QCN Evaluation

How does a multi-country, multilateral network focused on specific health care improvements evolve and what shapes its ability to achieve its goals?

MRC Health Systems Research Initiative (Data: 2019 to late‘21/early’22)

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Overview

1. Evaluation outcomes
2. Methods
3. **Results**
4. **Conclusions and Recommendations**

1. Research Questions & Objectives

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Evaluation Outcomes:

The main outcomes being evaluated in our research are:

1. At global and national levels: adoption of a shared agenda & goals to improve maternal & newborn health services (**network emergence**)
2. At national level: ownership of the policy and management work of the network (**network legitimacy**)
3. At local level: delivery of locally valued interventions (**network effectiveness**)

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2. Methods: i) Data

- Document Review:

  https://www.qualityofcarenetwork.org/

- Interviews
- Observations
  - QCN Meetings
  - Best and least performing hospitals
- Network Survey
- QCN Monitoring Data

2. Methods: ii) Analysis

- Policy Process Analysis
- Stakeholder Network Analysis
- Process Tracing
- Case study, cross-case, and case synthesis analyses

3. Results – Papers

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Paper 1: Network Emergence

Paper 2: Network Legitimacy

Paper 3: Network Effectiveness

Paper 4: Social Network Analysis

Paper 5: Theory of Change

Paper 6: Capacities

Paper 7: Learning and innovation

Paper 8: Experiences of evaluating QCN

Paper 9: Network Sustainability

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Factors that shaped speed, strength and extent of emergence of QCN in four pathfinding countries *

Policy Environment

Resources and initiatives dedicated to the issue

Data & health system capacity

Political developments and legacies/country leadership priorities

Nature of Network

Governance

Leadership

*draws on Shiffman et al (2016), Steenhoff et al (2017), Plamondon et al (2021), Shiffman (2017)

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Spectrum of Network Emergence   Why?

Pre-existing relationships, systems of governance, national quality initiatives, accountability, data collection & use

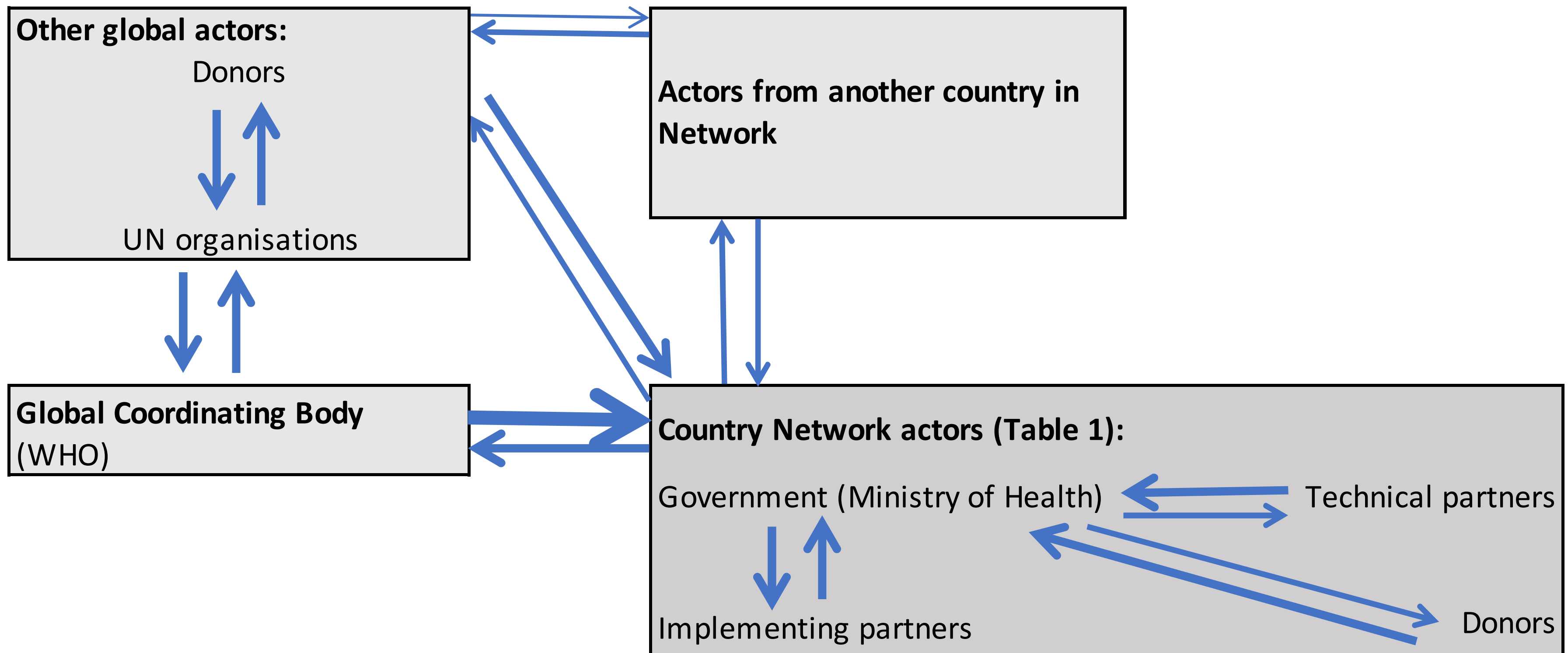
Continuity between actors and programmes

Strong focal leadership that pre-exists network & is resilient to personnel changes

Paper 2 – Network Legitimacy

Ownership of policy & management work required to set national aims and improve services

Political, normative and **cognitive** interactions between stakeholders:



Paper 2 – Network Legitimacy

Political interaction – collaborative efforts, collective decisions, sharing of resources – **Good: joint workshops, agreed goals & MOUs, logistic & financial support to facilities**

Normative interaction – interdependence of commitments, norms & principles – **Good: network stakeholders jointly pursuing agreed MNCH goals**

Paper 2 – Network Legitimacy

Cognitive interaction – exchange of information, transfer of concepts and methods – **OK: some information sharing, though lack of data; stakeholders not always using same implementation strategies or methods of quality improvement or agreeing on concepts e.g. importance of macro/meso systems-level improvements vs micro point of care improvements**

Interactions typology from Sanderink & Nasiritousi (2020)

Paper 2 – Network Legitimacy & Embededness

Points for discussion

Everyone on the same page (**high legitimacy**), but dependency on partners and donors for implementation (**low embeddedness and ownership?**)

Lack of harmonisation and bi-directional transfer of concepts and methods – may reflect lack of institutional capacity on QI methods & organisational culture not adapting to new networked ways of operating

Siloed geographical implementation in some countries

Learning platform not well utilised by local levels – limited influence of network on day-to-day practice in facilities so far?

Paper 3 – Network Effectiveness

Global level leadership strong

National-level activities strong in most countries

Local level activities less strong

Local activities by different (siloed) QCN-member NGOs & facility health workers sometimes unaware of QCN

awareness increased from 2019→2022

COVID-19 pandemic disruption → not enough time yet

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Points for discussion

More **time** and **long-term budgets** and **domestic funding** required

More focus on the periphery (local level facilities)

50% reduction in case fatality rates aspirational & not achievable within the time (or measurable)

Paper 4 – Social Network Analysis

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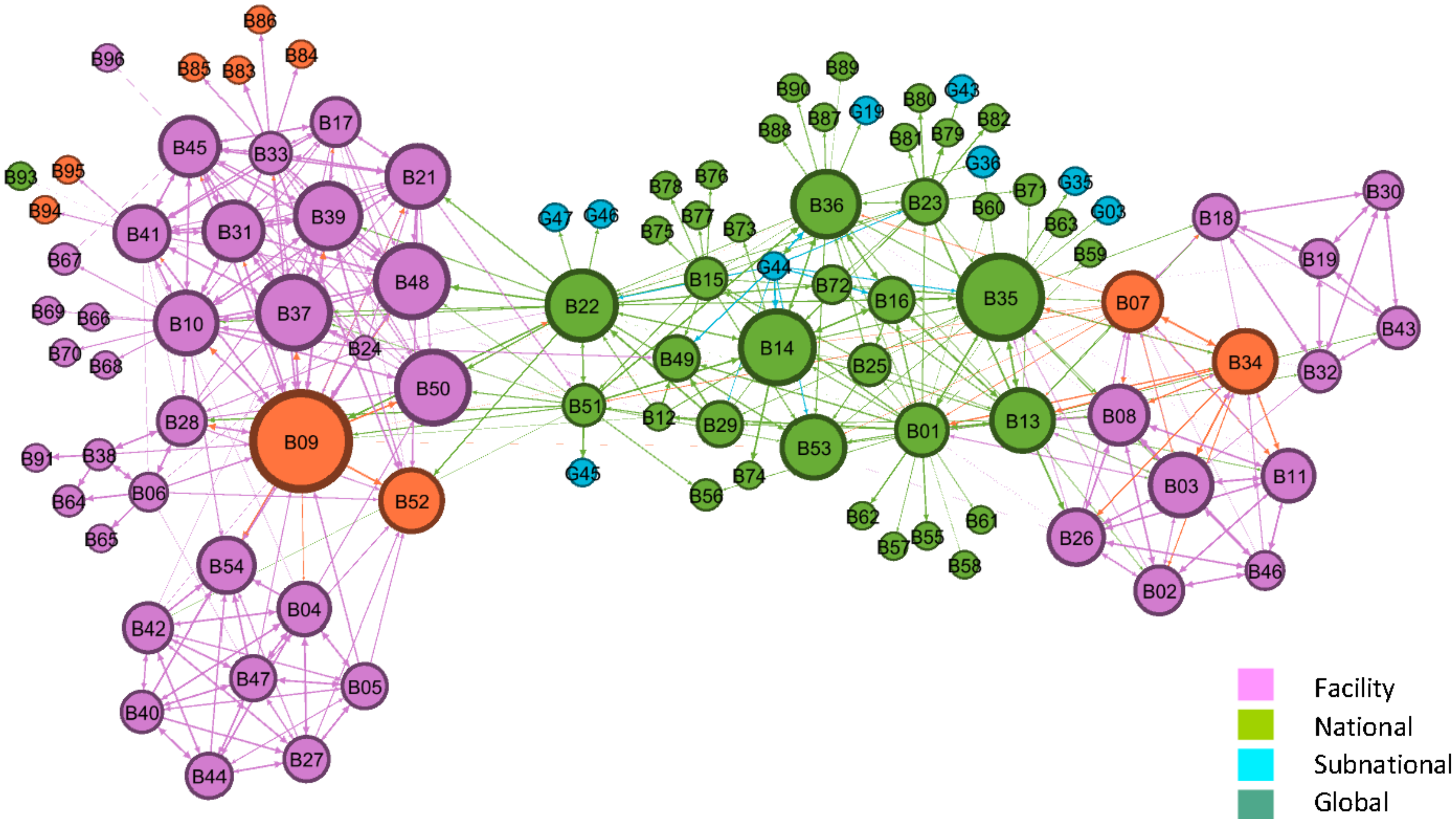
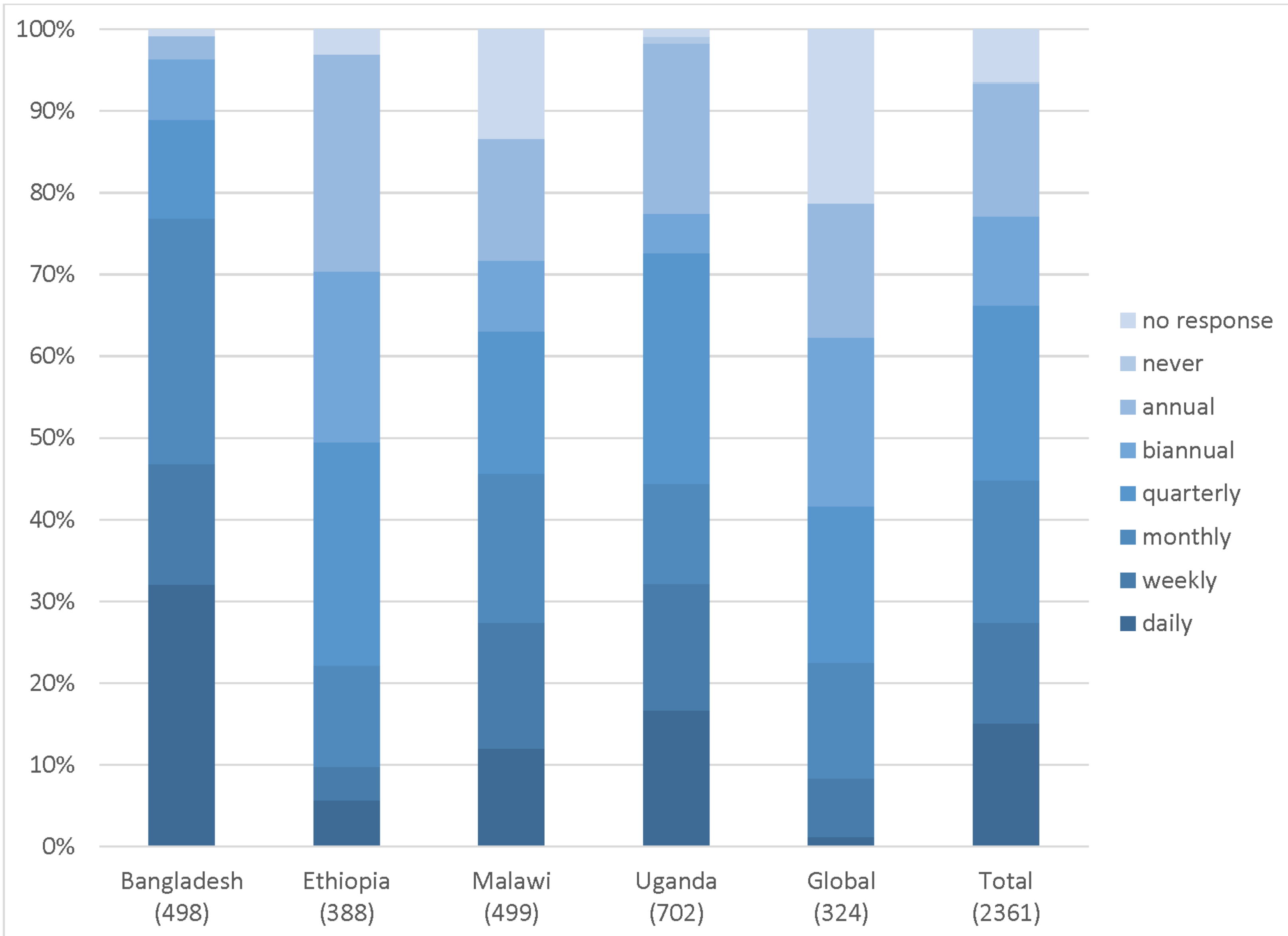


Bangladesh: Multiple-hub network Network density: 4.6%

Paper 4 – Social Network Analysis



Frequency of interactions by network

Recommendations

Further work is required to **strengthen the periphery** of the network in each country

Needs **greater investment** of time and resources at local level

& creating & strengthening **bi-directional links** from centre to periphery

+ **increasing frequency of interactions** between global-national-local levels

→ **Denser/more mature network** better able to facilitate improvement in quality of care

Paper 6 – Capacities

Individual

Retaining trained & motivated staff

Enhancing culture of documentation & data use

Importance of leaders to motivate individuals

Organizational

Inadequate staffing levels

Finding strategies to continuously build staff skills

Limited physical resources & processes in facilities

Paper 6 – Capacities

Systemic

- Policy alignment & partner coordination
- Burden of parallel reporting systems
- Paying for quality healthcare
- Managing disruptive events (e.g. COVID-19)

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Points for discussion

Capacity challenges encountered at individual, organisational and system levels hampered the initiative's ability to succeed as intended. Nonetheless, **sufficient gains have been made to warrant investing the time, effort and resources needed to sustain the Network rather than introducing other new programmes.**

Paper 9 – Network Sustainability

Sustainability Actions

1. Planning Opportunities for reflection and adoption
2. Government ownership with a plan for a phased transition
3. Motivating Micro-level actors
4. Institutionalizing the innovation within the health system
5. Managing Financial Uncertainties
6. Fostering Community engagement

Spicer et al (2018)

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Summary of emerging key findings (1/2)

Improving quality of care takes time & long-term commitments, continuity, leadership

Global & national level coordination well established, more to do at local level

Data systems to support learning & accountability still too weak / parallel & unintegrated

Summary of emerging key findings (2/2)

Domestic funding of implementation & homegrown quality improvement expertise needed

Facility- and District-wide systems improvements are needed to further enable frontline ward- and clinic-based improvements

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Thank you

Questions?

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