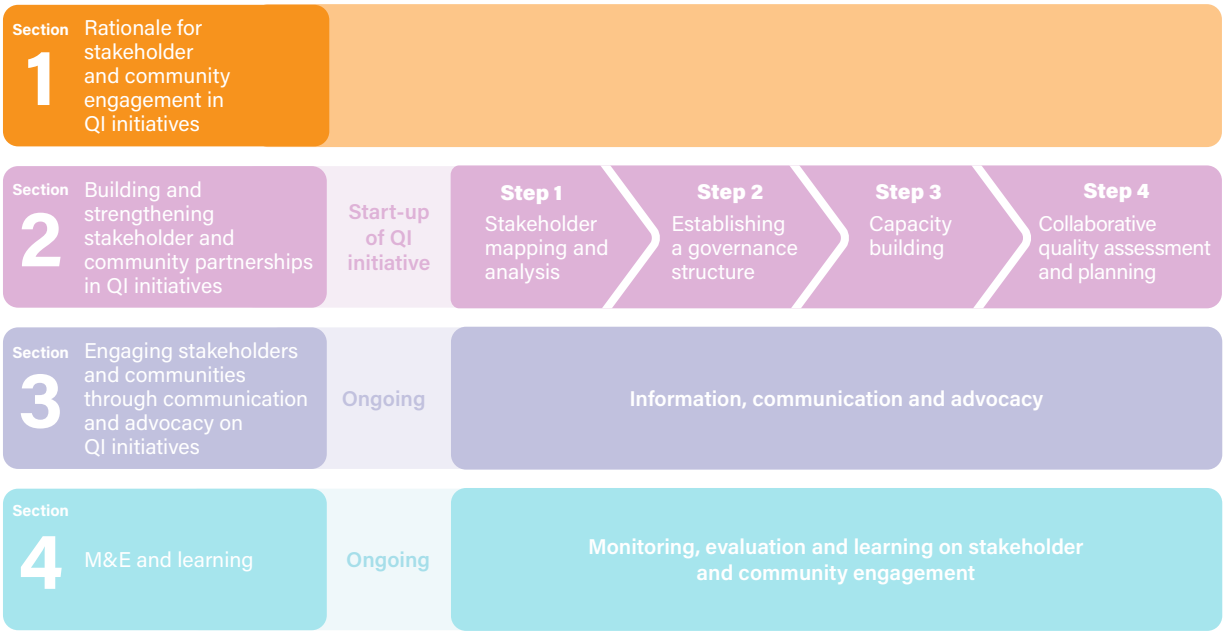
SECTION 1. RATIONALE FOR STAKEHOLDER AND COMMUNITY ENGAGEMENT IN QUALITY IMPROVEMENT INITIATIVES



While QoC is predominantly expressed at the level of the interaction between health providers and service users, it takes place within a much broader context, including the larger health system. At each level of the health system and in the different steps of the QI process, stakeholder and community engagement is crucial and will be shaped according to national, district and facility strategies to improve QoC. The rationale for engaging stakeholders and communities is generally perceived as follows:

- **Inclusion of broader determinants and intersectoral collaboration in QI initiatives.** QoC is a product of the wider health system and of social, political and economic determinants. The underlying causes of problems and the opportunities for solutions will be found across different disciplines and across the workings of government, private sector and civil society. By including stakeholders from different disciplines and sectors (e.g. water and sanitation, education, social affairs, finance, transport, local development), the complexity of factors that influence QoC in MNCH will be better understood. For example, as a key

component of safe and quality services, water, sanitation and hygiene (WASH) improves not only health outcomes and the experience of care, but also staff morale and the efficiency of services.[14]

- **Contribution of different stakeholders.** Although health system actors (MOH, decentralized departments, programmes and facilities) may lead the QI initiative, it is dependent on a range of stakeholders for successful implementation, including from those who influence factors beyond the direct provision of care, and those who have a direct or indirect influence on funding, resources and provision of services. These different stakeholders will need to contribute to the development of QoC plans, their implementation, and M&E.
- **Institutionalization of quality.** Through sustained stakeholder and community engagement, a culture of quality can be fostered whereby QoC in MNCH is advocated for and prioritized in policy and programming across the health system. Improving stakeholder and community engagement in QI initiatives for MNCH can also benefit other health services by putting quality on the agenda and by encouraging users to seek higher-quality services for all of their health-care needs.
- **Relevance and buy-in.** In a resource-constrained environment with competing health priorities, quality of MNCH may not always be a priority. Advocacy for a focus on QoC can be challenging. It is crucial to identify and engage key decision-makers and policy influencers to make the case for investment in QoC and to create an enabling and supportive environment for QI initiatives, including through increased support for stakeholder and community engagement.[15] By including a range of stakeholders, plans are better tailored to local contexts and to implementers' and users' realities. Plans have more potential to harness buy-in. Leaving out key groups or involving them too late in the process can undermine efforts to create effective partnerships.
- **Learning and promoting synergies.** Many countries are implementing multiple QI initiatives in MNCH and other sub-sectors. Stakeholder and community engagement allows for the opportunity to coordinate efforts and to share experiences and lessons learned across initiatives, in-country, between districts, and as well as cross-country.[16] Districts constitute important platforms for in-country learning by bringing together different stakeholders, encouraging their participation and contribution, strengthening synergy and avoiding duplication. Stakeholder engagement at the district level allows for the opportunity to share lessons across initiatives, not only with different health facilities but also with community representatives, local authorities, nongovernmental organizations (NGOs), and between districts.
- **The right to participation and empowerment.** Women's right to health and their right to participate in public life and political decision-making is enshrined in international legal frameworks such as the Committee on the Elimination of Discrimination Against Women (CEDAW) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa – better known as the Maputo Protocol. The latter provides for the protection and promotion of women's reproductive health rights, their dignity and non-discrimination in service delivery. The effective implementation of this right involves providing women and vulnerable groups opportunities to gain enhanced skills, knowledge and confidence to play an active role in QI initiatives and to participate in designing and implementing national health policies and programmes.
- **Enhancing accountability.** Accountability is both a mechanism and a process by which government, service providers, private actors, community members and other stakeholders are required to demonstrate, explain and justify how they have fulfilled their obligations towards quality MNCH.[17] Having mechanisms for the inclusion of users' voices during development of the strategy is important, but their voices are equally important when it comes to implementing and monitoring the strategy and ensuring accountability against jointly defined goals, targets and outcomes.[18] Stakeholder and community engagement can ensure that

14 WASH in health-care facilities: links with the Network for improving Quality of Care for MNCH. Geneva: World Health Organization; 2017 (https://www.who.int/maternal_child_adolescent/topics/quality-of-care/quality-of-care-brief-wash.pdf).

15 Handbook for national quality policy and strategy.

16 Handbook for national quality policy and strategy.

17 Adapted from: Accountability for children's rights. New York: UNICEF; 2015 (https://www.unicef.org/policyanalysis/rights/files/Accountability-for-Childrens-Rights-UNICEF.pdf).

18 Handbook for national quality policy and strategy.

governments, health providers and other stakeholders are held accountable for decision-making and for the services and quality they provide.[19]

- **Enhancing accessible, acceptable, respectful and people-centred MNCH care.** This kind of care can be enhanced through the integration of users' and communities' perspectives on QoC. Factors that affect the uptake and outcome of care are socioeconomic and cultural characteristics, accessibility of health facilities and QoC.[20] People's perceptions and experiences of quality – rather than clinical indicators of quality – are what drive service uptake and outcomes. Perceptions are shaped not only through individual encounters between service users and providers, but also by users' social networks, community norms and values, and peer influences.[21] Stakeholder and community engagement can provide opportunities to better understand QoC from service users' and communities' perspectives and to develop context-relevant QI initiatives that integrate social norms of acceptability and quality across the continuum of MNCH care.
- **Stakeholder and community ownership.** Stakeholder and community engagement can enhance communities' awareness of QoC, conditions of QoC and health systems challenges and scarcities; clarify expectations; and strengthen the communities' role in contributing to creating an enabling environment for QoC. Reorienting care around the needs, preferences and engagement of users and communities by health providers can be a powerful step to institutionalize QoC and increase the lifespan of QI activities.[22]

The link between stakeholder and community engagement and QoC improvement has not always been explicit. QoC has often been considered the professional domain of health planners, managers and health providers. While community engagement and participation have often been translated to community involvement in health promotion and programme implementation – or in some programmes, limited to introducing community health workers – it has been under-developed in QI initiatives.[23] "Communities" were mainly seen as passive recipients or beneficiaries of services and less as "stakeholders" with interests, influence and relevant contributions in areas to improve planning and service delivery, including in QI and monitoring. Community engagement as a QI strategy has recently emerged in the form of community-based monitoring interventions, or the introduction of client feedback mechanisms, also in MNCH.[24] A survey conducted in 2018 by WHO found that 60% of countries in the WHO regions (ranging from 47.1% in the Western Pacific to 72.7% in South-East Asia) have mechanisms in place at the facility level to solicit feedback on quality and access from community members, users and families.[25] Though linkages are emerging, the integration of stakeholder and community engagement in QI initiatives in a systematic and meaningful way, rather than only as a stand-alone QI intervention, remains a challenge in many settings.

19 Standards for improving quality of maternal and newborn care in health facilities.

20 Bohren MA, Hunter EC, Munthe-Kaas HM, Souza JP, Vogel JP, Gülmezoglu A. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. Reprod Health. 2014;11(1):71.

21 Hanefeld J, Powell-Jackson T, Balabanova D. Understanding and measuring quality of care: dealing with complexity. Bull World Health Organ. 2017;95(5):368–74.

22 Handbook for national quality policy and strategy.

23 George AS, Mehra V, Scott K, Sriram V. Community participation in health systems research: a systematic review assessing the state of research, the nature of interventions involved and the features of engagement with communities. PLoS One. 2015;10(10):e0141091.

24 Social accountability for women's, children's and adolescents' health: a symposium of evidence, practice and experiences. Meeting Report. New Delhi: PMNCH; 2018 (https://www.who.int/pmnch/media/news/2018/social-accountability-symposium-2018-report.pdf).

25 Policy Survey to track country progress in adopting WHO recommendations in national health policies, strategies, and guidelines related to RMNCAH. Geneva: World Health Organization; 2018.

Degrees of stakeholder and community engagement

Stakeholder and community engagement is often defined in terms of the degree to which engagement takes place: it can fall anywhere along a continuum ranging from passive involvement through public dissemination of information to active participation and shared decision-making.[26] For example, during situation analysis of QoC at the national level, **information and consultation (1)** is an appropriate approach to collect stakeholders' views on key political and institutional challenges. At the facility level, it may mean to collect women's, men's, and local leaders' views on, and experiences with, the quality of MNCH services. **Involvement (2)** requires more regular interactions to make sure stakeholders and communities are also involved in different stages from programme design and implementation to evaluation. **Collaboration (3)** refers to working in **partnership** with stakeholders and communities whereby decision-making is shared at different stages of a programme.

A QI initiative is likely to incorporate different degrees of engagement in different steps of the QI process, and this will change over time; it is important to note that the levels of engagement are complementary and not ranked. They are all valid approaches and may be more or less relevant and appropriate at different stages in QI initiatives, depending on the objectives of stakeholder and community engagement. Table 1 presents potential objectives of the three levels of engagement and illustrative examples for national, district and facility levels.

26 Examples of a continuum: Informing, consultation, co-production, delegated control, community control. In: Popay J (2006). Community engagement and community development and health improvement: a background paper for the National Institute for Health and Care Excellence (NICE). Outreach, consult, involve, collaborate, shared leadership. In: Working with individuals, families and communities to improve maternal and newborn health: a toolkit for implementation. An overview of implementation at national, province and district levels. Geneva: WHO; 2017; Fig. 3.1, p.25, based on the IAP2 Spectrum of Public Participation, 2004.

Table 1. Objectives and examples of levels of stakeholder and community engagement

Strategy →	Information and consultation	Involvement	Collaboration and partnership
Objective	To provide stakeholders with balanced information to assist them in understanding the QoC problem, programmes, and their involvement. To obtain stakeholder and community feedback on situation analysis, decisions and plans. To establish communication and information channels to ensure ongoing dialogue with stakeholders and communities beyond the planning stages.	To work directly with (national, district and facility level) stakeholders throughout the QI initiative to ensure that the concerns and aspirations of stakeholders and the community (and subgroups) are consistently understood, considered and integrated into the QI initiative. To establish engagement with increased participation and regular interaction and opportunities for stakeholders and communities to influence programming, process and outcomes. To develop specific sub-components of a QI initiative that address specific concerns of a stakeholder or community group and for which a specific structure (e.g. advisory board) may be set up.	To partner with stakeholders and communities in each aspect of decision-making, including the quality assessment, planning, selection and implementation of QI initiatives. To strengthen partnerships and joint decision-making through stakeholder and community representation and influence in the governance structure of the QI initiative (e.g. TWG, QI team, steering group) or through establishing complementary stakeholder and community initiatives that are driven by them (e.g. community quality monitoring) and facilitated by QI leadership or teams.
Illustrative examples – national level	There is public information, such as announcements on efforts to improve MNCH QoC, but no explicit efforts to involve stakeholders in analysis, planning and implementation.	Stakeholders are invited to one of the meetings of the MNCH QoC TWG to give their inputs on the operational plan. Some of their suggestions are incorporated.	There is stakeholder representation in the MNCH QoC TWG. Stakeholders' experiences, knowledge and resources are taken into account in the roadmap for MNCH QoC.
Illustrative examples – district level	There is public information, such as announcements on efforts to improve MNCH QoC, but no explicit efforts to involve stakeholders in analysis, planning and implementation. Existing multisectoral district platforms (e.g. local government health working group) are used to present QI initiatives and ensure ongoing dialogue with stakeholders.	Stakeholders are invited to one of the meetings of the MNCH QI team to give their inputs on the operational plan. Some of their suggestions are incorporated. Existing district platforms are used for regular interaction and for provision of opportunities for stakeholders and communities to influence programming, process and outcomes.	There is a conscious effort to select and partner with stakeholders (district assembly, local authorities, mayor, heads of school, traditional birth attendants [TBAs], representatives of women's groups) in the district by including them in the QI team. Stakeholders' experiences, knowledge and resources are integrated into the district operational plan and decisions are made jointly.
Illustrative examples – facility level	Programme information is shared in an ad hoc manner and is provided informally. There is public information, such as announcements on efforts to improve MNCH QoC, but no explicit efforts to involve stakeholders in analysis, planning and implementation.	Community stakeholders are consulted about programmes, initiatives and plans. They provide information that QI teams use to make decisions about the project.	Women and men are consulted separately and different groups and their participation opportunities are identified, including for marginalized groups. (Representatives of) women and community groups are part of the QI team and participate in decision-making during planning, implementation and evaluation.

In this module, it is envisioned that QI initiatives seek a ***collaborative*** approach to stakeholder and community engagement, encouraging partnerships and shared decision-making. Section 2 is designed to support this at the start-up of a QI initiative.