QUALITY OF CARE STRATEGIC ROAD MAP

REPRODUCTIVE MATERNAL NEWBORN CHILD AND ADOLSCENT HEALTH

DIRECTORATE OF REPRODUCTIVE AND CHILD HEALTH

MINISTRY OF HEALTH AND SANITATION

2020 – 2024

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List of Acronyms

ANC	Antenatal Care
ARI	Acute Respiratory Infection
BEmONC	Basic Emergency Obstetric and Neonatal Care
BPEHS	Basic Package of Essential Health Services
CHA	Community Health Assistant
CEmONC	Comprehensive Emergency and Obstetric Care
CHC	Community Health Centre
CHP	Community Health Post
CHW	Community Health Worker
CSOs	Civil Society Organizations
COD	Child Death Audit
CPD	Continued Professional Development
DHMT	District Health Management Team
DFID	Department for International Development
DHIS	District Health Information System
EBF	Exclusive Breast Feeding
EmONC	Emergency Obstetric and Newborn Care
ENC	Essential Newborn Care
ETAT	Emergency Triage Assessment and Treatment
GBV	Gender Based Violence
HII	High Impact Interventions
HRH	Human Resources for Health
IPC	Infection Prevention and Control
iCCM	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Newborn and Childhood Illnesses
LMIC	Low- and middle-income countries
MCHA	Maternal and Child Health Aides
MCHP	Maternal Child Health Posts
MDSR	Maternal Death Surveillance and Response
MPDSR	Maternal Perinatal Death Surveillance and Response
MS	Medical Superintendent
MOHS	Ministry of Health and Sanitation
ORT	Oral Rehydration Therapy
PAC	Post Abortion Care
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement
RMNCAH	Reproductive Maternal Newborn and Child
SBA	Skilled Birth Attendance
SOPs	Standard Operating Procedures
SLDHS	Sierra Leone Demographic Health Survey
TWG	Technical Working Group
ToC	Theory of Change

UHS	Universal Health Coverage
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

Forward

The strategic and new direction of the health sector as envisioned by the President His Excellency Julius Maada Bio is to transform the under-resourced, ill-equipped, dysfunctional and inadequate health infrastructure and healthcare delivery and make it high-quality, efficient, reliable, cost-effective, affordable and sustainable. The main thrust of this new direction is to accelerate access to quality health service for all the population particularly mothers, children and the elderly. As a country we are mindful of the challenges confronting the health sector and are well aware that, our success in attaining the Universal Health Coverage (UHC) depends on all people having access to quality, safe, effective and person-centered care. As a country, our health care aspirations is consistently in synch with the realization of the United Nations Sustainable Development Goals (Agenda 2030) and the development and adoption of the National Healthcare Quality and Patient Safety Strategy is one of those responses in ensuring that, no one is left behind.

This policy is inspired by the overall National Health Sector Strategic Plan (NHSSP, 2017-2021), the Health Sector Recovery Plan (HSRP, 2015-2020). It also recognizes and aligns with global, continental and regional policy frameworks such as the WHO National Quality Policy & Strategy (2018), the Quality of Care Network and the WHO Global Patient Safety Action Plan (2021-2030). The National Healthcare Quality and Patient Safety Policy has been developed through a collaborative and consultative approach led by the National QoC Steering Committee Chaired by the Chief Medical Officer Rev. Canon Dr. Thomas T Samba and other key stakeholders that represented various perspectives of the health sector. The process was managed by the National QoC Technical Working Group and the QoC Management Program of the Ministry of Health. Many in-depth interviews, multiple key stakeholder meetings fora to directly solicit inputs from patients, CSOs/NGOs, health experts and providers across the health system. This was done to ensure an appropriate design and effective implementation of the policy in a true spirit of partnership.

This National Healthcare Quality Strategy aims to coordinate health care quality at all levels of the health system, across both the public and private sectors, and all areas of health – with a particular focus on the following priority health areas: Reproductive, Maternal, Newborn, Infant, Child and Adolescent (RMNICA) health.

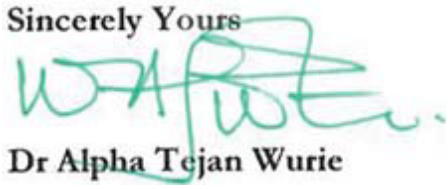
The Ministry will work closely with all its development partners and agencies and CSOs including patient groups through the established National Steering Committee and Technical Working Group to oversee successful and robust implementation of the policy using the prioritized interventions that will drive large-scale improvement in quality of care delivery over the next five years. This will ultimately move Sierra Leone towards our long-term goals of achieving the health outcomes of a lower-middle-income country by 2025 and of a middle-income country by 2035

Indeed, in implementing this National Healthcare Quality strategy, we aim to partner with all stakeholders, including our development partners, NGOs, Academia, CSOs and the patients and providers and the larger Sierra Leonean community in our quest to improve the quality of care. Through the accompanying Coordination and Accountability framework, the Ministry at its highest levels plans to hold wholly accountable all stakeholders critical to the successful implementation of this strategy.

The ultimate aim is to consistently improve the outcomes of clinical care, patient safety, and patient-centeredness, while increasing access and equity for all segments of the Sierra Leonean population, by 2024. This is done by ensuring reliable, excellent clinical care, protecting patients, staff, and attendants from harm, and improving the efficiency of the delivery of care, while increasing access, equity and dignity of care for all segments of the Sierra Leonean population

Finally, the Ministry recognizes that the finalization of this policy signifies a diligent attempt to improve the quality of care by harmonizing and building on previous efforts with a whole system approach under the proactive leadership of the Ministry itself. To this extent, we recognize and celebrate every identifiable organization and indeed everyone, both past and present, whose various and diverse roles have played no small part in bringing us this far. We look forward to improved health outcomes through integrated quality planning, quality assurance, control and continuous quality improvement functions that ensures better and more reliable care in a sustainable fashion.

Sincerely Yours



Dr Alpha Tejan Wurie

Minister of Ministry of Health and Sanitation

Acknowledgment

The National Quality and Patient Safety Policy (2020) was developed through a process of collaboration and partnership with inputs from experts and stakeholders.

The Ministry of Health and Sanitation (MoHS) acknowledges the leadership of the Honorable Minister of Health and Sanitation – Dr. Alpha T Wurie, Deputy Ministers I & II Dr. Anthony Sandi and Dr. Amara Jambai, Chief Medical Officer, Rev Canon Dr. TT Samba, and Director RCH, Dr. Sartie Kenneh under whose guidance this document was developed.

We would like to appreciate the dedication of the National Program Manager, Matron Margaret Titty Mannah and the staff of the National Quality Management Programme, MoHS for their tireless championing of Quality of Care (QoC) and Patient Safety. We acknowledge the valuable inputs, wealth of knowledge and expertise of the World Health Organization (WHO) International Consultant, Dr. Elom Otchi, the National Consultant WHO, Ernest Jabbie and colleagues at the WHO Country Office, Janet Kayita, James Bunn and Binyam Getachew Hailu, WHO AFRO, Nuhu Yaqub, and the Members of the QoC Technical Working Group (TWG) - PIH, CUAMM, IRC, ICAP, WHO, United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF), as well as technical support from the Global Quality, Equity and Dignity (QED) Network.

Funding for the development and implementation of the Quality of Care programme has come from many donors, notably Foreign Commonwealth and Development Office (FCDO) and to the Bill and Melinda Gates Foundation (BMGF). We are grateful for the continued support to the people of Sierra Leone

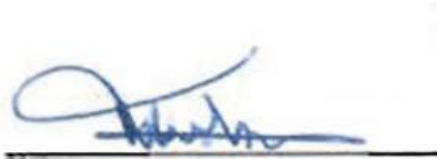
The MoHS is also indebted to the Directorates and Programs of the MoHS, regulatory bodies, private sector, health training institutions, professional associations and societies, Civil Society Organizations, Community members/representative's quality improvement focal persons and team members, and all other partner organizations and individuals who contributed to the development of this Policy through series of consultative meetings and working sessions over the period. The MoHS is pleased with their active participation, interest and support during the process.

Our special thanks and appreciation go to the all the frontline healthcare workers for their tireless efforts in ensuring the provision of quality and safe healthcare services across all the various levels of care in the country. We are most grateful to District Health Management Teams (DHMTs) and Hospitals currently implementing Quality Improvement initiatives in learning districts and facilities.

We are hopeful that this document will be used by all actors in the health sector to ensure harmonization of existing quality initiatives toward one common national aim of institutionalizing quality at all levels of the national health care system.

It is our hope that the efforts outlined throughout this Quality Management and Patient Safety strategic road map for the Ministry of Health and Sanitation will be given the necessary support by all the stakeholders to ensure improved quality of care outcomes for all people living in Sierra Leone.

Sincerely Yours



Rev. Canon Dr. Thomas T Samba, MD, MPH, FWCP

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Definition of terms

Accreditation: A formal process by which a recognized body, usually a nongovernmental organization, assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable and are designed to encourage continuous improvement efforts within accredited organizations. An accreditation decision about a specific health care organization is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years. Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation (Ronney, 1999).

Licensing: This describes a government-endorsed regulatory process to grant permission and specify scope for the healthcare practice of an individual or organization usually preceding accreditation (WHO, 2018)

Licensure: Licensure is a process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession. Licensure regulations are generally established to ensure that an organization or individual meets minimum standards to protect public health and safety. Licensure to individuals is usually granted after some form of examination or proof of education and may be renewed periodically through payment of a fee or proof of continuing education or professional competence. Organizational licensure is granted following an on-site inspection to determine if minimum health and safety standards have been met (Ronney, 1999).

Certification: This provides recognition from state, private or non-governmental bodies- for organizations, people, processes or objects that meet defined conditions developed for the certification process (WHO, 2018)

Quality: The degree to which health services for individuals and population increases the likelihood of desired health outcomes and is consistent with current professional knowledge. Six dimensions of healthcare defines its quality namely: safety, timeliness, effectiveness, efficiency, equity and patient centered care (WHO, 2018).

Quality Assurance: All the planned and systematic activities implemented within the quality system, and demonstrated as needed to provide adequate confidence that an entity will fulfil requirements for quality (Grace, 2009)

Quality Control: Operational techniques and activities that are used to fulfil requirements for quality

Quality Improvement: "An organizational strategy that formally involves the analysis of process and outcomes data and the application of systematic efforts to improve performance" (Grace, 2009)

Quality Management: All activities of the overall management function that determine the quality policy, objectives, and responsibilities, and implement them by means such as quality planning, quality control, and quality improvement within the quality system (Grace, 2009)

Quality Planning: Activities that establish the objectives and requirements for quality and for the application of quality system elements (Grace, 2009)

Regulation: The imposition of external constraints upon the behavior of an individual or an organization to force a change from preferred or spontaneous behavior (Grace, 2009)

Standard: An established, accepted and evidence-based technical specification or basis for comparison (Rooney, 1999).

1. Introduction

1.1 Background

Creating the right environment for improving quality of health care has become an important motivation for many countries of which Sierra Leone is no exception. Countries are not oblivious of the role healthcare quality initiatives play in building strong and resilient health systems. Quality of care is however an emerging phenomenon particularly in LMIC such as Sierra Leone. There is the need for high quality health systems that can be optimized to deliver care that guarantees an improvement or at least maintenance of health for patients including mothers, newborns and children, by being valued and trusted by all the inhabitants and can respond to the changing needs of the population (WHO, 2018).

One of the key functions of a health system is to ensure availability of health services that meet minimum quality standards. Good quality of care must be considered as the basic right of every patient particularly women and children. Quality care at the time of labor and childbirth can have the highest impact on reducing preventable maternal and neonatal deaths and stillbirths, as most of these deaths are concentrated in this period (NHSSP, 2015).

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. It focuses on people and is conscious of the fact that, people have the right to healthcare and to make healthcare decisions. (Institute of Medicine Committee for Quality Health Care, 2000).

Eight dimensions of healthcare defines quality. People centeredness is crucial because of information and power asymmetry *(or imbalance)* in healthcare between the providers and the patients. People therefore become agents of accountability who can hold health system actors to account. People centeredness also mean treating providers well and ensuring supportive work environment *(such as efficient and supportive management, appropriate role definition and clarity, and safe working conditions).* Demotivated providers cannot contribute towards the provision of quality healthcare. The health needs, knowledge and preferences of the people should shape the quality of care that is provided (Lancet, 2018).

There had been the release of three (3) important global reports in 2018 which have all simultaneously revealed the wide variation and defects with respect to the provision of quality and safe care to the hospital-going population. All these authors covered various aspects of quality of health systems and service delivery in the context of the sustainable development goals and universal health coverage. The evidence from the various reports have revealed widespread quality problems such as **underuse**, **overuse** and **misuse** of health services. The authors of these global reports make a clarion call for quality to be a core consideration at all levels of health system and service delivery (WHO, 2018).

A WHO report has revealed that, more than 6 million caesarean sections are performed annually with 50% of these occurring in China and Brazil alone. Similarly, hospitalizations in low-and middle-income countries such as Sierra Leone leads to 134 million adverse events annually and these adverse events contributes to more than 2.5 million deaths annually. It is further estimated

that, deaths from poor quality of care for selected sets of conditions accounts for between 5.7 million and 8.4 million annually representing 10-15% of the total deaths in LMICs (WHO, 2018).

In as much as modest progress have been made in improving quality of care outcomes for mothers, newborns and children globally, far too many of them *(i.e. women, children and newborn)* continue to die from preventable deaths. It is estimated that, about 303,000 women died due to maternal causes globally. Most of these deaths *(with about 99%)* occurred in LMICs and about 64% of these deaths occur in the WHO African Region (WHO, 2018).

The health system of the country can be described as very fragile and is still in the process of recovery after the 2014 Ebola virus outbreak. Substantial progress had been made towards the attainment of the MDG targets for health and nutrition prior to the onset of the Ebola outbreak in 2014 (DHS, 2013).

Sierra Leone has one of the highest rates of maternal and infant mortalities in the world with 1,360 per 100,000 live births of pregnant and expectant mothers dying. Women in Sierra Leone have a 1 in 17 lifetime risk of dying due to pregnancy or childbirth making it one of the countries in the world with the highest maternal lifetime risk in the world (WHO, 2015). According to DHS 2013 report, MMR was estimated to be 1165 per 100,000 live births. Maternal deaths account for 36% of all deaths among women ages 15-49 (DHS, 2013).

According to the national MDSR report for 2018, more than two-thirds (80.3%) of these deaths occur in health facilities and are preventable through effective public health measures. Maternal deaths in the communities and in-transit cumulatively account for less than 12% of the total maternal deaths in the country. Obstetric hemorrhage (46%), hypertension (22%), obstructed labor (21%) and sepsis (11%) remain the leading causes of mortality in Sierra Leone. Findings from maternal death investigations have clearly shown that maternal deaths in Sierra Leone are preventable. (MDSR, 2018).

The investigations done in the past few years have shown that most of the maternal deaths could have been prevented with quality antenatal care, a community preference for facility deliveries, skilled intrapartum and postpartum care, prompt referrals for emergencies and access to ambulance transport, or access to essential surgery and safe blood transfusion services. This is attributable to access to quality health care, which remains one of the major public health concerns attributed to inadequate human resources for health, limited health expenditure, and problems associated with the breakdown of the drug and medical supply chain (MDSR, 2018).

The WHO recommends a critical threshold of 23 skilled healthcare providers *(doctors, nurses, and midwives)* per 10,000 populations, however, the country suffers from extreme shortages of trained healthcare providers, having only 2 clinical health worker per 10,000 people. The healthcare system in the country is seriously underequipped, underfunded and understaffed. Almost 64% of skilled health worker posts are currently vacant. About half of the total nurse workforce in the country are 'volunteers' and not on any payroll. There was serious shortage of the necessary skilled and higher cadre manpower to provide the needed care. (MOHS, 2015).
The HRH gaps are severe for the midlevel midwifery and nursing cadres who provide the bulk of care for mothers and children, as well as for physicians and specialists. Where the personnel are available, they are mal-and inequitably distributed. For instance, the Western Area, especially

Freetown alone has more than 40% of the total midwives in the country and approximately 42% of the total health workforce employed by the MOHS while 10% are in Bo (the second largest city in the country) and the remaining 47% are spread throughout the rest of the country (MOHS, 2017).

A robust human resource information management system for the country does not also exist and this makes accurate demand and supply forecasting of human resource difficult. There is enormous training and capacity building sessions for various categories of healthcare providers in the country but there is little evidence of the impact of these training programs on outcomes of care (MOHS, 2017).

The Free Health Care Initiative (FHCI) was introduced in 2010 as part of efforts to increase access to maternal and child healthcare for under-fives, pregnant and lactating mothers. This was one of the means of improving access to these groups as one of the approaches to averting the high maternal and neonatal mortality deaths in health facilities across the country. Despite all these efforts at improving access and availability to healthcare services for this vulnerable group (i.e. pregnant women, lactating mothers and children under-five), major gaps still exist in the provision of quality and safe care (MOHS, 2017).

The supply and provision of resources such as equipment, medicines, logistics and supplies are not enough to guarantee the provision of quality and safe care to our clients. What is important in addition are new attitudes, skills and behaviors, including a change in mindset, supervision and feedback mechanisms, and the ability and willingness to learn from data. Until quality improvement becomes as central as universal health coverage with respect to service delivery, the attainment of the health targets in the WHO's SDGs might be elusive to several countries including Sierra Leone (WHO, 2015).

1.2 Organization of Healthcare in Sierra Leone

The Ministry of Health & Sanitation (MOHS) is the major healthcare provider in the country, fully operating all government healthcare facilities. The delivery of existing hospital services is provided by a network of establishments i.e. Government, Ministry of Defense and Education, Mission, Industrial (often a mines facility) NGOs and private healthcare. The provision of care by Government is done through a decentralized system of lower level Peripheral Health Units (PHUs) in the communities, which include the Community Health Centers (CHCs) at the chiefdom headquarter towns with an estimated target population of 10,000 to 20,000, and Community Health Posts (CHP) and Maternal and Child Health Posts (MCHP) in villages serving estimated populations between 5,000 and 10,000 and less than 5,000 respectively. These PHUs feed into district, regional and tertiary referral hospitals in the country. This is overseen by the DHMT headed by a DMO who is responsible for managing public health activities in the district. The country has a fledgling private sector across the various regions of the country (MOHS, 2015).

1.3 State of Quality in the Health Sector

This section analyzes the current state of healthcare quality in Sierra Leone through stakeholder interviews, observation and a review of the available literature. The analysis is organized guided by the health systems building blocks and explores how they have impacted on care outcomes

particularly with respect to safety, timeliness, effectiveness, efficiency, equity, patient centeredness, integrated and integrity.

Leadership and governance play a vital role in facilitating the provision of safe, timely, effective, efficient, equitable and patient centered health services. Effective leadership plays a critical role in helping to maintain public trust and respect in service delivery and the role of health professionals. Governance ensures the establishment of the necessary regulatory mechanisms' national authorities and other relevant bodies in defining the national standards of care, the scope of practice and professional rules and regulatory framework that operates as a mechanism to ensure integrity and accountability of the government (i.e. MOHS) to the public and providers. Governance also provides the necessary security in ensuring the provision of uninterrupted health services even in times of conflicts and natural disasters (WHO, 2018).

The country has developed a 5-year National Health Sector Strategic Plan whose vision is to have a health system that is of high-quality, accessible, affordable and equitable for all Sierra Leoneans by 2021. There have been tremendous efforts and initiatives in the development of health sector policies and strategies to facilitate improvement in the quality of care provided at health facilities, particularly to pregnant women, lactating mothers and children (MOHS, 2017).

There are numerous well-written policies and strategy documents developed by the MOHS to promote quality of care. However, there is inadequate deliberate system of prioritizing processes and assessing their extent of implementation of these policy documents. There is also inadequate and less effective dissemination mechanism to ensure that all stakeholders (both public and private sectors) are aware of the policy changes and strategic direction of the MOHS. This has led to the fragmentation of the system and little integration of efforts by the various stakeholders. These documents end up becoming 'well-written documents' whose implementation is left to the discretion and initiative of the leader.

There is visible will, commitment and support demonstrated for MNCAH initiatives in the country. The governance structure for quality is evolving. A quality management program evolved from quality of care secretariat has been established with an identified focal person in the MOHS. A Technical Working Group (TWG) and National Quality Steering Committee have been constituted and QI focal persons/coaches, teams or committees across the health system are established to implement quality improvement at all levels of health care. There is also a lack of clarity in most facilities where IPC Focal Persons are referred to QI Persons but perform strictly IPC functions.

There is no national policies and legislation nor a national healthcare quality roadmap that commits the MOHS to identify responsibilities and ensure accountabilities of public and private facilities and professional bodies. There are no systems or mechanisms in place to ensure that quality is maintained, sustained and even scaled up across the continuum of care. Partners/Donors in the quality of care space are not able to provide long-term program that guarantees sustainability and continuity in their absence. Quality improvement initiatives are donor/partner driven and fragmented.

Protocols and guidelines for the management of basic obstetric, newborn and child health conditions are available in most health facilities, however, there is no robust system in place to ensure stringent adherence resulting in wide variations in the provision of quality healthcare even within the same facility. Most of these protocols/guidelines do not also come with clear strategies for their implementation at the various levels of the health system resulting in weak accountability. Failure to do the needful does not attract any major sanctions *(if any at all)* and compliance does not also attract any rewards. Protocol adherence and ensuring its compliance have been very suboptimal.

1.3.1 Regulation

Health regulation is a quality assurance/control function exercised through regulatory bodies on behalf of the MOHS that are mandated and expected to license and register providers in their respective professions and prescribe general standards of practice to ensure that, providers are up-to-date through a system of renewal of licensees based on continuing professional development (CPD).

There are no regulatory boards/bodies for health professionals outside nursing/midwifery, pharmacy, medical and dental practitioners such as laboratory scientists, community health officers, radiographers and other allied health professionals. The existing regulatory bodies are however seriously challenged in the areas of human resources, logistics and infrastructure. The existing regulatory weakness compromises the quality assurance/control role of the MOHS. The MOHS does not have any agency or institution that is performing this role i.e. having a general oversight for quality (such as development of standards, protocols and guidelines) within the entire health system on its behalf. Ideally, the regulatory body should be independent and active in overseeing the health workforce that is providing MNH care. For each cadre that is providing MNH care, there is the need to define a scope of practice and standards for education, training, registration, licensing and relicensing.

Mandatory public reporting systems for medicines/drugs adverse events are very weak and almost non-existent in most health facilities. There are no functional DTCs in most of the health facilities, including the regional hospitals. The Pharmaceutical Society of Sierra Leone has equally not been able to undertake confidential enquiries for adverse events and outcomes, and these are not systematic, and the public is not aware of these reporting systems. Transfusion reaction reporting systems *(e.g. forms, reporting mechanisms, investigations, feedback etc.)* at the facilities were not available.

There are also evident weaknesses in the licensing regime for healthcare providers. For instance, nurses/midwives are licensed once every three (3) years while doctors and pharmacists are licensed annually. However, this regime *(i.e. licensing)* is very weak and laxed with many professionals particularly nurses/midwives practicing for more than four (4) years without renewal of their professional licenses or any evidence of continuous professional development. Furthermore, the licensing regime is only by the payments of the appropriate fees by the providers *(doctors/dentists, pharmacists and nurses/midwives)* with little or no emphasis on the completion of continuous professional development programs.

For the pharmacists, the Pharmacy Board is responsible for both the regulation of practice and products in the country. The pharmaceutical society *(which is an association of pharmacists)* of Sierra Leone also regulates an aspect of practice. There is no Council that has the sole purpose of regulating the practice of pharmacists in Sierra Leone.

There is weak licensing regime for public and private healthcare facilities in the country. Private facilities (e.g. hospitals, clinics and diagnostic centers) are inspected by the Accreditation Committee of the Medical & Dental Council before they are operational while the PSSL performs this function on behalf of the Pharmacy Board for privately owned pharmacies. There is no independent organization or agency of the MOHS that does this on its behalf. There is no accreditation program or external quality assurance systems for clinical laboratories and health facilities in the country.

There are no available and publicized minimum quality and safety standards/indicators for accrediting or licensing of healthcare facilities neither are there independent institutions *(public or private)* tasked with the mandate of licensing or credentialing health facilities/organizations in the country.

The nursing & midwifery board also has the mandate of accrediting nursing and midwifery institutions in the country to ensure they have the requisite infrastructure, equipment, personnel and other appropriate resources to ensure quality education and training of nurses and midwives. However, there are private nursing and midwifery training institutions that are not accredited by the board (nursing and midwifery) or any educational body but continue to churn out products especially the lower cadre of staff i.e. State Enrolled Community Health Nurses (SECHN) & Maternal Child Health Aids (MCHAIDs).

There is no identifiable agency or body responsible for the regulation of traditional medicine practice and practitioners in the country. Most of these practitioners are also not registered. There is also an absence of a minimum requirements to ensure their practice and regulation. Laws exist against drug peddling but the penalty for drug peddlers is also not deterrent enough and this has resulted in the influx of drug peddling in the country including the capital i.e. Freetown!

1.3.2 Medical Equipment and Supplies

There have been numerous initiatives to improve the quality of service delivery in Sierra Leone. However, optimizing the quality of care remains a persistent challenge across all the levels of care. While 90% of health facilities provide MCH services, the quality of these services remains sub-optimal. In recent health facility assessment, only 1% of health facilities had basic amenities (such as sanitation facilities, power supply, improved water supply, consultation room and internet connection) including standard measures for ensuring patient safety (WHO, 2012).

Just 35% of facilities had basic equipment (such as thermometers, stethoscopes, BP apparatus, adult and child scales and light source) required for service delivery. Even though several hospitals and CHCs have been upgraded to EmONC and BeMONC status, most of them do not yet meet the standards across the seven domains –with a lack of necessary equipment, staffing, drug

supplies, laboratory services, referral system, electricity, water and sanitation noted as frequent obstacles (SARA, 2017).

There are challenges with medicines availability, accessibility and affordability in the country. This has resulted in frequent stock-outs in the health facilities. The Free Health Care Initiative is also bedeviled with similar challenges. Often, life-saving medicines are not readily available in the facilities and relatives of patient are often required to go and buy before administration. There are also poor storage facilities for medicines, vaccines and other health commodities especially at the PHUs. There were observed instances where oxytocin and ergometrine were not stored in refrigerators as required.

Medicines imported by NGOs for humanitarian purposes do not go through the rigor of product importation mechanism and lack capacity for appropriate testing. They only receive attestation from the MOHS. The safety, efficacy and therapeutic effectiveness of such medicines cannot be guaranteed by the pharmacy board.

There is also a lack of appropriate and effective scheduled equipment maintenance system in the facilities. Erratic electricity supply is very common in the facilities. Most facilities do not have backup systems when the national grid goes off. For facilities with backup generators, lack of cash to buy fuel were a challenge. Most of the facilities also lacked the requisite infrastructure and critical equipment *(such as blood pressure machines, delivery beds and neonatal equipment)* to provide quality healthcare services to the clients. Lack of piped water supply to service delivery points such as labor wards, theatres and lying-in wards was also a major issue.

1.3.3 Clinical Audits, Near Miss Review and Mortality Audit

A clinical audit system exists for maternal and child mortalities in some of the major hospitals. There is an effort to introduce perinatal audits as well in selected facilities. These audits are however not guided by any objective protocols/guidelines and the recommendations are also not followed through to avert similar occurrences. Where they occur, these audits are also irregular. A maternal death surveillance reporting system is available in every district with focal persons in every facility. However, this is fraught with irregular and infrequent reporting of deaths when they occur, especially in the communities. There is also very low reporting of maternal deaths and where they are reported, audits are very shallow and not conducted in ways to identify the main underlying causes and institute mitigating measures to avert similar occurrences in the future.

1.3.4 Referral Services

There is a national ambulance service christened as 'NEMS *(National Emergency Medical Service)*' that is facilitating referrals and emergency medical service across the health system. The initiative was launched by the President. Ambulances have been pre-positioned at the various Chiefdoms and Teaching/Regional Hospitals. Referral coordinators have also been appointed and working in all these hospitals to ensure appropriate and smooth transfers of patients from one level of care to the other.

1.3.5 Infection Prevention and Control

There are varied models introduced and implemented by various partners across the health system. There are visible IPC structures with designated Focal Persons across all the health facilities visited. There were however challenges with the availability of the requisite resources for improving IPC practices in the facilities such as inappropriate waste bins and bin liners, broken incinerators, shallow and unprotected burning pits, inappropriate placentae pits among others (MOHS, 2018). Air drying was the method of hand-drying after washing. Hand-washing sites were distant from the clinical areas and this might impact compliance of healthcare workers. Alcohol hand-rub was not available in all patient-care areas in the facilities visited. In addition to this, IPC committees in facilities became inactive after partners folded up in the district. No regular meetings have taken place in most of these facilities afterwards.

1.3.6 Patient Safety

The use of the WHO surgical safety checklist was not in use in any of the facilities visited. Red markings in the theaters *(that ensured restricted access)* was not adhered to. Members of staff and visitors could walk in and out with their shoes, aprons etc. instead of changing. There was the lack of safe blood services in most of the health facilities. None of the facilities visited were doing appropriate cross-matching before transfusing. The facilities had no antihuman-globulin or water baths to ensure effective cross-matching and guarantee the safety of the blood. The blood was also not labelled as *"uncross-matched"* to enable the nurses and doctors at the frontline to put in extra precaution when transfusing blood. There is also no system in place for reporting and investigating adverse events related to blood transfusion.

1.3.7 Experience of Care

Major challenges persist in the quality of care (or quality of service delivery) despite the numerous efforts in improving access, availability and affordability to health services. Women have often complained of very horrifying experiences with inattention, carelessness and rude attitudes of healthcare providers including verbal and physical abuse like slapping (Theuring, S., 2018). Some women have further complained about negative experiences such as communication problems, being neglected and discrimination during the provision of service by healthcare providers. Some available evidence suggest that poor women were more susceptible to discrimination, inequity and unsupportive provider attitudes than women from higher socio-economic class (Treacy L., 2018).

The level of professionalism among the health providers continues to wane with blatant breaches in confidentiality and privacy; impatience, disrespect, insulting and dehumanizing attitudes towards clients; inadequate effective communication and transparency between clients and their family members. Family members are virtually used for errands in health facilities other than appropriately involving them in the care of their relations. Attitudinal and cultural change among healthcare workers is a necessary ingredient to facility the delivery of quality, equitable, dignifying and patient-centered care across all health facilities.

Invariably, providers have also accused health system managers of unbearable working conditions and increasing workload that has resulted in a climate of demotivation, frustration, harshness and their resultant negative attitude. In any case, the provision of quality and safe care

requires respectful, attentive and emotionally intelligent staff attitudes and competences. It is imperative for health service managers to recognize the importance of this subject and ensure that unfavorable working conditions are addressed for all providers as well as increase their social, communicative skills in stressful situations and their emotional intelligence competencies.

1.3.8 Community Involvement

Patients and communities play an integral role in helping service providers to identify gaps in service delivery and care through exit interviews, client's complaints systems and community engagements such as durbars and surveys. This serves as a rich source of data for the health facilities about how they can improve quality of care from the perspective of the client which would go a long way to improve to enhance public trust and confidence in the health system. Engagement of service providers at the facilities and communities they serve provides them an opportunity to understand the expectations, needs and preferences of service users and to build trust, involve and empower them in the process of health service delivery. However, there is very weak community involvement in the healthcare system and programs in the country. Community members are often passive consumers of healthcare services.

1.3.9 Partnership for Health

There is a heavy presence of partners and donors across the health system in the country. The MOHS collaborates and works with its partners to ensure improvement in access and quality of care to the people of Sierra Leone. Several facilities have been built, old ones have been refurbished, equipment and logistics have been provided, capacity of staff have been built and public health interventions have been promoted. However, partners' role in the quality of care space with respect to quality initiatives is not properly coordinated. Partners' adopt varied documentation and reporting approaches and requirements which results in duplication of efforts and difficulty in harmonizing whenever necessary. Most often, the private sector is not involved in these quality initiatives. Partners also seem to own all the interventions, including data that are being implemented in the facilities other than the facilities/MOHS.

1.3.10 Quality Improvement Methods

There have been several quality improvement efforts and initiatives at all levels of the health system. Most of these quality initiatives and efforts adopted various strategies, methods and teaching models. Some of the key quality improvement themes were Emergency Triage Assessment Treatment (ETAT), Obstetric mentorship program, Prioritization of critical gaps for interventions, mentoring follow-up visits, Capacity building including onsite activities, Infection prevention and control, supportive supervision, MDSR etc There is no unified quality improvement model that is agreed on and used in the country.

Health information in Sierra Leone is uploaded into the DHIS at the district level. Data is collated at the district/region level by the M&E officers who enter the data electronically into the DHIS. There is an agreed minimum patient data that should be collected in a standardized manner by health facilities, but this is not regularly done due to lack of data collection tools and lack of motivation to collect data as a responsibility. In addition, performance indicators are not strictly monitored for compliance and quality improvement at all levels. There is also the absence of a standardized harmonized tool for measuring the performance of indicators.

Accurate, complete and timely data is unavailable for clinical and health facility performance to be objectively measured. Medical records systems are largely paper-based and seriously challenged in documenting, tracking and generating indicators and indices real time for clinical and administrative review. Some facilities resort to the use of exercise books for the documentation of clinical notes. Where accurate, complete and timely data exists, health facilities do not make this available to the staff to facilitate evidence-informed decision making (Options, 2015).

LMIS is challenged with inadequate and in some instances a complete lack of tools like inventory cards, bill cards, etc. There is also a lack of data collection tools for appropriate data collection and reporting. This has led to quantification methods that are based on assumptions rather than evidence. There are also inadequate skills among frontline healthcare workers to appropriately quantify, forecast and manage health commodities in their facilities, resulting in stock outs and large-scale expiration of drugs.

1.4 Rationale

The country's health sector continues to evolve especially after the Ebola outbreak. The sector continues to attract and witness massive efforts at increasing geographical and financial access. For instance, more than 90% of health facilities in the country provide maternal and child health services. About 60% of all births in the country are attended to by skilled healthcare providers i.e. midwives (44%), MCH Aids (14%), and doctors (2%). Similarly, more than half (54%) of all deliveries occurred in a health facility. Furthermore, almost all women (97%) make at least one ANC visit while two-thirds (76%) make at least four (4) visits (WHO,2016). However, optimizing and ensuring the provision of quality of care remains a persistent challenge.

The situation on the ground confirms evidence from elsewhere that increasing the access to and utilization of facility-based maternal care alone does not necessarily translate into better maternal outcomes (Souza, 2013). WCO's work supporting MDSR reviews, emergency triage and assessment, (ETAT) for sick children visiting hospitals, other programme reviews as well as field monitoring visits indicate that despite these investments, mothers and newborns are still dying from avoidable causes, and the documentation of care, as well as the quality of it, leaves a lot to be desired.

Sierra Leone has aligned to the global vision of a ''world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies'' (MOHS, 2017).

Sierra Leone's five year Reproductive, Maternal, New-born, Child and Adolescent Health strategy 2017 to 2021 aims to accelerate reduction of preventable deaths of women, children and adolescents and ensure their health and wellbeing through increasing access to and utilization of quality evidence based RMNCAH high impact interventions at all levels of service delivery. One of four strategic objectives of the RMNCAH strategy is dedicated to improving the quality of care at all levels of service delivery (MOHS, 2017).

In 2017 Sierra Leone was admitted as the newest country among peers, participating in the Global Network for Improving Quality of Care for mothers', newborns and children. The network aims to deliver a vision of quality that is underpinned by the core values of quality, equity, dignity, and targets to halves institutional maternal and newborn deaths in 5 years. Whereas quality of care is a concern across all programmes, Sierra Leone embraced pragmatic approach to focus on MNCH QoC as pathfinder. The 10 participating countries are expected to lead the way in institutionalizing Quality of Care through a systems approach, implement global tools and MNCH standards in close collaboration with development and implementing partners, and demonstrate change in health outcomes.

This roadmap development is guided by the detailed situational analysis using the WHO MNH QOC analysis framework, strengths and weakness along the four strategic objectives of the framework: **Leadership, Action, Learning,** and **Accountability.** This road map has been designed to assist in providing the necessary direction and plan of MOHS in the QED agenda to all the key actors in quality of care space across all the levels of the healthcare system for improving the quality of care in Sierra Leone.

The roadmap emphasizes a continuum and synergistic approach to ensuring that health services meet and exceeds the expectations, preferences and needs of the patients and are provided in a ***safe, timely, efficient, effective, equitable and people-centered*** (respectful, dignifying and compassionate) manner. The roadmap will facilitate alignment of all partners and stakeholders in the quality of care space.

2. Prioritized Health System Issues Affecting Quality

2.1 Leadership & Governance

- Absence of effective and well-resourced regulatory bodies particularly for health facilities (both public and private).
- Absence of strong and functional quality management structures to effectively harmonize, coordinate and drive quality of care efforts across all the levels of healthcare
- Absence of external evaluation *(e.g. accreditation consisting of both internal and external assessment systems to review performance against standards)*, licensing and certification systems
- Suboptimal adherence to the available protocols/guidelines and standards in the provision of healthcare leading to numerous variations even in the same facility. Available protocols do not also provide clear strategies for their implementation at the various levels of the health system resulting in weak accountability
- Poor coordination and engagement of partners in the quality of care space
- Absence of *(and instance where it exists, weak)* clinical governance systems that incorporates clinical audit, clinical risk management, patient involvement, professional education and development, clinical effectiveness research and development, use of information systems, and institutional clinical governance committees

2.2 Health Workforce

- There are no regulatory bodies for health professionals outside nursing/midwifery, pharmacists and doctors/dentists. Existing regulatory bodies are very weak and poorly resourced.
- Lack of appropriately designed continuous professional development programs particularly in healthcare quality
- Weak capacity of frontline healthcare providers at all levels to collect, analyze and use data to improve quality of care
- Inadequate numbers of competent, skillful and emotionally intelligent health workers
- Increased numbers and use of 'volunteers' for service delivery

2.3 Medicines & Technology

- Absence of an independent organization for medical equipment and technology regulation and accreditation/licensing/ credentialing
- Unsafe blood and blood products
- Frequent stock outs of essential medicines

2.4 Health Information/Research

- Inadequate standardized and systematic data collection, synthesis, reporting and review (particularly process data) systems and irregular assessment of data quality and feedback to the districts/facilities
- Weak mechanisms for public reporting and accountability on quality of care
- Absence of a quality of care learning network among health facilities and data standards
- Inadequate conduct of operational research that identifies opportunities for improvement and interventions for health systems gaps
- Poor archival and medical records systems

2.5 Health Finance

- Absence of budget to finance quality of care and quality improvement activities
- Lack of robust system for protecting communities from financial hardship
- Limited allocation of government resources for health expenditure

2.6 Service

- Health service delivery is fraught with needless delays, needless harm, waste of resources, not evidence informed, corruption, lack of respect, dignity and compassion to service users
- Physical and verbal abuse of service users

2.7 Community Engagement

- Less knowledgeable and empowered community that can demand quality of care from the health system

2.8 Partnership

- Inadequate collaboration and coordination of partners in the QoC space
- Donors/Partners in the QoC space are not able to provide long-term programs that guarantees sustainability and continuity

2.9 Landscape analysis for QOC

The leadership management and coordination architecture for quality of care in Sierra Leone is still evolving, but some practical decisions have been made, to enable implementation. The Director RCH Directorate has been appointed as interim focal point for MNCH quality of care initiative, with the intention to evolve over time to a dedicated Directorate. A Quality Management Program that evolved from a quality of care secretariat in the Directorate has been established to serve as a pathfinder for the work on QoC.

To oversee the leadership and management of QOC and strengthen the governance structure at all level, ***a national steering committee*** has been formed and convene a meeting monthly to discuss progress and challenges on the QOC journey. The steering committee provide overall leadership, management and oversight to the quality of care program design and implementation beside promoting the quality of care agenda to be mainstreamed in the national health sector development plan and health system strengthening endeavor.

A quality of care ***technical working group*** was also formed and provided sound advice and technical directions for institutionalization of quality improvement and quality assurance in the context of QED network and RMNCAH Strategic priorities. A **district and facility quality of care committee** were established in learning facilities; however, many districts and facilities are still lagging in the formation of this structure that helps to translate and implement national QOC priorities as well as creating a common understanding in quality improvement concepts, approaches in the district and facilities. District and Hospital MDSR committee also exist in all districts and public hospitals that regularly notify deaths and review to determine cause of death and proffer solutions.

Sierra Leone has aligned to the global vision of a ‘’world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies’’. Sierra Leone’s five year Reproductive, Maternal, New-born, Child and Adolescent Health strategy 2017 to 2021 aims to accelerate reduction of preventable deaths of women, children and adolescents and ensure their health and wellbeing through increasing access to and utilization of quality evidence based RMNCAH high impact interventions at all levels of service delivery. One of four strategic objectives of the RMNCAH strategy is dedicated to improving the quality of care at all levels of service delivery. However, to spearhead implementation, an ad hoc operational plan that paved the way for the development of this roadmap was developed, supported and implemented.

National level stakeholder mapping and analysis of partner operating in various districts and facilities had been done; however, the mapping exercise was not regular requiring investment as it provides opportunities for coordinating QOC work, avoiding duplication of effort and streamlining One Plan, One Budget and One M and E framework. As national and district endeavor for development of health sector plan, emphasis need to be made to create a dedicated budget line for QOC to improve financing and accountability.

Sierra Leone developed and instituted quality improvement tools particularly for MDSR with tremendous experience on the area of reporting, reviewing and documenting maternal deaths. With support from partners, MOHS has instituted the conduct of child mortality audit including incorporation of perinatal death review in the existing MDSR system. Tools and guidelines have been developed to accelerate implementation. Relevant treatment protocols like ANC, EmONC guideline, IMNCI chart etc. were reviewed, updated and disseminated.

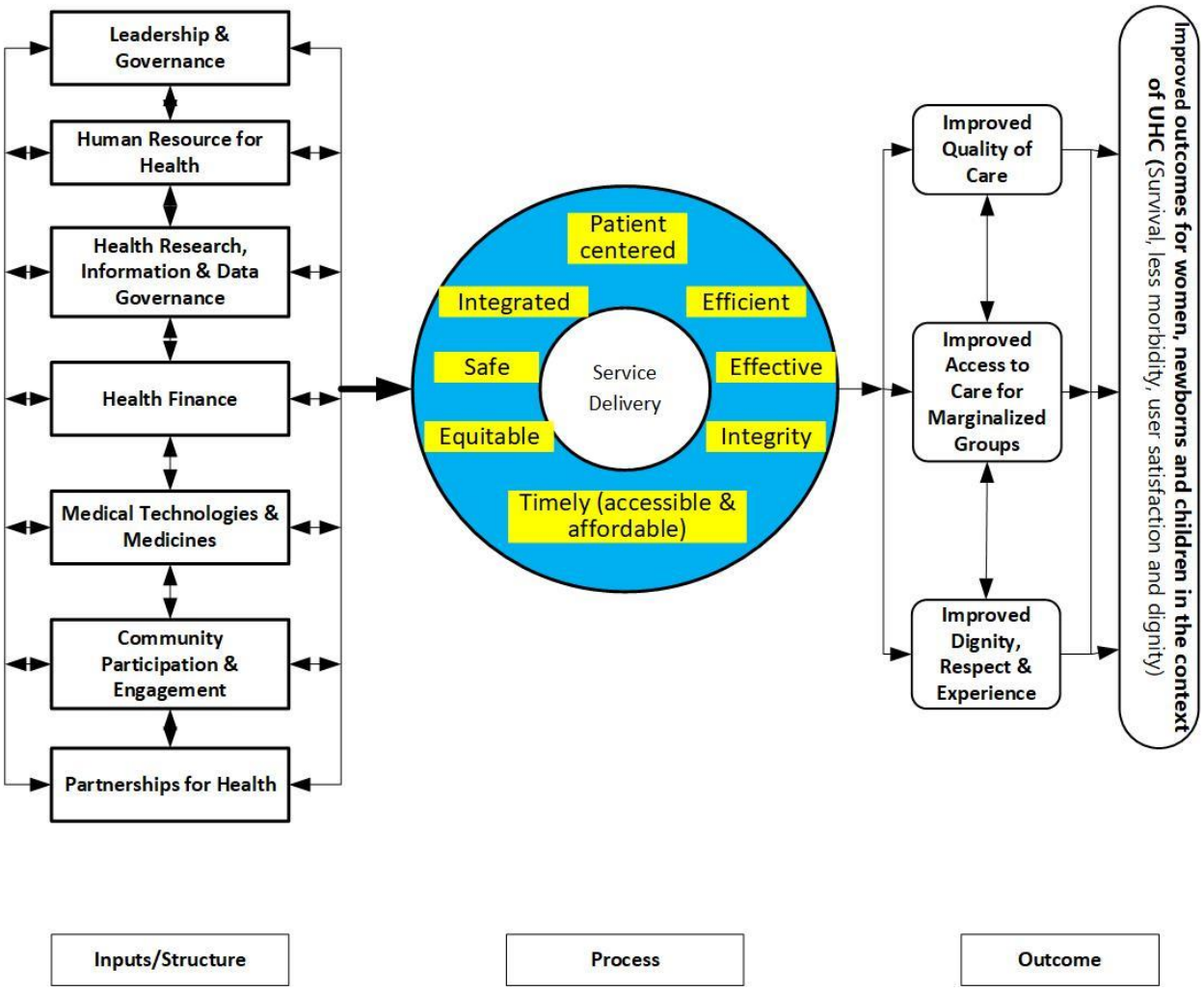
MOHS reviewed WHO MNH and Pediatric Standard for possible adaptation by bringing together RMNCAH partners, however, consensus has been reached in developing implementation package for priority intervention areas due to complexity and existing challenges of meeting the numerous standards. Implementation package for MNH development is already ongoing. The selection of learning sites and districts had already been completed having a total of 36 learning facilities and five districts. However, because of the limited technical and financial resources in the country, MOHS are planning to reduce the current number to a more realistic and manageable number.

The MoHS relies on partners to collate information, conduct analyses, monitor, document & report as well as provide oversight for ongoing work. Whereas this is happening for discrete initiatives, there is urgent work to be done in bringing all the quality improvement related activities under one roof and support capacity building through training, coaching and mentorship for improved ownership and sustaining of actions. Formation of learning collaborative is in its infant stage despite existence of opportunities where facility in charges come together for a-day long meeting at the district chaired by the DMO. Mechanism need to be established to use this platform as an opportunity for learning as well as supporting districts to organize a periodic robust learning meeting. Though some researches focusing quality and health system are currently underway, it is essential to systematically collect evidence on prioritized change packages to test and use for scale-up, adapting or abandoning.

National and district level supervision exists however fragmentation and vertical approach is one of the serious challenges affecting the health system. Effort need to put in place where an integrated RMNCAH supervision that incorporate QOC including data quality audit become a culture at national and district level. A national data quality audit exercise has already been started and discussion is ongoing to include some KPI/national common core indicator to be tracer indicator in this front.

MOHS had also managed to review and adapt WHO standard assessment tool and piloted in few hospitals and PHU's. Though assessment was done during the initial inception in few selected facilities, a comprehensive assessment of all learning facilities had not yet been done.

3. Theory of Change



Adapted from AfIHQSA, 2018

This theory of change is underpinned by the assumption that:
All the health systems building blocks will work synergistically to facilitate the provision and delivery of a health service that is equitable, efficient, effective, patient centered *(dignity and respect)*, timely *(accessible and affordable)*, safe, integrated and integrity *(devoid of corruption/collusion)*. These will invariably lead to the delivery of the desired quality outcomes of improved dignity, respect and experience, improved access to care for marginalized groups, and improved quality of care; and invariably result in improved outcomes for women, newborns and children in the context of UHC (survival, less morbidity, user satisfaction and dignity) in Sierra Leone.

4. Goal and Strategic Objective

4.1 Goals

The overarching goal of this roadmap is to **"ensure that every mother, newborn, child and adolescents receives quality care throughout the pregnancy, childbirth and postnatal period".** It will seek to facilitate a continuous improvement in the outcomes of maternal, newborn, children and adolescents and ***halve institutional maternal, newborn and child deaths*** in Sierra Leone.

4.2 The strategic objectives

Strategic Objective 1: Lead and manage a national MNCAH QoC initiative and strengthen national institutions and mechanisms to support quality of care

Output I: National and district leadership and governance structures for QoC are strengthened (or established) and functioning

Output II: Operational plan for improving quality of care in MNH services is developed, funded, monitored and regularly reviewed

Output III: National and district advocacy and mobilization strategy for quality of care is developed and implemented

Strategic Objective 2: Accelerate, scale up and sustain implementation of quality of care improvements for mothers, newborns, children and adolescents

Output I: National package of country adapted QoC standards, best practices and implementation interventions is compiled, incorporated into the operational plan and disseminated.

Output II: Quality improvement and management interventions for maternal and newborn health are implemented

Output III: Clinical management capabilities to support quality improvement are developed, strengthened and sustained

Strategic Objective 3: Facilitate learning, share knowledge and generate evidence on quality of care

Output I: Develop and strengthen data systems for quality of care improvement

Output II: Establish a virtual national and district learning system to share knowledge and link to global learning platform.

Output III: Establish a face to face national and district learning system to share knowledge and link to global learning platform.

Output IV: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up

Strategic Objective 4: develop, strengthen and sustain institutions and mechanisms for accountability for quality of care

Output I: National framework and mechanisms for accountability for QoC are established and functioning

Output II: Institutionalize system improvement capability for country-led scale-up and sustainability

5. Implementation Plan/Priority Action

S.No.	Strategic Objectives	Output	Level	Key Actions
1	SO1: Lead and manage a national MNCAH QoC initiative and strengthen national institutions and mechanisms to support quality of care	Output I: National and district leadership and governance structures for QoC are strengthened (or established) and functioning	National	Establish and strengthen functional national and district leadership structures for quality of care (Quality Management Unit)
				Constitute a functional multi-stakeholder national quality steering committee & technical working group for quality improvement
				Provide leadership for quality of care training for DMO, MS, national level directorate and programmes
				Establish functional national and district quality of care committees/teams *(with representatives from the civic society, patient groups and women's groups)*
				Ensure TWG is established at national and district level and meets regularly with TOR reviewed annually
				Review and amend TOR of the various quality of care structure at national level every year to adapt to changing need
				Support periodic meeting of the steering committee and the TWG
				Develop Policy briefs on quality of care
				Create demand for QOC using various approaches
				Establishment of hospital management board and orient on QOC
				Sensitize relevant stakeholders on QOC agenda
				Develop annual QOC operational plan and reviews
				Allocate sufficient budget for recruiting a dedicated QOC Officers at national, DHMT and Hospital level
		Output II: Operational plan for improving quality of care in MNH services is developed, funded, monitored and regularly reviewed		Conduct partners mapping every year
				Develop resource mobilization strategy/roadmap for QOC
				Review investment for QOC every year
				Conduct advocacy for resource mobilization, sensitization and partnership
				Harmonize QOC initiative by different directorate, DHMT and Hospitals
				Institute regular national reviews of QOC initiatives progress and targets at all levels

				Provide logistic and operational support for QOC management at national and district level
		Output III: National and district advocacy and mobilization agenda for quality of care is developed and implemented		Develop advocacy and community mobilization strategy/roadmap on MNCH QOC
				Mobilize professional associations, private sector, academia and civil society to champion the QoC agenda and support implementation
				Develop IEC/BCC materials on QOC
				Establish a social media platform disseminate information and advocate for QOC
				Disseminate MNCH QOC information through different mass media outlets
		Output I: National and district leadership and governance structures for QoC are strengthened (or established) and functioning	District	Establish, orientate, strengthen functional district and facility leadership structures for quality of care
				Constitute a functional multi-stakeholder networks of district QOC champions
				Establish a regular QOC leadership and management meeting with stakeholders at district level
				Establish functional district and facility quality of care committees/TWG/teams *(with representatives from the community, patient association and women's groups)*
				Adapt TOR of the various quality of care structure for district and facility
				Recruit and deploy a dedicated QOC Officers at DHMT and Hospital level
				Appoint QOC focal in each PHU's
		Output II: Operational plan for improving quality of care in MNH services is developed, funded, monitored and regularly reviewed		Create demand for QOC using various approaches
				Develop annual QOC operational plan for the district
				Conduct district performance review on QOC
				Mobilize resources for district QOC plan implementation
				District City Council allocate dedicated budget for QOC plan implementation
				Harmonize district QOC operational plan with partners
		Output III: National and district advocacy and mobilization agenda for quality of care is		Develop district specific messages on QOC
				Engage local media outlet and other means for sensitization and mobilization for QOC
				Organize sensitization/advocacy meeting with stakeholders on QOC agenda

		developed and implemented		
		Output I: National and district leadership and governance structures for QoC are strengthened (or established) and functioning	Facility	A hospital/facility QOC committee established/integrated to hospital/facility management committee
				Orient the hospital/facility committee on QOC agenda and TOR
				Establish QI teams at established at various point of care
				Ensure availability of dedicated QOC officer/focal point for QOC
		Output II: Operational plan for improving quality of care in MNH services is developed, funded, monitored and regularly reviewed		Develop annual QOC operational plan for the facility
				Conduct facility performance review on QOC regularly
				Mobilize resources for QOC plan implementation in the facility
				District City Council allocate dedicated budget for QOC plan implementation in facilities
				Harmonize QOC operational plan with partners supporting facilities
		Output III: National and district advocacy and mobilization agenda for quality of care is developed and implemented		Develop/adapt key messages for QOC for the facility
				Conduct outreaches for social mobilization
				Conduct periodic advocacy and sensitization meetings with staffs, community stakeholders and partners
				Ensure availability of IEC/BCC materials for advocacy and mobilization
	SO2: Accelerate, scale up and sustain implementation of quality of care improvements for mothers, newborns,	Output I: National package of country adapted QoC standards, best practices and implementation packages developed and implemented	National	Adapt/adopt WHO MNCAH QOC standard and audit tool
				Address structural, system and human resource barriers
				Develop implementation package for MNH and paediatric and adolescent health standard
				Conduct launching and orientation of the implementation plan for the national change packages to learning and non-learning facilities, directorates, programs
				Institute QOC for MNH in the training curriculum of nurses, midwives, CHOs and Medical Officers
				Develop SOP for hospital care management and roll out to hospitals
				Adapt checklist for assessment of QOC standards

	children and adolescents			Adapt checklist for QOC supportive supervision
		Output II: Quality improvement and management interventions for maternal, newborn, children and adolescent health are implemented		Identify learning districts and learning facilities
				Develop national training guide for quality improvement
				Develop national training guide for coaches/mentors
				Develop national and district coaches
				Conduct TOT training on QI to district coachers/facilitators
				Develop coaching and mentorship guideline
				Establish a remote support mechanism for districts
				Provide coaching and mentorship support to districts and facilities
		Output III: Clinical management capabilities to support quality improvement are developed, strengthened and sustained		Develop/adapt tools to conduct of clinical audit, mortality audit and near miss review
				Build capacity of national, districts and facilities on the use of audit tools
				Strengthen clinical audit, MPDSR, COD, Clinical Audit, Near Miss Review etc
				Introduction of safety checklist for clinical management e.g safe birth checklist, safe surgical checklist etc
				Establish/Strengthen a national professional association/society of pediatrician, obstetrician, surgery etc
				Conduct periodic clinical assessment/supervision on prioritized areas
				Conduct annual clinical safety/effectiveness summit
				Recruit national team of clinical coachers/mentors
				Develop clinical coaching guideline
				Train coachers/mentors on clinical coaching guideline
				Conduct periodic clinical mentorship/coaching to regional and district hospitals
		Output I: National package of country adapted QoC standards, best practices and implementation interventions is compiled, incorporated	District	Orientate WHO MNCAH QOC standard and audit tool to DHMT, district stakeholders and facilities
				Roll out implementation package for MNH and paediatric and adolescent health standard in facilities
				Conduct orientation of the implementation packages to learning and non-learning facilities and DHMT
				Train district coachers and facility in-charges on checklist for assessment of QOC standards

		into the operational plan and disseminated.		Train district coachers and facility in-charges on checklist for QOC supportive supervision
		Output II: Quality improvement and management interventions for maternal, newborn, children and adolescent health are implemented		Train facility in-charges on QI
				Orient facility management committee on QOC
				Maintain training database on regularly basis
				Establish a remote support mechanism for facilities
				Provide coaching and mentorship support to facilities
				Facilitate regular meetings of QOC leadership structures in the district and keep records of meeting minute
				Support prioritization, development and implementation of QI projects
		Output III: Clinical management capabilities to support quality improvement are developed, strengthened and sustained		Train districts and facilities on the use of audit tools for PHUs
				Strengthen MPDSR, COD, Clinical Audit and Near Miss Review in the district etc
				Orientation of safety checklist for clinical management e.g safe birth checklist etc
				Strengthen referral system in the district
				Conduct clinical supervision on Basic Obstetric Care, EmONC, IMNCI, IMAI, ENC
				Conduct clinical mentorship on Basic Obstetric Care, EmONC, IMNCI, IMAI, ENC
				Ensure availability of clinical guideline in health facilities
				Ensure health workers/clinicians are trained on available clinical guideline
		Output I: National package of country adapted QoC standards, best practices and implementation interventions is compiled, incorporated into the operational plan and disseminated.	Facility	Roll out of hospital SOP to all staffs
				Ensure all new staffs are orientated on SOP before deployed
				Develop QI projects based on national and district implementation packages
				Institute internal supportive supervision for QOC
				Conduct internal periodic assessment on QOC standards
				Conduct regular performance reviews on QOC
				Roll out implementation packages, standards and tools to all staffs
				Maintain training database
		Output II: Quality improvement and		Ensure health workers are trained on QI
				Ensure availability of training materials on QI, standards and tools for reference

		management interventions for maternal, newborn, children and adolescent health are implemented		Integrate/strengthen QOC supervision in to internal facility supervision by hospital management, clinical supervisor, matron, ward in-charges and unit heads
				Conduct hospital/facility management committee/QOC structures meetings
				Ensure various units have developed QI projects based on identified need
				Facilitate regular QI team meetings and monitor performance
		Output III: Clinical management capabilities to support quality improvement are developed, strengthened and sustained		Conduct internal periodic clinical assessment/supervision on prioritized areas
				Introduce and enforce use of checklists for clinical management e.g safe birth checklist, safe surgical checklist
				Develop internal clinical training schedules for clinicians
				Conduct monthly clinical performance reviews amongst clinicians
				Conduct monthly nursing care performance reviews amongst nurses and midwives
				Establish a clinical audit, MPDSR, COD committee in facilities
				Maintain mortality database for MPDSR and COD
				Ensure availability of clinical guidelines and enabling environments for improving clinical practices
	SO3: Facilitate learning, share knowledge and generate evidence on quality of care	Output I: Develop, strengthen and integrate data systems and use for improved quality of care	National	Develop and validate a national core set of QoC indicators
				Incorporate MNCH QoC indicators into the DHIS 2 system
				Strengthen data quality for RMNCAH (i.e. completeness, timeliness and accuracy)
				Strengthen data use for decision making
				Establish a system for the collection and reporting of case stories, best practices and improvement projects
				Maintain training database for QOC
				Develop digital system for monitoring QI projects
				Ensure the availability and use of adverse event reporting
		Output II: Establish national and district virtual learning system to share knowledge and link to global learning platform.		Establish virtual learning system
				Support districts and facilities with subscription of internet, air-time etc
				Conduct the virtual learning meeting on monthly basis with districts
				Support ICT equipment to facilitate data management and learning
				Facilitate hospital virtual learning meetings

		Output III: Establish a face to face national and district learning system to share knowledge and link to global learning platform.		Support national periodic review meetings to measure health sector performance
				Establish and strengthen a national learning network amongst hospitals
				Establish learning network amongst districts
				Establish a community of practice and learning collaboratives at the global, national and district levels
				Identify and disseminate best practices
				Disseminate best practices of a growing inventory of tested ideas
				Organize a national QOC learning summit
				Support exchange visit with districts and facilities
		Output IV: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up		Identify and package scalable change ideas on MNCH QoC
				Disseminate scalable change package to key stakeholders - (Conduct in-depth assessment and prepare contextual scalable package into the context to be tested)
				Publish scalable MNH QoC package using quality bulletin, peer reviewed journals
				Incorporate scalable MNH QoC to annual health plan
		Output I: Develop, strengthen and integrate data systems and use for improved quality of care	District	Monitor a national core set of QoC indicators
				Strengthen data quality for RMNCAH (i.e. completeness, timeliness and accuracy)
				Strengthen data use for decision making
				Support the collection and reporting of case stories, best practices and improvement projects
				Monitoring QI projects in the district
				Maintain training database for QOC
				Ensure the availability and use of adverse event reporting and tools
		Output II: Establish national and district virtual learning system to share knowledge and link to global learning platform.		Establish virtual learning system
				Support districts and facilities with subscription of internet, air-time etc
				Conduct the virtual learning meeting on monthly basis
				Facilitate hospital and referral network PHUs virtual learning meetings
				Facilitate districts and chiefdoms performance review meeting
		Output III: Establish a face to face national and		Support periodic review meetings to measure district health sector performance
				Establish a learning network amongst hospitals and CHCs

		district learning system to share knowledge and link to global learning platform.		Establish learning network amongst CHC's and lower PHU's
				Establish a community of practice and learning collaboratives at the district levels
				Organize a district QOC learning meeting
				Support exchange visit between facilities
		Output IV: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up		Identify and disseminate best practices and tested ideas
		Output I: Develop, strengthen and integrate data systems and use for improved quality of care	Facility	Monitor a national core set of QoC indicators
				Strengthen data quality for RMNCAH (i.e. completeness, timeliness and accuracy)
				Strengthen data use for decision making
				Support the collection and reporting of case stories, best practices and improvement projects
				Monitoring QI projects in the facility
				Ensure the availability and use of adverse event reporting and tools
		Output II: Establish national and district virtual learning system to share knowledge and link to global learning platform.		
		Output III: Establish a face to face national and district learning system to share knowledge and link to global learning platform.		Establish and strengthen a daily or weekly meeting amongst QI teams
				Strengthen periodic facility performance meeting
				Strengthen periodic learning meeting/learning collaborative amongst QI teams
				Identify best practices, case stories and tested ideas
		Output IV: Build evidence, infrastructure		Incorporate best practices in annual planning

		and will for future scale up, and undertake rapid scale up		
	SO4: Develop, strengthen and sustain institutions and mechanisms for accountability for quality of care	Output I: National framework and mechanisms for accountability for QoC are established and functioning	National	National accountability framework for QOC developed and rolled out
				Appropriate feedback mechanism for QOC established
				Develop quality indicator dashboards with the appropriate analysis to track progress at the facility, district and national levels
				Monitor data quality of HMIS for RMNCAH through regular DQA
				Design a data base for automation in (DHIS 2)
				Improve medical record keeping in all hospitals
				Develop and implement SRHR scorecard
				Develop and implement community scorecard
				Conduct regular annual review and multi-stakeholder dialogue for QOC
				Publish an annual QoC progress report
				Patient charter addressing RMNCAH and respectful care developed and rolled out
				Conduct periodic assessment on patient centered care
				Involve community and civic society in annual review and operational planning
				Establish separate cost centers for QOC and set system to track progress of expenditure through NHA
		Output II: Institutionalize system improvement capability for country-led scale-up and sustainability		Publish quality improvement work in quarterly health bulletin
				Conduct independent assessments of quality of care in district and health-care facilities
				Design CPD to train future MOHS staff to use systems improvement methods to lead, manage and implement change
				Develop a post-graduate diploma level QI and patient safety course curriculum and initiate training
				Incorporate QI in undergraduate training
		Output I: National framework and mechanisms for accountability for QoC	District	Ensure QOC indicators are regularly updated and published
				Ensure the conduct of client experience surveys and exit interviews
				Conduct baseline and follow up assessment of learning facilities using QOC standard audit tool

		are established and functioning		Roll out accountability framework for QOC at the facility
				Ensure implementation of SRHR scorecard
				Ensure implementation of community scorecard
				Publish annual progress report on QOC
		Output II: Institutionalize system improvement capability for country-led scale-up and sustainability		Publish quality improvement work in quarterly health bulletin
				Conduct independent assessments of quality of care in health-care facilities
				Train all new staffs on QI before deployment
				Conduct periodic assessment on patient centered care
				Conduct appraisal or performance reviews involving communities and other stakeholders
		Output I: National framework and mechanisms for accountability for QoC are established and functioning	Facility	Ensure QOC indicators and RMNCAH indicators are regularly updated
				Ensure the conduct of client experience surveys and exit interviews
				Conduct baseline and follow up assessment on QOC standard audit tool
				Roll out accountability framework for QOC at the facility
				Ensure implementation of SRHR scorecard
				Ensure implementation of community scorecard
				Involve facility management committee in planning and performance reviews
		Output II: Institutionalize system improvement capability for country-led scale-up and sustainability		Conduct self-assessments of quality of care in health-care facilities
				Train all new staffs on QI before deployment
				Conduct periodic assessment on patient centered care
				Conduct appraisal or performance reviews involving communities and other stakeholders
				Establish toll free center at facility level

6. Budget

S.No.	Strategic Objectives	Output	Level	Key Actions	2020 000	2021 000	2022 000	2023 000	2024 000
1	SO1: Lead and manage a national MNCAH QoC initiative and strengthen national institutions and mechanisms to support quality of care	Output I: National and district leadership and governance structures for QoC are strengthened (or established) and functioning	National	Establish and strengthen functional national and district leadership structures for quality of care (Quality Management Unit)	300,000	120,000	120,000	120,000	120,000
				Constitute a functional multi-stakeholder national quality steering committee & technical working group for quality improvement	10,000	5,000	5,000	5,000	5,000
				Provide leadership for quality of care training for DMO, MS, national level directorate and programmes	100,000	25,000	45,000	15,000	15,000
				Establish functional national and district quality of care committees/teams *(with representatives from the civic society, patient groups and women's groups)*	5,000	5,000	5,000	5,000	5,000
				Ensure TWG is established at national and district level and meets regularly with TOR reviewed annually	12,000	6,000	6,000	6,000	6,000
				Support periodic meeting of the steering committee and the TWG	3,000	3,000	3,000	3,000	3,000
				Create demand for QOC using various approaches	35,000	13,000	25,000	12,000	12,000
				Establishment of hospital management board and orient on QOC		5,000	65,000	22,000	5,000
				Sensitize relevant stakeholders on QOC agenda	170,000		20,000	20,000	20,000

				Develop annual QOC operational plan		150,000	150,000	150,000	150,000
				Allocate sufficient budget for recruiting a dedicated QOC Officers at national, DHMT and Hospital level	192,000	192,000	192,000	192,000	192,000
		Output II: Operational plan for improving quality of care in MNH services is developed, funded, monitored and regularly reviewed		Conduct partners mapping every year	2,000	2,000	2,000	2,000	2,000
				Develop resource mobilization strategy/roadmap for QOC			300,000		
				Conduct advocacy for resource mobilization, sensitization and partnership		18,000	45,000	13,000	25,000
				Harmonize QOC initiative by different directorate, DHMT and Hospitals		65,000	65,000	65,000	65,000
				Institute regular national reviews of QOC initiatives progress and targets at all levels	54,000	54,000	78,000	35,000	35,000
				Provide logistic and operational support for QOC management at national and district level	30,000	120,000	850,000	120,000	120,000
		Output III: National and district advocacy and mobilization agenda for quality of care is developed and implemented		Develop advocacy and community mobilization strategy/roadmap on MNCH QOC			300,000		
				Mobilize professional associations, private sector, academia and civil society to champion the QoC agenda and support implementation			250,000	133,000	85,000
				Develop IEC/BCC materials on QOC		250,000	50,000	120,000	80,000
				Establish a social media platform disseminate information and advocate for QOC	3,000	10,000	10,000	10,000	10,000

				Disseminate MNCH QOC information through different mass media outlets			65,000	23,000	47,000
		Output I: National and district leadership and governance structures for QoC are strengthened (or established) and functioning	District	Establish, orientate, strengthen functional district and facility leadership structures for quality of care		250,000	133,000	133,000	350,000
				Constitute a functional multi-stakeholder networks of district QOC champions and meets regularly		32,000	32,000	32,000	32,000
				Establish a regular QOC leadership and management meeting with stakeholders at district level		80,000	80,000	80,000	80,000
				Establish functional district and facility quality of care committees/TWG/teams *(with representatives from the community, patient association and women's groups)*	91,000	23,000	32,000	32,000	32,000
				Adapt TOR of the various quality of care structure for district and facility	5,000	5,000	5,000	5,000	5,000
				Recruit, deploy and orient a dedicated QOC Officers at DHMT and Hospital level	2,000	2,000	2,000	2,000	2,000
				Appoint QOC focal in each PHU's	5,000	5,000	5,000	5,000	5,000
		Output II: Operational plan for improving quality of care in MNH services is developed, funded,		Create demand for QOC using various approaches	3,000	10,000	25,000	5,000	5,000
				Develop annual QOC operational plan for the district		320,000	320,000	320,000	320,000
				Conduct district performance review on QOC			160,000	160,000	160,000

		monitored and regularly reviewed		Mobilize resources for district QOC plan implementation		200,000	200,000	200,000	200,000
				District City Council allocate dedicated budget for QOC plan implementation		15,000	15,000	15,000	15,000
				Harmonize district QOC operational plan with partners		48,000	48,000	48,000	48,000
		Output III: National and district advocacy and mobilization agenda for quality of care is developed and implemented		Develop district specific messages on QOC			63,000	63,000	63,000
				Engage local media outlet and other means for sensitization and mobilization for QOC		80,000	80,000	80,000	80,000
				Organize sensitization/advocacy meeting with stakeholders on QOC agenda			32,000	32,000	32,000
		Output I: National and district leadership and governance structures for QoC are strengthened (or established) and functioning	Facility	A hospital/facility QOC committee established/integrated to hospital/facility management committee	16,000	16,000	16,000	16,000	16,000
				Orient the hospital/facility committee on QOC agenda and TOR	160,000	160,000	160,000	160,000	160,000
				QI teams established at various point of care	60,000	60,000	60,000	60,000	60,000
				Ensure availability of dedicated QOC officer/focal point for QOC	60,000	60,000	60,000	60,000	60,000
		Output II: Operational plan for improving quality of care in MNH services is developed, funded,		Develop annual QOC operational plan for the facility	60,000	60,000	60,000	60,000	60,000
				Conduct facility performance review on QOC regularly	140,000	140,000	140,000	140,000	140,000
				Mobilize resources for QOC plan implementation in the facility	60,000	60,000	60,000	60,000	60,000

		monitored and regularly reviewed		District City Council allocate dedicated budget for QOC plan implementation in facilities	32,000	32,000	32,000	32,000	32,000
				Harmonize QOC operational plan with partners supporting facilities	32,000	32,000	32,000	32,000	32,000
		Output III: National and district advocacy and mobilization agenda for quality of care is developed and implemented		Develop/adapt key messages for QOC for the facility	32,000	32,000	32,000	32,000	32,000
				Conduct outreaches for social mobilization	85,000		85,000	85,000	85,000
				Conduct periodic advocacy and sensitization meetings with staffs, community stakeholders and partners			380,000	100,000	380,000
				Ensure availability of IEC/BCC materials for advocacy and mobilization			260,000		260,000
	SO2: Accelerate, scale up and sustain implementation of quality of care improvements for mothers, newborns, children and adolescents	Output I: National package of country adapted QoC standards, best practices and implementation packages developed and implemented	National	Adapt/adopt WHO MNCAH QOC standard and audit tool	78,000	33,000	25,000	25,000	25,000
				Address structural, system and human resource barriers			680,000	360,000	360,000
				Develop implementation package for MNH and paediatric and adolescent health standard		85,000			
				Conduct launching and orientation of the implementation plan for the national change packages to learning and non-learning facilities, directorates, programs		22,000	385,000		
				Institute QOC for MNH in the training curriculum of nurses, midwives, CHOs and Medical Officers			675,000		

				Develop SOP for hospital care management and roll out to hospitals		250,000	436,000		
				Adapt checklist for assessment of QOC standards and provide orientation	16,000		41,000		
				Adapt checklist for QOC supportive supervision and orientation		12,000	118,000		
		Output II: Quality improvement and management interventions for maternal, newborn, children and adolescent health are implemented		Identify learning districts and learning facilities	47,000	26,000			
				Develop national training guide for quality improvement	65,000	280,000			
				Develop national training guide for coaches/mentors		133,000	369,000		
				Conduct TOT training on QI to district coachers/facilitators			158,000	86,000	
				Develop coaching and mentorship guideline			123,000		
				Establish a remote support mechanism for districts			10000	10000	10000
				Provide coaching and mentorship support to districts and facilities		550,000	823,000	823,000	250,000
		Output III: Clinical management capabilities to support quality improvement are developed, strengthened and sustained		Develop/adapt tools to conduct clinical audit, mortality audit and near miss review		25,000	35,000		
				Build capacity of national, districts and facilities on the use of audit tools	369,000	458,000	250,000	132,000	132,000
				Strengthen clinical audit, MPDSR, COD, Clinical Audit, Near Miss Review etc	610,000	850,000	650,000	650,000	650,000

				Introduction of safety checklist for clinical management e.g safe birth checklist, safe surgical checklist etc			310,000	286,000	420,000
				Establish/Strengthen a national professional association/society of pediatrician, obstetrician, surgery etc			422,000	236,000	128,000
				Conduct periodic clinical assessment/supervision on prioritized areas		15,000	215,000	285,000	285,000
				Conduct annual clinical safety summit		150,000	50,000	50,000	50,000
				Recruit national team of clinical coachers/mentors		30,000	15,000	15,000	15,000
				Develop clinical coaching guideline			180,000		
				Train coachers/mentors on clinical coaching guideline			270,000	130,000	99,000
				Conduct periodic clinical mentorship/coaching to regional and district hospitals			220,000	580,000	783,000
		Output I: National package of country adapted QoC standards, best practices and implementation interventions is compiled, incorporated into the operational plan and disseminated.	District	Orientate WHO MNCAH QOC standard and audit tool to DHMT, district stakeholders and facilities			32,000	24,000	16,000
				Roll out implementation package for MNH and paediatric and adolescent health standard in facilities		66,000	280,000	340,000	
				Train district coachers and facility in-charges on checklist for assessment of QOC standards			132,000	189,000	
				Train district coachers and facility in-charges on checklist for QOC supportive supervision			132,000	189,000	93,000

		Output II: Quality improvement and management interventions for maternal, newborn, children and adolescent health are implemented		Train facility in-charges on QI	142,000	286,000	445,000	860,000	
				Orient facility management committee on QOC					
				Maintain training database on regularly basis	15,000	20,000	60,000	60,000	60,000
				Establish a remote support mechanism for facilities		42,000	83,000	123,000	60,000
				Provide coaching and mentorship support to facilities			190,000	190,000	190,000
				Facilitate regular meetings of QOC leadership structures in the district and keep records of meeting minute		132,000	132,000	132,000	132,000
		Output III: Clinical management capabilities to support quality improvement are developed, strengthened and sustained		Train districts and facilities on the use of audit tools for PHUs	150,000	186,000	250,000	150,000	
				Strengthen MPDSR, COD, Clinical Audit and Near Miss Review in the district etc	330,000	330,000	330,000	330,000	330,000
				Orientation of safety checklist for clinical management e.g safe birth checklist etc			88,000	32,000	32,000
				Strengthen referral system in the district		132,000	166,000	166,000	166,000
				Conduct clinical supervision on Basic Obstetric Care, EmONC, IMNCI, IMAI, ENC	266,000	342,000	342,000	342,000	342,000
				Conduct clinical mentorship on Basic Obstetric Care, EmONC, IMNCI, IMAI, ENC	266,000	342,000	342,000	342,000	342,000
				Ensure availability of clinical guideline in health facilities	100,000	180,000	180,000	180,000	180,000

				Ensure health workers/clinicians are trained on available clinical guideline	550,000	280,000	340,000	340,000	520,000
		Output I: National package of country adapted QoC standards, best practices and implementation interventions is compiled, incorporated into the operational plan and disseminated.	Facility	Roll out of hospital SOP to all staffs			80,000		
				Ensure all new staffs are orientated on SOP before deployed			25,000	30,000	30,000
				Develop QI projects based on national and district implementation packages			66,000	66,000	66,000
				Institute internal supportive supervision for QOC			20,000	20,000	20,000
				Conduct internal periodic assessment on QOC standards	35,000		42,000	42,000	42,000
				Conduct regular performance reviews on QOC		30,000	120,000	120,000	120,000
				Roll out implementation packages, standards and tools to all staffs			52,000	52,000	52,000
				Maintain training database			10000	10000	10000
		Output II: Quality improvement and management interventions for maternal, newborn, children and adolescent health are implemented		Ensure health workers are trained on QI	48,000	66,000	148,000	40,000	28,000
				Ensure availability of training materials on QI, standards and tools for reference			450,000	200,000	
				Integrate/strengthen QOC supervision in to internal facility supervision by hospital management, clinical supervisor, matron, ward in-charges and unit heads			120,000	120,000	
				Conduct hospital/facility management committee/QOC structures meetings	60,000	43,000	163,000	163,000	163,000

				Ensure various units have developed QI projects based on identified need		12,000	12,000	12,000	12,000
				Facilitate regular QI team meetings and monitor performance		26,000	26,000	26,000	26,000
		Output III: Clinical management capabilities to support quality improvement are developed, strengthened and sustained		Conduct internal periodic clinical assessment/supervision on prioritized areas			50,000	50,000	50,000
				Introduce and enforce use of checklists for clinical management e.g safe birth checklist, safe surgical checklist			128,000	178,000	66,000
				Develop internal clinical training schedules for clinicians			289,000	146,000	146,000
				Conduct monthly clinical performance reviews amongst clinicians			80,000	80,000	80,000
				Conduct monthly nursing care performance reviews amongst nurses and midwives			210,000	210,000	210,000
				Establish a clinical audit, MPDSR, COD committee in facilities	680,000	340,000	380,000	310,000	250,000
				Maintain mortality database for MPDSR and COD	56,000	56,000	56,000	56,000	56,000
				Ensure availability of clinical guidelines and enabling environments for improving clinical practices	30,000	30,000	30,000	30,000	
	SO3: Facilitate learning, share knowledge and generate	Output I: Develop, strengthen and integrate data systems and use for	National	Develop and validate a national core set of QoC indicators	28,000	28,000			
				Incorporate MNCH QoC indicators into the DHIS 2 system		32,000			

	evidence on quality of care	improved quality of care		Strengthen data quality for RMNCAH (i.e. completeness, timeliness and accuracy)		4,000	4,000	4,000	4,000
				Strengthen data use for decision making		52,000	52,000	52,000	45,000
				Establish a system for the collection and reporting of case stories, best practices and improvement projects		25,000	25,000	25,000	25,000
				Maintain training database for QOC		10,000	10,000	10,000	10,000
				Develop digital system for monitoring QI projects		30,000	30,000		
				Ensure the availability and use of adverse event reporting	22,000	22,000	22,000	22,000	22,000
		Output II: Establish national and district virtual learning system to share knowledge and link to global learning platform.		Establish virtual learning system		25,000	25,000		
				Support districts and facilities with subscription of internet, air-time etc		120,000	120,000	120,000	120,000
				Conduct the virtual learning meeting on monthly basis with districts		12,000	12,000	12,000	10,000
				Support ICT equipment to facilitate data management and learning		56,000	56,000	42,000	42,000
				Facilitate hospital virtual learning meetings		45,000	45,000	45,000	45,000
		Output III: Establish a face to face national and district learning system to share knowledge and link to global learning platform.		Support national periodic review meetings to measure health sector performance		86,000	86,000	86,000	86,000
				Establish and strengthen a national learning network amongst hospitals		20,000	20,000	20,000	20,000
				Establish learning network amongst districts		10,000	10,000	10,000	10,000

				Establish a community of practice and learning collaboratives at the global, national and district levels		35,000	35,000	35,000	35,000
				Identify and disseminate best practices		5,000	5,000	5,000	5,000
				Disseminate best practices of a growing inventory of tested ideas		5,000	5,000	5,000	5,000
				Organize a national QOC learning summit		110,000	110,000	110,000	110,000
				Support exchange visit with districts and facilities		30,000	30,000	30,000	30,000
		Output IV: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up		Identify and package scalable change ideas on MNCH QoC		2,000	2,000	2,000	2,000
				Disseminate scalable change package to key stakeholders - (Conduct in-depth assessment and prepare contextual scalable package into the context to be tested)		56,000	56,000		
				Publish scalable MNH QoC package using quality bulletin, peer reviewed journals		15,000	15,000	15,000	15,000
				Incorporate scalable MNH QoC to annual health plan		2,000	2,000	2,000	2,000
		Output I: Develop, strengthen and integrate data systems and use for improved quality of care	District	Monitor a national core set of QoC indicators		38,000	38,000	38,000	38,000
				Strengthen data quality for RMNCAH (i.e. completeness, timeliness and accuracy)	5,000	5,000	5,000	5,000	5,000
				Strengthen data use for decision making		32,000	32,000	32,000	32,000

				Support the collection and reporting of case stories, best practices and improvement projects		10,000	10,000	10,000	10,000
				Monitoring QI projects in the district		38,000	38,000	38,000	38,000
				Maintain training database for QOC		3,000	3,000	3,000	3,000
				Ensure the availability and use of adverse event reporting and tools	22,000	22,000	22,000	22,000	22,000
		Output II: Establish national and district virtual learning system to share knowledge and link to global learning platform.		Establish virtual learning system		15,000	15,000	15,000	
				Support districts and facilities with subscription of internet, air-time etc		55,000	55,000	55,000	55,000
				Conduct the virtual learning meeting on monthly basis		5,000	5,000	5,000	5,000
				Facilitate hospital and referral network PHUs virtual learning meetings		8,000	8,000	8,000	8,000
				Facilitate districts and chiefdoms performance review meeting		110,000	110,000	110,000	110,000
		Output III: Establish a face to face national and district learning system to share knowledge and link to global learning platform.		Support periodic review meetings to measure district health sector performance			80,000	80,000	80,000
				Establish a learning network amongst hospitals and CHCs		5,000	5,000	5,000	5,000
				Establish learning network amongst CHC's and lower PHU's		20,000	20,000	20,000	20,000
				Establish a community of practice and learning collaboratives at the district levels		35,000	35,000	35,000	35,000
				Organize a district QOC learning meeting		38,000	38,000	38,000	38,000
				Support exchange visit between facilities		25,000	25,000	25,000	25,000

		Output IV: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up		Identify and disseminate best practices and tested ideas		3,000	3,000	3,000	3,000
						12,000	12,000	12,000	12,000
		Output I: Develop, strengthen and integrate data systems and use for improved quality of care	Facility	Monitor a national core set of QoC indicators		6,000	6,000	6,000	6,000
				Strengthen data quality for RMNCAH (i.e. completeness, timeliness and accuracy)	5,000	5,000	5,000	5,000	5,000
				Strengthen data use for decision making		10,000	10,000	10,000	10,000
				Support the collection and reporting of case stories, best practices and improvement projects		35,000	35,000	35,000	35,000
				Monitoring QI projects in the facility		22,000	22,000	22,000	22,000
				Ensure the availability and use of adverse event reporting and tools		30,000	30,000	30,000	30,000
		Output II: Establish national and district virtual learning system to share knowledge and link to global learning platform.				40,000	40,000	40,000	40,000
						16,000	16,000	16,000	16,000
		Output III: Establish a face to face national and district learning system to		Establish and strengthen a daily or weekly meeting amongst QI teams		2,000	2,000	2,000	2,000
				Strengthen periodic facility performance meeting		2,000	2,000	2,000	2,000

		share knowledge and link to global learning platform.		Strengthen periodic learning meeting/learning collaborative amongst QI teams		10,000	20,000		
				Identify best practices, case stories and tested ideas		5,000			
		Output IV: Build evidence, infrastructure and will for future scale up, and undertake rapid scale up		Incorporate best practices in annual planning		12,000			
	SO4: Develop, strengthen and sustain institutions and mechanisms for accountability for quality of care	Output I: National framework and mechanisms for accountability for QoC are established and functioning	National	National accountability framework for QOC developed and rolled out		22,000	22,000	22,000	22,000
				Appropriate feedback mechanism for QOC established		10,000	10,000		
				Develop quality indicator dashboards with the appropriate analysis to track progress at the facility, district and national levels		18,000	18,000	18,000	18,000
				Monitor data quality of HMIS for RMNCAH through regular DQA		35,000	25,000	25,000	25,000
				Design a data base for automation in (DHIS 2)		35,000	25,000	25,000	25,000
				Improve medical record keeping in all hospitals		120,000	120,000	120,000	120,000
				Develop and implement SRHR scorecard		4,000	4,000	4,000	4,000
				Develop and implement community scorecard		25,000	15,000		
				Conduct regular annual review and multi-stakeholder dialogue for QOC		40,000	40,000	40,000	40,000

				Publish an annual QoC progress report		19,000	19,000	19,000	
				Patient charter addressing RMNCAH and respectful care developed and rolled out		12,000	12,000	12,000	12,000
				Conduct periodic assessment on patient centered care		5,000	5,000	5,000	5,000
				Involve community and civic society in annual review and operational planning		55,000	55,000	55,000	55,000
				Establish separate cost centers for QOC and set system to track progress of expenditure through NHA		35,000	35,000	35,000	35,000
		Output II: Institutionalize system improvement capability for country-led scale-up and sustainability		Publish quality improvement work in quarterly health bulletin		42,000	42,000	42,000	42,000
				Conduct independent assessments of quality of care in district and health-care facilities		6,000	6,000	6,000	6,000
				Design CPD to train future MOHS staff to use systems improvement methods to lead, manage and implement change		2,000	2,000	2,000	2,000
				Develop a post-graduate diploma level QI and patient safety course curriculum and initiate training		90,000	90,000	90,000	90,000
				Incorporate QI in undergraduate training		75,000	50,000	50,000	50,000
		Output I: National framework and	Dis tric	Ensure QOC indicators are regularly updated and published		10,000	10,000	10,000	10,000

		mechanisms for accountability for QoC are established and functioning		Ensure the conduct of client experience surveys and exit interviews		5,000	5,000	5,000	5,000
				Conduct baseline and follow up assessment of learning facilities using QOC standard audit tool		5,000	5,000	5,000	5,000
				Roll out accountability framework for QOC at the facility		3,000	3,000	3,000	3,000
				Ensure implementation of SRHR scorecard		3,000	3,000	3,000	3,000
				Ensure implementation of community scorecard		20,000	20,000	20,000	20,000
				Publish annual progress report on QOC		180,000	180,000	180,000	180,000
		Output II: Institutionalize system improvement capability for country-led scale-up and sustainability		Publish quality improvement work in quarterly health bulletin		40,000	40,000	40,000	40,000
				Conduct independent assessments of quality of care in health-care facilities		32,000	32,000	32,000	32,000
				Train all new staffs on QI before deployment		3,000	3,000	3,000	3,000
				Conduct periodic assessment on patient centered care		45,000	45,000	45,000	45,000
				Conduct appraisal or performance reviews involving communities and other stakeholders		35,000	35,000	35,000	35,000
		Output I: National framework and mechanisms for accountability for	Facility	Ensure QOC indicators and RMNCAH indicators are regularly updated		15,000	15,000		
				Ensure the conduct of client experience surveys and exit interviews		5,000	5,000	5,000	5,000

		QoC are established and functioning		Conduct baseline and follow up assessment on QOC standard audit tool		25,000	225,000	25,000	
				Roll out accountability framework for QOC at the facility		45,000	45,000		
				Ensure implementation of SRHR scorecard		55,000	55,000	55,000	55,000
				Ensure implementation of community scorecard			186,000	186,000	186,000
				Involve facility management committee in planning and performance reviews		45,000	45,000	45,000	45,000
		Output II: Institutionalize system improvement capability for country-led scale-up and sustainability		Conduct self-assessments of quality of care in health-care facilities		32,000	32,000	32,000	32,000
				Train all new staffs on QI before deployment		25,000	35,000	15,000	15,000
				Conduct periodic assessment on patient centered care	45,000	45,000	45,000	45,000	45,000
				Conduct appraisal or performance reviews involving communities and other stakeholders	32,000	32,000	32,000	32,000	32,000

7. Monitoring and Evaluation Framework

Indicator	Baseline	Target	Source	Frequency	Remark
Impact Indicators					
Institutional Maternal Mortality Ratio (MMR)	TBD	TBD	MDSR	Quarterly	GCCI
Institutional Under Five Mortality Rate	TBD	TBD	DHIS2	Quarterly	NCI
Institutional Neonatal Mortality Rate (NMR)	TBD	TBD	DHIS2	Quarterly	GCCI
Institutional Stillbirth Rate (Disaggregated by Fresh/Macerated) and (Hospital/PHU)	TBD	TBD	DHIS2	Quarterly	GCCI
Institutional Adolescent Birth Rate	TBD	TBD	DHIS2	Quarterly	
Outcome Indicators					
Maternal Deaths by cause (PPH, PE/E, Prolonged Labor, Infection/sepsis)	TBD	TBD	MDSR	Quarterly	GCCI
Maternal Cause-specific Case fatality rate (PPH, PE/E, infection/sepsis, prolonged labor)	TBD	TBD	MDSR	Quarterly	GCCI
% women with obstetric complication (PPH, PE/E, prolonged labor, infection/sepsis etc) treated in facility	TBD	TBD	MDSR	Quarterly	NCI
Facility skilled Birth Attendant Rate	TBD	TBD	DHIS2	Quarterly	NCI
Institutional Birth Rate	TBD	TBD	DHIS2	Quarterly	
Obstetric Complications Referral Rate (PHU to Hospital)	TBD	TBD	RC Data	Quarterly	NCI
Under-five Referral Rate (PHU to Hospital)	TBD	TBD	RC Data	Quarterly	NCI
Under-five death by causes (Hospital)	TBD	TBD	DHIS2	Quarterly	NCI
Neonatal death by causes (Hospital)	TBD	TBD	DHIS2	Quarterly	GCCI
Under-five causes case fatality rate (Hospital)- Malaria, Diarrhea, Pneumonia and Malnutrition	TBD	TBD	DHIS2	Quarterly	NCI
Newborn asphyxia rate	TBD	TBD	DHIS2	Quarterly	
Neonatal causes case fatality rate (Hospital)- Preterm, Asphyxia, Sepsis	TBD	TBD	DHIS2	Quarterly	
Bed Occupancy Rate (Obstetric)	TBD	TBD	RC Data	Quarterly	
Bed Occupancy Rate (Under Five)	TBD	TBD	RC Data	Quarterly	
Incidence of Surgical Site Infection (Maternal and Under-five)	TBD	TBD	RC Data	Quarterly	
Post Caesarian Section Morality Rate	TBD	TBD	MDSR/DHIS2	Quarterly	NCI
Caesarian Section Rate	TBD	TBD	DHIS2	Quarterly	NCI
% of newborns breastfed within 1 hour of birth	TBD	TBD	DHIS2	Quarterly	GCCI
% of premature babies initiated on KMC	TBD	TBD	DHIS2	Quarterly	GCCI
% of admitted children surviving from NICU/SBCU	TBD	TBD	DHIS2	Quarterly	NCI
% of under-five children with SAM recovering from treatment program	TBD	TBD	Nut. Data	Quarterly	
% of mothers/care takers that were satisfied with the care provided	TBD	TBD	DHIS2	Quarterly	NCI
Output/Process Indicators					
% of women assessed appropriately at admission	TBD	TBD	Audit/Super.	Quarterly	NCI

% of women with blood pressure, pulse and temperature monitored appropriately	TBD	TBD	Audit/Super.	Quarterly	NCI
% of postnatal mothers monitored appropriately for danger signs	TBD	TBD	Audit/Super.	Quarterly	
% of postnatal babies monitored appropriately for danger signs	TBD	TBD	Audit/Super.	Quarterly	NCI
% of mothers with obstetric complications (Hemorrhage, PE/E, Sepsis) treated at BeMONC/CeMONC facilities	TBD	TBD	DHIS2	Quarterly	NCI
% of women administered immediate post-partum uterotonic (i.e. active management of the third stage of labor)	TBD	TBD	DHIS2/Audit	Quarterly	GCCI
% of women with PE/E managed appropriately according to national protocol	TBD	TBD	Audit/Super.	Quarterly	
% of women who developed PPH receiving appropriate treatment according to national protocol	TBD	TBD	Audit/Super.	Quarterly	
% women with prolonged labor (active labor > 12 hours) managed appropriately according to national protocol	TBD	TBD	Audit/Super.	Quarterly	
% women who gave birth in the facility with signs of infection treated with appropriate antibiotics according to national protocol	TBD	TBD	Audit/Super.	Quarterly	
% of postpartum women discharged appropriately with accurately completed record	TBD	TBD	Audit/Super.	Quarterly	
% newborns with documented birthweight	TBD	TBD	Audit/Super.	Quarterly	GCCI
% newborns who received essential early newborn care (drying, skin to skin, delayed cord clamping, breastfeeding.)	TBD	TBD	Audit/Super.	Quarterly	NCI
% of hospitals that allow companion of choice during labour and childbirth	TBD	TBD	Audit/Super.	Quarterly	
% of women that wanted and had companion of choice during labour and childbirth	TBD	TBD	Survey	Biannual	GCCI
% of women that reported abuse during labour and child birth (disaggregated by type of abuse)	TBD	TBD	Survey	Biannual	GCCI
% postpartum women counseled on birth spacing and postpartum contraception options	TBD	TBD	Survey	Biannual	NCI
% of women who felt they were adequately informed by the health worker about their care including examination	TBD	TBD	Survey	Biannual	
% of women reported receiving dignified and respectful care during maternity visit	TBD	TBD	Survey	Biannual	
% of women who received pre-discharge counseling for mother and baby in the health facility	TBD	TBD	Survey	Biannual	GCCI
% of women discharged postpartum with modern contraceptive method of choice in the health facility	TBD	TBD	Survey	Biannual	
% of newborns < 2,000 gms initiated on KMC	TBD	TBD	Audit	Quarterly	
% newborns discharged with accurately completed record	TBD	TBD	Audit	Quarterly	
% of all children with general danger or emergency signs who required referral received correct emergency and/or prereferral treatment	TBD	TBD	Audit	Quarterly	
% of all children with pneumonia to whom oxygen was appropriately administered for the clinical indication	TBD	TBD	Audit	Quarterly	
% of all children with severe malaria who received the correct treatment (drug, dose, frequency, route of administration and duration) and supportive care according to national guidelines	TBD	TBD	Audit	Quarterly	

% of all children managed for diarrhea and some or no dehydration who were correctly prescribed ORS and zinc supplementation	TBD	TBD	Audit	Quarterly	
% of all children with severe febrile illness (e.g. malaria, meningitis, septicemia, dengue) who were monitored regularly for vital signs and level of consciousness until resolution of severe signs of illness	TBD	TBD	Audit	Quarterly	
% of all children < 5 years in the health facility who have been assessed for routine growth and delayed development, and /or malnutrition screenings documented on their child health card or booklet	TBD	TBD	Audit	Quarterly	NCI
% of careers in the health facility who have received counselling on breastfeeding and nutrition to ensure continued, appropriate feeding of the children in their care	TBD	TBD	Survey	Biannual	
% of all children with pneumonia or severe pneumonia who received correct antibiotic treatment (formulation, dose, frequency and duration) according to national guidelines.	TBD	TBD	Audit	Quarterly	NCI
% of all sick young infants classified as having PSBI or sepsis who were prescribed appropriate antibiotics (correct choice, dose, frequency, route of administration and duration) according to national guidelines.	TBD	TBD	Audit	Quarterly	
% of under five children with SAM treated in health facility	TBD	TBD	Nut. data	Quarterly	
% facilities in which QI team regularly extracts data for decision making	TBD	TBD	Report	Quarterly	
% maternal deaths reviewed with standard audit tools	TBD	TBD	MPDSR	Quarterly	
% perinatal deaths reviewed with standard audit tools (Hospital)	TBD	TBD	MPDSR	Quarterly	
% of facilities conducting clinical audit for maternal and newborn care (Hospital)	TBD	TBD	Audit	Quarterly	
% of facilities conducting clinical audit for admitted under-five children (Hospital)	TBD	TBD	Audit	Quarterly	
% of facilities conducting near miss review	TBD	TBD	Audit	Quarterly	NCI
% of districts with functional leadership and governance structures for MNCAH QOC	TBD	TBD	Report	Quarterly	
% of facilities with functional leadership and governance structures for QOC (disaggregated hospital and PHU)	TBD	TBD	Report	Quarterly	
% of districts with functional coordination mechanism (QOC committee) for QOC	TBD	TBD	Report	Quarterly	
% of health managers and leaders at national, district and facility levels trained on QI	TBD	TBD	Train Data.	Annual	
% of health facilities with at least 50% of health care workers trained on QI	TBD	TBD	Train Data.	Annual	
% of DHMT with 50% of DHMT staff trained on QI	TBD	TBD	Train Data.	Annual	
% of districts with RMNCAH QOC improvement plans	TBD	TBD	Report	Annual	
% of RMNCAH QOC annual plans at national and district levels funded	TBD	TBD	Report	Annual	
Number of advocacy events for RMNCAH QOC implemented at national and district levels	0	3	Report	Annual	
Number of best practices on MNCAH QOC documented and published	0	4	Report	Annual	
Number (%) of health facilities within a learning district which conducted baseline performance assessment on MNCAH QOC standards/audit	5	TBD	Assessment	Biannual	

Number (%) of health facilities within a learning district who design and implement improvement plans in collaboration with DHMT and FMC	TBD	TBD	Report	TBD	
Number (%) of districts which conducted regular learning collaborative sessions (Quarterly meetings)	TBD	TBD	Report	Quarterly	
Number (%) of districts participating in national learning collaborative sessions	TBD	TBD	Report	Quarterly	
Number (%) of QOC Program implementation reviews conducted	TBD	TBD	Report	Biannual	
Number (%) of facilities participating in district learning collaborative sessions	TBD	TBD	Report	Quarterly	
Number (%) of health facilities that publicly post patient charter	TBD	TBD	Report	Annual	
Number (%) of health facilities within district implementing community score cards	TBD	TBD	Report	Annual	
Number (%) of districts/facilities with regular DQA conducted	TBD	TBD	Supervision	Quarterly	
% of hospitals conducting regular experience of care survey	TBD	TBD	Report	Biannual	
% facilities with monthly QI review meeting	TBD	TBD	Report	Biannual	
% of all children discharged from the health facility within the past 24 h who had an accurately completed discharge summary of the care provided, outcomes and diagnoses (with ICD codes)	TBD	TBD	Audit	Quarterly	
% of all births and deaths occurring in the health facility that were appropriately registered in the national vital registration system	TBD	TBD	Audit	Quarterly	NCI
% of children admitted to the health facility for whom there is an up-to-date, appropriately completed monitoring chart that indicates that vital signs were monitored regularly	TBD	TBD	Audit	Quarterly	NCI
Number of supervisory visits to the health facility to improve QI, clinical competence and performance in the past 12 months	TBD	TBD	Report	Quarterly	
Number (%) of health facilities with functional QOC Committee	TBD	TBD	Report	Quarterly	
Number (%) of quarterly MOHS health bulletins where quality improvement work is highlighted	TBD	TBD	Report	Quarterly	
Number of policy briefs produced on quality of care	TBD	TBD	Report	Annual	
A post-graduate diploma level QI and patient safety course curriculum developed	0	Yes	Report	Annual	
A post-graduate level QI and patient safety training initiated	0	Yes	Report	Annual	
Annual progress report on QOC developed and printed	1	1	Report	Annual	
Input Indicators					
% CEmONC facilities with functional blood transfusion service	TBD	TBD	Assessment	Quarterly	
% facilities with essential (tracer) supplies available	TBD	TBD	LMIS	Quarterly	
% facilities with written, up-to-date clinical protocols	TBD	TBD	Assessment	Quarterly	
% facilities with suction device, mask and bag (size 0 and 1)	TBD	TBD	Assessment	Quarterly	

% facilities with standardized referral protocol for identification, management and referral of women/newborns with complications	TBD	TBD	Assessment	Quarterly	
% of facilities with basic sanitation available for women during and after labour and childbirth (private toilet/latrine, bathing.)	TBD	TBD	Assessment	Quarterly	GCCI
% facilities with standardized referral form	TBD	TBD	Assessment	Quarterly	
% facilities where physical environment allows privacy	TBD	TBD	Assessment	Quarterly	
% facilities displaying roster of staff on duty, shift times	TBD	TBD	Assessment	Quarterly	
% facilities with SBA available all the time in sufficient numbers to meet workload	TBD	TBD	Assessment	Quarterly	
% facilities with designated QI team	TBD	TBD	Assessment	Quarterly	
% facilities with basic water supply in maternity care areas (labor, birth, postnatal)	TBD	TBD	Assessment	Quarterly	
% facilities with basic healthcare waste management in maternity care areas	TBD	TBD	Assessment	Quarterly	
% facilities with basic hygiene provisions in maternity care areas (functional handwashing station, access to bathing/shower area, basic sterile equipment)	TBD	TBD	Assessment	Quarterly	GCCI
% facilities with adequate labor and childbirth areas/rooms for estimated number of births	TBD	TBD	Assessment	Quarterly	
% facilities with dedicated area in labour / childbirth area for resuscitation of newborns, which is adequately equipped	TBD	TBD	Assessment	Quarterly	
% facilities with regular source of electricity	TBD	TBD	Assessment	Quarterly	
% of health facility that has the essential equipment and supplies for assessing and monitoring paediatric emergencies (e.g. weighing scales, thermometer, blood pressure measuring device, blood glucose and oxygen saturation tests)	TBD	TBD	Assessment	Quarterly	NCI
Implementation Milestones (by Strategic Objective) adapted from WHO M & E Framework					
Leadership					
National and district governance structures for QoC are strengthened (or established) and functioning					
National leadership structure for quality of care in health services is strengthened (or established)	Yes	Yes	Report	Annual	
National steering group for quality improvement in MNCAH services is strengthened (or established)	Yes	Yes	Report	Annual	
Quality of care committees in district health management teams are established (including representatives from the community and women's associations) and functioning	Yes	Yes	Report	Annual	
Quality of care committees in hospitals and QI teams in health facilities are established (including representatives from the community and women's associations) and functioning	Yes	Yes	Report	Annual	
National vision, strategy and operational plan for improving quality of care in MNCAH services is developed, funded, monitored and regularly reviewed					

National vision, strategy and operational plan (with targets) for improving quality of care in MNH services is developed	Yes	Yes	Report	Annual	
Partners are aligned and resources mobilized for implementation of the national operational plan	No	Yes	Report	Annual	
Implementation of the national operational plan is costed, and funding allocated in the budget	Yes	Yes	Report	Annual	
Regular reviews of progress against targets are conducted and the national plan is adjusted as required	No	Yes	Report	Annual	
National advocacy and mobilization strategy for quality of care is developed and implemented					
Professional associations, academics, civil society and the private sector are brought together and mobilized to champion the Network and support implementation	No	Yes	Report	Annual	
National advocacy and mobilization strategy developed, implemented and monitored	No	Yes	Report	Annual	
Action					
WHO evidence-based standards of care for mothers and newborns are adapted and disseminated.					
National standards and protocols for MNCAH are compiled and reviewed	No	Yes	Report	Annual	
Update national standards, protocols and practice tools are disseminated to all revenant stakeholders and used	No	Yes	Report	Annual	
National package of improvement interventions is adapted (or developed) and disseminated					
Quality improvement interventions are compiled and reviewed, and best practice is identified	No	Yes	Report	Annual	
Quality of care situation is assessed, and quality gaps identified based on the national standards of care	No	Yes	Report	Annual	
Clinical and managerial capabilities to support quality improvement are developed, strengthened and sustained					
A national resource center, with tools to improve capabilities of health care providers and managers on QI is established and functioning.	No	Yes	Report	Annual	
National and district pools of consultants and facilitators with expertise in quality improvement are identified and trained	No	Yes	Report	Annual	
National quality improvement manuals for national, district, facility and community level groups and committees are developed and used	Yes	Yes	Report	Annual	
Monthly/Quarterly meetings for participatory learning on quality improvement at district, facility and community levels are scheduled and implemented	Yes	Yes	Report	Annual	
Learning					
Data systems are developed/strengthened to integrate and use quality of care data for improved care					
A national minimum set of MNCAH quality of care indicators at the district and national level developed, agreed and validated	Yes	Yes	Report	Annual	
A minimum set of MNCAH quality of care indicators in the national health information system established	Yes	Yes	Report	Annual	

System for collection and reporting of case histories, stories from the field, and testimonials developed and used	No	Yes	Report	Annual	
Key data is shared with health facility staff, district health teams and community groups to inform user decision-making, prioritization and planning	No	Yes	Report	Annual	
Mechanisms to facilitate learning and share knowledge through a learning network are developed and strengthened					
National resources on QoC are accessed through MOHS website	No	Yes	Report	Annual	
Virtual and face-to-face learning networks and communities of practice are established and supported at the national and district level	No	Yes	Report	Annual	
Learning collaboratives between health facilities and districts are established and supported	Yes	Yes	Report	Annual	
Data and practice are analyzed and synthesized to generate an evidence base on quality of care improvement					
Data is regularly analyzed and synthesized to identify successful interventions	Yes	Yes	Report	Annual	
Best practice/s is/are identified and disseminated in-country	No	Yes	Report	Annual	
Accountability					
National framework and mechanisms for accountability for QoC are established and functioning					
Quality indicator dashboards to track progress at facility, district and national levels are developed and regularly updated and published	No	Yes	Report	Annual	
Regular multi-stakeholder dialogue is conducted to monitor progress and resolve issues	No	Yes	Report	Annual	
Periodic independent assessments of progress to validate routinely reported results are conducted	No	Yes	Report	Annual	
Progress of the Network on MNH quality of care is regularly monitored					
Annual progress report on QOC is published	Yes	Yes	Report	Annual	
Annual performance review and planning meeting is held	No	Yes	Report	Annual	
Impact of the global initiative on MNH quality of care is evaluated					
Midterm review on QOC Strategic Road Map conducted	No	Yes	Report	Annual	
Terminal evaluation on QOC Strategic Road Map conducted	No	Yes	Report	Annual	

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