



Quality, Equity, Dignity

A Network for Improving Quality of Care  
for Maternal, Newborn and Child Health

## REPORT OF THE 2nd MEETING OF THE NETWORK FOR IMPROVING QUALITY OF CARE FOR MATERNAL, NEWBORN & CHILD HEALTH



DEMONSTRATING **ACCOUNTABILITY**  
**LEARNING** FROM IMPLEMENTATION

12-14 MARCH 2019, ADDIS ABABA, ETHIOPIA



## Contents

Acknowledgements .....	3
Abbreviations and Acronyms .....	4
Executive Summary .....	5
<b>1. Introduction .....</b>	<b>7</b>
1.1 Meeting overview .....	7
1.2 Opening session .....	7
1.3 Report on progress .....	9
1.4 Meeting methodology and overview.....	10
1.5 Country poster session .....	11
<b>2. Systems to Sustain Implementation of Quality of Care .....</b>	<b>11</b>
2.1 On-site support for QI.....	11
2.2 Data systems.....	15
2.3 Learning systems.....	21
2.4 Programme management .....	25
2.5 Community and stakeholders' engagement.....	26
<b>3. Leadership Working Group Recommendations.....</b>	<b>26</b>
<b>4. Key Messages and Conclusions .....</b>	<b>28</b>
4.1 Key messages from countries.....	28
4.2 Key message from partners .....	28
4.3 Statement from the 2 <sup>nd</sup> Network Meeting.....	29
<b>Annex 1: Meeting Agenda.....</b>	<b>31</b>
<b>Annex 2: Country Posters .....</b>	<b>32</b>
<b>Annex 3: Innovation Labs.....</b>	<b>33</b>
<b>Annex 4: Skill-building Labs .....</b>	<b>38</b>
<b>Annex 5: Meeting Statement .....</b>	<b>42</b>

*Cover photo: A young mother with an infant wait for their consultation at Mikawa Health Center in the Oromia region of Ethiopia, January 2013. ©UNICEF/Ose.*

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## Abbreviations and Acronyms

DHIS	District Health Information System
EmONC	emergency obstetric and newborn care
EMwA	Ethiopian Midwives Association
FMOH	Federal Ministry of Health
HMIS	health management information system
HCPPR	Health Care Provider Performance Review
HQSS Commission	Lancet Global Health Commission on High-Quality Health Systems in the SDG Era
IHI	Institute for Healthcare Improvement
LDHF	Low Dose High Frequency Approach
MCA	WHO Department of Maternal, Newborn, Child and Adolescent Health
MLS	mobile learning system
MNH	maternal and newborn health
MNCH	maternal, newborn and child health
MoH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MPDSR	maternal and perinatal death surveillance and response
QI	quality improvement
QoC	quality of care
RBF	results-based financing
SDGs	Sustainable Development Goals
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
URC	University Research Co.
WASH	water, sanitation and hygiene
WHO	World Health Organization

## Executive Summary

By the end of 2017, at least half the world's population could not obtain essential health services because they were inaccessible, unavailable, unaffordable or of poor quality. Achieving universal health coverage (UHC), emphasized in the Sustainable Development Goals (SDGs), "implies that all people have access, without discrimination, to nationally determined sets of the promotive, preventive, curative and rehabilitative basic health services needed and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship," (p. 4).<sup>1</sup> Improving quality of care is therefore critical for achieving UHC and the health-related SDG targets by 2030. The Lancet Global Health Commission on High Quality Health Systems in the SDG Era reiterates this idea, stating that "The burden of mortality attributable to poor care is larger than that due to lack of access to care," (p. 795).<sup>2</sup>

Responding to this call, the governments of Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Sierra Leone, Uganda and the United Republic of Tanzania established the Network for Improving Quality of Care for Maternal Newborn and Child Health (Quality of Care Network) in February 2017. Supported by WHO, UNICEF, UNFPA, technical partners and donors, the Network countries have developed national strategies for quality of care (QoC) in the health sector and are using maternal, newborn and child health (MNCH) as a pathfinder to learn how to implement QoC interventions in a sustainable way and at scale. Aiming to halve maternal and newborn deaths and stillbirths in health facilities by 2022, participating countries are working to improve QoC in health facilities by pursuing four strategic objectives:

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

The Ministry of Health of Ethiopia hosted the meeting in Addis Ababa, Ethiopia, on 12–14 March 2019. Over 240 participants representing 22 countries attended the meeting, including participants from the ten Network countries led by their Ministries of Health, technical and founding partners, members of academia and professional associations from both regional and global levels.

The objectives of the meeting were to facilitate learning among countries and partners by sharing best practices developed by the Network countries in organizing and implementing QoC for MNCH at the national, district and facility levels; to discuss challenges faced in this process and lessons learnt; and to propose a way forward for the Network in the next two years. The meeting agenda reflected the experiences of the Network countries in organizing and implementing QoC

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<sup>1</sup> United Nations General Assembly 67th session (2013). U.N Doc. A/RES/67/81\* - Resolution adopted by the General Assembly on 12 December 2012: 67/81. Global health and foreign policy. Geneva, United Nations: 1-6.

<sup>2</sup> The Lancet. (2018). "Putting quality and people at the centre of health systems." *The Lancet* **392**(10150): 795.



for MNCH at the national, district and facility levels. As a result, the agenda was organized around four interrelated systems to sustain implementation of QoC: (1) on-site support for quality improvement; (2) data systems; (3) learning systems; and (4) programme management for QoC.

The Network member countries renewed their commitment to continue working to improve quality, equity and dignity of mothers, newborns and children in health services. Participants agreed that the implementation of MNCH or any other health programmes with quality, in a sustainable way and at scale, will depend on governments' ability to develop and strengthen the four interrelated implementation systems, supported by community and stakeholders' engagement. Partners must rally around this platform and ensure that their support is directed towards the development of capability of the national health system. More specifically, the meeting concluded the following:

- Continuous commitment to QoC and leadership of national governments are needed for the implementation and sustainability of QoC.
- National partnerships and the alignment of implementing, technical and funding partners with national directions must be strengthened.
- Actions and mechanisms for on-site support of QoC at the district and facility levels must be scaled up to accelerate learning and to sustain implementation of QoC.
- Inclusion of QoC measures in national data systems and the utilization of these measures are necessary and urgent for improvement at all levels.
- Countries must continue to develop their contextualized learning platforms to ensure a local focus; however, these platforms must connect with each other through a global platform that facilitates inter-country exchanges and global learning.
- Emerging opportunities and innovations from implementation need to be harnessed and leveraged in all Network countries.
- Community engagement mechanisms to ignite demand and accountability for quality must be developed and made an active part of the QoC delivery platforms from point of care to the national level.
- Advocacy for quality must not be forgotten and needs to be strengthened at all levels.

At the end of the meeting, the Network welcomed Kenya as the 11<sup>th</sup> member country. Given that many more countries are interested to engage in the Network, participants agreed that the Network Secretariat and partners should support these countries by sharing the technical know-how and public goods developed thus far and by facilitating the participation of these countries in the global learning network.

# 1. Introduction

## 1.1 Meeting overview

The meeting took place over three days from March 12-14, 2019. The agenda (Annex 1) provided opportunities for learning and sharing among participants. It focused on four systems required to sustain implementation of quality of care (QoC) at the service-delivery level:

1. On-site support for quality improvement (QI)
2. Data systems
3. Learning systems
4. Programme management for QoC

Each theme was first discussed in a plenary session by a panel composed of Ministry of Health (MoH) representatives from selected countries and partners. The panel was then opened to the audience for questions and answers. Following the plenary session, working groups discussed the given theme in depth, focusing on the sharing of ideas. Results from the working groups were then reported back in the following plenary, and the results fed into lessons learned and the meeting conclusions.

The structure above was supported by four additional interactive sessions:

1. A poster session (Annex 2) during which the Network countries presented their progress along the four themes of the meeting;
2. Innovation labs (Annex 3), led by organizations that are developing and implementing innovations to improve the quality of maternal and newborn health care, that provided participants with opportunities to learn about and to test various innovations related to QoC;
3. Skill-building and brainstorming labs (Annex 4), led by partners or the Secretariat, that addressed topics relevant to improving QoC and utilized interactive methods to encourage active discussion and learning; and
4. A special session organized to showcase Ethiopia's approaches and progress made in institutionalizing the implementation of QoC nationwide. During the event, the Federal Ministry of Health (FMOH) of Ethiopia launched a special bulletin that summarized case studies documenting implementation of the QoC in Ethiopia.

Selected sessions from the three-day meeting were live streamed and are available to view on the [Quality of Care Network YouTube Channel](#).

## 1.2 Opening session

The first day of the meeting reviewed country progress and shared country experiences improving QoC for maternal, newborn and child health (MNCH). On behalf of the Government of Ethiopia and the FMOH, Hillina Tadesse, A/Director of the Health Service Quality Directorate of Ethiopia's FMOH, opened the meeting by welcoming all participants. In her speech, she highlighted the progress made by Ethiopia in improving health outcomes for women, children

and adolescents in the last decade. Strengthening health systems and improving the availability and equity of services remains a top priority for the Ethiopian government. The government is committed to expanding health services with quality. The establishment of the Quality of Care Directorate, the development of the national policy on QoC, and the strategy for expanding QoC structures and support from the national level to the community level will continue to be developed and strengthened as basis for achieving sustainability and prosperity of health of Ethiopians.

Andrew Likaka, Director of Quality Management Department in the MoH of Malawi, and Abosede R. Adeniran, Director of Child Health and National Focal Person MNH QoC in the FMOH of Nigeria, spoke on behalf of the Network Leadership working group. They emphasized that the country leadership and ownership provide the drive for implementation of QoC, and they described QoC as a movement and a responsibility of every country.

Her Excellency, the State Minister from the Federal Democratic Republic of Ethiopia FMOH, delivered a keynote speech in Amharic.

Anneka Knutsson, Chief of the Sexual and Reproductive Health Branch at UNFPA; Felicitas Zawaira, Director of the Family and Reproductive Health Cluster at WHO AFRO; and Anshu Banerjee, Director of Maternal, Newborn, Child and Adolescent Health at WHO, gave an overview of the global situation, including the challenges with quality presented by the SDGs and UHC, the Network's importance as a platform for accelerated action, and quality as a core requirement for UHC. (See Anshu Banerjee's presentation [here](#).)

Margaret Kruk, Chair of the Lancet Global Health Commission on High-Quality Health Systems in the SDG Era (HQSS Commission), gave the keynote address on the need for high-quality health systems for women and children. She emphasized the harm caused by a poor-quality health systems and the need to expand from micro-level fixes to system-level solutions. Margaret Kruk concluded her address by highlighting five key actionable solutions:

1. **Govern for quality.** Governing for quality requires creating a shared vision, developing learning systems, ensuring accountability and building partnerships. These components are key for a high-quality system.
2. **Redesign service delivery to maximize outcomes and involve other sectors.** Reorganizing services within the health system to provide services at the appropriate level will maximize outcomes, instil user confidence and lead to the achievement of high quality care.
3. **Transform the health workforce.** Strengthen health professional education and build an enabling work environment beyond graduation.
4. **Ignite demand for QoC.** Educate populations about QoC to ignite demand.
5. **Measure what matters efficiently and transparently.** Accurate measurement and monitoring of health, competent care and systems, patient experience and confidence are essential components.

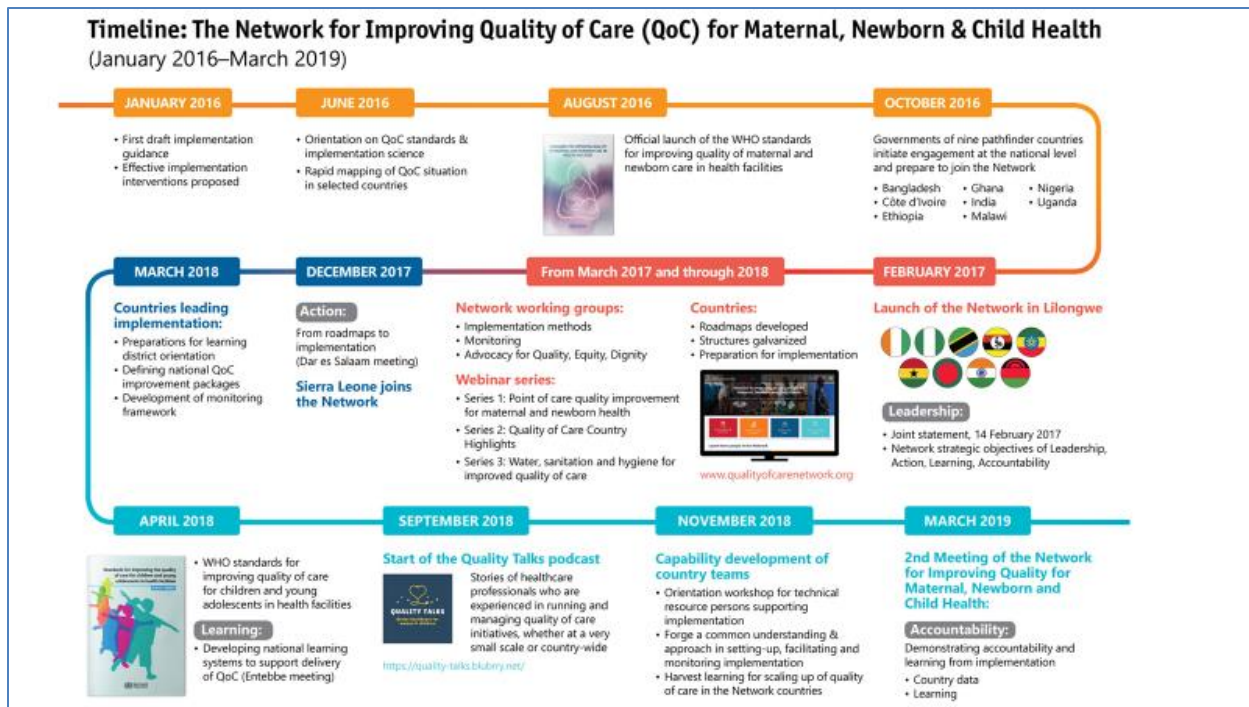
(See Margaret Kruk's presentation [here](#).)



### 1.3 Report on progress

On behalf of the Network Secretariat, Zainab Naimy, Nuhu Yaqub Jr. and Moïse Muzigaba summarized the Network’s progress and key activities undertaken since January 2016 (Image 1).

Image 1: Network implementation progress since its launch (2016-2019)



Country teams have made tremendous implementation progress with key milestones along the Network’s strategic objectives, as highlighted in image 2.

Image 2: Network countries' progress along the strategic objectives: A snapshot as of March 2019

Implementation milestones		Key: ● completed ● in progress ● not started or incomplete ● no data									
	Bangladesh	Côte d'Ivoire	Ethiopia	Ghana	India	Malawi	Nigeria	Sierra Leone	Tanzania	Uganda	
<b>National leadership for quality of care (QoC)</b>											
Supportive governance policy and structures developed or established	●	●	●	●	●	●	●	●	●	●	
QoC for maternal and newborn health (MNH) roadmap developed and being implemented	●	●	●	●	●	●	●	●	●	●	
Learning districts and facilities selected and agreed upon	●	●	●	●	●	●	●	●	●	●	
QoC implementation package developed	●	●	●	●	●	●	●	●	●	●	
Adaptation of MNH QoC standards	●	●	●	●	●	●	●	●	●	●	
<b>Action: Learning sites identified and prepared</b>											
Orientation of learning districts and facilities	●	●	●	●	●	●	●	●	●	●	
District learning network established and functional (reports of visits)	●	●	●	●	●	●	●	●	●	●	
QoC coaching manuals developed	●	●	●	●	●	●	●	●	●	●	
Quality improvement (QI) coaches trained	●	●	●	●	●	●	●	●	●	●	
On-site coaching visits occurring in learning districts	●	●	●	●	●	●	●	●	●	●	
<b>Learning and accountability: QoC MNH measurement</b>											
QoC for MNH baseline assessment completed	●	●	●	●	●	●	●	●	●	●	
Common set of MNH QoC indicators agreed upon for reporting from the learning districts	●	●	●	●	●	●	●	●	●	●	
Baseline data for MNH QoC common indicators collected	●	●	●	●	●	●	●	●	●	●	
Common indicator data collected, used in district learning meetings, and reported upwards	●	●	●	●	●	●	●	●	●	●	
Identification and agreement with an academic or research Institution to facilitate documentation of lessons learned in the implementation of QoC activities	●	●	●	●	●	●	●	●	●	●	
<b>Accountability and community engagement</b>											
Mechanism for community participation integrated into QoC planning in learning districts	●	●	●	●	●	●	●	●	●	●	

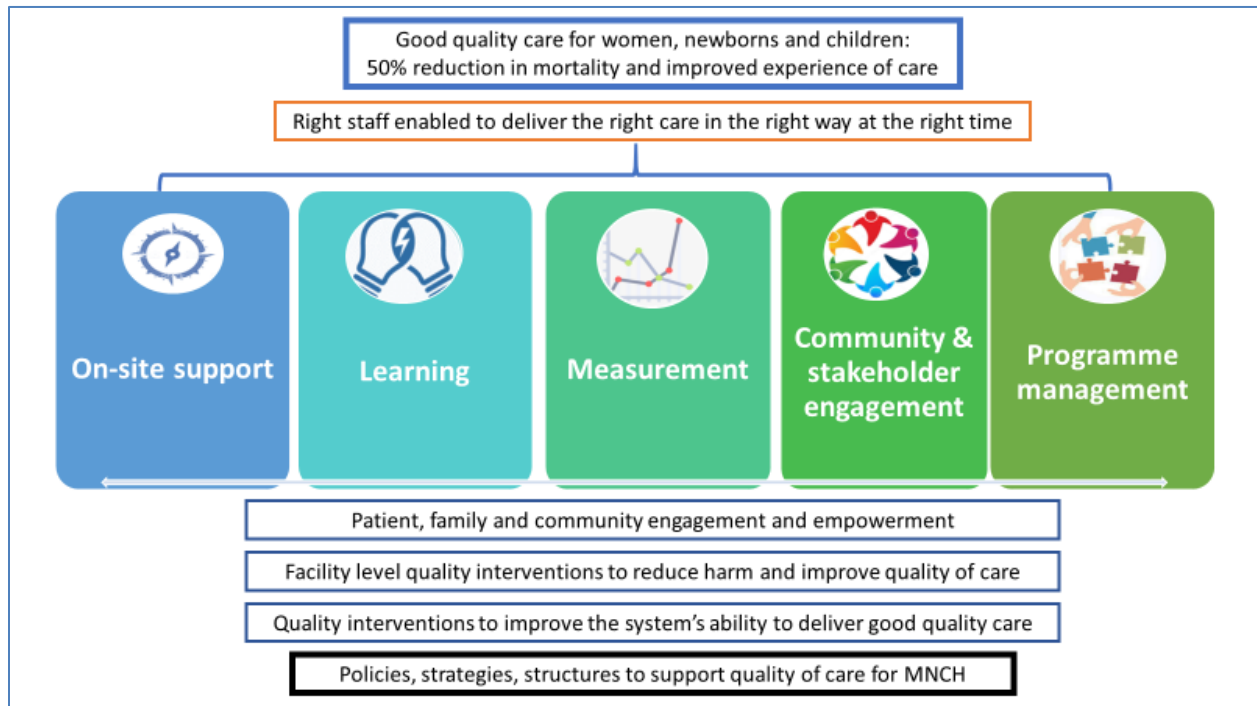
(See the Secretariat's presentation [here](#).)

### 1.4 Meeting methodology and overview

Blerta Maliqi and Nigel Livesley of the Network Secretariat presented the meeting methods. They explained the agenda and different methods, focusing their presentation on the four systems required to sustain implementation of QoC at the service-delivery level (Image 3):

- On-site support for QI
- Data systems
- Learning systems
- Programme management for QoC

Image 3: Systems required to sustain implementation of QoC at scale



(See their presentation [here](#).)

## 1.5 Country poster session

The country teams viewed posters (Annex 2) from the nine other countries and had the opportunity to discuss challenges and successes. The poster information was organized along the four themes of the meeting: on-site support for QI; data systems; learning systems; and programme management for QoC. In addition, countries shared concrete data and experiences from implementation of different initiatives aiming to improve quality at the point of care. These peer-to-peer discussions between country teams during the poster session allowed country teams to seek answers for specific questions relevant to their own health system.

## 2. Systems to Sustain Implementation of Quality of Care

### 2.1 On-site support for QI

This session explored country experiences developed while providing on-site support for QI for MNCH. Panelists from Ghana, Nigeria and Sierra Leone were invited to share and discuss their work related to the introduction and scaling up of QI approaches; structures and tools used in country to provide on-site support; challenges and lessons learned from the implementation of QI for MNCH at the national, district and facility levels, including in learning districts; and long-term strategies for developing QI capabilities, collaboration with partners and sustainability plans. Summaries of country panelists' commentaries and presentations appear below.

### **2.1.1 Ghana**

Robert Adatsi, Deputy Director of Clinical Care for Ghana Health Service in the Volta Region, discussed improving MNCH indicators through the use of QI methods. In Ghana, current interventions for on-site support include: five-day, half-yearly obstetric and paediatric specialist clinical coaching and mentorship outreach; shared learning sessions; capacity building for medical officers; maternal death audit and maternal peer review; training of midwives on use of partograph; monthly data quality audits and audits. Leadership commitment, a shared vision, teamwork and capacity building for staff are essential for continuous QI. Ghana looks forward to continuous QI initiatives and scaling up interventions in its remaining districts.

(See Robert Adatsi's presentation on Ghana [here](#).)

### **2.1.2 Nigeria**

Abosede R. Adeniran, Director of Child Health and National Focal Person MNH QoC in the FMOH of Nigeria, provided an overview of Nigeria's Saving Mothers Giving Life (SMGL) programme for on-site mentoring for MNH in the Cross-River State. A health facility assessment was conducted to identify relevant gaps, to shape discussions with the Cross River State government and stakeholders regarding roles and to facilitate the development of the operational plan. The QI approach included capacity building of different cadres of frontline staff, clinical mentoring, innovative tools (i.e. a mobile app), establishment of state/facility teams for QI and maternal and perinatal death surveillance and response (MPDSR), improved referrals, infrastructural upgrades, improved use of data and routine supportive supervisory visits. Nigeria experienced challenges related to facility staff attrition, increased workload of staff and challenges with logistics and sustainability. They learned that clinical mentoring complements residential trainings, and they experienced improved outcomes because of better coordination among partners. Joint mentorship visits by the Nigerian Society of Neonatal Medicine and the Society of Gynaecology and Obstetrics of Nigeria were imperative. Furthermore, Nigeria concluded that improved QoC for maternal and newborn health (MNH) increased demand for institutional delivery of services. Training, supervision and mentoring of service providers led to improved outcomes for mothers and newborns.

(See Abosede R. Adeniran's presentation on Nigeria [here](#).)

### **2.1.3 Ministry of Health and Sanitation, Sierra Leone**

A representative from the Ministry of Health and Sanitation provided an overview of Sierra Leone's on-site support approach that includes clinical mentorship, QI coaching and supportive supervision. Completed key activities include orientation and training, formation of the QoC governance structure, analysis of problems and prioritization. Sierra Leone is current in the process of developing change ideas and indicators. The next stage is to describe what happened when testing a change idea. Thus far, key lessons learned included:

- Sustained commitment from National, DHMT and hospitals/facilities;
- Alignment of partners to the national effort;

- Harmonized training module for QI;
- Improved reporting of QI projects from all learning facilities;
- Intrinsically motivated frontline healthcare workers to do QI;
- Technical capacity to institutionalize QI improved;
- Improved regular meetings among the learning hospitals sites;
- Formation of QoC governance structures; and
- Use of WhatsApp.

The most important strategies for developing and sustaining QI plans include:

- Integrating on-site support by clinical mentors and QI coaches;
- Improving operational capacity of national and district quality management structures;
- Moving from QoC focal persons to dedicated QoC officers;
- Strengthening the national reporting system for QoC projects across the country;
- Integrating QI into existing management structures;
- Collaborating with partners; and
- Providing continuous training, mentoring and coaching to a national pool of QI resources.

(See the presentation on Sierra Leone [here](#).)

#### 2.1.4 Partners' reflections

Country presentations were followed by reflections from key partners: Pierre Barker, Chief Global Partnerships and Programs Officer at Institute for Healthcare Improvement (IHI); Lily Kak, Senior Country Advisor at USAID; and Rajesh Mehta, Medical Officer for Child and Adolescent Health at WHO SEARO. They discussed that QI is simply a method to accelerate progress and to improve systems. The emphasis should not be on replacing what is currently being done with QI. A cultural change around QI is needed to encourage people to undertake this work and to improve their technical skills. Countries must improve the dose of QI by supporting personnel to do and to think about QI daily (a new specialized function of the work force). Building QI capabilities is not about a single training session; it must be progressive and supported by subsequent trainings. Support must be given to three streams of training/mentoring: (1) clinical practices, (2) QI science and (3) quality assurance. Clinical training and QI training should happen more frequently and become more integrated. Quality assurance is starting to happen and will occur less frequently.

#### 2.1.5 Working group summary

Selection and training of QI coaches	
Lessons learned	Short- and long-term plans
<ul style="list-style-type: none"> <li>• Coaching for QI needs to be investigated and strengthened; there</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-service training on QI includes training for tutors</li> </ul>

<p>is still a grey area on QI versus clinical coaching</p> <ul style="list-style-type: none"> <li>• Need to consider pros and cons of having separate or combined QI coaches and clinical mentors</li> <li>• If QI coaches and clinical mentors are separate, then visits need to be synchronised and clinical mentors should be trained on the basics of QI approaches</li> <li>• Mentors should be within the health system for sustainability</li> <li>• Tiers of coaches/mentors need to be defined</li> <li>• Coaches should have practical skills in the application of QI approaches</li> <li>• External coaches should build capacity of internal (facility-based) coaches</li> </ul>	<ul style="list-style-type: none"> <li>• Design motivation for coaches, including continuous development and learning opportunities</li> <li>• Include the private sector in QI coaching</li> <li>• Develop standard criteria for selection based on expected roles and responsibility</li> <li>• Develop facility-based (internal) coaches</li> <li>• Define the job description of a coach</li> </ul>
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<b>Managing on-site support</b>	
<b>Lessons learned</b>	<b>Short- and long-term plans</b>
<ul style="list-style-type: none"> <li>• Need for government leadership and coordination</li> <li>• Coaching at the facility level should be managed at sub-national level rather than the national level</li> <li>• The varied duration and varied activities during coaching visits may need further review by countries</li> <li>• External coaching is important to keep up enthusiasm and action</li> <li>• Online m-Health platforms can be used to complement on-site support</li> <li>• Intensive coaching required at start-up with less over time as the facility matures</li> <li>• Pool of coaches need to be developed and increased; otherwise, it becomes a challenge if coaches have to leave their primary work for prolonged periods of time</li> </ul>	<ul style="list-style-type: none"> <li>• Online m-Health platforms should be considered for coaching</li> <li>• Flexibility needed in plans for external coaches</li> </ul>



Funding on-site support	
Lessons learned	Short- and long-term plans
<ul style="list-style-type: none"> <li>• Mainly supported by partners at the current time</li> <li>• Government funding is critical for sustainability of on-site support</li> </ul>	<ul style="list-style-type: none"> <li>• Funding through central government funding streams should be considered</li> <li>• Districts should allocate funding through district plans</li> <li>• Development of sustainability plans and policy should address funding of QoC</li> </ul>

Integrating coaching into government systems	
Lessons learned	Short- and long-term plans
<ul style="list-style-type: none"> <li>• National framework and system for coaches needed</li> <li>• Partner alignment to government plans and guidelines</li> <li>• Government funding needed</li> <li>• Coaches should come from the government system</li> </ul>	<ul style="list-style-type: none"> <li>• Consider funding through the central government budget</li> <li>• Districts to include funding through district plans</li> <li>• Use existing chief quality officers as coaches for monthly and quarterly visits</li> <li>• Policy should ensure funding for QoC work</li> <li>• Human resource planning should consider QoC activities</li> </ul>

## 2.2 Data systems

This session explored the characteristics of data systems required to support efforts to improve QoC for MNCH in countries and to identify opportunities for integration with countries' broader health data improvements and investments. The main objective was to share and discuss challenges and lessons learned at national, district and facility levels, including in learning districts, in relation to: a) the readiness of data systems to collect and report on patient-level QoC indicator data, including the Network's common indicators in health information systems; b) the readiness of data systems to collect data and report on whether activities to improve QoC are being implemented and implemented effectively; and c) data usage to improve patient care and programme management for learning and accountability and to continuously track QoC progress. Panelists in this session also shared and discussed their countries' short- and long-term strategies

for strengthening data systems to allow for QoC monitoring, reporting and action. Representatives from the Ministries of Health of Côte d'Ivoire, Bangladesh and the United Republic of Tanzania presented their experiences in implementing data systems. Summaries of country panelists' commentaries and presentations appear below.

### **2.2.1 Côte d'Ivoire**

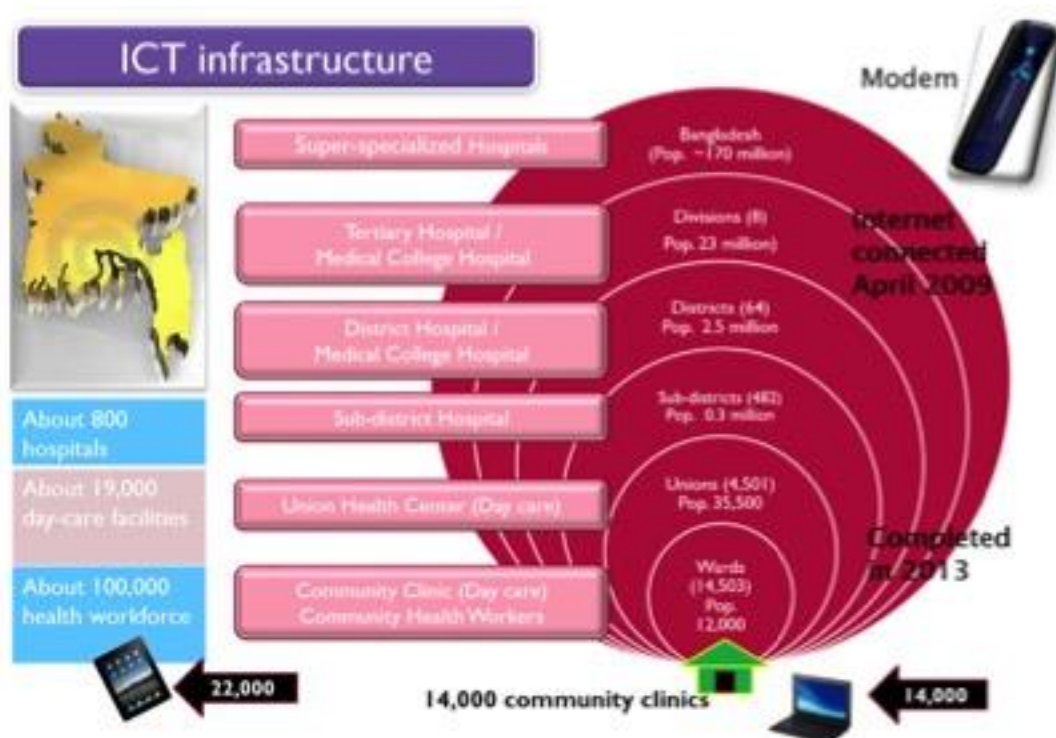
Claudine Ndiango, of the MoH Côte d'Ivoire, shared the progress made in providing on-site support. The country team has created a stakeholder consultation framework, identified a focal point to monitor and evaluate QI, and trained District Epidemiological Surveillance Officers. An assessment of QoC in 15 reference hospitals has concluded that 103 staff members were referred to the use of the WHO assessment tool for self-evaluation, and 15 improvement plans were developed and implemented to correct deficiencies. Data collection tools have been strengthened and are available. The maternal death review committees resumed their activities. Challenges included integration of certain quality indicators into the National Health Information System and regular analysis and dissemination of data to all stakeholders for realistic decision-making.

(See Claudine Ndiango's presentation on Côte d'Ivoire [here](#).)

### **2.2.2 Bangladesh**

Aminul Hasan, Deputy Director and Focal Person for the Quality Improvement Secretariat at the Ministry of Health and Family Welfare (MOHFW) in Bangladesh, provided an overview of the country's data system infrastructure that connects health providers nationwide with devices and internet access (image 4).

Image 4: Bangladesh's information and communications technology (ICT) infrastructure for health providers



Around 850 facilities have a signboard indicating how to send complains and suggestions directly to the MOHFW by SMS. A designated person from the MOHFW then conducts an enquiry into the SMS. Immediate action is taken on the same day, and beneficiaries get an immediate response. Health managers promise to solve the issue. A dynamic GIS platform makes it easy to plot health data on maps available up to sub-district level.

(See Aminul Hasan's presentation on India [here](#).)

### 2.2.3 Tanzania

On behalf of the MoH, Phineas Sospeter provided an overview of the government's data flow and use of data across different levels of the health system. Data are used for management and accountability. The star rating is an entry point for results-based financing (RBF). Facilities with zero stars do not qualify for service delivery. The District Health Information System (DHIS) 2 data are used as basis for verification during RBF and tracking of RMNCH progress (via a scorecard and dashboard). RBF provides direct funding to facilities, focusing on primary health care (e.g., dispensaries, health centres and district-level hospitals). Earning quantity is adjusted by the facility's quality score. Currently, the focus on immediate needs though this focus will change over time as the needs change. Payment is made after internal and external verification.

Tanzania has experienced challenges with its low level of data usage, integrating QI follow up and supportive supervision, ambitious targets for quality and sustaining quality of services at the

facility level. Next steps include adapting the WHO QoC framework for MNCH, developing a dashboard for QoC and integrating it into DHIS2, developing a QI training manual and developing clinical audit guidelines.

(Phineas F. Sospeter’s presentation on Tanzania is available [here](#).)

**2.2.4 Partners’ reflections**

Country reflections were followed by reflections from key partners: Kathleen Hill, Maternal Health Team Lead at MSCP/Jhpiego, and Will Zeck, Head of Global Maternal, Newborn and Adolescent Health Programs at UNICEF. They discussed how a monitoring framework outlines the kinds of data that are needed across the system. Using data to design and plan improvement work is essential. Countries are using a mix of data around planning and prioritizing. Challenges exist with a lack of basic data elements in routine information systems to allow us to know why women and newborns are dying. Implementation of QI principles can help improve the monitoring of data quality. When you begin to monitor, you can expect mortality rates to increase before they decrease – this is a sign of a good monitoring system. Integration of QI and capacity-building is necessary, as measurement is integral to QI skills and requires additional support. One must not only generate data; one must also use the data. Finally, the public and private sectors must work together and disclose their data. A culture of openness around data would benefit QoC efforts.

**2.2.5 Working group summary**

Lessons learned	What needs to be incorporated into country QoC
<i>Collecting, analysing and using common indicator data</i>	
<ul style="list-style-type: none"> <li>• Establish efficient data flow systems between all levels of the health system</li> <li>• When introducing an electronic system, maintain some overlap for verification until the new system is well established and validated</li> <li>• Designate focal persons for data who have an understanding of the data elements</li> <li>• Involve users of data</li> <li>• Establish a uniform understanding of common core indicators</li> <li>• Institute a mechanism for collecting data on experience</li> </ul>	<ul style="list-style-type: none"> <li>• Make sure there is overlap between paper and electronic systems for some time for validation of data</li> <li>• Expand the pool of health personnel managing data to allow for attrition</li> <li>• Harmonize data sources so that there is a common understanding on information captured especially on core indicators</li> <li>• Selected key indicators (though not all of them) should be included in the existing DHIS2</li> <li>• Align common core indicators with national definitions (e.g., for kangaroo mother care)</li> </ul>

Lessons learned	What needs to be incorporated into country QoC
<p>of care and data that are not already part of the DHIS</p>	
<p><i>Collecting, analysing and using improvement aim-specific data</i></p>	
<ul style="list-style-type: none"> <li>• There are too many tools, too many indicators and too much data produced by parallel systems</li> <li>• Availability of QI or performance management teams at different levels including community</li> <li>• Data transparency (e.g., display of data on facility premises for staff and clients)</li> <li>• Mobile feedback system especially important for experience of care</li> <li>• Need to validate data (falsifying data especially for RBF)</li> <li>• Development of dashboard in DHIS.</li> <li>• Inadequate capacity on data management</li> </ul>	<ul style="list-style-type: none"> <li>• Address the gaps as part of the lessons learnt</li> </ul>
<p><i>Improving skills on data collection, analysis and use</i></p>	

Lessons learned	What needs to be incorporated into country QoC
<ul style="list-style-type: none"> <li>• Useful to pair statisticians with technical officers for more accurate data representation for MNH</li> <li>• Sustainable skill-building; move from data consultants to people within the system</li> <li>• Use existing staff and improve retention of data focal persons</li> </ul>	<ul style="list-style-type: none"> <li>• Address the gaps as part of the lessons learnt</li> </ul>
<i>Improving data quality</i>	
<ul style="list-style-type: none"> <li>• Need for a validation system for data collection, entry and transmission</li> <li>• Important to triangulate data from various data sources, including surveys, MPDSR, DHIS2, HMIS and core indicators</li> <li>• Empower health workers to use the data and build their capacity</li> <li>• Data verification and validation are critical</li> <li>• Real-time data collection helps to improve data availability</li> <li>• Assign a responsible person for QoC data collection, reporting and analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Institute data verification systems and data validation meetings</li> <li>• Leverage DHIS2 to improve data quality</li> <li>• Institute a regular data monitoring system for the Network (via the Secretariat)</li> <li>• Standardize tool on experience of care with support from WHO</li> <li>• May need to review registers and reporting tools</li> </ul>
<i>Building a stronger culture to support data use for problem identification and solving</i>	
<ul style="list-style-type: none"> <li>• Tailor data collected to routine needs of health workers</li> <li>• Strengthen the MPDSR platform for QI and build in system alerts for response to MPDSR recommendations</li> <li>• Need for inclusivity of all players, including champions</li> <li>• Promote utilization of data at all levels</li> <li>• Regular QI team meetings important for problem identification and QI planning</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and implement a national data strategy</li> <li>• Establish data transparency mechanisms in health facilities</li> <li>• Build capacity of monitoring and evaluation officers in the MoH at the national level</li> <li>• Encourage facilities to use data relevant to their needs</li> <li>• Harmonize all data systems and promote the use of dashboards</li> </ul>
<i>Adapting existing data systems to measure QoC</i>	
<ul style="list-style-type: none"> <li>• Harmonization of national QI Indicators</li> </ul>	<ul style="list-style-type: none"> <li>• Institute a data strategy, where all indicators must be derived from</li> </ul>



Lessons learned	What needs to be incorporated into country QoC
<ul style="list-style-type: none"> <li>• Too many indicators in HMIS from different partners</li> <li>• Develop other interfaces that feed into existing system</li> </ul>	<p>and feed into a strategy that is country-owned and country-led</p> <ul style="list-style-type: none"> <li>• Strengthen MoH leadership for data systems around QoC data management</li> <li>• Adapt data collecting systems (and learn from other countries) to capture indicators not currently in HMIS</li> </ul>
<i>Measurement strategies to track implementation of QoC activities</i>	
<ul style="list-style-type: none"> <li>• Tracking experience of care indicators has been challenging</li> <li>• Regular monitoring and supervision important even with electronic systems</li> <li>• Importance of regular quality summits</li> <li>• Hold a regular QI programme review among the learning districts</li> <li>• Strengthen country-led data collection and reporting mechanisms for common core indicators</li> </ul>	<ul style="list-style-type: none"> <li>• Use multiple data capturing systems (paper and electronic), especially at facility level, to allow for source verification</li> <li>• Strengthen data monitoring</li> <li>• Consider a WhatsApp group to track progress</li> <li>• Incorporate discussions and a review of data into regular facility meetings</li> </ul>

### 2.3 Learning systems

This session explored the systems required to learn and to share learning about what works and what does not in improving QoC. The session objectives were to: (1) present experiences in developing a national learning system to support QoC and to inform programme redesign; (2) share and discuss challenges and lessons learned at the national, district and facility levels, including learning districts, in relation to: a) the establishment of learning collaboratives among teams, facilities and districts to share lessons learnt on QoC implementation; b) the standardization of documentation and sharing of lessons between facilities and districts; c) the integration of learning into existing management processes and mechanisms (e.g., periodic reviews, supervision); and d) the establishment of collaboration with national and regional institutions and organizations that work on implementation research and learning. Panellists from Ethiopia, Uganda and India discussed their countries’ visions for developing national learning systems to support QoC implementation and scale-up. Summaries of country panelists’ commentaries and presentations appear below.

#### 2.3.1 Ethiopia

Hillina Tadesse, A/Director of the Health Service Quality Directorate of Ethiopia's FMOH, presented Ethiopia's learning system and QoC governance structure which includes inter- and intra-facility learning systems. These learning systems are well performing hospitals clustered with poor performance facilities to build capacity, share best practices, identify gaps, create partnership and share learning. They have a lead hospital from which member hospitals can learn.

Monthly mentorship and coaching is done from lead hospitals and health centres. Quarterly learning sessions are followed by on-site supervision. Ethiopia also has a quality bulletin, review meetings and summits at the regional and national levels. Peer learning has resulted in increased efficiency of the health care system and improved quality of services.

Implementation challenges include finances, human resources, geography, monitoring and evaluation, lack of regular and proper reporting and lack of stakeholder ownership. Implementers are now trying to harmonize different mentorship activities and revitalizing the alliance moving forward.

(See Hillina Tadesse's presentation on Ethiopia [here](#).)

### **2.3.2 Uganda**

A representative from the Uganda country team noted that Uganda is in early stages of implementing its learning system in collaboration with Makerere University and the regional centre for QoC. Colleagues are trying to identify what needs to happen to create changes in quality and improvement. At the national level, Uganda is trying to understand the policy environment required to sustain QI.

Implementers understand the need for improving documentation, standardizing the format for documentation journals and introducing an electronic documentation journal. This system can also track time-series charts. All facilities at all levels are encouraged to share their learning, including at inter-district meetings and the annual QI conference. Additionally, implementers are trying to improve additional support to facilities and have a quality assessment tool for facilities to use.

Uganda is also developing four clinical skills labs, using WhatsApp to share learning between facilities and holding exchange visits. A client satisfactory survey at the national level showed that only 25% of clients are satisfied with health services. Both cross-district and cross-facility learning exists and has been helpful in addressing clients' concerns.

(See the presentation on Uganda [here](#).)

### **2.3.3 India**

Dinesh Baswal, Deputy Commissioner in charge of maternal health for the MOHFW in India, spoke about how India resented the build-up of the country's QI structure. Due to the large population, multiple initiatives have been attempted over time. Training materials and operational guidelines exist for multiple aspects of improving care. Existing quality systems

address different cadres and different levels of health care facilities, resulting in different standards, different measures and different checklists. Partners also implement multiple QI initiatives. laQshya, for example, is a labour room and maternity operating theatre QI initiative.

India has a central national quality committee and similarities at the state and districts levels. A high number of facilities have completed baseline assessments and gap analyses for improvement, where the facility can get state and/or national certification. This process includes 20 QI monitoring indicators and six cycles on QI (e.g., documentation, respectful maternity care, timely management).

(See Dinesh Baswal’s presentation on India [here](#).)

### 2.3.4 Partners’ reflections

Tamar Chitashvili, Director of MNCH/RH/FP/NCD at USAID ASSIST/URC; Peter Waiswa, Associate Professor at Makerere University; Shamsuzzoha Syed, Coordinator in the Quality Systems and Resilience Unit at WHO; and Karoline M. Linde, CEO of Laerdal Global Health, provided their reflections. The panellists emphasized having a judgement-free environment for optimal learning, as it is an essential aspect to sustaining and scaling up QI. The foundation of QI lies within leadership and management and should be based across all levels including the communities. QI must be managed and supported to be sustainable. The organizational structure of quality can be an enabling environment and mechanism for learning. Panellists also emphasised a systems approach to learning and the need to prioritize a technical program for QI. Strong leadership, quality training and a culture of excellence are required. Mentorships and use of digital innovation warrant consideration.

### 2.3.5 Working group summary

Learning with respect to QoC includes learning QI skills, sharing experiences and understanding the methodology to both conduct and coach QI. Participants emphasised distinguishing between learning QI skills and learning skills. They suggested using MPDSR as a starting point that can be shared with other facilities.

Health system level	Main questions	Possible solutions
Facility	<ul style="list-style-type: none"> <li>• How to identify problems</li> <li>• What worked and what did not</li> <li>• How to use QI tools</li> </ul>	<ul style="list-style-type: none"> <li>• Case-studies project</li> </ul>
District	<ul style="list-style-type: none"> <li>• How to organize coaching for QI teams</li> <li>• How to overcome resource challenges for QI activities</li> <li>• How to capture the interventions that worked</li> </ul>	<ul style="list-style-type: none"> <li>• Case-studies coaching</li> </ul>

	<ul style="list-style-type: none"> <li>• How to make time for learning</li> <li>• How to organize learning events</li> </ul>	
National	<ul style="list-style-type: none"> <li>• What are different ways of supporting districts</li> <li>• What macro-level implementation research is necessary</li> <li>• What curriculum is needed for pre-service and in-service QI</li> <li>• Who will drive the learning and be responsible for accountability</li> </ul>	<ul style="list-style-type: none"> <li>• Case-studies program implementation</li> <li>• Macro-level implementation research</li> <li>• Curriculum for pre-service and in-service QI</li> </ul>

Key challenges	Recommendations
Lack of training, orientation and facilitation skills	On-going learning for improvement skills through sharing of experiences
Documentation and reporting	Standardization of documentation methods  Need to disseminate existing formats and templates that can be adapted and used by countries
Cross-facility and cross-district learning for QI activities	Guidance on how to do learning
Government-led: Question of skill and resources  Academic institution: Skill and motivation  Partner led: Sustainability	<ul style="list-style-type: none"> <li>• Identify the need for a national learning system</li> <li>• Need for clarity on a national learning system and defining the role of the learning system at different levels</li> <li>• Consider pros and cons in selection government-led, academic-led or partner-led learning institutions</li> </ul>
Avenues for uniting facilities and districts are available, but converting them into learning opportunities is challenging	<ul style="list-style-type: none"> <li>• Need to build motivation into QI activities, such as acknowledgments and professional development</li> <li>• Guidance needed on how to make learning happen</li> </ul>

## 2.4 Programme management

This session explored the systems required to sustainably manage a QoC agenda at the national, district and facility levels as well as questions regarding mobilising investments for QoC. The objectives of the session were to: a) present current efforts towards developing a national QoC agenda that sets the foundation for implementation of QoC across all health programmes; b) share and discuss challenges and lessons learned at the national, district and facility levels, including learning districts. These challenges and lessons learned include: introducing and organizing support for implementation; sparking interest on change management and leadership for quality; overcoming silo implementation barriers between the new QoC structures and systems, and specific programmes; bringing resources for QoC; and Involving the community in QoC governance. The session examined the steps taken by Malawi and reflections from the other Network country teams to ensure a short- and long-term vision for embedding quality as a requirement for MNCH and for other programmes and to allow for sustainability and scaling up of QoC.

### 2.4.1 Malawi

On behalf of the MoH, Andrew Likaka, Director of Quality of Care Division, presented Malawi's experience with programme management for QoC. Malawi has a national policy and strategy for QoC and a technical working group for QoC. The country's approach has followed the Network's LALA framework:

- Leadership – Structures for quality and policy and strategy
- Action – Harmonized framework and roadmap for implementation
- Learning – Learning districts, facilities and a learning hub
- Accountability – Service charters, hospital ombudsman and monitoring framework

The MoH has also set up a technical working group for QoC. In Malawi, it is a principle for partners to plan and implement their work in alignment with the government. Quality needs to be demanded by the population, so service charters are created to inform people about what they can expect. A hospital ombudsman is available, if patients have experienced poor quality care.

At the point of delivery, the MoH's focus is on having a team at each facility to share its learning of mistakes and how to improve quality. Malawi has experienced structural challenges with resistance from other departments towards the new quality management department, managing expectations for scale up, linkages with other MoH departments and coordinating with partners at the district level. Embracing both successes and challenges will benefit a feedback system to improve QoC.

### 2.4.2 Reflections from Network country teams

Representatives from Bangladesh, Sierra Leone, Ghana and Tanzania reflected on Malawi's presentation. Bangladesh indicated that it has in-country funding for QI. The MoH's QoC Secretariat has a five-year plan and activities funded through implementation plans. QI activities have been funded by funds allocated by the government as well as by partners. Importantly,

much of the work is on a regular budget. Sierra Leone shared that the government has a four-year RMNCH plan with four strategic objectives. One of the strategic objectives is about improving QoC through QI and QA. The policies and strategies align with the Network's LALA (leadership, action, learning, and accountability) approach. Ghana and Tanzania addressed programmatic issues related to community engagement and mobilization for quality. For a long time in Ghana, communities have been involved in meetings due to a structure to include them. Communities must be represented in health facility management committees. For experience of care, community health committees are welcomed to do a facility walkthrough with the facility QI teams on quarterly basis and to score facilities on their experience. Scoring is linked to the district health system. Communities can also address the gaps they see, such as management of waste or renovation of facilities. Tanzania shared that community engagement is key at lower levels of the health system. Each health facility has established a committee to oversee facility-level services provided and to see how the workers are implementing the services. Communities have a lot of knowledge and must be continuously involved.

### **2.4.3 Partners' reflections**

Isata Dumbuya, RMNH Lead for Partners in Health Sierra Leone; Minara Chowdhury, Country Director Bangladesh for IHI and Senior Clinical QA and Accreditation Advisor for Save the Children in Bangladesh; and Paul Dielemans, Technical Advisor at GIZ Malawi provided their reflections on programme management. As a partner organization, it is important that Partners in Health Sierra Leone listens to the government about the country's needs and that the organisation work alongside the country's efforts. Partners must make sure that programmes are aligned with the country's objectives if such programmes are to be sustainable. Minara Chowdhury, Country Director Bangladesh for IHI and Senior Clinical QA and Accreditation Advisor for Save the Children in Bangladesh shared that there is a need to think about the country's primary aim and how to reach it. Collaboration between partners is key to avoid duplication and to maximize efforts to improve health. There is also a need to think beyond training to help the workforce. Community engagement and the collective thought process are essential. GIZ Malawi is using a harmonized systems approach looking on skills, infrastructure, etc. Using existing structures and systems is needed, and national ownership is important. While necessary, bringing all the programmes and departments together is challenging. Great work has been done at the national level in Malawi, so the country now needs to move to districts and facilities.

## **2.5 Community and stakeholders' engagement**

Community and stakeholders' engagement was highlighted thorough the meeting discussions as an important system to generate demand and to sustain implementation of QoC. However, considering countries have yet to progress on this area of work, it was agreed that this topic will be addressed at a future meeting.

## **3. Leadership Working Group Recommendations**

The meeting provided an opportunity for the leadership working group's annual face-to-face meeting. The group is composed of high-level MoH representatives from the ten Network



countries (i.e. Directors of QoC or MNCH) and Network partners representing the Network working groups on implementation, learning and monitoring. The main objectives of this working group meeting were to take stock of the work done so far by Network countries and to discuss a strategic way forward for the Network in the next three years. More specifically, the meeting touched upon the Network partnership model at the national and global levels, including: the technical working groups at the national level; the leadership and Network working groups at the global level; and suggest ways forward. The group's recommendations are highlighted below:

1. **Expand the Network's scope to include child and adolescent health.** In principle, it was agreed to expand along the continuum of child and adolescent health. Child health should be included on a country-by-country basis in response to national priorities, challenges and progress made with MNH. The Network Secretariat should establish a working group to advise on the strategies for scaling up (e.g., child health target setting; related implementation challenges; inclusion of upcoming small and sick newborn standards; possible expansion to cover the full continuum of care (e.g., adolescent)).
2. **Expand the Network and engage new countries.** The first wave of Network pathfinder countries continue to develop, learn, share and be accountable as a cohort. They form the Network's core for documentation of best practices, lessons learned, evidence syntheses and development of models of implementation. Countries interested in the Network should be able to benefit from the Network, if they meet the following criteria:
  - Have the highest level of government commitment and country leadership;
  - Have partners committed to harmonizing, aligning and supporting institutionalized implementation of QoC;
  - Have committed to align their efforts with the Network's objectives, including data sharing (which requires country resources directed to support data collection efforts, learning and sharing);
  - Have established targets and initiated implementation; and
  - Demonstrate a willingness to openly share knowledge and learning.

New countries should be able to access to Network resources, knowledge and lessons learned; learn from the Network's pathfinder countries; to obtain light technical assistance (requiring additional resources); to receive peer support from the pathfinder countries and to share their learning across the Network.

3. **Welcome Kenya as the 11th Network country.** The leadership working group welcomed Kenya to the Network and requested that the Kenya country team undertake the same critical steps as the other Network countries.
4. **Maintain Network support.** The leadership working group agreed to continue its role as a coordination mechanism between the Network countries. An agreement was reached to continue with the working groups for implementation, learning and monitoring and evaluation. The advocacy working group is still useful but must be reconstituted with a focus on both country- and global-level advocacy for quality, domestic resources and demand creation. WHO should continue to provide the Secretariat's support to the Network and is called upon to document and to share lessons learned thus far.

5. **Continue sharing progress and learning via Network leadership.** The leadership working group expressed a continued commitment to participate in periodic calls and one annual face-to-face meeting based on opportunity. Additional recommended leadership activities for sharing progress and learning include the following:
- Share biannual updates on the progress made in countries;
  - Hold periodic exchanges with peers on national technical working group functionality and activities;
  - Identify national, regional and global opportunities to advocate and present the Network's work on QoC (calendar of events and participation); and
  - Develop and follow up of a matrix of activities for countries, the Network Secretariat and partners.

## 4. Key Messages and Conclusions

### 4.1 Key messages from countries

Country participants recommitted their support for implementing QoC and strengthening national partnerships. Continuous commitment is required from all governments to reach the Network's common goal of halving maternal and newborn deaths in health facilities by the end of 2022. National partnership must be strengthened to ensure actual harmonization and coordination of activities among partners, and governments' capacity must be strengthened to support QoC processes everywhere. The strategic support and capacity development must be aligned long the four support systems for quality:

- On-site support as critical for scale up;
- Inclusion of QoC data in national systems;
- Contextualized learning systems linked to implementation that make specific references to clinical competency skill-building through mentoring and QI skill-building through QI coaching; and
- Programme management for effective streamlining within existing national structures and implementation efforts.

Implementation must leverage and harness the emerging innovations, including packages of QoC interventions. Community and stakeholders' engagement is the next frontier that must be addressed by all Network countries. The Network's next learning meeting should address this need. Finally, there is a need to continue engaging with advocates at all levels to strengthen advocacy for QoC, with the aim of mobilizing communities and additional resources needed to deliver quality care at all levels of the health system.

### 4.2 Key message from partners

During the closing session, Network partners shared their views and commitments to the Network. USAID indicated that the Network has been helpful in bringing quality to governments' high-level agendas. As QoC is a cross cutting area, multifaceted approaches are required with committed partners to mobilize resources, build effective partnership and establish close

coordination among other programmes. IHI noted that Network is demonstrating to the world how QoC is evolving. Effective partnerships at the country level should be encouraged and more resources should be made available to them. As we move ahead, partners shared two requests: (1) Involve district management and patients in the Network's future forums and (2) advocate for increased donor support at the district level.

The Bill and Melinda Gates Foundation expressed its commitment to the Network and will continue to fund strategic activities. The Gates Foundation advocated for stronger linkages with the Global Financing Facility. Given the implementation timeframe, the Foundation called upon the Network to be more strategic and to focus on how to evaluate milestones and outcomes to reduce the global burden of maternal and newborn mortality. MSD for Mothers said that innovations are available that could scale up QoC. Furthermore, they challenged the Network to strategically think about how to bring the private sector to the table and leverage the private sector's available innovations. To this end, MSD for Mothers committed to pilot work in Network countries that will explore these new dynamics.

UNFPA highlighted that quality should be taught as a transverse item in the university, while UNICEF reiterated that QoC should be the core driving force for attainment of UHC. The Network is great example of working as 'one UN' in line with the SDG agenda. UNICEF is committed to support the Network. WHO reiterated its commitment to the UHC and the quality agenda. Through the Network and its WHO-based Secretariat, the Network will continue to work with countries and partners to support implementation and to assist governments in their quests to achieve the Network's target of halving maternal and newborn deaths in participating facilities by the end of 2022.

#### 4.3 Statement from the 2<sup>nd</sup> Network Meeting

At the end of the meeting, participants endorsed a meeting statement (Annex 5) that reaffirmed their commitment to the Quality of Care Network's goals to halve maternal and newborn deaths and stillbirths and to improve the experience of care in participating facilities by 2022. Countries and partners committed to:

- Continue to work under government leadership and in collaboration and coordination with key stakeholders including implementing partners, professional associations, private sector, academia, research institutions, civil society and communities to implement the national strategies and plans for improving quality in MNCH services, including adolescents, as per country priorities;
- Continue to align efforts with national quality policies and strategies that provide a foundation for QoC and improved health outcomes at all levels, with MNCH as a pathfinder;
- Continue to advocate and mobilize domestic and additional external financial resources to support implementation and sustainability of QoC at scale;
- Support leaders and managers at the facility, district and national levels in their efforts to implement QoC and to provide on-site support to ensure that frontline health workers

acquire and maintain the clinical, QI and management skills required, including QI skill development in pre-service training;

- Generate, collect, analyse and use data and implementation research to accurately identify which activities are leading to better care;
- Build national learning systems that facilitate documentation and learning in support of QoC, while also contributing to exchange of best practices, expertise and experience through active participation in a global learning network;
- Commit to share what works and what does not work in implementing QoC in Network countries;
- Strengthen advocacy for QoC, including respectful care, at all levels;
- Engage communities, women and health providers, through social accountability processes, in the design, implementation and assessment of programmes to improve QoC;
- Identify and scale up the most effective models and innovations for sustainable implementation of QoC, including efforts to improve water, sanitation and hygiene (WASH) in health facilities.

## Annex 1: Meeting Agenda

Tuesday, 12 March 2019	
08:00—09:00	Registration
09:00—10:00	Opening session
10:00—10:30	Meeting overview and reports on Network progress
10:30—11:00	Coffee break
11:00—12:30	Meeting overview and reports on Network progress
12:30—14:00	Lunch
14:00—15:30	Poster session
15:30—16:00	Coffee break
16:00—17:30	Poster session
17:30—19:00	Innovation labs

Wednesday, 13 March 2019	
08:00—08:30	Recap of day 1
08:30—10:30	Plenary: systems to sustain implementation of quality of care (Part 1)
10:30—11:00	Coffee break
11:00—12:30	Working groups: on-site support for quality improvement and data systems
12:30—14:00	Lunch
14:00—15:30	Working groups: on-site support for quality improvement and data systems
15:30—16:00	Coffee break
16:00—17:30	Skill-building and brainstorming labs
17:30—21:00	Reception with Ethiopian poster gallery and networking

Thursday, 14 March 2019	
08:00—08:30	Recap of day 2
08:30—09:30	Plenary: systems to sustain implementation of quality of care (Part 2)
09:30—11:00	Working groups: learning systems
11:00—11:30	Coffee break
11:30—13:00	Plenary: systems to sustain implementation of quality of care (Part 3)
13:00—14:30	Lunch
14:30—15:30	Meeting recap and report from the leadership team
15:30—16:00	Coffee break
16:00—17:30	Way forward and closure



## Annex 3: Innovation Labs

The case-based innovation labs presented an exciting, interactive platform to share experiences and lessons learned implementing QoC innovations in different countries and settings. The labs thus created a shared foundation for participants to improve QoC for MNCH across countries. Summaries of the innovation labs appear below.

### Lab 1: United Nations Population Fund, Ethiopia

#### **Portable Mobile Learning System (MLS): A Training Solution for Health Workers**

*Aster Berhe and Ali Mahbub*

UNFPA launched a portable MLS in 2016 to train midwives and health workers in key skills to combat the most prevalent causes of maternal and newborn mortality. This model for a full-scale, low-cost MLS can be used to train targeted segments of the population in low-resource settings throughout the world. The MLS allows for any blank white wall in any setting (remote or urban) to become a classroom, so that multi-media training solutions can be used. The MLS is pre-loaded with world-class interactive multi-media training modules on key midwifery life-saving skills and obstetric emergencies that account for more than 90% of all maternal deaths. New courses and updates can be introduced via the internet, whenever it is available, and the system can be charged by solar power. A trainer is able to teach 40-50 students effectively for up to eight hours without interrupting the class due to a power outage. The MLS also allows trainers to reach difference audiences, such as lactating mothers, pregnant women and affiliated health facilities by preparing additional PowerPoints on different topics and video clips. The success of the pilot test in Ethiopia has led to the institutionalization of the MLS by in-service training sites and integration in a mentorship programme at UNFPA/EMwA sites.

### Lab 2: Ethiopian Midwives Association

#### **50,000 Happy Birthdays**

*Yeshitila Tesfaye and Tachawt Salilih*

The Ethiopian Midwives Association strengthens Midwives' Associations and advances the profession of midwifery in Ethiopia. Its *50,000 Happy Birthdays* programme contributes to quality maternal and newborn care by using simulation-based educational programmes to train, equip and empower midwives to save more lives at birth, and also contributes to reducing morbidity and ensuring a better birth experience.

In its innovation lab, EMwA displayed *50,000 Happy Birthdays* brochures; different simulators such as MamaNatalie Birthing, MamaBreast, Neonatalie and PreemieNatalie; and educational materials like Bleeding After Birth Complete (BABC), pre-eclampsia/eclampsia and Helping Baby Breathe (HBB) flip book with wall chart/poster.



Following an introduction and a project overview, EMwA explained the practical points of the simulators and the new method of on-site training. The Low Dose High Frequency (LDHF) approach uses an interactive technique to provide focused learning updates to improve competency and confidence of the entire health care team. In total, 120 meeting participants (50 men and 70 women) had an opportunity to learn about and test EMwA's innovations. Participants were especially interested to know how the referral linkage is integrated and whether health workers have a logbook to register the LDHF practice sessions.

### Lab 3: Federal Ministry of Health, Ethiopia

#### **I-CARE Initiative**

*Esayas Mesele and Yakob Seman*

While quality is one of the four pillars of the Ethiopian Federal Ministry of Health's (FMOH) Health Sector Transformation Plan, which started in 2016, much remains to be done to institutionalise a culture of quality and to achieve the plan's targets. To accelerate the quality agenda, the FMOH has developed the I-CARE initiative (Improving quality of care through: **C**ompassionate clinical care; **A**ccess to essential health service; **R**eform, redesign, and reward; and **E**ngagement of leaders, staff members, and stakeholders). The FMOH highlighted its innovative approach focusing on "Re-Orienting the National Actions to Institutionalise the Understanding and Practice of Quality Culture in all Ethiopian Health Facilities for Better Patient Experience and Health Outcomes."

### Lab 4: Jhpiego

#### **Helping Mothers Survive**

*Mintwab Gelagay*

Helping Mothers Survive (HMS) has been designed to improve capabilities of health providers in providing quality MCH care using LDHF. About a quarter of conference participants from various countries visited Jhpiego's HMS marketplace. The majority of the visitors had prior knowledge about the HMS program, and they appreciated the relevance of this new module 'Essential Care for Labor & Birth (ECL&B)' to improve skills of MNCH care providers and the readiness of health care facilities to provide quality care. Moreover, participants were fascinated by the method of teaching, LDHF, in its stimulus to enhance and recall skills. To learn more about the HMS programs, visit <https://hms.jhpiego.org> and contact Jhpiego's country offices.

### Lab 5: Laerdal Global Health

## **Safer Births Bundle**

*Karoline M. Linde and Alemnesh Reta*

Laerdal Global Health works closely with partners to develop simple, durable, culturally adaptable and affordable products, and to design programmes to educate on lifesaving skills. Laerdal Global Health presented the Safer Births Bundle, which is a bundle of therapeutic and training tools that integrates improved monitoring of the fetus and newborn resuscitation in a QI system.

## **Lab 6: Maternity Foundation**

### **Safe Delivery App**

*Agnete Nørrelund and Hiwot Wubshet*

The Safe Delivery App is a smartphone application developed by Maternity Foundation in partnership with Universities of Copenhagen and Southern Denmark. The App uses simple, intuitive animated instructions to guide healthcare workers in basic childbirth emergencies and includes quizzes, practical procedures and drug lists that healthcare workers can always refer to. The App is based on global clinical guidelines and adapted and translated into numerous local guidelines and languages. All features and functions are designed for low-literacy, low-income settings and work offline once downloaded.

The Safe Delivery App is free to download. To date, it has been downloaded more than 60,000 times in over 40 countries, primarily by healthcare workers in low- and middle-income countries. To ensure that the Safe Delivery App supports existing in-country maternal and newborn health activities, Maternity Foundation works through partners on the ground to implement the App. Several of the Maternity Foundation's project- and partner-countries are members of the Quality of Care Network, including Ethiopia, India, Ghana and Tanzania.

The key to the Safe Delivery App's success is that it is implemented and brought to life through strong partners on the ground. The innovation lab was thus a great opportunity for Maternity Foundation to reconnect with current partners and to introduce its work to potential new partners – this is essential for the Foundation's work to expand its reach and outcomes of the App.

In its innovation lab, Maternity Foundation connected with organisations, leaders and professionals from 21 different countries, some of which the Foundation is already working in and some of which the Foundation sees great potential for introducing the App. The innovation lab gave participants a unique opportunity to interact, ask questions and learn from each other. The innovation lab was also a great opportunity for Maternity Foundation to learn from other partners sharing innovative solutions.

## Lab 7: Mbarara University of Science and Technology (MUST)

### **Augmented Infant Resuscitator (AIR)**

*Naome Nsiimenta*

MUST, a public university accredited by the National Council for Higher Education in Uganda, has won acclaimed recognition globally for best practices in outreach and community relations. AIR is a bold, universally acceptable add-on device to existing resuscitation bag mask devices that enables ventilation of newborns and records objective performance and outcome data. It provides intuitive, real-time, actionable feedback to birth attendants during ventilation.

## Lab 8: Mbarara University of Science and Technology (MUST)

### **Protecting Infants Remotely by SMS (PRISMS)**

*Martin Mukama*

MUST, a public university accredited by the National Council for Higher Education in Uganda, has won acclaimed recognition globally for best practices in outreach and community relations. PRISMS, a mobile phone application, has three fundamental functions: 1) it guides newborn care by providing instant clinical management decisions; 2) it offers continuous newborn care clinical education to health providers; and 3) it empowers health managers with real-time surveillance data on the burden of neonatal morbidity and quality of care parameters vital for objective decision-making and resource allocation.

## Lab 9: mobile Helping Babies Survive (mHBS) Initiative

### **mHBS/DHIS2 App**

*Saptarshi Purkayastha*

The mobile Helping Babies Survive powered by DHIS2 (mHBS/DHIS2) app is an open-source, Android-based digital health tool designed to support the successful dissemination and implementation of evidence-based programmes for respectful maternal and newborn care. mHBS/DHIS2 supports functions for linkage to educational resources, training, quality monitoring and evaluation, data collection, and reporting for the *Helping Mothers' Survive* and *Helping Babies Survive* programmes. Integration with DHIS2 mobile provides off-line functionality, access to a wide range of customizable dashboard and data visualization features, and uniquely positions mHBS for global scale-up and sustainability.

## Lab 10: MSD for Mothers

## **CHAMPION (Carbetocin Haemorrhage Prevention) Project**

*Temitayo Erogbogbo*

MSD for Mothers works to improve maternal health by empowering women, equipping health providers and strengthening health systems. Its CHAMPION project is a collaboration between Merck for Mothers, Ferring and the WHO to address the unmet needs for the prevention of postpartum haemorrhage after vaginal delivery through an effort to increase public-sector access to heat-stable carbetocin in low- and lower middle-income countries at an affordable and sustainable price.

### **Lab 11: Nivi**

#### **askNivi**

*Cynthia Kahumbura*

Having launched in Kenya and recently India, Nivi, has been contributing to lowering maternal mortality rates by providing women with information on family planning methods, access to facilities as well as follow up on uptake of method. With MoH officials and development agencies attending the innovation labs, Nivi showcased the capabilities of integrating its platform to meet the theme *Quality, Equity and Dignity*. As Nivi focuses on consumer engagement and how to use the platform to convert intent to uptake, Nivi is always putting the patient first and providing feedback on QI for facilities.

### **Lab 12: WHO Ethiopia Country Office**

#### **Improving quality of the MDSR system**

*WHO Ethiopia Country Office*

The WHO Ethiopia Country Office, in collaboration the University of Aberdeen, implemented Evidence for Action (E4A), a five-year multi-country programme funded by the UK Department for International Development. In Ethiopia, E4A developed, implemented, and sustained a national maternal death surveillance and response (MDSR) system. The WHO Ethiopia Country Office highlighted its innovative project focusing on improving the quality of the MDSR system using the integrated disease surveillance and response (IDSR) – public health emergency management (PHEM) platform.

## Annex 4: Skill-building Labs

The skill-building labs addressed topics of relevance to improving QoC through the use of interactive learning methods to encourage active discussion and learning amongst participants. Summaries of the skill-building labs appear below.

### Lab 1: National directions on QoC: a practical approach

*Matthew Neilson and Shamsuzzoha Syed, WHO*

In the skill-building lab on National Directions on QoC, participants discussed the critical need for countries to develop and implement national quality policy and strategy as a foundation for coordinated, systematic and sustainable improvement in quality across the health system. Based on the content of the WHO handbook for national quality policy and strategy, discussions focused on the eight common elements to be considered in development of such national directions: national health goals and priorities; local definition of quality; stakeholder mapping and engagement; situational analysis; governance and organisational structure; interventions for improvement; health management information systems and data systems; and quality indicators and core measures. Participants also discussed the vital interface with quality-related technical programmes, such as MNCH programmes, noting the need for integration of strategic efforts and the potential for such programmes to act as pathfinders for implementing national directions on quality.

### Lab 2: Network orientation for new countries

*Network Secretariat*

This orientation was intended for participants from non-Network countries or organization who were interested in becoming involved with the Network. Discussion topics included:

- Introduction to the Network (e.g., objectives, impact)
- Overview of Network activities
- Opportunities to engage with the Network (e.g., knowledge resources, communities of practice, webinars)
- How to join as a partner organization or participating country

### Lab 3: Strategies for improvement database

*Alex Rowe, Centers for Disease Control and Prevention*

In the “Strategies for improvement database” skill-building lab, the focus was on the Health Care Provider Performance Review (HCPPR), which is a systematic review of the effectiveness of more than 100 strategies to improve health worker performance (and therefore health care quality) in low- and middle-income countries. Key results of the HCPPR were published in 2018 by Rowe et al. in *The Lancet Global Health* (available at: [http://dx.doi.org/10.1016/S2214-109X\(18\)30398-X](http://dx.doi.org/10.1016/S2214-109X(18)30398-X)); however, this published analysis involved a considerable amount of pooling across contexts (e.g., all countries were combined) and health conditions. As it would be useful for programs to perform tailored, context-specific analyses of the HCPPR database, participants in the lab were given a brief overview of HCPPR methodology (Objective 1) and provided an orientation to HCPPR databases (Objective 2) that are freely available at the HCPPR website ([www.hcperformancereview.org](http://www.hcperformancereview.org)). On this website, users can view a video tutorial about the review, download the review’s databases as simple Excel files and perform rapid analyses with an easy-to-use on-line tool (that is described in the video tutorial).

#### Lab 4: Water, sanitation and hygiene (WASH) in facilities

*Margaret Montgomery, WHO*

The skill-building lab on WASH brought together governments and partners working in Ghana, India, Ethiopia and Malawi to discuss global efforts, standards and their implementation and integration of WASH into quality efforts. Two new WHO/UNICEF global reports to be launched in April 2019 highlight that billions of people are provided care in facilities with no water, sanitation, hand hygiene and health care waste services. Yet solutions do exist. Eight practical steps have been identified, including developing national roadmaps, strengthening monitoring and engaging communities. Ethiopia shared the example of the Clean and Safe Health Facilities national program that has institutionalized a culture of “cleanliness being everyone’s business” and thereby advanced efforts on quality. Ghana provided the example of how WASH is included in the new National Healthcare Quality Strategy; there is regular monitoring within the national health database and a WASH/IPC technical guide with indicators has been developed. India shared the example Kayakalp that incentivizes improvements through intra- and inter-facility sharing as well as financial incentives. Finally, a short overview of the [Water and Sanitation for Health Facility Improvement \(WASH FIT\) tool](#) was given including a demonstration of low-cost chlorine residual and water quality testing. Such testing can be part of broader efforts to safely manage water to ensure water quality standards in health care facilities are consistently met.

#### Lab 5: Innovation labs

Following Tuesday evening’s innovation labs, participants followed up with the organizations developing and implementing innovations to improve the quality of MNH (see Annex 3) to share implementation experiences and to brainstorm about how these innovations and others could be implemented and taken to scale in different countries and settings.

## Lab 6: Advocacy efforts for quality, equity and dignity

Bénédicte Walter, WHO

Skills in this lab highlighted work on advocacy strategies based on evidence at the national and sub-national levels to create and sustain political will and demand for improved quality of MNCH. Both advocacy successes and failures were of interest. Discussions on approaches to humanizing care, the provision of respectful care, demand creation approaches, and accountability (and the information and tools needed to facilitate accountability) at all levels of the health system were welcomed.

## Lab 7: Quality, equity and dignity knowledge management and learning platforms and tools

Moïse Muzigaba, WHO

Participants attending this lab were introduced to existing and evolving quality, equity and dignity knowledge management platforms and tools. The aim of the session was for participants to discuss the purpose, key features, functional requirements, and capabilities of these modules and tools for effective and efficient use at the country level and the Network at large. Participants had the opportunity to collectively identify strengths and possible risks for adopting these tools, and to provide context-specific insights that need to be considered by the Secretariat.

## Lab 8: Developing implementation research questions

Debra Jackson, UNICEF

Many countries expressed interest in conducting implementation research at the 2018 meeting in Uganda. This lab assisted each country team with focusing their implementation research question and beginning the process of developing a research proposal to submit to the Secretariat for funding.

## Lab 9: Links between emergency obstetric and newborn care (EmONC) and QoC

Anneka Knutsson, UNFPA

This lab addressed the strengthening of national network of referral (EmONC) facilities in eight countries in sub-Saharan Africa (Benin, Burundi, Côte d'Ivoire, Guinea, Madagascar, Senegal, Sudan, and Togo). The approach implemented in these countries consists of:



- the identification of referral (EmONC) facilities (using GIS/AccessMod and other criteria);
- the monitoring of key sexual and reproductive health (SRH) and maternal and newborn health (MNH) indicators in these facilities; and
- the set-up of QI cycles to address gaps (e.g. PDSA, mentorship programme).

The presentation also covered the critical role of midwives in the provision of quality SRH/MNH services and provided examples of national approaches for QI (and linkages with MPDSR). This approach will be implemented in additional countries in 2019, potentially Mauritania, Chad, Burkina Faso and Sierra Leone.

### Lab 10: Enhancing synergies between MPDSR and QI in Network countries

*Kathleen Hill, MCSP/Jhpiego; Maurice Bucagu, WHO; and Tedbabe Degefi Hailegebriel, UNICEF*

MPDSR and the Network's implementation approaches aim to improve health outcomes for women and newborns and share many common elements. When appropriately aligned at country level, these approaches have the potential to accelerate improvements in quality of care and to increase efficiencies in programming. This interactive session built familiarity with MPDSR and Network resources and explored ways to optimize synergies between MPDSR and QI in Network countries. A draft conceptual framework on strengthening linkages between MPDSR and Network QI approaches was shared for participant feedback.

## Annex 5: Meeting Statement



Quality, Equity, Dignity  
A Network for Improving Quality of Care  
for Maternal, Newborn and Child Health

### Committed to Quality, Equity and Dignity

#### **Statement of the second meeting of the Network for Improving Quality of Care for Maternal, Newborn and Child Health**

14 March 2019, Addis Ababa, Ethiopia

- Committing to the 2030 Sustainable Development Goal 3 (SDG3) to '*ensure healthy lives and promote well-being for all at all ages*', to the Global Strategy for Women's, Children's and Adolescent's Health, in particular the targets to end preventable maternal newborn and child mortality, to the principles of quality, equity and dignity, and to achieving universal health coverage;
- Acknowledging the findings and recommendations of the three reports on quality health systems: *High-quality health systems in the Sustainable Development Goals era: time for a revolution* by the Lancet Global Health Commission on High Quality Health Systems in the SDG Era; *Crossing the Global Quality Chasm: Improving Health Care Worldwide*, by the National Academies of Sciences, Engineering, and Medicine; and *Delivering Quality Health Services: A Global Imperative for Universal Health Coverage*, a joint publication by the World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD), and the World Bank Group;
- Recognising the progress that the ten pathfinder countries, Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Sierra Leone, Tanzania and Uganda, leading the Network for Improving Quality of Care for Maternal, Newborn and Child Health (Quality of Care Network) have made since its launch in February 2017 to put in place national structures and plans for quality of care, adapt, adopt and implement WHO's standards for improving quality of maternal and newborn care and standards for improving the quality of care for children and young adolescents in health facilities, at the national, district and facility levels, and set up learning systems;
- Welcoming twelve<sup>i</sup> new countries and countries from other regions<sup>ii</sup> interested to learn and be involved in institutionalising quality of care based on the strategic objectives of the Quality of Care Network;
- Reaffirming our commitment to the statement of the 1st meeting of the Quality of Care Network in February 2017 in Malawi;
- Acknowledging the challenges that countries are facing in scaling up and sustaining delivery of quality of care and reaching everyone, everywhere;
- Appreciating lessons learnt in the process of implementing quality improvement activities and encourage use of existing opportunities for further development;
- Recognising the growing role and the need to engage and work with the private sector beyond the public sector;

We, the participants in the second meeting of the Network for Improving Quality of Care for Maternal, Newborn and Child Health from twenty-two countries, national, regional and global partners, development organisations, NGOs, private sector, professional associations, academia and research institutions in the Quality of Care Network:

— Reaffirm our commitment to the goals of the Quality of Care Network to halve maternal and newborn deaths and stillbirths and improve the experience of care in participating facilities by 2022.

— And commit to:

- Continue to work under government leadership and in collaboration and coordination with key stakeholders including implementing partners, professional associations, private sector, academia, research institutions, civil society and communities to implement the national strategies and plans for improving quality in maternal, newborn and child health services, including adolescents, as per country priorities;
- Continue to align our efforts with national quality policies and strategies that provide a foundation for quality of care and improved health outcomes at all levels, with maternal, newborn and child health as a pathfinder;
- Continue to advocate and mobilise domestic and additional external financial resources to support implementation and sustainability of quality of care at scale;
- Support leaders and managers at facility, district and national levels in their efforts to implement quality of care and to provide on-site support to ensure that front line health workers acquire and maintain the clinical, Quality Improvement (QI) and management skills required, including QI skill development in pre-service training;
- Generate, collect, analyse and use data and implementation research to accurately identify what activities are leading to better care;
- Build national learning systems that facilitate documentation and learning in support of quality of care, while also contributing to exchange of best practices, expertise and experience through active participation in a global learning network;
- Commit to share what works and what does not work in implementing quality of care in Quality of Care Network countries;
- Strengthen advocacy for quality of care, including for respectful care at all levels;
- Engage communities, women and health providers, including through social accountability processes, in the design, implementation and assessment of programmes to improve quality of care;
- Identify and scale up the most effective models and innovations for sustainable implementation of quality of care, including efforts to improve water, sanitation and hygiene in health facilities.

— Finally, as members of the Quality of Care Network, we gratefully acknowledge the technical leadership and support of the World Health Organization, UNICEF and UNFPA, implementing and funding partners, to facilitate the Quality of Care Network, enable transformation in health and sustainable development for every woman, newborn, child and adolescent everywhere to survive and thrive.

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<sup>1</sup> Botswana, Cameroon, Chad, DRC, Kenya, Liberia, Mozambique, Namibia, Niger, Senegal, South Sudan, Sudan

<sup>2</sup> Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka and Timor-Leste