# Monitoring Framework

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

## Contents

## Quality of Care Network Goals

- **Reduce maternal and newborn mortality** – reduce maternal and newborn deaths and stillbirths in participating health facilities by 50% over five years.
- **Improve experience of care** – enable measureable improvement in user satisfaction with the care received

## Purpose of the Monitoring Framework

This Monitoring Framework provides guidance on the monitoring and evaluation (M&E) needs for the Network for Improving Quality of Care for Maternal, Newborn and Child Health (the "Quality of Care Network"), which is being launched by nine countries, supported by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) and partners from all stakeholder groups.

The Monitoring Framework aligns with the Quality of Care Network goals, strategic objectives and implementation framework *(1)*, as well as the 2016 WHO *Standards for improving quality of maternal and newborn care in health facilities (2)*.

Considering the diverse range of stakeholders involved in the Quality of Care Network, the Monitoring Framework attempts to balance the monitoring needs across nine unique countries and data users at multiple levels of the health system: facility, district, national and global. To this end, the Framework articulates guidance for review by stakeholders rather than prescriptive instructions. Each country has an existing data and monitoring system and its monitoring needs will vary depending on the country context. The Monitoring Framework builds on the 2016 WHO *Standards for improving quality of maternal and newborn care in health facilities (2)* and also on complementary monitoring frameworks, indicators and measurement methods, including global monitoring frameworks, such as those for ending preventable maternal mortality (EPMM) *(3)*, the Every Newborn Action Plan (ENAP) *(4)* and the Every Woman Every Child (EWEC) Global Strategy for Women's, Children's and Adolescents' Health *(5)*. The Quality of Care Network encourages countries to incorporate, as appropriate, quality of care (QoC) indicators, tools and methodologies into their existing information systems to support improved QoC for mothers, newborns and children. A common set of core indicators is proposed for measurement across all of the countries so that performance of the Network can be monitored, and to facilitate learning within countries and across the nine countries.

## Monitoring components

The Monitoring Framework outlines four key components, visualized and summarized in Table 1, which can be adapted and integrated into existing country health information and monitoring systems.

**Table 1: Monitoring components and link to learning agenda**

| Monitoring component | Description of the component | Description of measurement | Facility manager and QI team | District managers | National MOH leadership |
|---|---|---|---|---|---|
| **1. Quality improvement (QI) measures (facility teams)** | To support rapid improvements in quality of care led by facility-based QI teams supported by district/regional (or other sub-national administrative managerial unit) managers | • For use by QI teams to support rapid improvement of specific care processes and health outcomes<br>• Flexible menu of prioritized measures (not prescriptive) linked to WHO quality statements in the eight standards[a]<br>• May require purpose-built data collection systems (e.g. checklist, column added to registers); ad hoc as required | **HIGH** data collection and use | **HIGH** data collection and use | Moderate data use |
| **2. District/regional performance monitoring measure** | To support district/regional managerial and leadership functions in improving and sustaining quality of care (QoC) in facilities | • Sentinel performance measures to track key district functions and inform management of quality activities<br>• Selected process/output and outcome measures<br>• Measures of facility readiness, especially for essential inputs in standards 2 (information), 3 (referral), 7 (human resources) and 8 (commodities)<br>• Typically measured via inspection systems and routine data systems | Moderate data collection and use | **HIGH** data collection and use | Moderate data use |
| **3. Common core measures** | To provide a common set of standardized indicators for use by all stakeholders at every level of the health system and to track performance across countries | • 5–10 quality measures related to essential maternal and newborn health (MNH) care processes and outcomes for tracking across countries<br>• Aligned with standardized global measures (EPMM, ENAP, EWEC, etc.)<br>• Feasible to measure via routine information systems<br>• For use by **all stakeholders** (facility, regional, national and global, including civil society) | **HIGH** data collection and use | HIGH data use | HIGH data use |
| **4. Implementation milestones** | To track implementation steps and progress against strategic objectives (leadership, action, learning and accountability), in line with global implementation guidance | • Focused on country level milestones to realize improvements in quality of care.<br>• Typically collected via desk review. See Annex 3 for more details.<br>• Relevant for **all stakeholders** | Moderate data collection and use | Moderate data collection and use | **HIGH** data collection and use |

ENAP: Every Newborn Action Plan; EPMM: ending preventable maternal mortality; EWEC: Every Woman Every Child.

[a] The eight standards from the WHO *Standards for improving quality of maternal and newborn care in health facilities (2)*. See Fig. 1.

Tables 1 outlines the primary stakeholders (users) and the measurement description of each component. Indicators and key data users for each component are not mutually exclusive and some indicators may be selected for use as part of more than one monitoring component (e.g. postpartum haemorrhage incidence and case fatality rate may be useful as a quality improvement (QI) measure and as a district/regional performance measure). The results generated in each of the monitoring components will contribute to in-country and cross-country learning as part of the Quality of Care Network's global learning platform.

## Measurement methods

With the exception of the core measures, the Quality of Care Network indicators, measurement methods and data sources will vary according to each country's monitoring framework, which will leverage a diverse set of data sources including, but not limited to, the following:

**Continuous (routine) data collection:**

- **Health management information systems (HMIS)**: To varying degrees, HMIS (such as the District Health Information System [DHIS2]) can provide routine (monthly) information on service utilization, delivery of high-impact interventions, incidence of institutional complications, case fatality rates and mortality.
- **Patient records / health-care facility registers**: These can provide more detailed information on interventions provided and adherence to standards for more complex care processes.
- **Maternal and perinatal death surveillance and response (MDSR) systems**: MDSR can provide detailed case-by-case information about cause of death and underlying contributors, including the quality of the care provided.
- **Civil registration and vital statistics (CRVS) systems**: CRVS can provide information on mortality and population-based denominators (e.g. estimated births).
- **Client questionnaires**: Structured questionnaires can provide information about client priorities for care and experiences of care.

**Periodic data collection:**

- **Health-care facility assessment systems**: These systems, such as Service Availability and Readiness Assessment (SARA), Service Delivery Indicators (SDI), Service Provision Assessment (SPA) and service delivery point (SDP), can provide periodic information on service availability, readiness, management and finance. Additional information on users' and providers' experiences of care will be derived from:
  - **Client exit interviews** – to assess experience of care and user satisfaction

  - **Provider interview (and vignettes)** – to assess provider knowledge, self-reported practice and training
  - **Simulations of care** – to assess provider competence and skills for discrete tasks (e.g. resuscitation of newborn using mannequin)
  - **Observation** – to assess provider performance and adherence to standards of care as part of clinical care
  - **Records review** – to assess quality of documentation and adherence to standards of care
  - **Client interviews and focus group discussions** – to gather and review qualitative and quantitative information about clients' priorities for care, experiences of care and future care-seeking intentions.
- **Population-based health surveys**: These surveys, such as the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS), can provide information on intervention coverage, treatment-seeking behaviour, and patient self-reported practices and experiences of care.
- **Desk review and stakeholder interviews**: These can provide information on activities undertaken and achievement of specific implementation milestones.

Each measurement method and data source has inherent strengths and weaknesses which will need to be considered as countries define an optimal and feasible monitoring framework for their country context. For example, health-care facility assessments provide tremendous depth of information, but are resource-intensive and thus are usually not feasible for routine (e.g. monthly) performance monitoring.

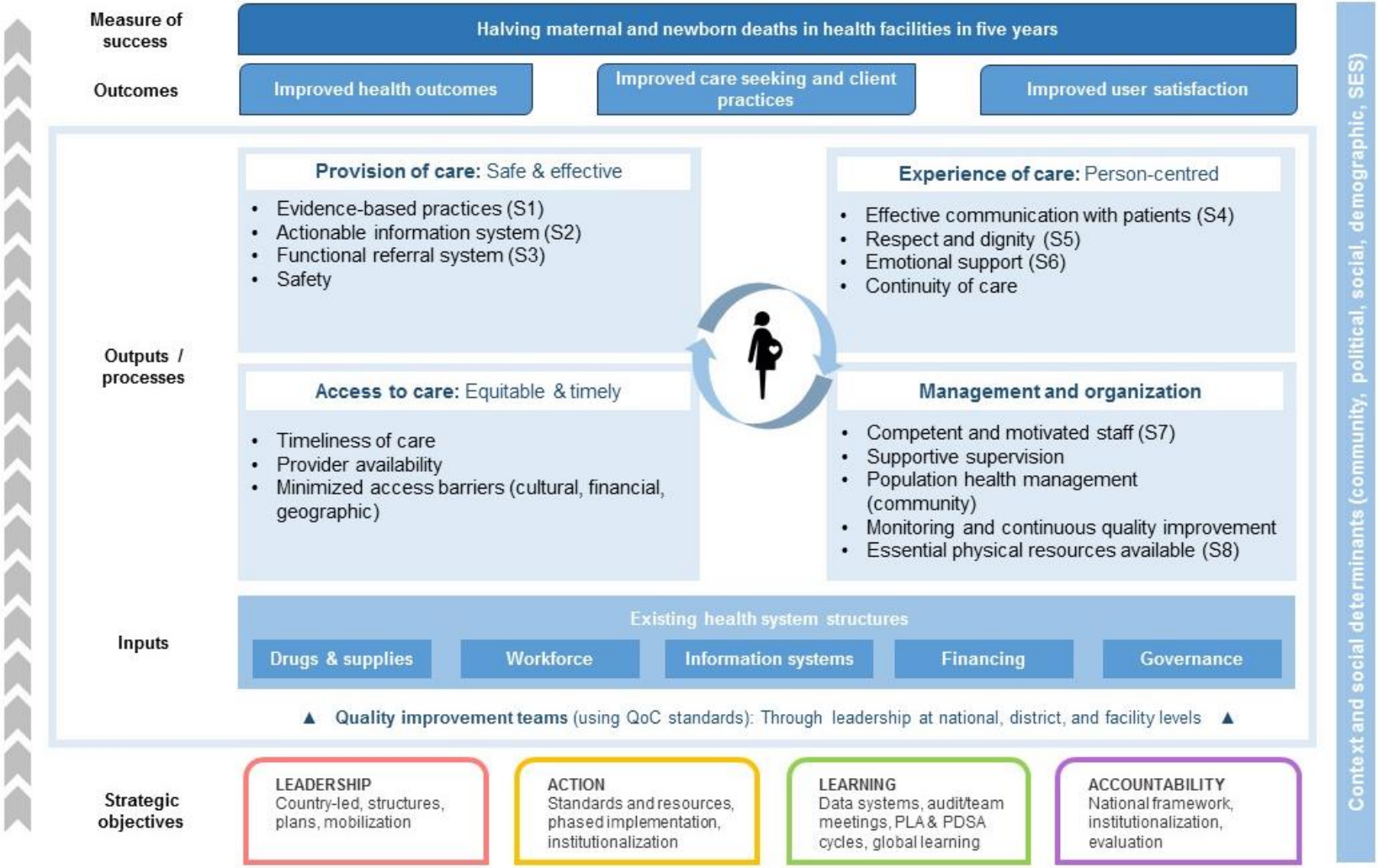
As part of each country's monitoring framework, stakeholders will need to define priority quality measures for routine tracking at national, regional/district and facility level. While some quality measures will be tracked and analysed on a routine basis, other measures will be monitored by a QI team for a finite period – typically using purpose-built data sources (e.g. checklists, added columns to patient registers) – while the team works to improve a specific process of care (e.g. improve management of newborn asphyxia). Not all such measures will need to be, or should be, incorporated into routine national or local information systems.

Many country information systems lack the primary data needed for routine measurement of quality of care (QoC) processes and health outcomes. Registers often lack necessary data points to assess the QoC processes (e.g. percent of newborns with asphyxia resuscitated), especially for more complex clinical processes. In some instances, a standardized facility patient record may not be available. Many national health information systems contain relatively few quality indicators, making it difficult to extract and aggregate performance data across multiple facilities at the desirable scale. Health workers and staff often lack exposure to and capabilities for monitoring QoC, including calculation of relevant measures and visualization and analysis of trends over time (e.g. with a time series trend or run chart).

Countries will need to consider many factors as they define the specific measures that will be included in their country-level QoC monitoring framework. For example, they will need to consider existing data availability, data sources, and which new measurement methods will be feasible in the national context. Poor data quality is a problem in many settings and continuous monitoring of data quality will be an important activity as part of quality assurance.

The Quality of Care Network will help support the participating countries to build information systems and health worker capabilities for monitoring QoC through several mechanisms, including a user-friendly web-based platform of resources. For example, the Network will act as a repository for lists of standardized quality indicators, data collection and measurement methods, and tools. Making use of existing validated tools and analysis methods can save time and resources. Currently, certain areas of quality measurement remain relatively undeveloped with respect to methods and validated tools, particularly for patient satisfaction and experience of care. The Network's web-based platform will be an important communication vehicle and repository of resources as new methods and tools are developed across countries. Importantly, countries are encouraged to identify and communicate information gaps, which can help push researchers to develop new methods and tools.

**Fig. 1: Monitoring logic model: unpacking the links between the strategic objectives and the outcomes of the Quality of Care Network**




PDSA: plan-do-study-act; PLA: participatory learning and action; QoC: quality of care; SES: socioeconomic status.
Note: S1–S8 refer to the eight standards from the WHO *Standards for improving quality of maternal and newborn care in health facilities (2)*.

## The monitoring logic model

The monitoring logic model (Fig. 1) visually unpacks the links between the Quality of Care Network's strategic objectives (i.e. leadership, action, learning and accountability), and the goal of reducing maternal and newborn mortality *(1)*.

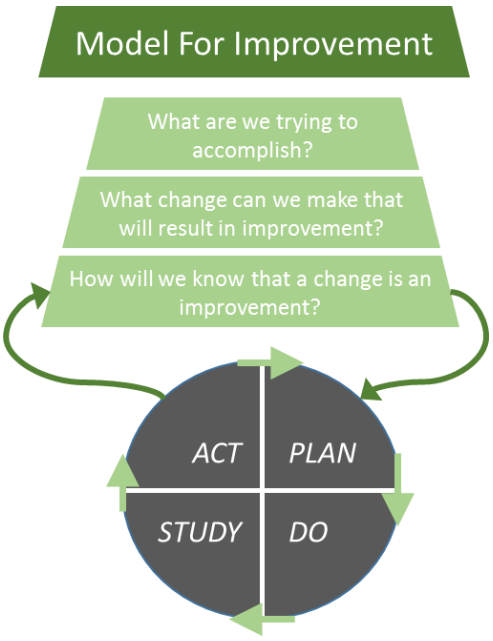
The monitoring logic model builds on several important conceptual models, including the WHO vision paper on quality of care for pregnant women and newborns *(6)*, the Primary Health Care Performance Initiative (PHCPI) *(7)*, the WHO and International Health Partnership (IHP+) country-led platform for information and accountability *(8)*, and the WHO's *Monitoring the building blocks of health systems (9)*. The monitoring logic model is a helpful organizing principle; however, users can reorganize it as needed for their unique context or current priorities. Each country's monitoring needs are unique, but all should attempt to capture at least some indicators from each of the logic model's four central elements: (1) Management and organization; (2) Access to care; (3) Provision of care; and (4) Experience of care.

## Using data for improving quality: model for improvement and the plan-do-study-act (PDSA) cycle

The "model for improvement" (Fig. 2) is one implementation model that provides a structured way to improve the delivery of care. This model uses three questions to structure an improvement plan for better care:

1. What are we trying to accomplish? (a specific numeric and time-bound aim)
2. What change can we make that will result in improvement? (the ideas for change that we can test)
3. How will we know that a change is an improvement? (the measures we will use to track progress for improving care).

**Fig. 2: PDSA Cycle**




The concept of "trying out" ideas and learning what works and what does not is an essential part of implementation designs that can be adapted to local context. One method for testing new ideas for improvement is the "plan-do-study-act" (PDSA) cycle. The PDSA cycle is designed to help QI teams to methodically test and iteratively refine ideas on a small scale before committing to larger-scale implementation. QI teams need to collect real-time data to undertake these tests and track performance of the maternal and newborn care system.

In most cases, the data tracked in the Monitoring Framework will be used for PDSA tests, but some PDSA cycles will use ad hoc measures.

It should be noted that the PDSA cycle is just one example of a test system for new ideas; countries can use other problem-solving or implementation research strategies, as needed.

## Network resources

To support countries with the development and implementation of their Monitoring Framework, the Quality of Care Network will provide resources including, but not limited to:

- **A web-based repository of monitoring tools and guidance**: This will include indicator sets, validated data-collection tools, analysis methods, manuals and capacity-building materials.
- **Technical assistance**: When requested by countries, the Network can facilitate technical assistance to help with the design and implementation of a country-level monitoring framework.
- **A web-based dashboard and tools to track performance**: The Network will develop a web-based dashboard to showcase implementation status and progress towards the collective goals across countries.
- **Links to related initiatives**: The Network will help to connect countries with relevant M&E and health information system initiatives, such as the Health Data Collaborative (HDC) and Primary Health Care Performance Initiative (PHCPI).

## Implementation guidance

As outlined in the "Implementation Guidance" brief *(10)*, some initial next steps for strengthening monitoring systems and data use at different levels of the health system are shown in Table 2.

**Table 2: Next steps for strengthening monitoring systems and data use**

| National | District/regional | Facility |
|---|---|---|
| • Establish (or strengthen) **a minimum set of indicators** for quality of care (QoC) monitoring at national, district and health-care facility levels<br>• Based on need, adapt or develop **district and facility data-collection tools** (registers and primary patient records) to capture essential data<br>• Develop a reliable and transparent **reporting system for facility, district and national levels**<br>• Develop **indicator dashboards** to make indicator data widely accessible and transparent, and use benchmarking to illustrate excellence and variation<br>• Identify and train **national- and district-level facilitators** in analysing and communicating the chosen quality improvement (QI) data and indicators | • **Integrate indicators** for QoC in district management systems, and build a system for monthly tracking<br>• Assess **district-specific baseline values, synthesize and widely disseminate the data**<br>• Strengthen the **capacity of district health management team staff** to review data, ensure their reliability and act upon the information<br>• **Address** structural, system and human resource barriers by providing financial, technical and material **resources and skills-building**<br>• Periodically **share dashboards and progress** with stakeholders and **establish mechanisms for periodic review** | • Continuously **identify the standards and indicators** that the facility will use for quality improvement (QI) and quality control (QC) **of the prioritized processes** of care **and outcomes**<br>• Establish a **baseline and track monthly performance** on the prioritized QoC indicators<br>• Establish a **mechanism to continually disseminate performance** indicators to facility staff, patients, families and community<br>• Strengthen the **capacity of the QI team** to generate and use data for improving QoC<br>• **Benchmark best practices** and update facility information systems to reflect the improvements<br>• Participate in district-level events where **the facility staff** can **compare and discuss** its indicators and QI activities **with other facilities staff** |

## Annex 1: Common core indicators – a list for discussion

The table in this annex provides a preliminary list of common core indicators for review, discussion and feedback.

| Domain | Indicator (all facility-based) | Definition | Reference |
|---|---|---|---|
| **Outcome** | 1. Maternal mortality ratio (MMR) | Number of maternal deaths among 100 000 deliveries in the health-care facility | WHO 100 Core[a], EPMM, ENAP, GS, SDG |
| | 2. Stillbirth rate (disaggregated by fresh and macerated) | Proportion of babies delivered in the facility with no signs of life and born weighing at least 1000 grams or after 28 weeks of gestation | WHO 100 Core[a], ENAP, GS |
| | 3. Pre-discharge neonatal death rate | Proportion of babies born live in the facility dying prior to discharge from facility | WHO QoC |
| | 4. Measure of respectful maternity care (client experience of care) | *To be determined* | *To be determined* |
| | 5. Proportion of women who developed severe postpartum haemorrhage (PPH) | Proportion of women who deliver in the facility and develop severe PPH | WHO QoC |
| **Output / process** | 6. Proportion of women administered immediate postpartum uterotonic (i.e. active management of the third stage of labour) | Proportion of women and girls who gave birth in the facility receiving oxytocin immediately after birth | EPMM |
| | 7. Proportion of maternal and perinatal deaths and near-misses reviewed with standard audit tools | Proportion of all maternal and perinatal deaths and near-misses occurring in the facility that were reviewed with standard audit tools | WHO QoC |
| | 8. Proportion of newborns breastfed within one hour of birth | Proportion of babies born live in the facility that were breastfed within one hour of birth | WHO 100 Core[a]; ENAP; GS |
| | 9. Proportion of newborns not breathing / crying spontaneously at birth for whom additional resuscitation actions (stimulation and/or bag and mask) were taken. | Proportion of newborns not breathing/crying spontaneously at birth in the facility for whom additional resuscitation actions (stimulation and/or bag and mask) were taken | ENAP |
| | 10. Proportion of newborns under 2000 grams initiated on facility-based kangaroo mother care (KMC) | Proportion of babies born live in the facility weighing under 2000 grams initiated on facility-based KMC | ENAP |
| | 11. Proportion of deliveries where delivery attendant washed hands with soap | Proportion of deliveries in the facility where the delivery attendant washed hands with soap before providing delivery care | *Pending* |

ENAP: Every Newborn Action Plan; EPMM: ending preventable maternal mortality; GS: Global Strategy; QoC: quality of care; SDG: Sustainable Development Goal.

[a] Indicator definition adapted to facility-based data collection *(11)*.

## Annex 2: Quality improvement (QI) measures – an example

Each of the eight WHO standards for improving quality of maternal and newborn care in facilities includes several **quality statements** and associated **measures** *(2)*. **Quality statements** are concise, prioritized statements designed to help drive measurable improvements in care. Three types of measures are defined for each quality statement:

- **Inputs** – what must be in place for the desired care to be provided
- **Outputs** (process) – whether the desired process of care was provided as expected
- **Outcome** – the effect of the provision and experience of care on health and people-centred outcomes.

The WHO quality statements and measures can be used to inform the improvement areas prioritized by the teams at the district and facility level to monitor performance of essential functions (e.g. round-the-clock availability of essential commodities) and quality of maternal and newborn care in facilities. The table below summarizes illustrative input, output/process and outcome measures for two WHO quality statements highlighting links to monitoring framework components.

| **WHO quality statement** | **Illustrative input, output and outcome measures** | **Monitoring Framework component** |
|---|---|---|
| **WHO Quality Statement 1.3 (evidence-based care):** Women with postpartum haemorrhage (PPH) receive appropriate interventions according to WHO guidelines | • **Input measures**:<br>  • Proportion of facilities with functional uteronic available around the clock in the delivery room<br><br>➢ **Process/output measures**:<br>  • Proportion of women delivered who received immediate postpartum uteronic (PPH prevention)<br>  • Proportion of women with PPH treated with therapeutic uteronic<br><br>➢ **Outcome measures:**<br>  • Proportion of women who developed PPH (incidence)<br>  • Proportion of women with PPH who died (case fatality rate) | - QI measure<br>- District performance measure<br><br>- QI measure<br>- Core indicator (PPH prevention)<br><br>- QI measure<br>- District performance measure |
| **WHO Quality Statement 7.3 (motivated, competent staff):** Managerial and clinical leadership (district/facility) fosters an environment that supports facility staff in continuous QI | ➢ **Input measures:**<br>  • Facility has designated QI team and responsible personnel<br>  • Proportion of all facility (district) managers trained in QI and leading change<br><br>➢ **Output/process**: | - District performance measure<br>- Implementation milestone<br><br>- Implementation milestone |

| | | |
|---|---|---|
| | • Facility team meets at least monthly to review data, monitor QI performance, address problems, recognize improvement<br>• Facility leadership communicates performance through established monitoring mechanisms to all relevant staff (e.g. dashboard of key metrics)<br><br>➢ **Outcome:**<br>• Evidence for improved performance of system according to facility (district) dashboard | - QI measure<br>- District performance measure |

A number of initiatives – such as "First Embrace" in the WHO Western Pacific Region *(12)* – are gaining important experience at the regional and country levels with tracking and using measures to strengthen performance of essential system functions (e.g. around-the-clock availability of functional commodities) and to improve processes of care and experience of care for mothers and newborns.

## Annex 3: Implementation milestones – a recommended starting point

The table in this annex presents a recommended starting point for the implementation milestones, which track progress against the Quality of Care Network's strategic objectives: leadership, action, learning and accountability. Additional details can be found in the working document on the quality of care (QoC) strategy *(1)* and in the country implementation guidance *(10)*. This list is preliminary; more detailed definitions and data sources will be forthcoming.

| Implementation milestones (by Strategic Objective) | Source |
|---|---|
| **1. Leadership** | |
| **1.1 National and district governance structures for quality of care (QoC) are strengthened (or established) and functioning** | |
| 1.1.1 National leadership structure for QoC in health services is strengthened (or established) | Desk review |
| 1.1.2 Ministerial, multistakeholder steering group for quality improvement in maternal and newborn health (MNH) services is strengthened (or established) | Desk review |
| 1.1.3 QoC committees in district health management teams are established (including representatives from the community and women's associations) and functioning | Desk review |
| 1.1.4 QoC committees in hospitals and quality improvement (QI) teams in health-care facilities are established (including representatives from the community and women's associations) and functioning | Desk review * (a,b) |
| 1.1.5 Liaison mechanism between groups at the three levels (national, district and health-care facility) on quality issues is established and functioning | Desk review * (a,b) |
| **1.2 National vision, strategy and operational plan for improving QoC in MNH services are developed, funded, monitored and regularly reviewed** | |
| 1.2.1 National vision, strategy and operational plan (with targets) for improving QoC in MNH services are developed | Desk review |
| 1.2.2 Partners are aligned and resources mobilized for implementation of the national operational plan | Desk review |
| 1.2.3 Implementation of the national operational plan is costed and funding allocated in the budget | Desk review |
| 1.2.4 Human resources for implementation of the national plan are committed and roles and responsibilities of different stakeholders are agreed | Desk review |
| 1.2.5 Regular reviews of progress against targets are conducted and the national plan is adjusted as required | Desk review |
| **1.3 National advocacy and mobilization strategy for QoC is developed and implemented** | |
| 1.3.1 Professional associations, academics, civil society and the private sector are brought together and mobilized to champion the Quality of Care Network and support implementation | Desk review |
| 1.3.2 National advocacy and mobilization strategy is developed, implemented and monitored | Desk review * (b) |
| **2. Action** | |
| **2.1 WHO evidence-based standards of care for mothers and newborns are adapted and disseminated** | |
| 2.1.1 National standards and protocols for maternal and newborn QoC are compiled and reviewed | Desk review |
| 2.1.2 National standards and protocols are adapted and updated using WHO standards of MNH care | Desk review |

| | | | |
|---|---|---|---|
| | | 2.1.3 National standards and protocols are incorporated into national practice tools | Desk review |
| | | 2.1.4 Updated national standards, protocols and practice tools are disseminated to all relevant stakeholders and used | Desk review * (a,b) |
| | **2.2 National package of quality improvement (QI) interventions is adapted (or developed) and disseminated** | | |
| | | 2.2.1 QI interventions in the country are compiled and reviewed and best practice is identified | Desk review |
| | | 2.2.2 QoC situation is assessed and quality gaps identified based on the national standards of care | Desk review |
| | | 2.2.3 National package of QI interventions to address identified quality gaps is developed and disseminated, drawing on the WHO QI intervention | Desk review |
| | **2.3 Clinical and managerial capabilities to support QI are developed, strengthened and sustained** | | |
| | | 2.3.1 A national resource centre, with tools to improve capabilities of health-care providers and managers is established and functioning | Desk review * (b) |
| | | 2.3.2 National and district pools of consultants and facilitators with expertise in QI (including participatory learning and action [PLA]) are identified and trained | Desk review |
| | | 2.3.3 National QI and PLA manuals for national-, district-, facility- and community-level groups and committees are developed and used | Desk review * (a,b) |
| | | 2.3.4 Monthly meetings for participatory learning on QI at district, facility and community levels are scheduled and implemented | Desk review * (a,b) |
| | **2.4 QI interventions for MNH are implemented** | | |
| | | 2.4.1 Demonstration sites for QoC in MNH services are identified and established to implement national package of QI interventions | Desk review |
| | | 2.4.2 Change package is adapted to district context | Desk review |
| | | 2.4.3 Resources and technical support to implement the change package in the districts are provided | Desk review |
| | | 2.4.4 Success of demonstration sites is regularly reviewed and assessed | Desk review * (a,b) |
| | | 2.4.5 Refined package of effective and scalable QoC interventions is identified from demonstration sites | Desk review |
| | | 2.4.6 Implementation of refined package of interventions is expanded into new districts and health-care facilities | Desk review * (a,b) |
| **3. Learning** | | | |
| | **3.1 Data systems are developed/strengthened to integrate and use QoC data for improved care** | | |
| | | 3.1.1 A national minimum set of MNH QoC indicators at the district and national level, aligned with the core global indicators, is agreed and validated | Desk review |
| | | 3.1.2 Process to add a minimum set of MNH QoC indicators in the national health information system is established and supported | Desk review |
| | | 3.1.3 Data collection, synthesis and reporting are standardized and data quality is monitored and assessed | Desk review * (a,b) |
| | | 3.1.4 Capabilities in data collection, synthesis and use at health-care facility, district and national levels are strengthened | Desk review |
| | | 3.1.5 System for collection and reporting of case histories, stories from the field, and testimonials is developed and used | Desk review * (a,b) |
| | | 3.1.6 Key data are shared with health-care facility staff, district health teams and community groups to inform user decision-making, prioritization and planning | Desk review * (a,b) |
| | **3.2 Mechanisms to facilitate learning and share knowledge through a learning network are developed and strengthened** | | |

| | | | |
|---|---|---|---|
| | | 3.2.1 National and international resources on QoC are accessed through a dedicated QoC website | Desk review |
| | | 3.2.2 Virtual and face-to-face learning networks and communities of practice are established and supported at the global, national and district levels | Desk review * (a,b) |
| | | 3.2.3 Learning collaboratives between health-care facilities and districts are established and supported | Desk review * (a,b) |
| | | 3.2.4 Government focal point and national institution to coordinate and sustain a national learning network are identified | Desk review |
| | **3.3 Data and practices are analysed and synthesized to generate an evidence base on QoC improvement** | | |
| | | 3.3.1 Data are regularly analysed and synthesized to identify successful interventions | Desk review * (a,b) |
| | | 3.3.2 Best practices and variations are identified and disseminated in-country and between countries | Desk review |
| **4. Accountability** | | | |
| | **4.1 National framework and mechanisms for accountability for QoC are established and functioning** | | |
| | | 4.1.1 Quality indicator dashboards to track progress at facility, district and national levels are developed and regularly updated and published | Desk review * (a,b) |
| | | 4.1.2 Inputs and outputs in the national operational plan for QoC are tracked and regularly reported, and reports are disseminated to stakeholders and discussed in national forums | Desk review * (b) |
| | | 4.1.3 Regular multistakeholder dialogue is conducted to monitor progress and resolve issues | Desk review * (a,b) |
| | | 4.1.4 Periodic independent assessments of progress to validate routinely reported results are conducted | Independent assessment |
| | **4.2 Progress of the Quality of Care Network on MNH QoC is regularly monitored** | | |
| | | 4.2.1 Annual progress report on the Quality of Care Network is published | Desk review |
| | | 4.2.2 WHO Quality of Care Network plan is reviewed, revised and shared | Desk review |
| | | 4.2.3 Annual review and planning meeting of the Quality of Care Network (members and affiliates) is held | Desk review |
| | | 4.2.4 Learnings of implementation are summarized and made available in the public domain (including peer-reviewed publications) | Desk review |
| | **4.3 Impact of the global initiative on MNH QoC is evaluated** | | |
| | | 4.3.1 Country-specific evaluation designs are developed and agreed | Desk review |
| | | 4.3.2 Pre-intervention qualitative and quantitative data collection is established and implemented | Desk review * (a,b) |
| | | 4.3.3 Interim impact analysis is performed and used to inform programme implementation | Desk review * (a,b) |
| | | 4.3.4 Final impact analysis is performed and disseminated | Desk review |

* = Indicator has more detailed data source requirements.

a = Indicator may require subnational (e.g. district, facility, community) data collection.

b = Indicator may require regular or ongoing (e.g. quarterly, 6-monthly, annual) update of information.

## Notes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