Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia Region

A Regional Framework

World Health Organization
Regional Office for South-East Asia
Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia Region

A Regional Framework
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Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia

You must be the change you wish to see in the world.

*Mahatma Gandhi*

Improvement is, I believe, an inborn human endeavour. My belief arises mostly from watching children. You cannot find a healthy child who does not try to jump higher or run faster. It takes no outside incentive. Children smile when they succeed; they smile to themselves. And so, it is my premise that almost all human organizations contain in their workforce an internal demand to improve their work. Improvement is not forcing something; it is releasing something.

*Donald M Berwick (Institute for Healthcare)*

### Abbreviations

- **DPRK** Democratic People’s Republic of Korea
- **IM(N)CI** Integrated Management of (Neonatal and) Childhood Illness
- **MDG** Millennium Development Goal
- **MNCAH** maternal, newborn, child and adolescent health
- **PDSA** plan–do–study–act
- **QI** quality improvement
Impressive progress has been made in the South-East-Asia Region in reducing child and maternal mortality in the last two decades with significant improvement in reproductive health outcomes, too. Several countries of our Region are on track for achieving Millennium Development Goals 4-5. Member States are also progressively expanding implementation of adolescent-friendly health services.

While there has been progressive improvement in the coverage of reproductive, maternal, newborn, child and adolescent health services, there is evidence that effective lifesaving interventions are often of sub-optimal quality. A number of studies over the past years have documented the poor quality of care provided to neonates and children, as well as deficiencies in maternal health care, for both routine and emergency services. Likewise, assessment of adolescents / youth-friendly health services in several countries have identified gaps in the quality of care provided.

Poor quality is found to be responsible for low utilization of health-care services by the population leading to inadequate progress towards achieving MDGs 4 and 5 in some countries. Universal Health coverage also emphasizes good quality of health care in addition to expanded availability of essential services.

The Global Strategy for Women’s and Children’s Health has recognized that improving the coverage as well as quality of health services will lead to acceleration of progress towards achieving MDG 4 and 5. As recommended by the United Nations Commission for Information and Accountability, “quality of care” is one of the essential parameters in the evolving discourse around the post-MDG development agenda, with universal health care as the centrepiece, wherein the quality of health care would, hopefully, receive the attention it deserves. The South-East Asia Region is taking important steps in this direction.

This Regional Framework for improving quality of care aims to position quality of care at the centre of universal health coverage and in post-2015 development priorities and ensure that it receives the attention it deserves. The framework promotes quality improvement across the Reproductive-Maternal-Newborn-Child-Adolescent Health continuum at all levels of care that aims to achieve “effective coverage”, meaning high and equitable coverage of quality care. It delineates activities to take place at the regional and the country levels.

I am sure Member States will find the Regional framework for improving quality of care useful for adaptation and application in their own settings.
Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia
Beyond coverage: quality of care

Impressive progress has been made in the South-East Asia Region to reduce child and maternal mortality over the last two decades. Significant improvements in reproductive health outcomes have also been observed in the Region. Member States have implemented adolescent-friendly health services that are now being progressively scaled up. Several countries of the Region are on track to meet the Millennium Development Goals (MDGs) 4 and 5, the reduction of child and maternal mortality by two thirds and three quarters, respectively.

While there has been progressive improvement in the coverage of reproductive, maternal, newborn, child and adolescent health (RMNCAH) services, there is evidence that potentially life-saving interventions are often delivered with insufficient quality.\(^1\) Several studies document that the quality of care provided to newborns and children is often poor, particularly at the hospital level\(^2\),\(^3\),\(^4\) and that severe deficiencies exist in the quality of interventions for maternal health, for both routine and emergency care.\(^5\),\(^6\) The same holds true for the quality of care provided within the private sector. Slow progress towards good health outcomes, as well as low utilization of health-care services in many settings, can be partially attributed to the poor quality of the services provided. Clearly, universal coverage of health-care services will not result in improved health outcomes and saved lives if the quality of the interventions is insufficient. Poor quality of services may even be detrimental, harming the health of the individual as well as leading to adverse effects on future health-seeking behaviour of communities.\(^6\)

A strategic framework for health service delivery must move beyond the traditional debates about provision of services at the community versus health facility and referral levels, or vertical disease-based versus integrated programmes. Evidently, neither the provision of services through community health workers without a functioning referral system for the very sick, nor detached tertiary care facilities serving the few and leaving many to die uncounted in the communities, would provide as much value as a functioning system providing quality care for all newborns, children, adolescents and mothers across all levels. *However, all too often systems-level improvement does not occur and the price of failing to improve health service delivery is a worsening of health disparities both local and global.*\(^7\)

This Regional Framework aims to build on the thrust provided by the United Nations Secretary General’s Strategy – *Every Woman and Child* and the United Nations Commission for Information and Accountability to position quality of care at the centre of debate on universal health coverage in post-2015 development phase and to ensure quality of care receives the attention it deserves.

The framework proposes a quality improvement (QI) system that extends across the RMNCAH continuum and at all levels of care and aims to achieve “effective coverage”, meaning high and equitable coverage of quality care.\(^8\) It delineates activities to take place at the national, regional and the country level.
Dimensions of quality

The framework aims to achieve quality of care in six dimensions:9

1. **Effectiveness**: health care provided adheres to an evidence base and results in improved health outcomes for individuals and communities, based on need.
   - Any form of treatment or patient care provided at the health-care facility is based on protocols and guidelines that follow international scientific evidence.
   - Health-care providers have skills and competency to provide the required health services.
   - The health facility has the equipment, supplies, and basic infrastructure necessary to deliver the required health services.
   - Health-care providers are able to dedicate sufficient time to work effectively with their patients.

2. ** Appropriateness**: health care is delivered in a manner that maximizes resource use, avoids waste and provided in a setting where skills and resources are appropriate to medical need.
   - The required health-care services fulfil the needs of all patients either at the point of health service delivery or through referral linkages.
   - Services are organized to provide continuity over time (within one health facility) and between providers (referral to and from higher or lower levels of care).
   - Resources are used appropriately to ensure optimum benefits for patients and the population.

3. **Accessibility**: health care provided is timely, geographically reasonable and affordable.
   - The hospitals have 24 hours of operation for emergency care and deliveries.
   - Policies and procedures are in place that ensure that health services are either free or affordable (and informal payments are avoided).

4. **Acceptability**: health care provided takes into account the preferences and aspirations of individual service users and the cultures of their communities.
   - The health care provided is patient-centred, responsive to and respectful of the patient’s values and choices to promote patient satisfaction.
   - All areas of the health facility have a safe, clean and appealing environment.
   - Policies and procedures are in place that guarantee confidentiality.
   - The health facility ensures privacy.
   - Health-care providers are non-judgemental, considerate, and easy to relate to.
   - The facility ensures that a system for triage is in place and consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral is organized.
   - A system to collect patients’ views and feedback is organized and taken into account when planning services.
5. **Equity**: health care provided does not vary in quality because of personal characteristics such as age, gender, race, ethnicity, geographical location or socioeconomic status.
   - Policies and procedures are in place that do not restrict the provision of health services on any terms.
   - Health-care providers treat all patients with equal care and respect, regardless of status.

6. **Safety**: health care provided minimizes risks and harm to service users and providers.
   - The provided health care ensures that the patients and staff do not suffer undue harm from the treatment itself or from the manner in which it was given.

The situation in South-East Asia

Bangladesh, India, Indonesia, Myanmar and Nepal have the highest burden of maternal and child mortality in the Region and their progress towards the MDGs and expansion of coverage of essential interventions for maternal and child health are closely monitored and reported by the *Countdown 2015* initiative. Figures 1 below, depict the coverage of selected interventions for reproductive, maternal, newborn and child health for 10 of the 11 countries in the Region.

Decline in maternal and child mortality and achievement of MDGs in countries of the South-East Asia Region

Progress has been made with the expansion of coverage of essential interventions. However maternal and child mortality rates remain high in some countries (Figure 2–5); while the data show that there is still some scope for improving coverage further, none of the available data provide information on the quality of health interventions delivered. Reductions of under-5 and maternal mortality in relation to MDG targets are shown for all 11 South-East Asia countries.

**Figure 1**: Coverage (%) along the continuum of care (without adolescent health) for countries in the South-East Asia Region

Source: For the five Countdown countries (Bangladesh, India, Indonesia, Myanmar and Nepal), data were extracted from Countdown country profiles (primary source demographic health surveys (DHS), multiple indicator cluster surveys (MICS), other national sources); for Bhutan, DPR Korea, Maldives, Thailand and Timor-Leste, data were extracted from latest DHS and/or MICS where available. No data were available for Sri Lanka.
Figure 2: Under-5 mortality rates (deaths/1000 live births) in the South-East Asia Region, by year

Figure 3: Progress towards MDG 4 in the South-East Asia Region

*Target: Countries that reach the dotted red line have achieved MDG 4 and reduced the under-5 mortality rate by two thirds between 1990 and 2015; bars above the dotted red line indicate exceeding the target, bars underneath indicate insufficient progress.


Figure 4: Maternal mortality rates (maternal deaths/100 000 live births) in the South-East Asia Region

Figure 5: Progress towards MDG 5 in the South-East Asia Region

*Target: Countries that reach the dotted red line have achieved MDG 5 and reduced their maternal mortality rate by three quarters between 1990 and 2015; bars above the dotted red line indicate exceeding the target, bars underneath indicate insufficient progress.

Quality of care in countries of the Region

Published and unpublished data from assessments of maternal and newborn, child and adolescent health in Bangladesh,\textsuperscript{10} Indonesia\textsuperscript{4,5} and Nepal show that quality of care RMNCAH interventions is unsatisfactory. To make further progress towards ending preventable maternal, newborn and child mortality improvement in quality of care would be crucial. Lack of triage and inadequate assessment, late treatment, inadequate drugs supplies, poor knowledge of treatment guidelines and insufficient monitoring were key adverse factors observed across study areas and countries. Practitioners were often neither aware of nor followed evidence-based guidance on best practice.

While Indonesia, for example, has increased skilled birth attendance from 41% in 1992 to 82% in 2010, maternal and infant mortality continue to remain high and evidence from small-scale studies indicates that quality of care continues to pose a challenge. High coverage by skilled attendants will have an impact only when these attendants follow the basic procedures and perform life-saving procedures when needed. Examples for quality approaches are shown in the two vignettes below.

Several Member States have scaled up provision of adolescent friendly health services. Assessment of quality of such services in a number of countries has shown poor compliance to national standards of adolescent friendly services.
Vignette I: Assessment of the quality of paediatric care in referral hospitals of Nepal within a quality improvement approach

The Ministry of Health and Population of Nepal has implemented the Integrated Management of Childhood Illness (IMCI) and Community Based Newborn Care Programme (CBNCP) to reduce neonatal and childhood morbidity and mortality. A referral system with regional, subregional and central hospitals designated as referral centres has been put in place, although little is known about the quality of care provided at these referral hospitals.

A cross-sectional descriptive study using both qualitative and quantitative methods was carried out at four referral hospitals (1 central, 2 regional and 1 subregional) to assess the availability of trained health-care providers, the quality of case management of common paediatric conditions, and the performance of the hospital support system including physical infrastructure, laboratory and pharmacy services and hospital statistics.

The tool used for the assessment was adapted from the WHO Generic tool for the assessment of the quality of hospital care for children. It was reviewed by the study team for its consistency with national standards and guidelines; the finalized tool comprised 15 sections and additional subsections.

Main findings of the assessment included a lack of human resources and deficient case management of common childhood conditions. While the management of malnutrition and measles was reasonably good, management of difficult breathing, febrile illnesses, diarrhoeal diseases and neonatal conditions did not adhere to international standards and triage was non-existent. Poly-pharmacy and overuse of broad-spectrum antibiotics were widespread and treatment protocols often non-existent. Hand hygiene was not practised. Equipment and supplies were inadequate and ill-maintained. In-hospital pharmacies did not exist and government supplies of essential drugs largely inadequate. While electricity and backup power and running water were available in all study hospitals, adequate and well-maintained infrastructure was missing. Record-keeping was found to be very poor especially in outpatient departments and emergency rooms. Laboratory services were reasonably good in all four study hospitals and results of basic tests were available within a reasonable time. No proper referral and transport system was in place.

Key recommendations to address these findings included the procurement and supply of essential drugs, equipment and supplies. This entails the establishment of a mechanism to ensure adequate maintenance, development of standard treatment protocols, including for the rational use of antibiotics and job-aids, regular training for doctors, nurses, paramedics and support staff and supportive supervision of hospital staff at all levels.

The assessment is a first step within a larger process to improve the quality of care. Next steps include the expansion of the process to lower level hospitals and health facilities, implementation of the recommendations, including the promotion of infection control and rational use of antibiotics. Follow-up and the use of the assessment tool for self-assessment are planned as well as regular reassessment of quality of care.

The Regional framework includes establishment of quality improvement structure and process that enables improvement in quality of care based on such assessments.
Vignette 2: Assessment of the quality of care for mothers and newborns in 100 health facilities in Indonesia

Despite socioeconomic progress and an increase in skilled birth attendance in Indonesia from 41% in 1992 to 82% in 2010, maternal and infant mortality remain high with an estimated maternal mortality rate (MMR) of 190 per 100 000 live births and a neonatal mortality rate of 15 per 1000 live births according to WHO estimates. An Indonesian health survey from 2012 suggests even higher rates of 359/100 000 and 19/1000 respectively.¹

Although the MMR is decreasing, the national target for MDG 5 of 102 maternal deaths per 100 000 by 2015 will not be achieved at the current rate of reduction. Important factors influencing mortality rates are the quality of obstetric and neonatal emergency care services and the functioning referral in case of complications between the different levels of care.

Anecdotal evidence and small-scale studies indicate that the quality of care is often low and referral not functioning appropriately. A standard assessment tool for maternal and newborn care based on WHO tools and Indonesian basic and comprehensive emergency obstetric and neonatal care guidelines was developed. This supported a systematic assessment in 20 districts and 40 sub-districts of 10 randomly selected provinces. A total of 100 assessors were trained and a team of eight people including obstetricians, midwives, general practitioners, staff of the Ministry of Health and United Nations agencies assessed each district. The aim of the assessment was to gather information on the quality of maternal and newborn health care provided at facility level, to understand the reasons for high mortality rates and to identify key areas of pregnancy, childbirth and newborn care that need urgent attention for improvement. Aggregated findings from all facilities provide an insight in the quality of maternal and neonatal care at the national level and provide an indication about areas that need improvement in future. The common gaps that were identified include incomplete medical records, poor competencies of healthworkers, poor counseling of patients and poor infrastructure. The assessment found a need to put in place standards and guidelines; develop (self-) assessment tools and indicators to monitor adherence to standards as well as a strategy to foster motivation and professional development providing the right incentives.

Next steps include the development of a Framework of MNCH Improvement Quality of Care in Indonesia in line with the Regional and Global Framework. This initial assessment is seen as a component of the framework, which needs to include technical support to develop or revise policies, laws, norms, regulations and clinical guidelines, strengthening of pre- and in-service training, the establishment of a functioning referral system and the systematic introduction of maternal and perinatal audits.

¹ Indonesia Demographic and Health Survey 2012.
The continuum of care

The continuum of care can be defined over the dimension of time (throughout the life cycle including before and during pregnancy, childbirth, the newborn period, childhood and adolescence), and over the dimension of place or level of care (community, first level health facility, referral hospital).

Evidenced-based packages of interventions for family planning, safe abortion care and MNCAH have been defined and published.11 These packages of services will save lives and avert the majority of preventable deaths, if they are delivered with high coverage and quality across all levels of care, with functional linkages between levels of care in the health system and between service-delivery packages.12

Services to be provided throughout both dimensions of the continuum are illustrated in Figure 6.

**Figure 6:** Interventions and packages of services for improving maternal, newborn, child and adolescent health along the continuum of care to be delivered at all levels of care

<table>
<thead>
<tr>
<th>Levels of care</th>
<th>Reproductive health</th>
<th>Maternal health</th>
<th>Newborn health</th>
<th>Child health</th>
<th>Adolescent health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>• Emergency care</td>
<td>• Emergency obstetric care</td>
<td>• Newborn resuscitation</td>
<td>• Emergency care</td>
<td>• Emergency care</td>
</tr>
<tr>
<td></td>
<td>• Case management for STIs/HIV</td>
<td>• Skilled care at birth</td>
<td>• Management of a newborn with severe illness</td>
<td>• Case management of severe illness</td>
<td>• Case management for STIs/HIV</td>
</tr>
<tr>
<td></td>
<td>• Elective abortion</td>
<td>• Management of complications of pregnancy, childbirth and immediate postpartum period, including caesarean section, blood transfusion, hysterectomy Induction/ augmentation of labour</td>
<td>• PMTCT</td>
<td>• Elective abortion</td>
<td>• Elective abortion</td>
</tr>
<tr>
<td></td>
<td>• Post-abortion care</td>
<td>• Treatment of medical conditions, side effects and/or complications</td>
<td></td>
<td>• Post-abortion care</td>
<td>• Post-abortion care</td>
</tr>
<tr>
<td></td>
<td>• Treatment of medical conditions, side effects and/or complications</td>
<td></td>
<td></td>
<td>• Treatment of medical conditions, side effects and/or complications</td>
<td>• Treatment of medical conditions, side effects and/or complications</td>
</tr>
</tbody>
</table>

| **Health facility** | • Counselling and provision of the full range of family planning methods | • Monitoring of progress of pregnancy and assessment of maternal and fetal well-being including nutritional status (4 antenatal care visits) | • Newborn resuscitation | • Integrated management of childhood illness |
|                     | • Prevention and management of STIs/HIV | • Detection of problems complicating pregnancy | • Exclusive breastfeeding | • Immunization |
|                     | • Elective abortion | • Referral | • Infection prophylaxis and treatment | • Malaria insecticide-treated bed nets |
|                     | • Referral | | • Immunization | • Nutrition, including vitamin A and zinc |

Youth-friendly health services providing comprehensive package of services including modern/safe contraception, prevention of HIV/AIDS, STIs, violence (and consequences), smoking, unwanted pregnancies and malnutrition

Case management of common illnesses Referral
**Community**

- Health promotion and education
- Adolescent and pre-pregnancy nutrition
- Distribution of methods of contraception, including emergency contraception
- Identification of signs of domestic and sexual violence and referral
- Prevention of STI/HIV

<table>
<thead>
<tr>
<th>Education</th>
<th>Promotion and support for:</th>
<th>Promotion and support for:</th>
<th>Promotion and support for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and counselling</td>
<td>exclusive breastfeeding</td>
<td>breast feeding and appropriate complementary feeding</td>
<td>breast feeding and appropriate complementary feeding</td>
</tr>
<tr>
<td>Birth planning, advice on labour, danger signs and emergency preparedness</td>
<td>thermal protection</td>
<td>recognition of problems, illness and timely care-seeking</td>
<td>recognition of problems, illness and timely care-seeking</td>
</tr>
<tr>
<td>Education about clean delivery, and early care for neonates including warmth, immediate and exclusive breastfeeding</td>
<td>infection prevention</td>
<td>identification and referral of children with signs of severe illness</td>
<td>identification and referral of children with signs of severe illness</td>
</tr>
<tr>
<td></td>
<td>care of a small baby</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>recognition of problems, illness and timely care-seeking</td>
<td></td>
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<tr>
<td></td>
<td>routine care visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>birth registration</td>
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</tr>
</tbody>
</table>

Promotion and support for:

- Breastfeeding and appropriate complementary feeding
- Recognition of problems, illness and timely care-seeking
- Identification and referral of children with signs of severe illness
- Identification and management of diarrhoea, pneumonia and malaria

PMTCT, prevention of mother-to-child transmission; STI, sexually transmitted infection.

Adapted from the Conceptual and Institutional Framework of the Partnership for Maternal, Newborn and Child Health; WHO Packages of Interventions for Family Planning, Safe Abortion Care, Maternal, Newborn and Child Health; and Kerber KJ, de Graft-Johnson JE, Bhutta ZA et al, Continuum of care for maternal, newborn, and child health: from slogan to service delivery.

## The framework’s vision

The vision of the framework is that all countries of the South-East Asia Region provide universal access to quality care for every woman, newborn, child and adolescent at all levels of care.

The framework’s goal is that all countries of the Region improve the quality of reproductive, maternal, newborn, child and adolescent health services by

- identifying key areas for improvement
- addressing bottlenecks that hinder the provision of care
- implementing a continuous and sustainable QI system.

## Regional objectives

The framework aims to fulfil the following objectives by 2020.

SEARO will support all Member States to ensure that in the area of RMNCAH

- a National Quality Framework is developed
- quality standards and clinical protocols are developed in line with international standards
- tools are developed for the assessment of quality of care against set standards and clinical protocols
- assessors have been trained to assess quality of care against set standards, and assessments have been carried out
- a QI mechanism is established and a collaborative improvement approach is being implemented
- a reporting mechanism is established for quality of care, patient safety and adverse events
Country health system targets

To be able to reach the targets listed below and to provide quality of care at all levels of the health system, several inputs have to be in place, notably human resources, infrastructure, drugs supplies and equipment. These inputs need to be used appropriately, effectively and efficiently to ensure that health services are delivered according to standards and ultimately that the targets are reached and the desired outcomes – the improved health of women, newborns, children and adolescents – are achieved (Figure 7).

Figure 7: Flow of inputs, processes and outputs to achieve standards of care

**Hospital level** (all facilities providing inpatient care)
- 90% of all hospitals are implementing mortality audits including adverse events audits regularly (at least every three months) which lead to relevant QI actions
- 90% of all hospitals are providing services for high-risk pregnancy and emergency obstetric and newborn care according to standards (national treatment guidelines)
- 90% of women giving birth at the hospital receive care according to standards (national treatment guidelines)
- 90% of newborns delivered at the hospital receive care according to essential newborn care standards (national treatment guidelines)
- 90% of children admitted to the hospital with pneumonia and/or diarrhoea are treated according to standards (national treatment guidelines)
- 90% of adolescents receive care according to national treatment guidelines including a home, education/employment, eating, drugs, sex, suicidality (HEADSS) assessment
- 90% of hospitals have essential drugs lists and had no stock-outs of essential drugs within the last three months.

**Health facility level** (all facilities where outpatient care is provided)
- 90% of women seeking antenatal care at the health facility receive the care according to standards (national guidelines) during at least four visits
- 90% of women giving birth at the facility receive care according to standards (national treatment guidelines)
- 90% of newborns presenting for care at the health facility are treated according to IM(N)CI guidelines (or other national standards)
- 90% of women and adolescents seeking reproductive health services including abortion services and family planning services receive these according to national standards
- 90% of children presenting for care at the health facility are treated according to IM(N)CI guidelines (or other national standards)
- 90% of adolescents seeking care at the health facility receive services according to youth-friendly health services (YFHS) standards (or other national standards).
- 90% of hospitals have essential drugs lists and had no stock-outs of essential drugs within the last three months.

Community level
- 90% of women and newborns receive a postnatal visit within 2 days after birth/after discharge from the hospital/health facility according to national standards
- 90% of women including adolescents have access to a community health worker and family planning methods according to national standards.

Progress towards these targets will be measured using data collected through health facility and hospital assessments as well as through national health information systems and demographic and health surveys as appropriate. The mechanism for collecting quality of care indicators will be as defined and implemented at the global level.  

A systematic process for implementation

The implementation of a systematic process at the country level with support from the regional level will help to ensure that health-care interventions are delivered with adequate quality and that harmful practices are avoided. The proposed systematic process entails the following seven key components (Figure 8) led by the ministry of health:

1. Getting started
   - Identify leadership and champions
   - Define roles at various levels
2. Setting standards of care
   - Develop guidelines based on standards
   - Develop an assessment tool based on standards and guidelines
3. Assessing current quality of care and identifying gaps in quality with reference to the established standards. Professionals (Pediatricians, Obstetricians) are trained to access quality of care by using the tools developed in the country
4. Improvement
   - Create improvement teams to identify problems and implement solutions
   - Implement a collaborative approach to ensure adherence to guidelines based on standards of care
   - Train health providers (in technical and QI methods) to implement the quality improvement system
5. Continuous monitoring of performance and provision of supportive supervision and (self-) assessments of quality of care to measure progress towards the achievement of standards

**Figure 8:** Seven key components of the systematic process

- **1. Getting started**
  - Identification of leadership and champions
  - Defining roles at various levels (systematic process)

- **2. Standards**
  - Definition of standards of care
  - Review of and agreement on standards for all areas and levels of care
  - Development of guidelines and an assessment tool based on standards

- **3. Assessment (external baseline)**
  - Assessment of quality of care and identification of gaps with reference to the established standards

- **4. Improvement**
  - Implement solutions: Implementation of improvement activities to address the identified gaps with reference to the established standards
  - Technical and QI training
  - Collaborative problem solving meetings

- **5. Monitoring and (self-) re-assessment**
  - Continuous monitoring of performance and provision of supportive supervision and (self-) assessments of quality of care to measure progress towards the achievement of standards

- **6. Documentation and dissemination**
  - Documentation and publication of quality improvement efforts
  - Recognizing and celebrating the achievements of the standards

- **7. Scaling up**
  - Scaling up to all hospitals and health facilities and communities
6. Documentation and publication of QI efforts and recognition and celebration of achievements of the standards

7. Scaling up to all hospitals and health facilities and communities

The main areas of ongoing action to implement the process to guarantee adequate quality of care are summarized in Figure 9.

**Figure 9:** Core components to ensure adequate quality of health care interventions

1. Getting started

**Identification of leadership and champions**

An institutional basis and leadership at different organizational levels is essential to get started, take the improvement process forward and ensure its sustainability. The Ministry of Health will normally take the lead in countries. A national-team (steering committee) for improving quality of care should be set up, if it does not already exist.

Decision-makers may require orientation on the importance of improving quality of care. The level where these decision-makers are located will vary from country to country as many countries have undergone decentralization to varying degrees with transfer of political, fiscal and administrative powers to subnational governments.
Furthermore, it is essential to ensure leadership at the hospital and facility levels where the improvement activities will be implemented: champions or key health-care professionals with clinical, managerial, interpersonal and motivation skills that can lead the improvement of care need to be identified.

**Defining roles at various levels**

The roles and responsibilities at the different levels (national, subnational, health professional bodies, etc. and the national steering committee) will vary. At the country level, governments, usually through the Ministry of Health, have a supporting, coordinating and regulatory role by committing sufficient resources, by setting standards for the different levels of care and by including the improvement process for care in national plans of action. At the local level, strong leadership is required by senior management in the health facilities to implement improvements and facilitate collaboration with the relevant stakeholders. Health professional bodies and academic institutions will contribute to the improvement process by providing expertise at the national and local level, by including improvement processes in curricula, and by promoting hospitals and health facilities that meet the required standards of care.

**National level**

The Government, usually through the Ministry of Health, should ensure that improvement of quality of care is included in national policies and plans of action and other strategic directions. Improvement of care should be an integral part of the mandate of all relevant health programmes at the national level. Comprehensive plans should outline and make available the necessary human, financial and organizational resources to ensure a continuum of care, from the family-community to the health centre, to first level hospitals and thereon to tertiary facilities. Collaboration with other groups working on health-related activities should be ensured.

Setting of national standards for care is a core function at the central level (refer to section: Standards).

**National team (steering committee) for improving care**

A national team (steering committee) for improving care may be established to assist the improvement process. This team brings together government workers with the formal mandate and those with technical expertise to lead the improvement process. The group should have representatives from the ministry of health; doctors, nurses and midwives from main referral hospitals; medical and nursing associations, United Nations agencies; donors; health financing; and accreditation bodies.

The role of the national team (steering committee) is to:

- address improvement issues that require policy decisions
- establish national standards for care
- oversee national or subnational planning and coordination of the improvement process
- develop quality focus areas for the improvement process at national level
- Provide ongoing technical expertise and support to the health facility and hospital improvement teams
- coordinate national monitoring of the process.
Health professional bodies

Health professional bodies, including medical faculties, schools of public health, public and private institutions for training health workers, and medical and nursing professional associations, will have senior clinicians and academics with technical expertise to guide the improvement process. Health professional bodies could be assigned specific roles. For example, medical and nursing associations could play an important role in setting standards and monitoring hospitals and facilities. Similarly, they could play a significant role in introducing aspects of quality care in pre-service education of doctors, nurses and midwives.

Other parties

International organizations, donors, health-care financing and hospital accreditation bodies may also have a leadership role in some countries by ensuring standards of care for services they are funding or supporting. Local committees for quality of public services and civil society could also contribute.

Subnational or district level

Depending on the degree of decentralization, many of the above functions will be under the mandate of the subnational or district level.

Health facility and hospital level: the improvement team

Health facilities and hospitals may receive government support and/or financial and technical support from other sources, including nongovernmental organizations. As improving care primarily takes place at the facility and hospital level, strong leadership from the health facility or hospital director, administrator and senior clinicians is essential.

The role of the improvement team at the health facility (see Annex 1) includes:

• initiating action for improvement
• facilitating the improvement process
• collaborating with other improvement teams through the collaborative approach
• coordinating with higher levels on the improvement process
• monitoring the improvement process at regular intervals
• communication with the community.

2. Setting standards of care

The setting of standards of care is based on evidence, official guidelines and international assessment tools. Standards are established in order to agree on what is expected and against which benchmark performance will be assessed. In many countries a multitude of guidelines exist that support the provision of health care; unfortunately they are often outdated and sometimes contradictory. The initial step in the improvement process is to review and update these guidelines to ensure that they are in line with the latest evidence-based WHO guidelines.

During this process, standards of care for the different levels of health care provision will need to be agreed upon, in line with current evidence and recommendations and relevance to the needs of the country, i.e. taking the preferences and expectations of the population into account.
The standards should cover and include all the dimensions of quality like effectiveness, appropriateness, accessibility, acceptability, equity and safety described earlier.

The input of a large number of stakeholders (as described above) may be required, and political decisions may have to be taken, for example on human resource development, job descriptions and task shifting, where needed and appropriate. The outcome of this process will be availability of established standards for RMNCAH care at all levels (hospital, health centre/midwifery clinic, as well as community-based services), guidelines and job aids (e.g. in form of desk guides, pocket books, websites and/or smart phone applications). It is critical to widely communicate the defined standards of care to health-care providers, across the country.

Links to health systems approaches such as human resource planning and training, drug supplies and equipment, and financing should be ensured, and specific approaches in these areas need to be defined.

An assessment of the current quality of care (as described below), should be incorporated into the standards development process in order to gain a perspective on how far current practice differs from internationally accepted standards. Such an assessment might also ensure that improvement targets are realistic rather than aspirational.

3. Assessments

Assessing current quality of care needs to be carried out to portray the current situation, identify deviations from agreed standards and, at a later stage, measure progress towards the achievement of the standards.

An assessment tool based on the established national standards and guidelines (or an adaptation of the WHO Generic Integrated Assessment Tool based on international standards) will have to be developed. Once the assessment tool has been developed, a sample of health facilities can be assessed. The assessment process requires capacity-building of assessors including an orientation of the assessment team on the assessment tool and the process ahead of them.

Findings of the sample baseline assessment should be shared widely with all stakeholders and used to refine the standards, where needed, and to define the needed improvement actions through the collaborative improvement process (see below). Identified shortcomings that concern the health systems at large (supply of essential drugs, staffing, etc.) can be brought to the attention of the responsible administrative units and plans to address these deficiencies developed in collaboration with them. Client perspectives should be an integral part of the assessment process. Client exit interviews during the assessment process, and also on a regular basis through suggestion or feedback boxes, allow further improvement based on the opinion of clients.

Selection of the assessment teams

Assessors are selected from staff from all facilities and hospitals involved in the process; external facilitators should assist each assessment team. In the initial assessment, staff members are not involved in assessing their own facilities but instead those of their peers. The team should consist of facility and hospital staff and Ministry of Health staff at national or subnational level. It is important that clinicians are in the team to assess case management. Nurses and midwives must also be included.
As this is part of a collaborative process and intended to be a team exercise, no-one working at the facility or hospital expressing interest in participating should be excluded. The size of the teams may vary depending on the size of the facility and hospital to be assessed and on how many clinical areas are included. For example, two to four assessors are required to assess the quality of paediatric care provided at a middle-sized district hospital.

**Training assessors**

Assessors should be trained by somebody experienced in the assessment process. Ideally, the training team should include external facilitators, who add validity to the process. Assessors would be oriented to all sections of the assessment tool, method of data collection and process to be followed. They need to be made aware of the standard treatment guidelines as per the national standards. Assessors would be trained on summarizing the findings of assessment, interpretation and to prepare recommendations for improvement.

### 4. Improvements

Improving quality of care requires

- a collaborative approach to ensure adherence to guidelines based on standards of care
- creation of improvement teams to identify problems and implement solutions
- training of health providers (in technical and QI methods) to implement the quality improvement system.

Once the results of the baseline assessments are available, the scope of the collaborative improvement process can be defined in discussion with all stakeholders. The health facilities and hospitals that participated in the baseline assessment are best suited to be targeted first, as areas in need of improvement have already been identified. However, since it is a cyclical process it is also possible to select a different group of health facilities for the first round of the improvement process, for example based on a specific geographical location. However, health facilities that were not included in the initial assessment will have to undergo at some stage an assessment of the quality of current care provided to identify areas of weakness, ideally by an external assessment.

Based on the results of the assessment, a gap analysis should be carried out and improvement plans developed. The collaborative approach has been demonstrated to be a powerful tool to bring about change and achievement of standards\textsuperscript{14,15,16} as it not only creates capacity but also motivation, team spirit and competition. Ideally, staff from 10–20 health facilities in a geographic area should be brought together to discuss common problems and identify areas where they can learn from each other. For health centres and clinics, the process might be facilitated by their respective referral hospitals. Private hospitals and health facilities should be included in the process as in many settings a large part of care is provided by the private sector.

The collaborative process will also lead to the identification of necessary actions that are beyond the authority and responsibility of the individual health facility/hospital and need to be communicated to higher levels (especially concerning the health systems issues). Quality improvement and technical capacity will be developed through this process.

As a next step, the developed improvement plans will be implemented at the participating health facilities and agreed upon indicators collected to measure progress. Health facility staff from the
participating hospitals and health facilities are brought together every 4–6 months to share their experiences, and report on achievements made and challenges encountered. In addition, they can learn from each other’s experiences, embark on joint problem-solving activities, as well as receive specific technical and QI training, as required. Going through the improvement cycle – planning (plan), implementing (do), monitoring (check), acting (act) – several times over a period of 2–3 years, defined standards should be achieved.

After the identification of areas that need improvement in order to meet the standards, improvement actions will have to be implemented. Staff at all levels need to be motivated and empowered to take actions to improve performance and quality of care. Motivation has been described to depend largely on sense of purpose, mastery and autonomy. By empowering staff to set up improvement teams, set priorities for improved work and to share their experiences in the context of a collaborative approach and/or at (inter)national conferences, staff motivation may be increased. Annex 1 contains proposed steps for implementing quality improvement activities at the health facility and/or hospital level.

Upon reaching this stage, the collaborative process could be linked up with external accreditation or certification. If this way is taken, it should ideally include accreditation by patients, or at least the results of client satisfaction surveys should be part of the accreditation process and performance indicators.

Figure 10: Implementing a systematic approach
5. Monitoring and reassessment

Continuous monitoring of performance and provision of supportive supervision and (self-) assessments of quality of care to measure progress towards the achievement of standards are key for the functioning of the improvement process. Unfortunately, evidence suggests that monitoring and supervision, while almost always acknowledged as being crucially important, are virtually never backed with the resources – financial or human – required to be effective. The implementation of this framework would empower staff at all levels to use standards, guidelines and tools to self-assess their adherence to nationally accepted standards. If standards are spelled out explicitly and health workers know what is required of them, they can use the tools to assess the adherence to standards for self-assessment and to guide their work and improve performance. Ideally self-assessment should happen on a continuous basis by every health worker, and on an institutional basis at the hospital and health facility at least six monthly for selected areas. External assessment should be carried out at least every 1–2 years to validate findings of self-assessment. Monitoring is only meaningful if it leads to concrete improvement actions. Therefore, findings should always feed back immediately to the people who are powered to bring about change.

Client satisfaction should be included in the monitoring process and client perspectives heard and concerns addressed in improvement activities.

6. Documentation and dissemination

Implementation of changes in care and results of improvement processes should be documented, published and disseminated, and the achievements of the standards celebrated, for example in meetings with relevant staff, first level health facilities or hospitals and the wider public and scientific community, as relevant. Collaborative meetings are an ideal opportunity for implementers to present experiences with the improvement process. Results can be presented verbally or in pictorial form, e.g. posters, graphs, scorecards, newsletters and stories. The information could be published in national medical journals, printed in local or national newspapers or presented on the radio or other forms of media in the country. Country experiences could be submitted to peer-reviewed journals. Collaborative meetings are also a good opportunity to celebrate success and connect to the wider health community.

If a formal accreditation or certification process is put in place, health facilities and hospitals adhering to standards and therefore providing quality of care should be made publicly recognizable, for example through certificates, logos or other recognition processes – hospital of the year.
7. Scaling up

Quality improvement is a dynamic process that can start at many different places at the same or different times. It does not have to be a strictly coordinated top-down venture but can grow from both bottom and top. The main coordination required is the establishment of standards and accompanying guidelines that may need updating as new evidence becomes available. The improvement process has the potential to be responsive to changing epidemiology, demography as well as legal and social factors.

If the country embarks on a national process, assessments, planning and improvement processes may initially be conducted in defined geographical areas. Lessons learnt from the first cycle of improvements can then be reviewed to evaluate overall progress. If progress is perceived to be satisfactory, the process can be scaled up to ensure universal quality care. If progress is perceived to be patchy, a detailed assessment of the poor improvement areas will give insight into obstacles that can be directly addressed and efforts can be redirected towards overcoming these obstacles.

During the scaling-up process links should be established to existing professional regulation, accreditation and prequalification mechanisms, or if these do not yet exist the process can be used to institute them.

Integration into pre-service training

Quality improvement should be part of pre-service training to ensure that all health workers have the knowledge and necessary skills to provide quality care to mothers, newborn, children and adolescents. The concept of quality, standards of care, and evidence-based medicine should be integrated into the pre-service training of future generations of health care providers, in order to allow for sustainability of quality improvement efforts. This requires the incorporation into the curricula of medical schools and nursing and midwifery training schools.

The proposed systematic approach (see Implementation) is based on attributes of scaled up public health programmes identified by the Centre for Global Development and by WHO and on the nine-step scaling up approach recommended by WHO.

Roles at the regional level

At the start of the process

Regional and international agencies will be called upon to provide technical assistance for country activities. These activities include the development of regional tools and guidelines and support to countries throughout the above-described process. Assistance should be provided to review and update existing guidelines to be in line with the latest available evidence and international guidelines and to agree upon minimum standards of care that guarantee appropriate quality of care and avoid harmful practice.

The development of job aids summarizing the updated guidance and standards concisely will be useful: desk guides, pocket books, websites and/or smart phone applications based on international standards can serve as reference tools with the possibility to be incorporated in training tools.
A generic regional assessment tool is being made available to countries as a template for adaptation, both for external assessments by experts as well as for self-assessment within health facilities in the context of the quality improvement approaches. The tool is constructed in a modular way and includes administrative and health systems components that are relevant across all areas of care, and specific clinical modules that need to be assessed by the experts of the specific areas, i.e. reproductive, maternal, newborn, child and adolescent health.

After the process has started

Collaborative review mechanism at regional level

Similar to the platform to share experiences that will be created through this process within countries, regional collaborative review meetings among countries of the South-East Asia Region will be organized on a regular basis. This will bring together implementers to share experiences, discuss and learn from each other.

Monitoring progress

Proposed regional process indicators to track progress in Member States of the South-East Asia Region are:

- The number of countries that have developed a National Quality Framework for RMNCAH
- The number of countries that have developed quality standards and clinical protocols in line with international standards
- The number of countries that have developed tools to assess the quality of care against set standards and clinical protocols
- The number of countries that have trained assessors to assess quality of care against set standards
- The number of countries that have established a reporting mechanism for quality of care and adverse events
- The number of countries that have established an accreditation/certification methodology against set standards.
Conclusion

Improving the health of mothers, newborns, children and adolescents will remain aspirational if quality of care is not put at the centre of debates on universal health coverage and receives the attention it deserves during the post-2015 development agenda.

The Regional Framework for Improving the Quality of Care proposes a quality improvement system that extends across the RMNCAH continuum and all levels of care. It aims to achieve “effective coverage”, defined as high and equitable coverage of quality care. Its implementation stands for a fundamental shift in policy to accept quality of care as essential and to empower health providers to take responsibility for the improvement of their work of saving lives and averting preventable death.
Annex. Implementing quality improvement activities at the health facility and/or hospital level

In a quality improvement organization, each health-care provider and staff member believes that change and improvement are an intrinsic part of everyone’s work every day, in all parts of the system. Shifting to this new focus involves substantial reframing of the idea of the work of health care, as well as the use of a wide variety of tools and methods.\(^2\)

Implementing quality improvement activities at your health facility/hospital*

**Step 1:** Setting up a quality improvement (QI) team  
**Step 2:** Defining the problem  
**Step 3:** Implementing change  
**Step 4:** Measuring results  
**Step 5:** Sharing results and spreading change

* Adapted from Health Quality Ontario, Quality Improvement Guide,\(^2\) and University Research Co., LLC, Quality Improvement Handbook for TB and MDR-TB Programs.\(^2\)

**Step 1: Setting up a QI team**

To improve care effectively, all staff must accept quality improvement as their responsibility and feel they are empowered to actually make a difference. As QI is most effective when internally driven, responsibility for its implementation should be taken on by a group of staff members who will ideally form a QI team (Box).

Two or more people from the health facility/hospital where health services need to be improved can create a QI team. The team members should either share similar tasks or be responsible for complementary tasks that affect the quality of services. These teams could also include counterparts (e.g. supervisors) from the district or be constituted as a combined team from the hospital and health facility in the catchment area. Middle and/or top management will be ideally, but not mandatorily involved in a QI team. The QI team may decide to have a rotational membership system, giving other staff members the opportunity to participate as team members.

Non-QI team staff members can participate in monitoring and analysing results, and promoting change. Once the QI team is assembled, it begins the journey to understand what improvements should be made and how to know that its efforts have created a positive change.
QI team composition

A team is generally composed of two or more staff members representing different functions. Selected members should:

• have interest in improving quality
• have good communication skills, ability to work with and listen to others
• represent different services, such as case management, nursing, pharmacy, outreach.

QI team role

• Initiate action for quality improvement using the (self-) assessment tool and other data sources to identify problems continually and develop corrective action plans
• Facilitate the improvement process: hold and document meetings to review progress and discuss quality issues, and inform, train and involve other staff in the quality improvement process
• Collaborate with other improvement teams through the collaborative approach
• Coordinate with higher levels on the improvement process
• Periodically evaluate progress: monitor and document corrective actions to assess whether they meet expectations
• Communicate with the community
• Publicize quality changes for staff and patients
• Collect and record information on key indicators.

Source: Adapted from University Research CO., LLC, Quality Improvement Handbook for TB and MDR-TB Programs.

How to do it?

• Assemble a team.
• It’s important to make sustainability and expansion a focus and priority from the beginning of any initiative – this is not something that can be successfully addressed after a project is complete.

Step 2: Defining the problem – assessing quality of care

Standards and guidelines form an extremely important part of quality improvement. They define the required quality of care and serve as a basis to identify the inputs and processes needed to ensure quality of care in order to improve health outcomes. These standards can be translated into guidelines and assessment tools.

During this phase, improvement teams will explore the systems and processes in place and determine the underlying problems that contribute to less desirable results.

How to do it?

• Carry out a (self-) assessment to identify the current quality of care provided using an assessment tool based on standards, e.g. adaptation of WHO Integrated Assessment Tool.
  o Tools such as a fishbone analysis and the ‘5 whys’ can be used to explore identified problems further
• The team should review the (self-) assessment results, identify gaps in quality and set overall goals that they would like to achieve within specific timeframes.

• Essential to understanding the current situation is learning what patients/clients actually experience during the health care delivery process and what they would want or need if care processes were changed.

• Start to create a list of improvement opportunities that address the problems identified.

Step 3: Implementing change

Once there is a clear understanding of the opportunities for improvement, teams can begin brainstorming and testing ideas through Plan-Do-Study-Act (PDSA) cycles. This is an exciting phase that provides teams the opportunity to exercise creativity and challenge the status quo by trying different improvement ideas. The PDSA approach allows teams to try ideas on a small scale, which can smooth out any concerns in the process before sharing the success or failure of the tried change more widely. It builds confidence in the change process and creates buy-in by involving individuals that are truly affected by the proposed changes.

Once teams have trialled their improvement ideas through small sets of change and have demonstrated improvement in different scenarios – therefore have a high degree of confidence that the changes are indeed an improvement – they are ready to progress to implement changes formally into everyday practice in the unit or department where the work is done.

How to do it?

• Begin testing. Document the testing so that the team can test multiple ideas simultaneously and clearly see what works well and what processes require some tweaking.

• Formalize and standardize the changes and document the new process. Include information about the required steps in many places, such as: new staff orientation, training sessions for current staff, job descriptions, and policies and procedures.

• Create an ongoing measurement plan. Ensuring that staff members adopt the changes requires a measurement plan to monitor adoption and continual improvement. QI teams need to identify a few key measures that will assist in determining whether new processes are being followed; detect problems; and alert staff if processes are not functioning as intended.

Step 4: Measuring results

Indicators are necessary to monitor progress. Indicators can be selected based on nationally adopted standards. Indicators can be of several types including input, process and output indicators. Improvement teams are encouraged to choose their own performance indicators to measure progress towards the standard they chose to achieve at each point in time. At the beginning these may be largely input indicators – for example if commodities such as antibiotics, blood products, oxygen need to be put in place to enable the delivery of standards. Once these inputs are made available the teams may choose to focus on process indicators – percentage of children with cough and difficult breathing treated correctly (or at the hospital level, 90% of children admitted with pneumonia are treated according to standards (national treatment guidelines)).

Progress towards the achievement of standards will lead to better quality of care and ultimately contribute to improved outcome indicators, e.g. decline in case fatality rate or teenage pregnancies.
It is important to know that outcome indicators often first deteriorate with improving quality as the caseload may increase and more serious cases are taken on. It is therefore essential to collect data to be able to show that the denominator has changed and the situation is improving overall even if indicators suggest otherwise.

How to do it?

• Create a measurement plan.
• Measure whether a change has the desired impact and outcome.

**Figure A1.1**: Inputs, processes and outputs needed to be in place to achieve the standard

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**Step 5: Sharing results and spreading change**

For sustainable change the QI team needs to continue sharing the improvement story and how changes have had a positive impact on the patient/client experience and outcomes. It is important to clarify the “what’s in it for me” in order to help staff understand how they benefit from ongoing improvement.

As appropriate, begin to think about how to spread the change beyond the current unit or department to the entire organization. Create a team of people to help with this next step of planning.

How to do it?

• Share the stories of failure, improvement and success from the PDSA cycles. Document the exciting impact that the changes have on all the individuals involved in the process.
• Create and implement a spread plan. To determine where best to begin to spread improvement, the QI team should turn to those enthusiastic and accepting of change for improvement’s sake. In other words, take the path of least resistance. By concentrating first on units or departments eager for the change, teams can build the momentum necessary to ultimately engage individuals or departments raising the most barriers to change.
• Communicate changes. Include items like the reason for changes and why all patients and staff will be positively affected by the changes. Appeal to the emotional as well as the logical side of the individuals with whom you are communicating.
• Create a measurement plan for spread. The measurement plan should contain key measures for continually assessing the performance and reliability of the improved processes. The measures will allow QI teams to quickly assess whether processes have begun to break down and enable immediate action.

• Remember that quality improvement is a process that requires going through the improvement cycle over and over again, demanding stamina and determination. But it is worth it!
References


The Regional Framework on improving quality of care for reproductive, maternal, newborn, child and adolescent health (RMNCAH) aims to position quality of care at the centre of universal health coverage and in post-2015 development priorities and ensure quality of care receives the attention it deserves. The structured framework and assessment tools developed consensually to establish a quality improvement (QI) process with which the Member States could achieve the global standards of RMNCAH continuum at all levels of care and aims to achieve “effective coverage” in the Region and matches with the advocacy for concerted efforts to accelerate progress towards achievement of MDGs 4 and 5. This framework will be useful for partner agencies, professional associations and other national stakeholders.