time and/or part-time M&E posts
c. Percentage of M&E full-time and/or part-time posts filled
d. Government M&E employees have permanent posts (i.e. establishment posts that are reflected in the entity's official organisational structure and budget
e. There are an adequate number of epidemiologists, IT specialists and database managers in key agencies
f. There are an adequate number of qualified data managers at National and Subnational levels.
g. Each decentralized local government authority where the RMNCAEH+N QoC is implemented is coordinated has at least one qualified person who is dedicated full-time to data management.
h. M&E responsibilities are clearly defined in job descriptions.
i. External M&E technical support is required (at times) on an ongoing basis to fulfill routine M&E tasks usually the responsibility of government
j. Recognizing that most entities do not have the human resources needed to fulfill their mandate, the technical assistance is made available when and, in the quantity, needed and of the type needed.
k. The entity has the written mandate to execute its M&E functions
l. With or without technical assistance, the entity is fulfilling its M&E mandate by delivering the M&E services and deliverables for which it is responsible to sufficient quality.
m. Staff at the entity have in their job descriptions, specific responsibilities related to:
    - Organizational structure
    - Human capacity
    - Partnerships

- National M&E plan
- National M&E work plan
- Advocacy, communication and culture
- Routine monitoring
- Surveys and surveillance
- National and sub national databases
- Supportive supervision and data auditing
- Evaluation and research
- Data dissemi- nation and use

n. M&E staff are adequately motivated through salary, benefits, and career prospects and qualified staff can be recruited and retained

2. **Human Capacity for RMNCAEH+N QoC MEAL**

a. The RMNCAEH+N QoC M&E-related skills and competencies of the M&E staff at the entity have been assessed within the past 2 years
b. Staff at the entity involved in M&E have the skills and competencies needed to fulfil the entity's RMNCAEH+N QoC MEAL mandate
c. The GAPS in terms of the M&E related skills and competencies required by the entity's staff responsible for M&E have been incorporated into the entity's Human Capacity Building Plan
d. It is an under-funded priority and there are written plans to support pre-service training and/ or recruitment and retention of additional epidemiologists, IT specialists and database managers in key entities
e. There is nationally endorsed M&E training curriculum (appropriate for personnel within or supported by your entity)
f. M&E human capacity relative to the M&E system is being built through colleges, universities and/or technical schools
g. M&E human capacity relative to M&E is being built through routine supervision and/or on-the-job training (OJT) and mentorship
h. The RMNCAEH+N QoC M&E human capacity building offered is coordinated to avoid duplication
i. There is a national database or register of who is receiving M&E training to avoid duplication and assure complementarity
j. There is a national database of trainers and other technical serv- ice providers capable of building M&E capacity

3. **Partnerships to Plan, Coordinate and Manage the M&E System**

a. There is a RMNCAEH+N M&E subcommittee under the RMNCAEH+N Quality of Care technical working group coordinated by FMOH and SMOH.
b. The RMNCAEH+N M&E subcommittee coordinated by the FMOH and SMOH meets monthly.
c. The entity/ties partcipate/s actively in the RMNCAEH+N M&E subcommittee coordinated by FMOH and SMOH.
d. International development partners actively participate in the RMNCAEH+N M&E subcommittee coordinated by FMOH and SMOH.

e. TOR for the RMNCAEH+N M&E subcommittee coordinated by FMOH and SMOH clarifies the TWG's role in approving documents, providing technical leadership, and coordinating the RMNCAEH+N QoC M&E system
f. The National RMNCAEH+N Quality of Care technical working group coordinated by FMoH makes decisions via a consensus building process.
g. There is a national M&E technical working group coordinated by FMoH
h. The National M&E TWG coordinated by FMOH and SMOH meets quarterly
i. An inventory of stakeholders for RMNCAEH+N QoC M&E is periodically updated
j. There are well developed mechanisms (e.g. feedback reports, newsletters) to communicate about RMNCAEH+N M&E activities and decisions.

4. **National, Multi-sectoral RMNCAEH+N M&E Plan**

a. There is a national RMNCAEH+N multi-sectoral M&E plan.
b. Entities actively participated in development of the national RMNCAEH+N multi-sectoral M&E plan

5. **Annual, Costed, National RMNCAEH+N M&E Plan**

a. There is a National M&E Work Plan that includes the current year
b. Activities in the National M&E Work Plan have been costed for the current year
c. Activities in the National M&E Work Plan are allocated specific time frames for implementation
d. Activities in the National M&E Work Plan are allocated to at least one lead agency for implementation
e. The costs of the M&E work plan are included in the official government budget (e.g. Medium Term Expenditure Frame- work of Government)
f. Resources are available to meet agency- specific M&E work plan requirements
g. The M&E work plan containing the current year was developed or modified based on the achievements (progress) against the previous year's activities.
h. Total cost of the current year National M&E Work Plan for the current year (US Dollars)
i. Percentage of total cost of the current year National M&E Work Plan which has been secured
j. Percentage of total RMNCAEH+N M&E funding from development partners allocated for M&E plan

6. **Communication, Advocacy and Culture for RMNCAEH+N M&E PLAN**

a. There are people who strongly advocate for and support M&E within the agency/organization
b. Frequency with which the performance of the M&E system is communicated/reported to you
c. National M&E system information products (reports, website content, emails, newsletters, maps, tables, charts, etc) are useful
d. M&E personnel are part of the management and planning team

7. **Routine RMNCAEH+N M&E Programme Monitoring**

a. National guidelines exist that document the procedures for recording, collecting, collating and reporting programme monitoring data from health information system, and therefore the procedures for managing routine data

b. National guidelines exist that document the procedures for recording, collecting, collating and reporting routine programme monitoring data from civil society/community-based systems for data
c. National guidelines exist that provide instructions on how data quality should be maintained from the health information system(s) and therefore the quality of data
d. National guidelines exist that provide instructions on how data quality should be maintained (e.g., avoiding double counting, assure reliability and validity) from civil society/communitybased systems
e. National guidelines and a system exist for monitoring and managing the supply of drugs related to program areas
f. National guidelines exist to assure that individual medical records support quality and continuity of health care related to program areas
g. National guidelines exist to support reporting of health data by private sector health facilities related to program areas
h. The same operational definitions of routine monitoring (program output) indicators (from the national M&E system) are systematically used by all groups delivering services in program areas
i. Supplies and equipment are available for routine program monitoring of program area
j. Entities delivering the same services use standardized data collection forms
k. Entities delivering the same services use standardized report- ing forms
l. People with assigned responsibilities have been assuring data quality prior to submission to the next level
m. During previous data auditing visits, all source documents (e.g., completed forms) have been available for auditing purposes
n. Officers responsible for receiving reports from lower levels, systematically verify their completeness, timeliness and identify obvious mistakes before aggregating the data
o. Mechanisms/procedures are in place to reconcile discrepan- cies in reports and to provide systematic feedback, including reconciliation of discrepancies in reports, etc.
p. Outputs of routine program monitoring contribute to the indi- cators as defined in the national M&E plan
q. Financial resources/investments for RMNCAEH+N QoC are monitored and reported to the National RMNCAEH+N Quality of Care Technical Working Group.

8. Surveys and Surveillance RMNCAEH+N M&E

a. Health facility surveys at RMNCAEH+N QoC related service delivery points are conducted every 2-3 years.
b. National surveys or surveillance with behavioral component of RMNCAEH+N QoC in the general population are conducted every 2-3 years
c. Surveys and surveillance conducted to contribute to measuring indicators in the national RMNCAEH+N QoC MEAL plan
d. National RMNCAEH+N QoC surveys (public and private sectors) are conducted every 5years

9. National and Sub-national RMNCAEH+N M&E Databases

a. Database/s for electronically capturing and storing data gener- ated for/by the national HIV M&E system is functional

b. There is a functional integrated database for electronically capturing and storing data on a wide range of health services (possibly including but not limited to HIV/AIDS services
c. Structures, mechanisms procedures and time frame for transmitting, entering, extracting, merging and transferring data between databases that support the national HIV M&E system exist
d. IT equipment and supplies are available for maintaining the national and sub national HIV databases
e. Quality control mechanisms are in place to ensure that data are accuratedly captured
f. Human resources for maintaining and updating the national and sub national HIV databases are adequate
g. Human resources for maintaining and updating the national and sub national HIV databases are adequate

10. Supportive Supervision and Data Auditing for RMNCAEH+N QoC M&E

a. National guidelines and tools for supportive supervision on M&E exist (as standalone or as a chapter/module of more comprehensive supervision guidelines
b. Supportive supervision was conducted as per the national protocols, in the past 6 months
c. Supportive supervision results have been recorded and feedback provided to supervisees
d. Entities can access supervision and data auditing results, and follow up on recommendations made during supervision visits
e. A protocol for auditing routine RMNCAEH+N QoC service data from health service delivery points exists
f. A protocol for auditing routine RMNCAEH+N QoC service data from civil society/commuity-based programmes exists
g. National protocol for auditing data used in the national set of RMNCAEH+N QoC indicator values exists
h. Data auditing is conducted as per the time frames stipulated in the national data auditing protocol
i. Data auditing results have been recorded and feedback provided to those entities whose data were audited

11. RMNCAEH+N QoC Evaluation and Research Agenda

a. An inventory (register/database) exists of RMNCAEH+N QoC research, and evaluation institutions and their activities in the country (completed, proposed and active) and has been updated in past 12 months
b. A mandated national team/committee and procedures exists which is responsible for coordinating and approving (new) RMNCAEH+N QoC research and evaluations.
c. The team/committee mandated for coordinating and approving RMNCAEH+N QoC research and evaluations has met as scheduled in the last 12 months
d. Procedures exist for the mandated team/committee to coordinate (new) HIV research and evaluation
e. An HIV research and evaluation agenda exists that directs future HIV research and evaluation
f. The HIV research and evaluation agenda has been prioritized based on input from key HIV and research stakeholders

g. The HIV research and evaluations agenda is being used to approve new studies.
h. The HIV research and evaluations findings are being used in policy formulation, planning and implementation
i. Research and evaluation findings are regularly disseminated and discussed
j. Financial resources are earmarked/available for conducting planned research and evaluations
k. Joint reviews of the HIV response takes place during annual reporting, mid-term and end-of term NSP reviews

12. Data Dissemination and Use for RMNCAEH+N QoC

a. HIV stakeholder information needs have been assessed
b. Information products are regularly dissemi- nated to the data providers.
c. Information products are regularly sent to a wide variety of stakeholders- other than the data providers
d. National and sub national information products meet HIV stakeholders' information needs
e. There are guidelines to support the analysis, presentation and use of data (e.g. graphs on walls showing cumulative coverage) at facility level
f. Stakeholders have access to the data/information products in the public domain (on line or central info center)

Furthermore, the Monitoring and Evaluation Subcommittee will update the National RMNCAEH+N QoC TWG biannually on the summary of action points on the 12 components for effective functionality using the table 3 below:

S/N	COMPONENT	SUMMARY OF ACTION POINTS
1	Organizational Structure	
2	Human Capacity	
3	Partnerships	
4	National M&E Plan	
5	National M&E Costed Workplan	
6	Advocacy, Communication and Culture	
7	Routine Monitoring	
8	Surveys and Surveillance	
9	National and Subnational databases	
10	Supervision and Data Auditing	
11	Evaluation and Research	
12	Data Use	

1.3.3 Goal/vision of the national MEAL plan

GOAL:

- To establish a coordinated and effective national system for tracking and management of strategic information on RMNCAEH+N QoC.
- To track National RMNCAEH+N QoC progress in line with the global monitoring framework that aligns with the WHO Standards for improving maternal & newborn care in facilities and the Network for Improving Quality of Care for Maternal, Newborn & Child Health.
- To have quality data and direct specific interventions to achieve the overall goal (s) of RMNCAEH+N quality of care
- To learn from State experiences via data sharing and improve practices and activities in the future.
- To have internal and external accountability of the RMNCAEH+N QoC resources used and the results obtained.

VISION:

- To encourage programme or project Staff to think strategic and clearly about what resources would fast track interventions in halving maternal, newborn and child mortality and morbidity, achieve the Goal 3 of the Sustainable Development Goals (SDG) and strengthen data systems for effective documentation and evidenced based decision making in Nigeria.

1.3.4 Objectives of the national MEAL plan

The RMNCAEH+N QoC MEAL plan will leverage on the Quality of Care strategic objectives agenda which is structured around four strategic objectives, summarized by four keywords: leadership, action, learning and accountability.

Strategic Objective 1: **LEADERSHIP** - To Build and strengthen national institutions and mechanisms for improving monitoring of quality of care for RMNCAEH+N.

Targets: (at least 80 percent of identified institutions and coordinating structures strengthened towards improvement of QoC)

Activities:

i. Integrate RMNCAEH+N quality of care monitoring into existing Federal and Subnational governance structures.
ii. Strengthen RMNCAEH+N quality of care advocacy and mobilization including funding strategies for QoC monitoring and evaluation.
iii. Drive an operational roadmap for RMNCAEH+N QoC MEAL Plan at Federal, States and LGA levels.

Strategic Objective 2: **ACTION** - To Operationalize and sustain implementation of quality of care monitoring processes for improvements in RMNCAEH+N.

Targets: (80 percent of supported health facilities implementing and monitoring of 15 Core QI standard indicators)

Activities:

i. Adoption of the MEAL Plan by implementing facilities at Federal, State and LGA levels.
ii. Develop National and Subnational context specific guidelines for MEAL implementation and ensure widespread dissemination.
iii. Implement capacity building of QI teams on data management to support quality improvement in health facilities at least once a year.
iv. Incorporate and disseminate QoC M&E standard of procedure and protocols within training health institutions, professional organizations, and regulatory bodies across State/LGAs and HFs.
v. Conduct annual facility assessment for QoC facilities (learning sites) to ascertain progress
vi. Conduct baseline assessment for new QoC facilities (learning sites) to ascertain status.
vii. Strengthen data systems - Incorporating QoC Indicators to strengthen existing DHIS-2 & NDR Systems and standardize tools for data collection and reporting
viii. Ensure regular dissemination of information to all stakeholders including learning sites, LGA, State and Federal, Partners and global learning network.
ix. Provide guidance to the QoC TWG on criteria for the selection of demonstration states and learning sites across the country.

Strategic Objective 3: **LEARNING** - To facilitate learning, knowledge sharing and evidence-based training on quality of care.

Targets: (80 per cent increase in the number of learning site sharing knowledge and generating evidence for QoC)

Activities:

i. Develop TWG Mechanisms and tools for regular information sharing, training, documentation, and dissemination on best practices of RMNCAEH+N QoC at federal and subnational levels
ii. Conduct trainings at all levels on the appropriate use of QoC M&E guidelines
iii. Build capacity programme for various health workforce (such as managers, health workers and M&E staff) on QoC data collection, analysis, and use
iv. Establish and maintain a virtual learning system for improving MNH QoC
v. Develop and maintain a repository of products and tools for QoC - ensure regular updating of website dedicated to QoC and robust linking of MoH platform to relevant sites
vi. Develop and maintain a system for inter-state collaborative learning – Whatsapp group developed to enhance communication between implementing States and Federal
vii. Develop an enhanced change package of tested ideas to inform program delivery
viii. Disseminate successful change ideas for planning and scale-up and documentation of best practices.

Strategic Objective 4: **ACCOUNTABILITY** - To strengthen institutions with tools and mechanisms of accountability for the quality of care

Targets: (80 percent implementation and tracking accountability framework in all the MDAs on QoC)

Activities:

i. Engage through health-related advocacy between key stakeholders, government officials, policymakers, and political leaders on MNH QoC

ii. Engage citizens in MNH QoC policy designs through interactive platforms such as social media, town hall meetings, Health rights education etc
iii. Track counterpart funding systems at inception of all MNH QoC initiatives
iv. Support and Supervise States to implement MPDSR in line with national guidelines
v. Establishment of a unit to be responsible for QoC under the oversight of the Honourable Minister for health
vi. Use FMOH and other government websites to disseminate policies, guidelines, strategies, and protocols on QoC

The main purpose of this M&E plan is to track National QoC RMNCAEH+N progress in line with the global monitoring framework that aligns with the WHO Standards for improving maternal & newborn care in facilities and the Network for Improving Quality of Care for Maternal, Newborn & Child Health. (The Network). This MEAL plan also provides guidance to effect corrective measures where necessary, supporting monitoring periodically that checks the performance of the program/services when compared to set milestones and targets. It improves learning and accountability by providing guidance on appropriate adjustments that can be made from input to output monitoring towards achieving the QoC program goal. A common set of indicators is recommended for measurement in all Quality, Equity, Dignity (QED) participating health facilities in Nigeria to monitor performance on a small number of common indicators and to facilitate learning within various health facilities from primary to tertiary level.

The RMNCAEH+N QoC strategy is evaluated at specific points in the program cycle namely: baseline, midline, and end line. This will provide information for judging the effectiveness of the strategy itself and creates opportunities for scaling up, expanding the scope, dropping unimpactful interventions and incorporating new evidence and lessons learnt in the design of a new strategy. This is in alignment with the M&E Plan for the National Strategic Health Development Plan II (2018-2022).

1.3.5 THE NATIONAL MEAL PLAN SYSTEM COMPONENTS

The purpose of monitoring QoC is based on the 4 major monitoring components, namely, quality improvement (QI) measures for our health facilities, state performance monitoring measures, tracking of implementation milestones, and lastly tracking the common 15 standard indicators to demonstrate country progress.

The table below shows how the monitoring components are linked to the learning and accountability purpose of this QoC M&E plan.

Monitoring Component		learning and accountability purpose	Team
1	QI measures for Health Facilities	QI teams make use of this to support specific care processes Prioritize measures on the standards to be applied and maintained at health facilities	Facility heads, incharge's, medical directors
2	Performance Monitoring measures at state level	Review QI inputs, processes, outputs, and outcomes from data that feeds from facilities to the LGAs, states and National platforms Measure facility readiness to uphold QI standards on Knowledge sharing, referrals, health workforce and commodities	State QoC TWG

3	Tracking of Milestones	Ensure key milestones are progressively tracked and feedback mechanisms are put in place to all relevant stakeholders	States QoC TWG National QoC TWG Nigeria QED Secretariat
4	Tracking of common15 quality indicators	All 15 standard indicators on MNCH QI inputs, processes, outputs, and outcomes tracked in all health facilities across the country aligned with the standardized global measures of the Ending preventable maternal mortality (EPMM), Every New Born Action Plan (ENAP) etc. Check the feasibility of these indicators captured and tracked on routine data capturing tools including the HMIS Facilitate learning and exchange of best practices monitoring and tracking these indicators during review meetings Participate in the QED Network stakeholder's meetings and use data for learning during these meetings	High data use and application by facility managers, LGA data officers, State data officers and HMIS focal points, Federal ministry of Health, global stakeholders, donors, civil society, and media.

Table 2: Monitoring components

CHAPTER 2
QOC INDICATORS AND TRACKING

2.0 COMMON INDICATORS TRACKING AT ALL LEVELS OF CARE

A common set of indicators is recommended for measurement in all Quality, Equity, Dignity (QED) participating facilities in Network countries to monitor performance on a small number of common indicators and to facilitate learning within and across Network countries. It is important to note that common indicators are complementary to other QED monitoring components (TABLE 1). Indicators will be calculated and used by facility QI teams, LGA, State & National managers as part of regular monitoring to improve care. Most indicators will be calculated using routine measurement methods and data sources. Supplemental collection methods (e.g., periodic facility assessment/baseline assessment) can complement routine monitoring to inform understanding of critical quality gaps and to inform the design and evaluation of QI interventions.

Tracking of the established fifteen (15) set of global indicators should be collected and reported. It will serve the following purposes:

- Encourage health facilities to improve the quality of record-keeping and in-facility data collection.
- Encourage national health information systems to integrate sentinel measures of quality of care.
- Increase the accountability of national health systems, thus adding to broader improvement of quality of health care.
- At global level, highlight the need for a shift from just “increasing coverage” of health services and commodities for maternal, newborn and childcare to a more balanced focus on “coverage and quality”.

Selection criteria for common indicators include:

- Relevant and useful for most QED stakeholders.
- Aligned to the extent possible with standardized global MNH indicators (Every Woman Every Child, EPMM, ENAP, WHO 100 core indicators).
- Clearly provide information regarding whether (or not) health outcomes, care processes or inputs are improving

TABLE 3: THE FIFTEEN (15) CORE INDICATORS FOR ALL LEVELS OF CARE

	INDICATOR NAME	OPERATIONAL DEFINITION	DATA SOURCES	FREQUENCY
1	**Institutional** Maternal deaths	Maternal death is defined as the death of a woman at a facility while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravate by the pregnancy or its management but not from accidental or incidental.	HMIS/facility register	Monthly
2	**Institutional** Maternal deaths by cause	Number of maternal deaths at a facility classified by cause (ICD-MM	HMIS/facility register	Monthly
3	Newborn deaths by cause	Number of neonatal deaths at a facility classified by cause (ICD-PM). Neonatal deaths referring to deaths during the first 28 completed days of life in each period	HMIS/facility register	Monthly
4	Facility stillbirth rate (disaggregated by fresh and macerated)	Number of babies delivered in a facility with no signs of life and born weighing at least 1,000 grams or after 28 weeks of gestation, per 1000 births (alive or dead at birth)	HMIS/facility register	Monthly
5	Pre-discharge neonatal mortality rate	Number of babies born live in a facility who die during the first 28 of completed days of life and prior to discharge from facility, per 1000 live births each year or period	HMIS/facility register	Monthly
6	Obstetric case fatality rate	Proportion of women who are admitted to a facility with obstetric complications (both direct and indirect) or who develop such complications after admission in the facility and die from these complications before discharge. (Exclude accidental or incidental deaths)	HMIS/facility register	Monthly

7	Pre-discharge counselling for the mother and the baby	Proportion of women who received pre-discharge counselling for the mother and the baby (as per the WHO standards) in each period	Client questionnaire (sample of women) (e.g. exit interview)	Biannual
8	Companion of choice	The proportion of women who wanted and had a companion supporting them during labor and childbirth in the health facility	Client questionnaire (sample of women) (e.g. exit interview)	Biannual
9	Verbal or physical abuse	Proportion of women who experienced physical or verbal abuse during labour or childbirth in the health facility (Abuse defined as 1) physical: slapped, pinched, or punched etc by a health worker 2) verbal: shouted at, screamed at, insulted, scolded, or mocked etc by a health worker or other staff	Client questionnaire (sample of women) (e.g. exit interview)	Biannual
10	Breastfeeding within one hour of birth	Proportion of babies born alive in a facility who are breastfed within one hour of birth	HMIS/facility register	Monthly
11	Immediate postpartum uterotonic administration	Proportion of mothers who gave birth in a facility who received a prophylactic uterotonic agent immediately (Ideally within a minute) after birth for prevention of PPH	HMIS/facility register	Monthly
12	Facility newborns weighing	Proportion of live births and stillbirths in a facility with documented birth weight	HMIS/facility register	Monthly
13	KMC initiation for premature newborns	Proportion of newborns weighing ≤ 2,000g who are initiated on KMC (or admitted to KMC unit if separate unit exists)	HMIS/facility register	Monthly
14	Basic hygiene provision	The proportion of facilities in which delivery rooms have at least one functional hand washing station with water and soap available	Facility survey	Biannual

15	Availability of basic sanitation to women and families	Proportion of facilities with basic sanitation (clean running water, waste disposal facilities, toilets, and sanitary material) available for women during and after labour and childbirth.	Facility survey	Biannual

2.1 INDICATORS FOR TRACKING STANDARD MEASURES AT ALL LEVELS OF HEALTH FACILITY

2.1.1 INPUT MEASURES

Inputs is one of the measures for quality statements and are what must be in place for the desired care to be provided. Quality statements are concise prioritized statements designed to help drive measurable improvements in care. All Quality, Equity, Dignity (QED) participating facilities in Nigeria must prioritize the provision of inputs per domain to achieve the desired process of care and the effect of the provision and experience of care on health and people centered outcomes.

The standard input measures (Table 4) can be used to inform the improvement areas prioritized by the teams at the LGA and facility levels to monitor performance of essential functions (e.g., 24/7 availability of essential commodities) and quality of maternal and newborn care processes in facilities. The table below outlines illustrative input per domain quality statements highlighting links to components of the monitoring framework.

It is important to track the inputs quarterly by the facility QI teams, LGA, State & National managers using the input monitoring form as part of regular monitoring to improve care and facilitate learning within States. The input monitoring form in annex II, will measure the inputs into the six (6) pillars of the health system building blocks, on which the conceptual framework of quality of care is built on. On the other hand, focusing on these separate components helps put boundaries around this complex construct and permits the identification of indicators and measurement strategies for monitoring progress and a criterion for scale up and sustainability in the Nigeria RMNCAEH+N QoC agenda.

2.1.2 OUTPUT MEASURES

Outputs (process) are measures for quality statements to know whether the desired process of care was provided as expected. Most health facilities in Nigeria do not collect many measures on processes of care. These measures are important for staff in facilities to use to see if they are providing good care to all patients. There often need to be some adaptations at facility level to help people collect and use process and outcome data. Some of these data also need to be reported to LGA and State or National levels so that LGA and States programmes/project managers can monitor important health outcomes and the results of efforts to improve care. Examples of some of the process indicators are % women getting uterotonic immediately after giving birth and % babies receiving immediate skin-to-skin care. Table 4.2 illustrates the outputs any healthcare facility can prioritize and measure depending on the issues contributing to mortality and morbidity. It also should be measure per domain area aligning to the framework which leverage on health system strengthening.

2.1.3 OUTCOME MEASURES

These illustrates the importance of tracking the input and output measures in the health facility. A combination of input and output will strategically effect on the provision and experience of care on health and people centered outcomes. Assessing quality of care can be difficult because it can cover both the complex processes of evaluating, diagnosing and treating a patient as well as the outcomes of that treatment for the patient. In most definitions, quality of care is seen to be multidimensional: care is said to be of high quality if it is effective, safe, centered on the patient's needs and given in a timely fashion. Health outcomes incudes; mortality, morbidity, disease outbreaks, health status, disability, and wellbeing; they all occur because of prioritizing weak or strong health system inputs and measures at the Subnational levels. An

aggregate data is displayed at the National level which score the country's RMNCAEH+N health indices. Table 4.3 illustrates the outcome measures for the RMNCAEH+N Quality of Care.

TABLE 4.1: STANDARD INPUT MEASURES AT ALL LEVELS OF HEALTH FACILITY

STANDARD 1. EVIDENCE-BASED CARE
% facilities in which basic essential equipment and supplies are not available within 3 days
% facilities with written, up-to-date clinical protocols
% facilities in which magnesium sulfate and antihypertensives are not available within 3 days
% facilities in which uterotonic drugs are not available within 3 days
% CEmONC facilities with functional blood transfusion service
% facilities in which supplies/equipment for vacuum or forceps-assisted delivery are not available within 3 days
% facilities in which antenatal corticosteroids available are not available within 3 days
% facilities in which first- and second-line antibiotics are available within 3 days
% staff with recent in-service training of 12 months interval
% facilities in which suction device, mask and bag (size 0 and 1) are not available within 3 days
% facilities in which supplies/equipment for thermal care and feeding of small babies are not available within 3 days
% facilities with no displays of infant formula, bottles, teats
STANDARD 2. HEALTH INFORMATION SYSTEMS

% facilities with standardized registers, patient charts and data collection forms
% facilities with functional system for classifying maternal and newborn diseases and health outcomes, including death, aligned with ICD (e.g. ICD-MM/ ICD-PM)
% facilities with standard operating procedures for checking, validating and reporting data
STANDARD 3. REFERRAL
% facilities with standardized referral protocol for identification, management and referral of women/newborns with complications
% pre-referral sites/facilities in which supplies for stabilization and prereferral treatment are not available within 24 hours
% facilities in which there are no ready access to functioning ambulance or emergency transport
% facilities with up-to-date list of network facilities providing referral services
% facilities with reliable communication methods for referrals and consultation
% facilities with standardized referral form
STANDARD 4. COMMUNICATION
% facilities with accessible health education materials
% facilities with written policy to promote interpersonal communication and counselling
% facilities with standard form for documenting clinical progress and care
% facilities with written protocols for verbal and written handovers (shift change, intra-facility transfer, referral, discharge)
STANDARD 5. RESPECT AND DIGNITY

% facilities where physical environment allows privacy
% facilities with written, up-to-date protocols to ensure privacy and confidentiality
% facilities with written accountability mechanism in the event of mistreatment
% facilities with written, up-to-date zero-tolerance nondiscriminatory policies on mistreatment
% facilities with written, up-to-date policies on obtaining informed consent
% facilities with standard informed consent form
STANDARD 6. EMOTIONAL SUPPORT
% facilities with written, up-to-date policies that allow companion of choice during labour and delivery process
% facilities with labour and childbirth areas organized to allow for private space
% facilities with written, up-to-date protocol on minimizing unnecessary interventions
STANDARD 7. MOTIVATED STAFF
% facilities displaying roster of staff on duty, shift times
% facilities with skilled birth attendant available all the time in sufficient numbers to meet workload
% available posts that are filled by staff with necessary competence
% facilities with standard procedures for recruitment, motivation and retention
% facilities with programme for continuing professional and skills development

% skilled birth attendant staff with recent in-service training
% facilities with written, up-to-date plan for improving quality of care and patient safety
% facilities with designated QI team
% facilities with mechanism for regular collection of information on patient and provider experiences
% facilities with an established liaison mechanism to district (and/or national level) on quality issues
STANDARD 8. PHYSICAL ENVIRONMENT
% facilities with basic water supply in maternity care areas (labour, birth, postnatal)
% facilities with basic environmental cleaning practices in maternity areas (labour, birth, postnatal); written cleaning protocols, trained cleaning staff and providers
% facilities with basic health-care waste management in maternity care areas
% facilities with basic hygiene provisions in maternity care areas (functional handwashing station, access to bathing/shower area, basic sterile equipment)
% facilities with basic sanitation available for women during and after labour and childbirth (toilet, latrine)
% facilities with written protocol and awareness materials (posters) on WASH and waste management
% women reporting satisfactory access to water
% facilities with adequate labour and childbirth areas/rooms for estimated number of births
% facilities with dedicated area in labour/childbirth area for resuscitation of newborns, which is adequately equipped

% facilities with policy and space for rooming-in of mothers and babies 24 hours a day
% facilities with regular source of electricity
% facilities with essential laboratory supplies and tests

TABLE 4.2: STANDARD OUTPUT MEASURES AT ALL LEVELS OF HEALTH FACILITY

STANDARD 1. EVIDENCE-BASED CARE
% staff with recent in-service training
% facilities with recent supportive supervision
% women assessed appropriately at admission in labour [prenatal history/risk factors, vital signs, danger signs, physical examination]
% women monitored appropriately during labour [see forthcoming 2018 WHO intrapartum care recommendations]
% women with blood pressure, pulse and temperature monitored appropriately [admission, labour, postpartum period]
% women with appropriate monitoring during postpartum period for danger signs, including bleeding [per local protocol and national/global guidelines]
% women with severe PE/E treated with magnesium sulfate
% women with PE/E managed appropriately based on maternal/fetal status and gestational age
% women administered immediate postpartum uterotonic (PPH prevention)*
% women who developed PPH receiving appropriate treatment (composite indicator, e.g. uteronic, tranexamic acid, uterine balloon tamponade, etc.)
% women with prolonged labour (active labour > 12 hours) managed appropriately (composite indicator) (see WHO 2018 intrapartum care recommendations)

% women with prolonged/obstructed labour who gave birth by C-section
% women with preterm pre-labour rupture of membranes who received prophylactic antibiotics
% preterm newborns whose mothers received corticosteroids when indicated
% women with C-section who received prophylactic antibiotics before C-section
% women with pre-labour rupture of membranes who received antibiotics
% uncomplicated, vaginal births where episiotomy performed
% newborns breastfed within one hour of birth
% newborns with documented birthweight
% newborns who received essential early newborn care (drying, skin to skin, delayed cord clamping, breastfeeding)
% postnatal mothers/babies monitored appropriately for danger signs (vital signs/clinical signs)
% newborns receiving vitamin K and full vaccination
% newborns breastfed exclusively at time of discharge
% postpartum women counselled on birth spacing and postpartum contraception options
% women discharged postpartum with contraceptive method of choice
% live births delivered in the facility that were notified by the facility to the civil registrar (in the context where health workers/health facilities have responsibility to notify live birth to the civil registrar)
% women/families who received postpartum counselling on importance of birth registration and obtaining a birth certificate and the process for registration of their infants with the civil registrar to obtain a birth certificate (applicable for all facilities, regardless of civil registration laws and policies in the country)

% live births delivered in the facility that were registered in the civil registry by the facility (applicable where health workers/health facilities have responsibility to register live births into the civil registry)
Proportion of newborns < 2000 grams initiated on KMC (or admitted to KMC unit if separate unit exists)**
% eligible neonatal babies (≤ 2000 grams) who receive near continuous KMC
% newborns of mothers with signs of infection who are evaluated for infection and treated as appropriate
% newborns with signs of infection who received appropriate antibiotics
% women who received augmentation of labour (uterotonics) with no indication of delay in labour progress
% women with uncomplicated, spontaneous vaginal birth in whom episiotomy performed
STANDARD 2. HEALTH INFORMATION SYSTEMS
% facilities with birth and death registration linked to vital national registration system
% newborns discharged with accurately completed record
% newborns with patient identifier and individual clinical medical record
% postpartum women discharged with accurately completed record
% facilities in which QI team regularly extracts data, calculates and visualizes prioritized quality indicators
% facilities conducted at least one recent review of maternal and perinatal death
% maternal deaths reviewed with standard audit tools
% perinatal deaths reviewed with standard audit tools
% QED facilities implementing “full” cycle of MPDSR according to WHO technical guidance (maternal and perinatal)

STANDARD 3. REFERRAL
% women/newborns who fulfilled criteria for referral and were referred
% women/newborns with complications transferred to appropriate care level with referral note
% women presenting to labour ward who report receiving immediate attention upon arrival
% referred newborns with counter-referral feedback information
% referred women with counter-referral feedback information
STANDARD 4. COMMUNICATION
% staff with recent training on interpersonal communication
% facilities receiving supportive supervision that addresses counselling
% women receiving postnatal information and counselling before discharge**
% women for whom a partograph has been completed
STANDARD 5. RESPECT AND DIGNITY
% staff with recent training on respectful care
STANDARD 6. EMOTIONAL SUPPORT
% women who wanted and had a companion of their choice in labour [childbirth]**
% staff with recent training on providing emotional support
STANDARD 7. MOTIVATED STAFF

% births attended by a skilled birth attendant
% staff who supervised/mentored to support clinical competence and QI in last quarter
% staff who can identity and report on at least one clinical activity in which they are personally involved
Measure of health worker experience of providing care in the facility and/or support – to be determined
% facilities with QI review meeting within at least past one month
% leaders at facility trained in QI and leading change
% QI meetings held in last 12 months
% facilities that participated in data sharing with district and community to inform user decisionmaking, prioritization and planning
% Leaders communicated performance through established mechanisms (e.g. dashboards)
% Facilities with an established liaison mechanism to district (and/or national level) on quality issues
STANDARD 8. PHYSICAL ENVIRONMENT

TABLE 4.3: STANDARD OUTCOMES MEASURES AT ALL LEVELS OF HEALTH FACILITY

STANDARD 1. EVIDENCE-BASED CARE
Number of maternal deaths (per 100 000 live births in health facility)
Number of maternal deaths classified by cause (ICD-MM)
% women with specific obstetric complication (PPH, PE/E, prolonged labour, infection/sepsis)

Obstetric case fatality rate (disaggregated by direct and indirect causes when possible)
Maternal cause-specific case fatality rate (PPH, PE/E, infection/sepsis, prolonged labour)
PE/E case fatality rate (valid only in high-volume facilities or when aggregated across multiple facilities)
PE/E case fatality rate (valid only in high-volume facilities or when aggregated across multiple facilities)
% all women who gave birth in the facility whose active first stage of labour > 12 hours
% women with obstructed labour with unmet need for C-section
Case fatality rate for women with prolonged labour (valid only in high-volume facilities or when aggregated across multiple facilities)
Newborn asphyxia rate (adverse intrapartum outcome)
Maternal infection/sepsis case fatality rate (valid only in large facilities or when aggregated across multiple facilities)
Pre-discharge neonatal mortality rate
Facility stillbirth rate (disaggregated by fresh and macerated)
Neonatal deaths classified by cause
Facility intrapartum stillbirth rate (plus fetal heart rate documented at admission)
% newborns with specific complications (prematurity, possible serious bacterial infection, asphyxia)
Neonatal cause-specific case fatality rate
% live-born newborns not breathing after additional stimulation who were resuscitated with bag and mask
STANDARD 2. HEALTH INFORMATION SYSTEMS

% facilities where data regularly reviewed and used to make decisions on QI
STANDARD 3. REFERRAL
% newborns who died before or during transfer to higher-level facility
% newborns referred from facility who completed referral
% pregnant or postpartum women who died before or during transfer to higher-level facility
% women referred from facility who completed referral
STANDARD 4. COMMUNICATION
% women who felt they were adequately informed by the health workers about their care, including examinations
% women who reported they were given an opportunity to discuss their concerns and preferences
STANDARD 5. RESPECT AND DIGNITY
% women reported receiving dignified and respectful care during maternity visit
% women who gave birth in facility who reported physical or verbal abuse to themselves [or their newborns
% women who felt adequately informed by health workers about their health and care
STANDARD 6. EMOTIONAL SUPPORT
% women undergoing bereavement or adverse outcome who report additional emotional support from facility staff
STANDARD 7. MOTIVATED STAFF

% women reporting sufficient staff at health facility
STANDARD 8. PHYSICAL ENVIRONMENT
% women reporting satisfactory access to water
% women reporting clean physical environment

2.2 QOC FACILITIES DATA FLOW AND MONITORING AND EVALUATION SCHEDULE.

The table below highlights the data flow and schedule for monitoring and evaluation of RMNCAEH+N QoC efforts at all levels of healthcare and tiers of governance in the country. It includes the indicator domain/type, the frequency of measurement, data sources and responsible entities.

TABLE 5: Data flow and Monitoring and evaluation schedule.

Area/Component	**Frequency**	**Data Sources**	**Responsible 1(handles data at the source)**	**Responsible 2 (handles data from responsible 1 at the LG/state)**
Fifteen (15) common indicators at all levels	Monthly/Quarterly	NHMIS/Facility registers/Client Questionnaire/Facility Survey.	Facility OIC / QI Team	LGA HMIS Officer/State M&E Focal Officer
Service delivery indicators	Monthly	NHMIS/Facility registers	Facility OIC / QI Team	LGA HMIS Officer/State M&E Focal Officer.
Input measures (see table of standards in 2.2)	Quarterly monitoring	Input Monitoring Form	Facility OIC / QI Team	LGA M&E/State HMIS & M&E Officers/StateFocal Officer
SCHEDULE FOR SUPPORT SUPERVISION, DATA REVIEW AND FACILITY ASSESSMENTS				

Area/Component	Frequency	Data Sources	Responsible 1(handles data at the source)	Responsible 2 (handles data from responsible 1 at the LG/state)
Facilitative/supportive Supervision from BHCPF/State teams..	Month or quarterly (LGA/State) Bi-annual (Federal)	National digital ISS tool	State/Federal M&E Team	Federal & State/LGA HMIS/M&E Focal Officers
Data Quality Assessment (DQA)	Month or quarterly (LGA/State) Bi-annual (Federal)	National digital ISS tool	State/Federal M&E team	Federal & State/LGA HMIS/M&E Focal Officers
Facility Assessment/Baseline Assessment	Annual	National Facility assessment tool	State/Federal M&E team	Federal & State/LGA HMIS/M&E Focal Officers

2.3 RMNCAEH+N QoC MEAL DATA SOURCES

Most indicators will be calculated using routine measurement methods and data sources. Supplemental collection methods (e.g., periodic facility assessment/baseline assessment) can complement routine monitoring to inform understanding of critical quality gaps and to inform the design and evaluation of QI interventions. The National, State and LGA data officers will leverage on diverse set of data sources, including, but not limited to:

2.3.1 ROUTINE DATA COLLECTION SOURCES

a. HMIS Patient records/facility registers

These can provide more detailed information on interventions provided and adherence to standards of care for more complex processes of care that are not typically aggregated in HMIS at subnational or national levels. – Data aggregated within HMIS or District Health Management Information System 2 [DHIS2]): Selected data from facility registers are typically aggregated in HMIS (e.g. DHIS2). To varying degrees, HMIS can provide routine (e.g. monthly) information on service utilization, provision of high-impact interventions, incidence of institutional complications, number and causes of death, and case fatality.

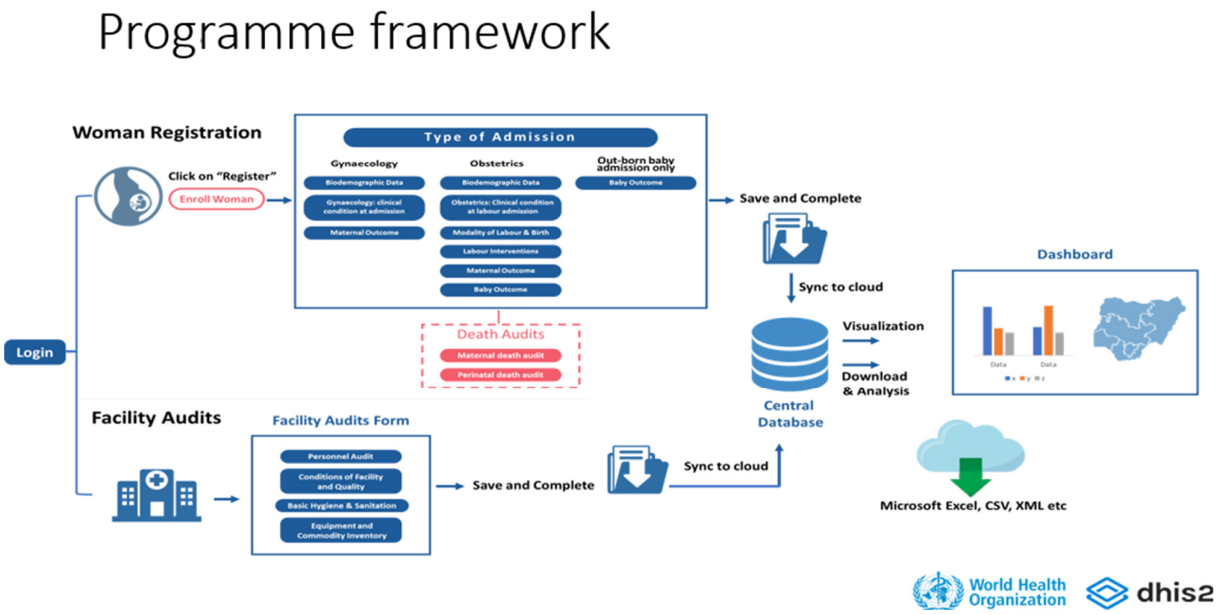
b. Maternal death surveillance and response and perinatal death audits

These can provide detailed case-by-case information about cause of death and underlying contributors, including QoC provided and using the MPDSR assessment tools.

c. MPDSR/QOC Data Integration Guidance at Service Delivery Level

The Government of Nigeria is pioneering this innovation on data integration and management for MDPSR/QI indicators. This is because of the overlapping nature of these indicators aimed at improving quality of care at the facility level.

There has been a transition plan following an initial pilot project implementation. The guidance below provides information on the responsible officers that will input these data on the cloud when these activities are rolled out.



Maternal Perinatal Database for Quality Equity and Dignity (MPD-4-QED)

Table 6: MPDSR/QoC indicators and data collection

SN	Level	Data input tool	*Data Source	Responsible Officers	Frequency
1	Tertiary Health Facility	Handheld tablet or Computer with MPD-4-QED	HMIS/Facility Registers	Medical Record Officers	Monthly

2	Secondary Health Care Facility	Handheld tablet or Computer with MPD-4-QED	HMIS/Facility Registers	Medical Record Officers/State NHMIs/M&E Officers	Monthly
3	Primary Health Care Facility	Handheld tablet or Computer with MPD-4-QED	HMIS/Facility Registers	Facility M&E Officer LGA NHMIS/M&E Officers	Monthly

***All cloud-based reports for each service delivery level are collated, summarized, and presented at the State QoC TWG and National QoC TWG for further review and possible actions.**

d. DHIS2

e. Civil registration and vital statistics

These provide information on mortality and population-based denominators (e.g. estimated births).

f. Logistics management information systems (LMIS) and supply chain management

The availability, distribution and quantity of medicines, commodities and medical supplies are often routinely tracked in LMIS or other supply chain management systems from central warehousing to service delivery points, such as health facilities.

g. Administrative records (Human resources and staff training)

The placement, availability and training of health staff are often routinely tracked at facility, district and/or national levels in human resource information systems.

2.3.2 PERIODIC DATA COLLECTION SOURCES

a. Client surveys

Structured quantitative questionnaires (e.g. brief client exit survey) can provide information on a client's priorities for care and experience of care. Since three of the eight WHO QoC standards address experience of care, it is likely that QED facilities may support episodic brief surveys of women and families (e.g. brief structured exit questionnaire).

b. Staff/provider interview

These are useful for assessing provider knowledge, self-reported practice and training.

c. Input monitoring form

The input monitoring form in annex 1I, will measure the inputs into the six (6) pillars of the health system building blocks, on which the conceptual framework of quality of care is built on. On the other hand, focusing on these separate components helps put boundaries around this complex construct and permits the identification of indicators and measurement strategies for monitoring progress and a criterion for scale up and sustainability in the Nigeria RMNCAEH+N QoC agenda.

d. Simulations of care

These assess provider competence and skills for discrete tasks (e.g. resuscitation of newborn using mannequin; postpartum counselling).

e. Observation

Provider performance and adherence to standards of care during real time clinical care can be assessed through observations (e.g. as part of baseline assessment or periodic peer-to-peer observation). Service readiness (e.g. stock availability or condition of water and sanitation facilities) or other operations can also be assessed.

2.3.3 OBSERVATION

a. Periodic health facility assessments

These tools generate important supplemental information (e.g. baseline or periodic facility assessment) using a combination of routine and non-routine data sources (such as those highlighted above). Facility assessments can be an important source for data that are not routinely available in most health systems to provide a deeper and more nuanced understanding of the QoC. More in-depth information on users' and providers' care experience and priorities can be collected through baseline and/or periodic client interviews and focus group discussions and other qualitative methods to supplement routine quantitative data sources (e.g. client survey).

b. Population-based health surveys

These can provide information on intervention coverage, treatment-seeking behavior, patient self-reported practices and experience of care and other variables

c. Desk review and stakeholder interviews

Information on activities undertaken or completed and achievement of specific implementation milestones can be obtained through these two methods.

2.4 National QoC Review Meeting Update Template for States

States are expected to send reports of programmatic implementation and data to the Secretariat of the QOC TWG in the Department of Family Health, FMOH every quarter which will be summarized quarterly as implementation milestones to be reviewed at the quarterly TWG meeting and transmitted to WHO QED Network secretariat once approved by the TWG. Table 7 shows the implementation milestones expected to be reported by the states.

Table 7: Strategic update for States

SN	ACTIVITY AREA to be reported
Leadership	
1	Has the TWG meetings been held in the quarter? When was the last meeting held?
2	Is there a State QoC operational plan embedded in the state AOP for the year? What is the level of implementation?
3	Has a debrief been done to the Honourable Commissioner of Health?
Action	
1	Have there been refresher training on QI approaches at the QoC learning sites? Have you scaled up QI approaches to other facilities?
2	Do your QoC Sites have the relevant clinical protocols/standing orders on Maternal and Newborn health?
3	What capacity building activities have been conducted for programme managers, health workers and M&E staff in the last quarter on QoC data collection, analysis, and use?
Learning	
1	How often are Facility QI team meetings held at the QoC Sites in your State. (No of meetings per month)
2	How often does onsite coaching visits occur (number of visits per facility per month)
3	Is there a Platform for documentation of best practices through the State?
4	How many facilities implementing QI activities are learning sites? list all of them.
5	What inputs have you received, and how has that improved care?
6	How many sessions of peer-to-peer learning have been done? When was the last peer to peer done? dd/mm/yyyy
Accountability	
1	What advocacy and stakeholder engagement activities have been conducted on MNH QoC?
2	How often do you report the activities of the learning sites to SMOH?

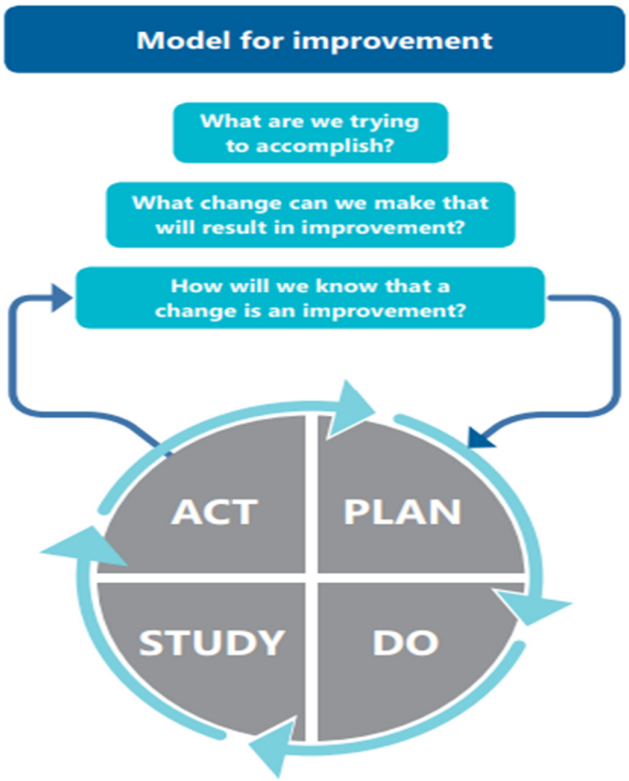
3	Partner supporting the state health facilities on QI. List the partners
4	Collaboration with the MPDSR committee in the facilities? if yes, indicate how and success made
5	What funding stream are you using for QoC -BHCPF, State Budget, Partners?
Crosscutting	
1	Lessons learnt
2	challenges
3	Recommendations.

Table 8: Indicators and data update for states

S/N	OPERATIONAL
1.	Number of learning sites (facilities) per State
2.	Number of learning sites (facilities) with functional QI team
3.	Six (6) most prevalent QoC issues identified by QI team in the last quarter
4.	Three most prevalent QoC issues solved by QI team in the last quarter
5.	Number of QoC Partners supporting State
	PROGRAMME
6.	Total number of maternal deaths across learning sites in the State
7.	Total number of neonatal deaths in learning sites in the State
8.	Total number of U5 deaths in learning sites in the State
9.	Total number of stillbirths at learning sites (disaggregated – fresh/macerated)
10.	Total number of mothers in labour ward who received prophylactic uterotonic agent within a minute after delivery
11.	Total number of facilities (learning sites) that reported stock-out of prophylactic uterotonic agent in the last month/quarter
12.	Total number of women who reported that they were abused physically or verbally by health workers during delivery
13.	Total number of women who reported they were allowed to have their companion of choice during delivery
14.	Total number of women who were refused request to have their companion of choice during delivery
15.	Total number of reports of negative attitude of health workers
16.	Total of babies born alive in learning sites facility who are breastfed within one hour of birth
17.	Total number of learning sites with dedicated and functional ambulance or linked to the National ambulance service

18.	Total number of learning sites with facility owned telephones (especially in the maternity ward) for communication
19.	Total number of learning sites with uninterrupted supply of water in the maternity area including labour ward
20.	Total number of learning sites with single area or room that allows for privacy for women and companion of choice for all deliveries
21.	Total number of PPH cases in facilities (learning sites) per month/quarter
	DATA MANAGEMENT
22.	Total number of learning sites (facilities) that have complete set of reporting NHMIS Tools (Versions 2018) in learning sites
23.	Total number of learning sites reporting to DHIS-2 using electronic means/devices in the State
24.	Number of facilities that had DQA conducted in the last quarter
25.	Number of learning sites (facilities) that conducted ISS in the last quarter
26.	Reporting rates of learning sites

2.5 USING DATA TO IMPROVE QUALITY



The plan, Do, Study, Act (PDSA) cycle is designed to help QI teams methodically test and iteratively refine ideas on a small scale before committing to larger scale and implementation. The PDSA is an important tool that can be used to track the performance of the 15 standard indicators and to demonstrate this, each facility is required to have a Visible PDSA Chart in all health facilities. Quality Improvement (QI) teams need to collect real-time data to undertake these tests and track performance of the 15 standard quality of care indicators in National Reproductive, maternal newborn, child, Adolescents, Elderly plus Nutrition (RMNCAEH+N) care systems. In most cases, the data tracked in the monitoring framework will be used to assess whether PDSA tests and other QI interventions are (or are not) improving care.

To improve the quality of services for the identified problem in the health facility, the team needs to:

- Identify some changes (ideas) that they think will work in their situation
- Review the possible change ideas if these are important for patient care and are likely to be effective and feasible at their workplace
- Test the idea/s to learn if these work and to adapt them for your setting, as required

There may be many problems and solutions that can be explored, but teams may choose to focus on solutions that are actionable within their sphere of influence in the short term, while advocating for more long-term systemic change

There are several types of changes that you can make in your health facility. Some of the main categories include:

- Eliminate waste by stopping unnecessary treatments or steps of care – stop doing harmful or useless (even if harmless) practices
- Reorganizing the sequence of tasks or reassigning tasks to different staff.
- Improve the patient relationship and communication - her experience of the care received – listen to what patients want
- Manage variation in the existing treatment and care practices – make work (process of care) more standard and predictable

Testing the change idea: It is rare that any change will work perfectly the first time. It will usually need some adjustment to work in your setting. Because of this, it is important to test the new ideas to learn how they work and to adjust them.

The PDSA cycle is very useful for this. PDSA stands for: Plan, Do, Study, Act. These are steps to take when testing a new idea

- **Plan** –you decide how the change idea will be implemented.
- **Do** – carry out the change
- **Study** – the team reviews whether the desired change has been carried out as planned; what they learned from the test; whether it was a success, or a failure based on the collected data
- **Act** – the team decides what to do next depending on the experience and result of implementing the change idea.

Planning a test

- Who will test the change/new idea
- What they will do
- When they will do it
- What you want to learn from the test
- It is important to emphasize that a team can do small scale PDSA cycles very quickly.

For example, when someone is cooking, and they decide to add salt and see if it tastes better, they are doing a PDSA. Teams can do short PDSA cycles as well to learn how new ideas are working and to adapt them.

Plan step of the PDSA cycle:

Do"- In this step the assigned person in the team tests the change as per the plan developed in the previous step.

Often things do not happen as planned. It is important in the 'Do' step to document any challenges or deviations from the original plan.

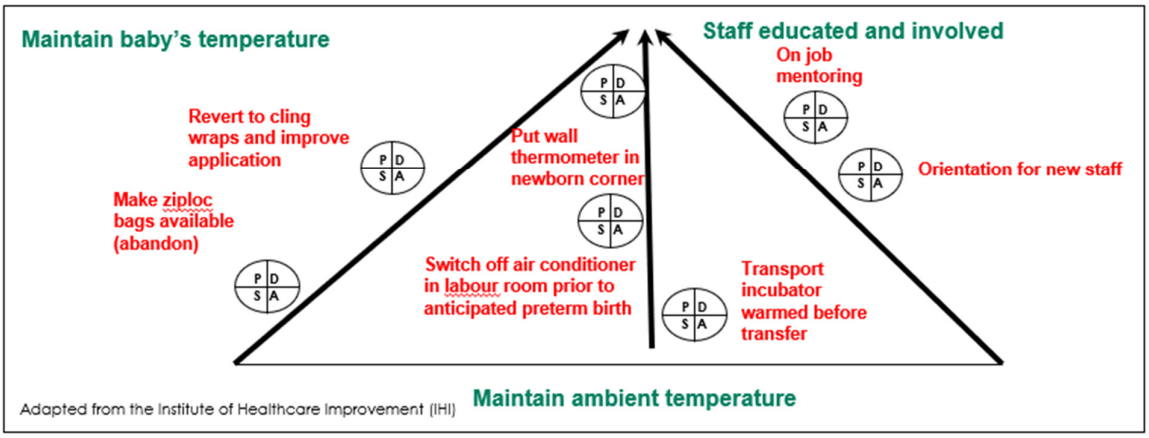
Study - The team reviews what they learned from the test: whether it is feasible in our work setting whether it was successful in addressing the problem as hypothesized by the team

Act - After studying the results of implementation the team will decide to:

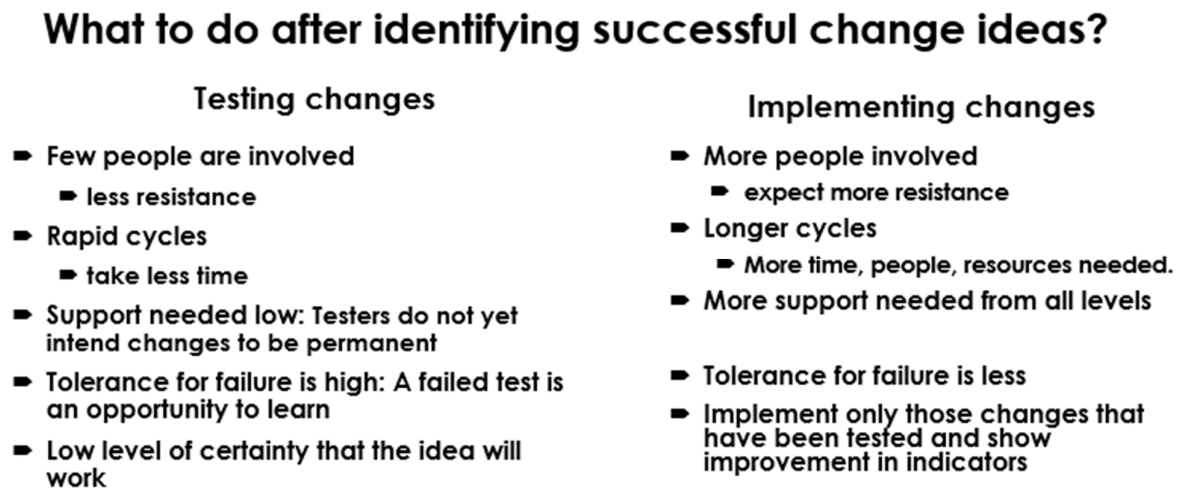
- Adapt the change – if it has not fully succeeded, make some modifications, and implement again
- Adopt the change – if it works perfectly make sure everyone in the health facility uses this change
- Abandon the change – if it does not work at all or makes things worse so stop doing it
- Testing on a small scale means that there won't be any harm and provides an opportunity to learn. It also allows you to make modifications to your idea before you apply it at a large scale.
- As much as possible, it is good to test each change idea individually otherwise you won't know which idea worked and which one did not.
- It is also important to highlight that some of your change ideas will not work. That is expected.
- It is good to test the change/ idea in different working conditions to learn if the change always works, for example, testing on weekends or nighttime will let you know if changes will work when there are fewer staff.

Multiple changes towards a single aim

Aim: Reduce severe hypothermia in newborn babies by 50% in 3 months



- No QI project will reach its aim with only one PDSA. You will need to do multiple PDSA's depending on your analysis and identified causes and change ideas.
- In this example multiple change ideas were tested to reduce hypothermia in newborn babies. Some of these change ideas were abandoned (Ziploc bags), some were adapted or adopted.
- Try to test one change at a time. The changes in the illustration can happen at different times in the health facility



Once you have identified a successful change idea by doing PDSAs you can then 'implement' the change across the unit or ward or health facility.

In quality improvement the term 'implement' refers to applying a successful change idea to a larger scale. You should only implement changes that have been shown to be successful in PDSA's.

CHAPTER 3

Linking Standards to Measurements

Each of the eight WHO standards for improving quality of maternal and newborn care in facilities includes several quality statements and associated measures. Quality statements are concise prioritized statements designed to help drive measurable improvements in care.

Three types of measures are defined for each quality statement:

- Inputs: what must be in place for the desired care to be provided)

- Outputs (process): whether the desired process of care was provided as expected

- Outcome: the effect of the provision and experience of care on health and people centred outcomes.

The WHO quality statements and measures can be used to inform the improvement areas prioritized by the teams at subnational including facility levels to monitor performance of essential services and quality of maternal and newborn care processes in facilities. Annex III outlines illustrative input, output/process and outcome measures which are to be tracked in Nigeria as quality statements highlighting links to components of the monitoring framework

Chapter 4

COORDINATION AND IMPLEMENTATION ARRANGEMENTS FOR THE QOC M&E PLAN

4.0 Coordination and Institutionalization of Quality of Care MEAL (In line with the Health Information System Policy 2021 to 2025)

QoC data coordination is to promote governance, ownership, and inclusiveness of stakeholders at all levels in data generation and use of findings for improved quality of care and sustainable learning. QoC data governance highlights the principle of managing and coordinating the availability, consistency, integrity, security, and utilization of collected data for dissemination and timely decision making. It ensures a level of authority and control over data with regards to the people, processes, and technologies needed to collect, manage, store and secure QoC data within the health system. It is also important for quality data generation. For effective management of data on QoC, reliable and appropriate data need to be continuously collected and analyzed for health planning, programming and to inform improvement in health for all. To this effect, governments with key stakeholders at all levels must provide effective leadership and governance in matters relating to the health information system.

4.1 Data Management for RMNCAEH+N QoC MEAL Plan (inline with the M&E of the NSHDP II)

The Data management will comprise of all processes related to the RMNCAEH+N QoC data collection, analysis, synthesis, and dissemination. RMNCAEH+N QoC data flow will be aligned with the existing national data management systems. Data collection for tracking the progress of this MEAL plan will occur both at the primary, secondary, and tertiary facility levels depending on the specific indicators and health facility choice.

Data Collection: RMNCAEH+N QoC data gathering will be sources of all relevant tools leveraging on some form of paper and wholistic electronic implementation to collate, analyze and report the data. It is the way to go due to reflections from data experiences. This will also obtain from all relevant sources for collation, analysis and reporting.

Data Collation: RMNCAEH+N QoC data will be summarized in different format leveraging on electronic dashboards, standardized format which will be done electronically or manually and at a different level (LGA, State and National).

Data Analysis: RMNCAEH+N QoC data will be reviewed using statistical applications, selecting or discarding certain subsets based on specific criteria and other techniques. It will be be analysis to enable data users to understand or interpret the results and use for evidence based decision making.

Data Quality Management

Instituting the use of electronic based tools to track RMNCAEH+N QoC data will ease collection, collation and reporting and birth a data quality management system. This will form the bedrock of good RMNCAEH+N data and should be be the criteria on which quality systems should be incorporated at the levels of data collection, collation, analysis, and reporting.

Table 16: RMNCAEH+N QoC TWG Monitoring and Evaluation COLLECTION, COLLATION AND ANALYSIS

SN	LEVEL	RESPONSIBLE	TIMELINE
1	National	M&E Subcommittee, National TWG	Quarterly
2	State	M&E Subcommittee, States TWG	Quarterly
3	LGA	Facility in charge LGA Quality Improvement Team	Quarterly
4	Health Facilities	Medical Record Officer	Monthly

*Reporting checklist, mode of entry and submission to be developed and shared. C

4.1 Monitoring and Reviewing QoC AOP Implementation (From AOP)

A mechanism for reviewing and updating the QoC M&E plan should also be included. This is because changes in the program can and will affect the original plans for both monitoring and evaluation.

The implementation of the QoC will be routinely monitored, reviewed, and evaluated to ensure the country is on track in line with the set objectives and targets. The purpose of the QoC evaluations is to improve the effectiveness of the QoC and to inform programming decisions. The structure of the evaluation process is to track results against indicators across the "Results Chain" or Theory of Change, with emphasis being placed on tracking outputs, outcomes and impacts of various interventions. Occasionally, evaluations will be conducted by respective MDAs, in collaboration with development partners, relevant stakeholders or jointly with independent consultants to determine issues relating to relevance, effectiveness, efficiency, Value-for-Money (VfM), impact and sustainability of service delivery.

This QoC M&E Plan has made provision for routine monitoring through the Core Indicators outlined, Joint Annual Reviews (JAR), a Mid-Term Review and End Term Evaluation of the QoC. However, reviews will not be limited to these baselines, mid and/or end-term evaluations. Evaluations may be triggered by certain performance issues in the relevant MDAs and may require an external independent review to be commissioned. "Mixed Methods" approaches will be used in conducting QoC evaluations. It is also important to ensure that evaluation data is disaggregated by gender, age, or other important characteristics that will inform equity.

4.2 RMNCAEH+N QoC Tools & Dashboards.

The development of a National QoC dashboard is key to ensure data analysis, documentation, time series, trends, and visualization of the fifteen core indicators**.** The dashboard will be a module on the DHIS2, health facilities implementing QOC therefore will need to ensure good quality of data on the core indicators in the DHIS2. The dashboard will be useful for national and state level visualization of results and also useful for trend analysis for each facility. This will be reviewed in the meetings of the National M&E subcommittee and reported to the TWG periodically.

4.3 QOC INTEGRATED SUPPORTIVE SUPERVISION.

Integrated Supportive Supervision (ISS) is conducted by the Federal Governments and State Governments to ensure management of resources and best delivery of healthcare services in health facilities. It involves inspecting, controlling, supervising, and giving support to health workers, to improve their skills and performance, and ultimately, health service delivery.

QoC milestones, standard indicators and key quality checklists have not yet been included in the federal and state ISS checklists. So, in the interim, while we use the existing checklists, LGA and State QI leads should ensure the data management processes including reporting of QI indicators are conducted monthly with quarterly state level review meetings. The ISS checklist will be updated to include QI checklist at the LGA, state and federal level so the existing ISS tools used in the states apply for QoC for the time being

- Frequency, period of supervision

4.3.1 PHC level QoC supervision

The QoC process is linked with the existing supportive supervision processes at the national and state level. While the QoC process focuses almost entirely on service delivery, the PHC supportive supervision process aims to assess critical health system input areas such as human resources, health equipment, commodity and supplies, and infrastructure.

The frequency of PHC supportive supervision by the national team will take place quarterly. It is recommended that states/LGAs carry out supportive supervision to PHC facilities at least once a month. For each round of supervision, selection of supervision sites (State/LGA/HF) will be conducted by the BHCPF team in PRS unit of NPHCDA and NEMCHIC/SEMCHIC/LEMCHIC across the three levels.

The PHC RMNCAH+N supportive supervision tool will leverage on the existing quality assessment checklist use to track the basic healthcare provision fund (BHCPF) implementation.

4.3.2 Secondary and tertiary level QoC Supportive supervision

The development of a QoC checklist for the secondary and tertiary level of healthcare is of importance and aligning to existing structures

Chapter 5

STAKEHOLDER ROLES AND RESPONSIBILITIES FOR THE IMPLEMENTATION ARRANGEMENTS FOR THE NATIONAL M&E PLAN

5.1 National QOC M&E subcommittee:

The terms of reference of the committee includes:

- Led by QOC M&E focal person from department of Health, planning, research and statistics, FMOH
- Membership from M&E focal persons from MDAs and Development partners in the QOC TWG.
- The National TWG shall set criteria for membership and ensure at least 80% attendance in all subcommittee meetings or be replaced.
- Roles include Inspections of health facilities, monitoring and evaluation, health records data
- Roles includes scaling health facilities to e data centres
- Roles includes health facility certification by data criteria.
- Roles include development and implementation of a national QOC MEAL plan.
- Monitoring of data from facilities and data analysis for review by the National QOC TWG.
- Roles includes setting up of DHIS2 learning hubs in Universities, States or IT centres.
- Roles includes establishing the DHIS2 learning curricular to scale DHIS2 instances in Nigeria M&E systems.

5.2 State QOC M&E subcommittee:

The terms of reference of the committee includes:

- Led by QOC M&E focal person from department of Health, planning, research and statistics, SMOH
- Membership from M&E focal persons from MDAs and Development partners in the QOC TWG.
- Roles include development and implementation of a national QOC MEAL plan.
- Monitoring of data from facilities and data analysis for review by the State QOC TWG.

5.3 State HMIS officer

- Data review and data quality assessment
- Data analysis and interpretation for review by the state QOC TWG

5.4 LGA M&E officer

- Monthly data collection from health facilities and review of the monthly update of the dashboard.
- Data quality assessment and mentoring on quality data

5.5 DEVELOPMENT PARTNERS

- Engage with the National QoC TWG at the Quarterly meetings.
- Engage with the M&E subcommittee meeting monthly
- Support the implementation of the RMNCAEH+N QoC MEAL plan inline with the National RMNCAEH+N QoC TWG

5.6 CSO'S & MEDIA

- Support the tracking of inputs in the States using the INPUT MONITORING FORM.
- Support the RMNCAEH+N accountability mechanism of this MEAL plan.
- Engage with with decision makers on the State of RMNCAEH+N QoC using the MEAL plan data sets.

5.7. QoC responsible Officer(s) for M&E at the Facility level

The leadership of the team designates the M&E focal point of the team or responsible person applicable in the team to ensure collection, reporting and management of QI indicators at the facility level. The list below is not exclusive of the established M&E structures at all levels but meant to strengthen existing structures.

5.7.1 At the Primary Health Care Facility level:

1. Officer in charge of the primary health care facilities or designated
2. The facility M&E officer or data clerk who is part of the QI team (where applicable).

5.7.2 At the Secondary Health Facility Level:

1. Head of Medical records
2. Director planning, research, and statistics.
3. Medical Director/Chief Medical Superintendent of the health facility/Head of hospital management board or Hospital Management Committee.

4. Designee by either 1-3 listed above (Chief Nursing Officer etc.)

5.7.3 At the Tertiary Health care Facility Level

1. Heads of Medical records
2. Directors of Administration
3. Head of medical store**/**LMCU Coordinator representative
4. Chief Medical Directors and Chairman Medical Advisory Committee

Note: Participating facilities at all levels of care (Primary, Secondary and Tertiary) have the obligation to share QoC information with statutory M&E structures - Routine and periodic Health Information Systems (HIS); Health Committees, Departments, Programmes, Agencies, Parastatals, and Partners at Federal, States and LGA levels (where applicable).

CHAPTER 6

6.1 Work Plan and Budget for the QoC RMNCAEH+N M&E Plan

The RMNCAEH+N QOC MEAL PLAN 2022-2027 work plan and budget below align with the strategic objectives and key activities outlined in Section 1.4 of this QoC MEAL Plan. This work plan and its budget only reflect an estimation of the costing. State-specific costed MEAL Plan will be developed and aligned with each State QoC TWG priorities and corresponding QoC Annual Operational Plans (AOP). The National QoC TWG will work with the States QoC TWG to develop a costed MEAL plan for implementation and support domestication at state level.

The costing of the MEAL plan cannot be estimated as what it will entail requires huge resources because of the following:

- Institutionalization of the RMNCAEH+N QoC MEAL plan in all 36 States and FCT.
- Transition from paper to electronic
- Establishment of DHIS 2 Learning hubs for peer to peer and high-level academic and professional review.
- Capacity building for M&E programme and technical officers.
- Recruitment of M& E programme and technical officers.
- Assessment, Supportive supervision at all levels of healthcare facilities
- Data collection and analysis at all levels of healthcare facilities

Data in the 21st Century is like Oil in the 18th Century: an immensely, untapped valuable asset. Like oil, for those who see data's fundamental value and learn to extract and use it there will be huge rewards.

We're in a digital economy where data is more valuable than ever. It's the key to the smooth functionality of everything from the National government to local government. Without it, progress would halt. Data infrastructure is still a cost center nowadays and should become a profit center by using the data to improve everything, day by day. Nigeria must begin treating data as an enterprise-wide corporate asset while also managing the data locally within business units.

Table 15: Costed workplan for RMNCAEH+N QOC MEAL PLAN

STRATEGIC OBJECTIVE 1: LEADERSHIP TO BUILD AND STRENGTHEN NATIONAL INSTITUTIONS AND MECHANISMS FOR IMPROVING MONITORING OF QUALITY OF CARE FOR RMNCAEH+N. TARGETS: AT LEAST 80 PER CENT OF IDENTIFIED INSTITUTIONS AND COORDINATING STRUCTURES STRENGTHEN TOWARDS IMPROVEMENT OF QOC.	Timeframe						Budget in million ₦				
	2022	2023	2024	2025	2026	2027	2022	2023	2024	2025	2026
Integrate RMNCAEH+N quality of care monitoring into existing National and Subnational governance structures.							3	3	3	3	3
Strengthen RMNCAEH+N quality of care advocacy and mobilization strategy							5	3	2	1	1
Established linkage with Health Partners Coordination Committee (HPCC) for coordinated Government and Development Partners funding to strengthen RMNCAEH+N QoC at National and Subnational level.							3	-	-	-	-
Drive an operational roadmap for RMNCAEH+N QoC MEAL plan for National and Subnational levels.							1	-	-	-	-

STRATEGIC OBJECTIVE 2: ACTION TO OPERATIONALIZE AND SUSTAIN IMPLEMENTATION OF QUALITY OF CARE MONITORING PROCESSES FOR IMPROVEMENTS IN RMNCAEH+N TARGETS: 80 PERCENT OF SUPPORTED HEALTH FACILITIES IMPLEMENTING AND MONITORING OF 15 CORE QI STANDARD INDICATORS	Timeframe						Budget in million ₦				
	2022	2023	2024	2025	2026	2027	2022	2023	2024	2025	2026
Strategic Objective 2: ACTION Adoption of the MEAL plan by implementing facilities at Federal and State levels.							3	3	3	3	3

Develop National and Subnational context specific guidelines for MEAL implementation and ensure widespread dissemination							5	3	2	1	1
Annual capacity building of QI teams to support quality improvement in health facilities.							3	-	-	-	-
Incorporate and disseminate a QoC standard of procedure and protocols within training health institutions, professional organizations, and regulatory bodies across state/LGAs and HFs.							1	-	-	-	-
Annual facility assessment for participating QoC facilities to monitor progress.											
Baseline assessment for new QoC facilities to ascertain status.											
Data systems strengthening											
Ensure regular dissemination of information to States											
QoC TWG to set criteria for selection of demonstration states and sites – 112 facilities selected across the 6 geo-political zones.											

STRATEGIC OBJECTIVE 3: LEARNING **TO FACILITATE LEARNING, KNOWLEDGE SHARING AND EVIDENCE-BASE TRAINING ON QUALITY OF CARE** **TARGETS: (80 PER CENT INCREASE IN THE NUMBER OF LEARNING SITE SHARING KNOWLEDGE AND GENERATING EVIDENCE FOR QOC)**	**Timeframe**						**Budget in million ₦**				
	2022	**2023**	**2024**	**2025**	**2026**	**2027**	**2022**	**2023**	**2024**	**2025**	**2026**
Incorporate QoC Indicators to strengthen existing DHIS-2 & NDR Systems.							3	3	3	3	3
Standardize tools for data collection and reporting							5	3	2	1	1

Develop TWG mechanisms for regular sharing, training, documentation, and dissemination of best practices of RMNCAEH+N QoC across health facilities							3	-	-	-	-
Conduct trainings at all levels on the appropriate use of QoC guidelines							1	-	-	-	-
Develop capacity programmes for various health workforce (such as managers, health workers and M&E staff) on QoC data collection, analysis, and use							3	3	3	3	3
Establish and maintain a virtual learning system for improving MNH QoC							4	4	4	4	4
Develop a repository of products and tools for QoC							4				
Develop a system for inter-state collaborative learning – WhatsApp group developed to enhance communication between implementing States and Federal											
Develop an enhanced change package of tested ideas to inform program delivery											
Regular updating of website dedicated to QoC and robust linking of the MoH platform to relevant sites											

STRATEGIC OBJECTIVE 4: ACCOUNTABILITY **TO STRENGTHEN INSTITUTIONS WITH TOOLS AND MECHANISMS OF ACCOUNTABILITY FOR THE QUALITY OF CARE** **TARGETS:(99 PERCENT IMPLEMENTATION AND TRACKING ACCOUNTABILITY FRAMEWORK IN ALL THE MDAS ON QOC.)**	**Timeframe**						**Budget in million ₦**				
	2022	**2023**	**2024**	**2025**	**2026**	**2027**	**2022**	**2023**	**2024**	**2025**	**2026**
Employ health-related advocacy to engage key stakeholders, government officials, policymakers, and political leaders on MNH QoC							3	3	3	3	3
Engage citizens in MNH QoC policy design through interactive platforms such as social media, town hall meetings, health rights education et							5	3	2	1	1

Track counterpart funding systems at inception of all MNH QoC initiatives							3	-	-	-	-
Support and supervise States to implement MPDSR in line with national guidelines							1	-	-	-	-
Establishment of a unit responsible for QoC under the oversight of the Honourable Minister for health											
Use FMoH and other government websites to disseminate policies, guidelines, strategies, and protocols on QoC											
Develop a system for inter-state collaborative learning – WhatsApp group, Telegram developed to enhance communication between implementing States and Federal											
Develop an enhanced change package of tested ideas to inform program delivery											
Regular updating of website dedicated to QoC and robust linking of the MoH platform to relevant sites											

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52. Diana Sera	WHO
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LIST OF TABLES AND CHARTS

Annexes 1

The list of Stakeholders Implementing RMNCAEH+N QoC

S/N	STAKEHOLDERS	ROLES AND RESPONSIBILITIES
1	Department of Family Health (FMoH)	• Coordinates and provides leadership roles. • Serves as the national coordinating platform for QoC • Ensures identification and use of data for evidence based QoC, dialogues and decision making. • Leads resource mobilization for national level QoC
2	Department of Health Planning, Research & Statistic (FMoH)	• Leads tracking monitoring and review of performances. • Ensures identification and use of data for evidence-based QI
3	Department of Hospital Services (FMoH)	• Coordinates and provides leadership role for the implementation of QoC at the tetiary level of care in Nigeria.
4	National Primary Healthcare Development Agency	• Coordinates and provides a leadership role for the implementation of QoC at the primary level of care in Nigeria. • Provides technical and programmatic support to States Primary Healthcare board and LGAs on implementation of QoC at PHC level • Mobilizes resources for PHC QoC implementation.
5	States Ministry of Health	• Serves as the States coordinating platform for QoC • Ensures identification and use of data for evidence based QoC, dialogues and decision making. • Leads resource mobilization for State level QoC • Coordinates and provides a leadership role for the implementation of QoC at the secondary level of care in Nigeria.
6	WHO	• Coordinates and provides technical guidance for the implementation of QoC in Nigeria. • Serves as the Country secretariat for the QED network. • Provides technical support to National QoC TWG in the Implementation of QoC in Nigeria, including implementation in health facilities in FCT, Kebbi and Sokoto.

7	UNICEF	• Implementing QI in selected primary, secondary & Tertiary health facilities in Kebbi, Niger, Adamawa, Bauchi, Kano. • Provides technical support to National QoC TWG in the Implementation of QoC in Nigeria.
8	USAID/IHP	• Implementing QI in selected secondary and primary health facilities in Bauchi, Kebbi, Sokoto, Ebonyi States and FCT.
9	JHPIEGO	• Implementing MSD for Mothers Quality of Care project in selected primary, secondary and private health facilities in FCT & Lagos. • Supporting the implementation on indirect causes of maternal mortality (Focus on risk factors for CVD & Pre-Eclampsia/Eclampsia) in Nigeria.
10	CHAI	• Support the roll-out of a revised quality of care strategy in alignment with national strategy in program States (Kaduna, Kano, Katsina & Rivers). • Support the establishment and institutionalization of Quality Improvement (QI) dashboards and Quality-of-Care (QoC) teams for continuous monitoring.
11	UNFPA	• Support & Coordinate Implementation of QoC in Gombe State
12	PATHFINDER	• Support the TWG for coordinating & Implementation of QoC.
13	WRA	• Support the TWG for coordinating & Implementation of experience of care QoC in Niger state. • Support to the Advocacy sub-committee
14	NEST 360	• Newborn Essential Solutions and Technologies is implementing in Oyo & Lagos State.

ANNEX II

INPUT MONITORING FORM

FEDERAL MINISTRY OF HEALTH **NATIONAL RMNCAEH+N QUALITY OF CARE TECHNICAL WORKING GROUP**		
RMNCAEH+N QUALITY OF CARE INPUTS MONITORING FORM		
STATE:	**FACILITY NAME:**	**MONTH/YEAR:**
***STATE MINISRY OF HEALTH CAN PRIORTIZE THIS INPUT MONITORING FORM TO TRACK INPUT MEASURES IN THEIR STATE HEALTH FACILITY.** *** AN ELECTRONIC FORM WILL BE LINKED TO THE DHIS 2 AND THE RMNCAEH+N QoC DASHBOARD FOR ANALYSIS**		
HEALTH SYSTEM BUILDING BLOCKS AND QoC METADATA	**MAX POINTS**	**SCORE**

A. **LEADERSHIP / GOVERNANCE**		
1.facilities with written, up-to-date clinical protocols on PE/E, PPH, PRETERM, BIRTH ASPHYXIA, ANC, PNC, etc	**1 POINT /protocol**	
2. facilities with accessible health education materials	**1**	
3. facilities with written policy to promote interpersonal communication and counselling	**1**	
4.Facilities with standard form for documenting clinical progress and care	**1**	
5. facilities with written protocols for verbal and written handovers (shift change, intra-facility transfer, referral, discharge)	**1**	
6.facilities where physical environment allows privacy	**1**	
facilities with written, up-to-date protocols to ensure privacy and confidentiality	**1**	
7.facilities with written, up-to-date zero-tolerance nondiscriminatory policies on mistreatment	**1**	
8.facilities with written, up-to-date policies on obtaining informed consent	**1**	
9.facilities with written, up-to-date policies that allow companion of choice during labour and delivery process	**1**	
10.facilities with written, up-to-date plan for improving quality of care and patient safety	**1**	
11.facilities with designated QI team	**1**	
facilities with written protocol and awareness materials (posters) on WASH and waste management	**1**	
12.facilities with policy and space for rooming-in of mothers and babies 24 hours a day	**1**	
13.facilities with regular source of electricity	**1**	
14.facilities with essential laboratory supplies and tests	**1**	
15.facilities with an established liaison mechanism to district (and/or national level) on quality issues	**1**	
2. **HEALTH SERVICE DELIVERY**		
16.facilities with written, up-to-date clinical protocols	**1**	
17.CEmONC facilities with functional blood transfusion service	**1**	
18.facilities with standardized referral protocol for identification, management and referral of women/newborns with complications	**1**	
19.facilities with up-to-date list of network facilities providing referral services	**1**	
20.facilities with written, up-to-date protocols to ensure privacy and confidentiality	**1**	
21.facilities with basic water supply in maternity care areas (labour, birth, postnatal)	**1**	
22.facilities with basic environmental cleaning practices in maternity areas (labour, birth, postnatal); written cleaning protocols, trained cleaning staff and providers	**1**	
23.facilities with basic health-care waste management in maternity care areas	**1**	
24.facilities with basic hygiene provisions in maternity care areas (functional handwashing station, access to bathing/shower area, basic sterile equipment)	**1**	

25.facilities with basic sanitation available for women during and after labour and childbirth (toilet, latrine)	**1**	
26.facilities with adequate labour and childbirth areas/rooms for estimated number of births	**1**	
27.facilities with dedicated area in labour/childbirth area for resuscitation of newborns, which is adequately equipped	**1**	
28.facilities with policy and space for rooming-in of mothers and babies 24 hours a day	**1**	
3. **HEALTH WORKFORCE**	**1**	
29.staff with recent in-service training of 12 months interval	**1**	
30.facilities displaying roster of staff on duty, shift times	**1**	
31.facilities with skilled birth attendant available all the time in sufficient numbers to meet workload	**1**	
32.available posts that are filled by staff with necessary competence	**1**	
33.facilities with standard procedures for recruitment, motivation and retention	**1**	
34.facilities with programme for continuing professional and skills development	**1**	
35.skilled birth attendant staff with recent in-service training	**1**	
36.facilities with mechanism for regular collection of information on patient and provider experiences	**1**	
4. **HEALTH INFORMATION**		
37. facilities with standardized registers, patient charts and data collection forms	**1**	
38. facilities with functional system for classifying maternal and newborn diseases and health outcomes, including death, aligned with ICD (e.g. ICD-MM/ ICD-PM)	**1**	
39. facilities with standard operating procedures for checking, validating and reporting data	**1**	
40. facilities with reliable communication methods for referrals and consultation	**1**	
41. facilities with standardized referral form	**1**	
42. facilities in which there are no ready access to functioning ambulance or emergency transport	**1**	
43. facilities with standard form for documenting clinical progress and care	**1**	
44. facilities with standard informed consent form	**1**	
facilities with mechanism for regular collection of information on patient and provider experiences		
5. **ESSENTIAL MEDICINES**		
45. magnesium sulfate and antihypertensives	**1**	
uterotonic drugs		
46. facilities in which basic essential equipment and supplies are not available within 3 days	**1**	
47. % CEmONC facilities with functional blood transfusion service	**1**	
48. facilities in which supplies/equipment for vacuum or forceps-assisted delivery are not available within 3 days	**1**	
49. facilities in which antenatal corticosteroids available are not available within 3 days	**1**	

50. facilities in which first- and second-line antibiotics are available within 3 days	**1**	
51. facilities in which suction device, mask and bag (size 0 and 1) are not available within 3 days	**1**	
52. pre-referral sites/facilities in which supplies for stabilization and prereferral treatment are not available within 24 hours	**1**	
6. **RMNCAEH+N QoC HEALTH FINANCING**		
53. Total expenditure on RMNCAEH+N QoC by the State Government and National	**1**	
54. National and State Government allocation on RMNCAEH+N QoC	**1**	
55.Total ratio of household out of pocket payments for RMNCAEH+N health services	**1**	
TOTAL (%)		

KEY FOR INPUT MONITORING FORM PER HEALTH FACILITY.		
1	**POOR STATE OF HF**	**0% - 40%**
2	**FAIR STATE OF HF**	**40% - 60%**
3	**GOOD STATE OF HF**	**60%-90%**
4	**QED STATE OF HF**	**90%-100%**

ANNEX III

DOMAIN 1 – Evidence based practice.

GOAL: Every woman, newborn and child receive routine, evidence-based care, and management of complications during pregnancy, labour, childbirth, and the early postnatal period.

Table 9: Standard 1 Statements & Indicators.

Standard Statement	Indicator	Indicator type	Indicator Level	Data Sources	Freq. of Collection	Responsible Org	Baseline	2021	2022
Women are assessed routinely on admission and during labour and childbirth and are given timely, appropriate care	% of women with blood pressure, pulse and temperature measured	National	Output	NA	Annual	FMOH SMOH LGAs	0		
Newborns receive routine care immediately after birth.	% of newborns breastfed within one hour	National	Output	DHIS2	Annual	FMOH SMOH LGAs			
	% of Newborns who received immediate drying	National	Output	DHIS2	Annual	FMOH SMOH LGAs			
	% of Newborn of who had immediate skin to skin contact	National	Output	DHIS2	Annual	FMOH SMOH LGAs			

	% of Newborn with delayed cord clamping	National	Output	DHIS2	Annual	FMOH SMOH LGAs			
	% of newborn with documented birth weight	National	Output	NA	Annual	FMOH SMOH LGAs			
Mothers and newborns receive routine postnatal care.	% postnatal mothers/babies monitored for danger signs (vital/signs/clinical signs)	National	Output	NA	Annual	FMOH SMOH LGAs			
Women with pre-eclampsia or eclampsia promptly receive appropriate interventions, according	% of women with severe pre-eclampsia or eclampsia treated with Mag. Sulfate.	National	Output	DHIS2	Annual	FMOH SMOH LGAs	0		
Women with postpartum hemorrhage promptly receive appropriate interventions,	% women administered immediate postpartum uterotonic (PPH prevention)	National	Output	DHIS2	Annual	FMOH SMOH LGAs	0		
Women with delay in labor or whose labor is obstructed receive appropriate interventions,	% women with prolonged / obstructed labor who gave birth by C-section	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs	0		

Newborns who are not breathing spontaneously receive appropriate stimulation and resuscitation with a bag-and-mask within 1 min of birth,	% live newborns not breathing after additional stimulation who were resuscitated with bag and mask	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs	0		
Women in preterm labour receive appropriate interventions for both themselves and their babies,	% of women with preterm pre-labour rupture of membranes who received prophylactic antibiotics	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs	0		
	% of women with preterm labour who received steroids (dexamethasome)	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			
Preterm and small babies receive appropriate care	% of eligible neonatal babies (=<2000g) who receive continuous kangaroo mother care (KMC)	National	Output	DHIS2(REFERENCE SHEET 1.8-2.5KG)	Annual	FMOH SMOH LGAs	0		
Women with or at risk for infection during labour, childbirth or the early postnatal period promptly receive appropriate interventions,	No of Health care staff in the health facility who received in-service training and regular refresher sessions in the recognition and management of	National	Input	Proposed Tools for Learning Sites (Input monitoring form)	Annual	FMOH SMOH LGAs			

according to WHO guidelines.	maternal peri-partum infections at least once every 12 months								
Newborns with suspected infection or risk factors for infection are promptly given antibiotic treatment, according to WHO guidelines	% of newborns of mothers with signs of infection who are evaluated for infection and treated as appropriate.	National	Output	DHIS2	Annual	FMOH SMOH LGAs			
	% newborns with signs of infection who received antibiotics	National	Output	DHIS2	Annual	FMOH SMOH LGAs			
Community volunteers (CHIPS) support pregnant women to develop birth preparedness plan	Proportion of pregnant women in the community that have a birth preparedness plan	National	Output	CHMIS reporting instance	Annual	FMOH/NPHCDA SMOH LGAs			
WDCs Identify and resolve issues of non-compliance to facility delivery	Proportion of WDCs that report on resolution of issues of non-compliance to facility delivery	National	Output	**WDC reporting tools**	Annual	FMOH SMOH LGAs			

Pregnant women are transported from the community to the health facility during labour and emergencies	Proportion of Communities with established emergency transport systems	National	Output	Facility ETS registers	Annual	FMOH SMOH LGAs			
	Proportion of women that are transported through ETS during labour and emergencies	National	Output	Facility ETS registers	Annual	FMOH SMOH LGAs			
Community volunteers (CHIPS agents) are engaged to generate demand for delivery in health facilities	Proportion of communities with Volunteers (CHIPS agents)	National	Output	CHIPS data tools	Annual	FMOH SMOH LGAs			

DOMAIN 2 - Actionable information systems
GOAL: The health information system enables use of data to ensure early, appropriate action to improve the care of every woman and newborn.
Table 10: Standard Statements 2, Quality Measure & Indicators

Standard Statement	Indicator	Indicator type	Indicator Level	Data Sources	Freq. of Collection	Responsible Org	Baseline	2021	2022
Every woman and newborn has a complete, accurate, standardized	% postpartum women discharged with accurately completed records.	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			

medical record during labour, childbirth and the early postnatal period.									
	% newborns discharged with accurately completed record	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			
Every health facility has a mechanism for data collection, analysis and feedback as part of its activities for monitoring and improving performance around the time of childbirth.	% Facilities in which QI team regularly extracts data, calculates, and visualizes prioritized quality indicators.	Global	Output	Proposed Tools/database for Learning Sites	Annual	FMOH SMOH LGAs			
	% Facilities where data regularly reviewed and used to make decisions on quality improvement.	Global	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			
	% perinatal deaths reviewed with standard audit tools	National	Output	MPDSR	Annual	FMOH SMOH LGAs			

Every Community structures sets up and maintains Community information boards for community data visibility and action	% LGAs where scorecard data is used to provide information on areas that need action	National	Output	CHIPS data tools	Annual	FMOH SMOH LGAs			
Monthly CHIPS review meetings are held with WDCs and CHEWs/OICs to reconcile track CHIPS activities within the community	Proportion of monthly CHIPS reports received at the health facility	National	Output	CHIPS data tools	Annual	FMOH SMOH LGAs			

DOMAIN 3 - Functional referral systems

GOAL: Every woman and newborn with condition(s) that cannot be dealt with effectively with the available resources is appropriately referred.

Table 11: Standard Statements 3, Quality Measure & Indicators

Standard Statement	Indicator	Indicator type	Indicator Level	Data Sources	Freq. of Collection	Responsible Org	Baseline	2021	2022
Every woman and newborn is appropriately assessed on admission, during labour and in the early postnatal	% women/newborns who fulfilled criteria for referral and were referred	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			

period to determine whether referral is required, and the decision to refer is made without delay									
Sick Newborns are transported from the community to the health facility during emergencies.	% newborns with complications transferred to appropriate care level with referral note	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			
Women are transported from the community to the health facility during emergencies.	% women with complications transferred to appropriate care level with referral note	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			
Women experiencing postpartum haemorrhage in communities are referred	Proportion of Established MCH Emergency transport system in communities	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			
Pregnant women are transported from the health facility to higher level of care	Proportion of Health facilities having ambulances	National	Output	Proposed Tools for Learning Sites	Annual	FMOH SMOH LGAs			

DOMAIN 4 - Effective communication

GOAL: Communication with women and their families is effective and responds to their needs and preferences

Table 12: Standard Statements 4, Quality Measure & Indicators

Standard Statement	Indicator	Indicator type	Indicator Level	Data Sources	Freq. of Collection	Responsible Org	Baseline	2021	2022
All women and their families receive information about the care and have effective interactions with staff.	% women receiving postnatal information and counseling before discharge	National	Output	NA - Exit interview may be conducted to elicit for this information.	Annual	FMOH SMOH LGAs			
	% women who felt they were adequately informed by the health workers about their care, including examinations	National	Output	NA - Exit interview may be conducted to elicit for this information	Annual	FMOH SMOH LGAs			
All women and their families experience coordinated care, with clear, accurate information exchange between relevant health and social care professionals.	Proportion of Health Workers trained on behavioral change communication towards community clients	National	Output	NA - Exit interview may be conducted to elicit for this information	Annual	FMOH SMOH LGAs			

	Proportion of WDCs sensitized on RMNCAEH+N QOC	National	Output	NA - Exit interview may be conducted to elicit for this information	Annual	FMOH SMOH LGAs			

DOMAIN 5 - Respect and preservation of dignity
GOAL: Women and newborns receive care with respect and preservation of their dignity.
Table 13: Standard Statements 5, Quality Measure & Indicators

Standard Statement	Indicator	Indicator type	Indicator Level	Data Sources	Freq. of Collection	Responsible Org	Baseline	2021	2022
All women and newborns have privacy around the time of labour and childbirth, and their confidentiality is respected	% women reported receiving dignified and respectful care during maternity visit	National	Output	NA - Exit interview may be conducted to elicit for this information	Annual	FMOH SMOH LGAs			
No woman or newborn is subjected to mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.	% women who gave birth in facility who reported physical, verbal or sexual abuse to themselves [or their newborns]	National	Output	NA - Exit interview may be conducted to elicit for this information	Annual	FMOH SMOH LGAs			

All women have informed choices in the services they receive, and the reasons for interventions or outcomes are clearly explained.	% women who felt adequately informed by health workers about their health and care	National	Output	NA - Exit interview may be conducted to elicit for this information	Annual	FMOH SMOH LGAs			
	% women who felt waiting time prior to care would discourage subsequent visits	National	Output	NA - Exit interview may be conducted to elicit for this information	Annual	FMOH SMOH LGAs			

DOMAIN 6 - Emotional and psychological support
GOAL: Every woman and her family are provided with emotional support that is sensitive to their needs and strengthens the woman's capability.
Table 14: Standard Statements 6, Quality Measure & Indicators

Standard Statement	Indicator	Indicator type	Indicator Level	Data Sources	Freq. of Collection	Responsible Org	Baseline	2021	2022
All women are offered option of companion of choice during labour and delivery	% facilities with written, up-to-date policies for one person of woman's choice during labour and delivery	National	Input	Observation ISS Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			
	Proportion of women who had a companion	National	Input	Observation ISS Proposed	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			

	of their choice during labour and delivery			Tools for Learning Sites(Input monitoring form)					
	Proportion of women of were satisfied with the services provided	National	Input	Observation ISS Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			
Support to strengthen her capabilities	% staff with recent training on providing emotional support	National	Input	Admin, SI Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			
All women are provided with emotional support by their families and communities during labour and delivery and following bereavement	% of women undergoing bereavement ~~who~~ or adverse outcome who report additional emotional support from facility staff Proportion of women who were satisfied that their choices and preferences were respected Proportion of women provided with emotional support by her family/ community/CHIPs agent	National	Input	NA - Exit interview may be conducted to elicit for this information Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			

DOMAIN 7 - Competent and motivated human resources
GOAL: For every woman and newborn, competent, motivated staff are consistently available to provide routine care and manage complications.
Table 15: Standard Statements 7, Quality Measure & Indicators

Standard Statement	Indicator	Indicator type	Indicator Level	Data Sources	Freq. of Collection	Responsible Org	Baseline	2021	2022
Access at all times to Skilled Birth Attendant	% facilities displaying roster of staff on duty, shift times	National	Input	Observation Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			
	% facilities with SBA available all the time in sufficient numbers to meet workload	National	Input	Observation, Admin Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			
	% births attended by a skilled birth attendant	National	Outcome	NDHS	5years	FMoH/NpopC			
Skilled Birth Attendant have competence and skills	% facilities with standard procedures for recruitment, motivation and retention	National	Input	NA Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH			
	% facilities with programme for continuing professional and skills development	National	Input	Admin Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			

	% SBA staff with recent in-service training	National	Input	Admin Proposed Tools for Learning Sites(Input monitoring form)	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			
	% staff who supervised/mentored to support clinical competence and QI in last quarter	National	Output	ISS Report	Quarterly	FMoH/SMoH/ NPHCDA/SPHCDA			
Leadership in continuous quality improvement (QI)	% facilities with designated QI team Proportion of facilities with designated quality Assessment teams	National	Input (QI)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities with QI review meeting within at least past one month	National	Input (QI)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	Proportion of facilities that developed quality improvement plans following the last QA visit	National	Input (QI)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				

	Proportion of facilities that have implemented the QI plan developed following the last QA visit	National	Input (QI)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% leaders at facility trained in QI and leading change	National	Input (QI)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities with mechanism for regular collection of information on patient and provider experiences	National	Input (QI)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities that participated in data sharing with LGA and community to inform user decision-making, prioritization, and planning	National	Input (QI)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				

DOMAIN 8 – Essential physical resources
GOAL: The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines, supplies and equipment for routine maternal and newborn care and management of complications.
Table 16: Standard Statements 8, Quality Measure & Indicators

Standard Statement	Indicator	Indicator type	Indicator Level	Data Sources	Freq. of Collection	Responsible Org	Baseline	2021	2022
WASH are functioning, reliable, safe and sufficient	% facilities with basic water supply in maternity care areas (labor, birth, postnatal)	National	Input (WASH)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities with basic environmental cleaning practices inmaternity areas (labor, birth, postnatal); written cleaning protocols, trained cleaning staff and providers)	National	Input (WASH)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities with basic healthcare waste management inmaternity care areas	National	Input (WASH)	ISS Report/Proposed tools.	Quarterly				

				Proposed Tools for Learning Sites(Input monitoring form)					
	% facilities with basic hygiene provisions inmaternity care areas (functional handwashing station, access to bathing/shower area, basic sterile equipment)	National	Input (WASH)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities with basic sanitation available for women during and after labour and childbirth (toilet, latrine)	National	Input (WASH)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities with written protocol and awareness materials (posters) on WASH and waste management	National	Input (WASH)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
Labor, Childbirth and Postnatal Care appropriately organized	% facilities with adequate labor and childbirth areas/rooms for estimated number of births	National	Input (INFRASTRUCTURE)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				

	% facilities with dedicated area in labour / childbirth area for resuscitation of newborns, which is adequately equipped	National	Input (INFRASTRUCTURE)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities with policy and space for rooming-in of mothers and babies 24 hours a day	National	Input (INFRASTRUCTURE)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
Adequate energy supply, Laboratory Supply and Equipment	% facilities with regular source of electricity	National	Input (INFRASTRUCTURE)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				
	% facilities with essential laboratory supplies and tests	National	Input (INFRASTRUCTURE)	ISS Report/Proposed tools.	Quarterly				
	% of Facilities with adequate stock of medicines/drugs	National	Input (INFRASTRUCTURE)	ISS Report/Proposed tools. Proposed Tools for Learning Sites(Input monitoring form)	Quarterly				

*****Indicators highlighted in green are already in the DHIS2.

*Indicators highlighted in yellow are to be be linked to the DHIS2. However, supplemental collection tools will be used to generate data for baseline.