INTEGRATING STAKEHOLDER AND COMMUNITY ENGAGEMENT IN QUALITY OF CARE INITIATIVES FOR MATERNAL, NEWBORN AND CHILD HEALTH

A module of the "Improving the quality of care for maternal, newborn and child health – Implementation guide for national, district and facility levels"

World Health Organization

unicef
for every child

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ABBREVIATIONS AND ACRONYMS

CBO	community-based organization
CEDAW	Committee on the Elimination of Discrimination against Women
CLMDR	community-linked maternal death review
IFC	individuals, families and communities
M&E	monitoring and evaluation
MNCH	maternal, newborn and child health
MNH	maternal and newborn health
MOH	ministry of health
NGO	nongovernmental organization
PCA	participatory community assessment
PMTCT	prevention of mother-to-child transmission
QI	quality improvement
QoC	quality of care
TBA	traditional birth attendant
TWG	technical working group
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

THE ORIENTATION MODULE AT A GLANCE

What is this document?

This module aims to make stakeholder and community engagement an integral part of quality improvement (QI) initiatives and suggests approaches to make stakeholder and community engagement comprehensive (engagement throughout the maternal, newborn and child health QI planning, implementation, and monitoring and evaluation cycle) and meaningful (supporting efficiency as well as partnership building and empowerment goals).

Who is it for?

It is meant for policy-makers and programme implementers who are interested in and/or (aim to) initiate and support stakeholder and community engagement in QI initiatives in maternal, newborn and child health across different levels. More specifically, it provides operational guidance to QI teams.

How should it be used?

Users of this module can use it to learn about the following topics:

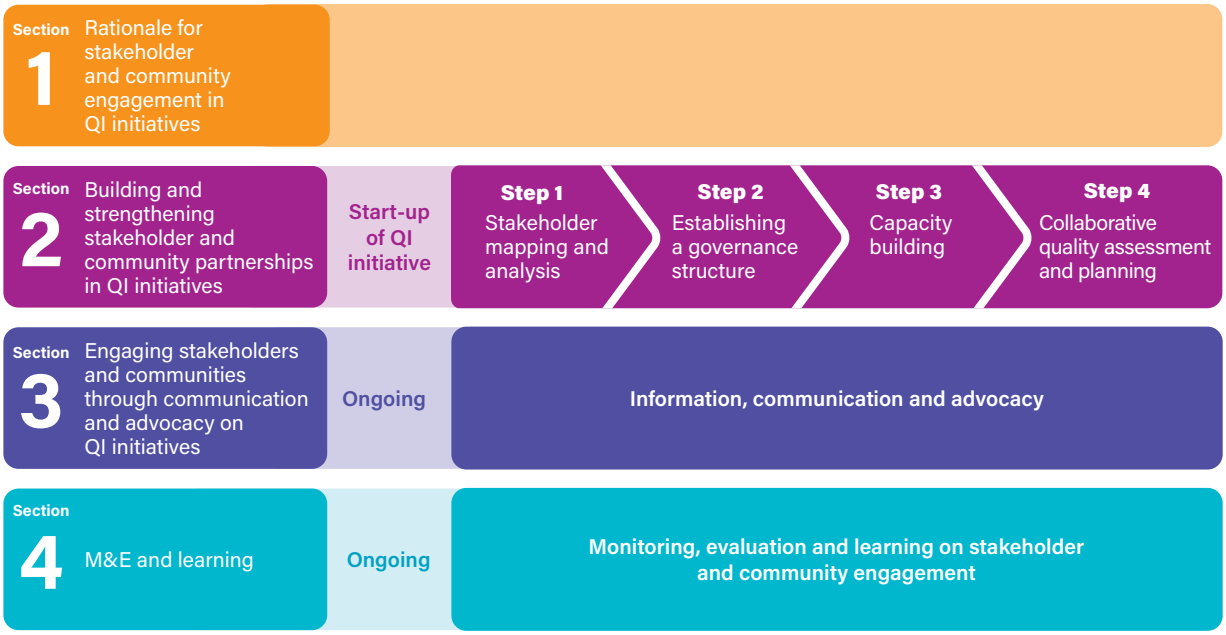
- Why there is a need for stakeholder and community engagement in QI initiatives.
- Who should be engaged in QI initiatives, why and how, and what can be done to build and strengthen QI partnerships.
- How to conduct collaborative quality assessments.
- How to develop information, communication and advocacy strategies.
- What can be learned from stakeholder and community engagement.

These topics are addressed in four sections, each providing practical guidance. At the end of each section, key references and tools are presented that may be consulted by readers who wish to access examples and more detailed "how to" guidance.

Structure of the module

Fig. 1 presents the structure of the module. The practical parts of the module (Sections 2, 3 and 4) align with the start-up and ongoing activities described in the implementation guide for national, district and facility levels.

Fig. 1. Structure of the module



Where available, we have indicated existing resources or tools developed by partners of the Network for Improving Quality of Care for Maternal, Newborn and Child Health (QOC Network) or other organizations. These tools were identified in the mapping exercise and may be of use to the reader when moving forward in implementation. Their inclusion in the module is not an endorsement of the tools by WHO and UNICEF. Further details of the mapping can be found at this link: https://who.int/activities/tools-to-support-the-integration-of-stakeholder-and-community-engagement-in-quality-of-care-initiatives-for-maternal-newborn-and-child-health

INTRODUCTION

Background

Health facilities that are properly staffed and equipped can provide high-quality care during the crucial moments surrounding labour and childbirth, for both the mother and baby. In fact, 75% of newborn deaths can be prevented with high-quality care, as can the majority of maternal deaths and stillbirths.[1] Continued emphasis on quality of care (QoC) in facilities is critical to advancing maternal, newborn and child health (MNCH).[2] In this process, stakeholder and community engagement is integral to ensuring that the care for women and newborns is of sufficient quality and according to their preferences and needs.

The Network for Improving Quality of Care for Maternal, Newborn and Child Health (QOC Network) aims to reduce maternal and newborn mortality, and stillbirths, and to improve experiences of care. The QOC Network sets out to achieve a vision where every pregnant woman and newborn infant receives quality care throughout pregnancy, childbirth and the postnatal period. Currently, 10 countries across sub-Saharan Africa and South Asia have joined the QOC Network: Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Sierra Leone, United Republic of Tanzania and Uganda.

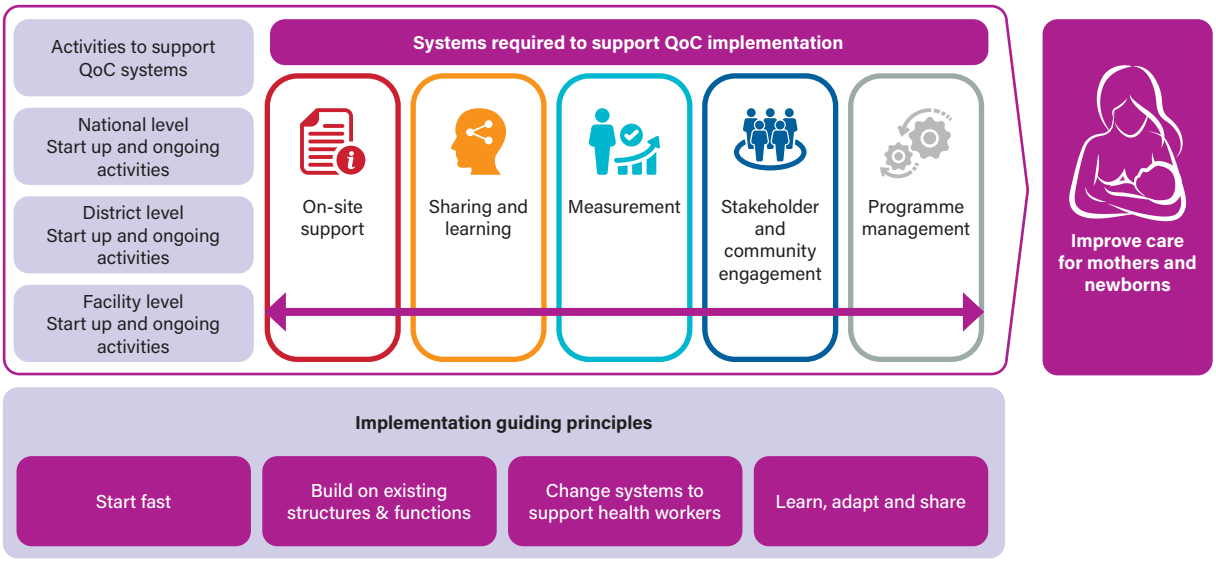
In 2018, WHO conducted a scoping review that identified and reviewed existing guidelines, systematic reviews and primary studies around introducing stakeholder and community engagement into quality improvement (QI) processes. A comprehensive mapping exercise complemented the scoping review by collecting and synthesizing implementation tools used by different organizations to implement stakeholder and community engagement in QI initiatives. This module translates the findings of the scoping review and mapping exercise into actionable guidance and complements the implementation guide[3] developed by the QOC Network by expanding on the component of stakeholder and community engagement in QoC implementation (see Fig. 2).

1 Ending preventable newborn deaths and stillbirths. Geneva: WHO and UNICEF; n.d. (https://www.who.int/life-course/news/events newborns-stillbirths-75percent-preventable-lr-reduced.pdf).

2 Chou VB, Walker N, Kanyangarara M. Estimating the global impact of poor quality of care on maternal and neonatal outcomes in 81 low- and middle-income countries: a modeling study. PLoS Med. 2019;16(12):e1002990.

3 The Network for Improving Quality of Care for Maternal, Newborn and Child Health (QOC Network). Improving the quality of care for maternal, newborn and child health – Implementation guide for national, district and facility levels. Geneva: WHO; forthcoming.

Fig. 2. Implementation guide components



Source: Improving the quality of care for maternal, newborn and child health – Implementation guide for national, district and facility levels.

Aim of this module

This module aims to make stakeholder and community engagement an **integral** part of quality improvement (QI) initiatives, and suggests approaches to make stakeholder and community engagement **comprehensive** (engagement throughout the MNCH QI planning, implementation, monitoring and evaluation [M&E] cycle) and **meaningful** (supporting efficiency as well as partnership building and empowerment goals).

If stakeholder and community mapping and analysis, and the development of an engagement strategy are made an explicit part of QI initiatives, engagement is more likely to be systematic and meaningful in the governance structure and coordination mechanisms of the QI initiative, as well as in the implementation approach.

Readers of this module are encouraged to explore, test and learn from the guidance and resources offered, as appropriate and in line with stakeholder and community engagement processes already in place. This module will support the development of planned, meaningful and sustainable stakeholder and community engagement strategies and activities to make sure that every pregnant woman, newborn and child receives high-quality care in health services.

Target audience

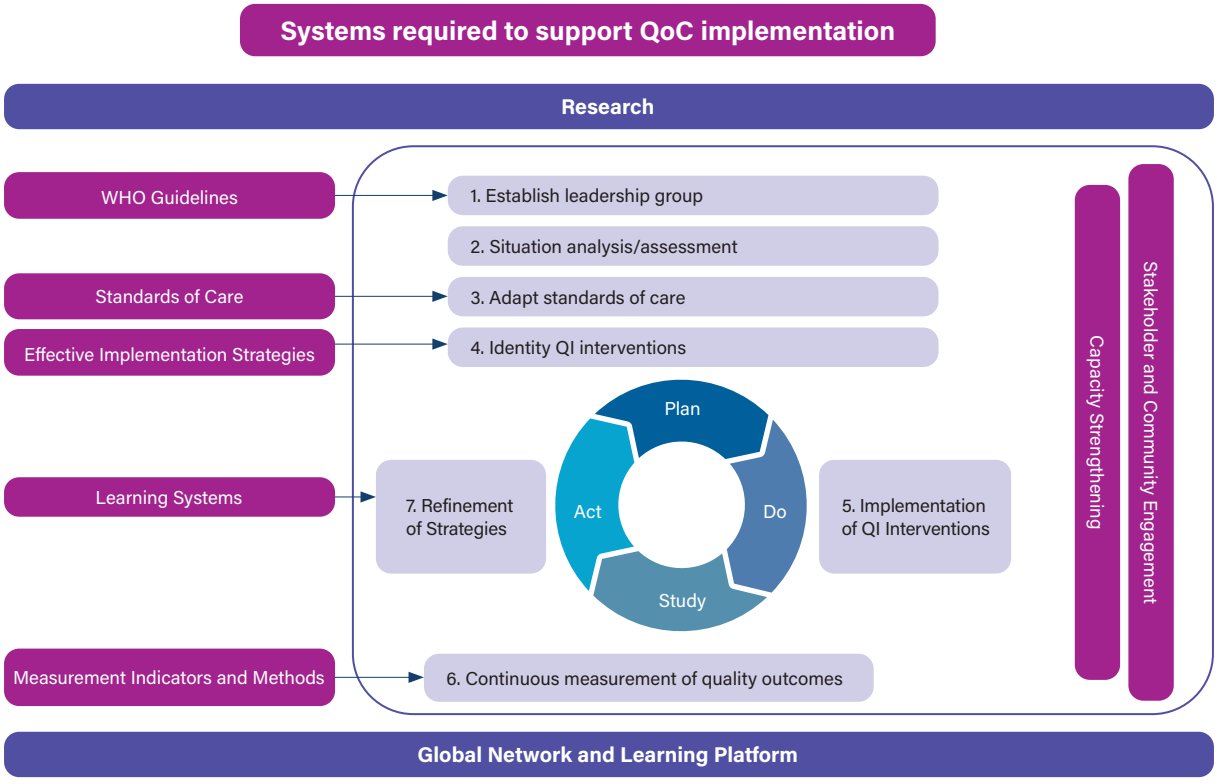
This module will support policy-makers and programme implementers who are interested in and/or (aim to) initiate and support stakeholder and community engagement in QI initiatives in MNCH across different levels. More specifically, it provides operational guidance to QI teams, which, in this module, refers to teams or working groups that take the leadership in stakeholder and community engagement in QI initiatives in MNCH. QI teams may be called by different names in various countries and may operate at different levels. They can be ministry of health (MOH) departments, teams and staff at the national level working on MNCH, community participation, community health, health promotion or QoC, or, as suggested in the implementation guide, technical working groups (TWG) at the national level overseeing QI initiatives. At the district and facility levels, this module may be used by QI teams, district health management teams, facility managers, and others involved in QI in MNCH. It is important to identify a group of individuals inside these structures (QI teams or TWG) who take the responsibility for stakeholder and community engagement activities, and who receive the mandate and resources to conduct (a selection of) steps identified in this module.

How to use this module

This module can be used to identify concrete steps and actions that need to be taken to support stakeholder and community engagement in QI for MNCH. Each section starts with a guidance section and is complemented by a list of resources that readers can consult to access more detailed "how to" guidance and examples.

- Section 1 outlines the **rationale** for stakeholder and community engagement in QI initiatives in MNCH and provides some key concepts used.
- Section 2 provides guidance to audiences at national, district and facility levels **on building and strengthening stakeholder and community QI partnerships** in MNCH in an explicit and systematic way. It supports the integration of stakeholder and community engagement in QI planning, as well as collaborative quality assessment. These strategies support the start-up phase described in the implementation guide[4] (see Fig. 3, steps 1–4).
- Section 3 can be used by QI teams seeking to **sustain** stakeholder and community engagement by developing targeted information, communication and advocacy strategies. These strategies support the ongoing activities described in the implementation guide (see Fig. 3, step 5).[5]
- Section 4 proposes approaches and tools to **monitor, evaluate and document** stakeholder and community engagement, in particular, QI partnerships. These strategies support the measurement, learning and refinement activities described in the implementation guide (see Fig. 3, steps 6 and 7).[6]

Fig. 3. Quality of care framework (implementation guide)



4 Ibid.

5 Ibid.

6 Ibid.

Box 1 summarizes the key concepts used in this module.

Box 1. Key concepts used in this module

Quality of care (QoC) – QoC is defined as "the extent to which health-care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered".[7]

Quality of MNCH care – This refers to "the degree to which maternal and newborn health services (for individuals and populations) increase the likelihood of timely, appropriate care for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and take into account the preferences and aspirations of individual women and their families". The WHO framework for the quality of maternal and newborn health care identifies three QoC dimensions (provision of care, experience of care, and resources) and eight QoC standards (see Table 2) that should be targeted to assess, improve and monitor care along two important and interlinked dimensions of provision and experience of care.[8] Stakeholders and communities are important participants in each of the domains and dimensions as service users, supporters and influencers.

Quality improvement (QI) – QI is "an organizational strategy that formally involves the analysis of process and outcomes data and the application of systematic efforts to improve performance".[9] In this module, this concerns strengthening one or more dimensions of quality in order to improve MNCH care performance. This module uses the term quality improvement (QI) initiative to refer to improvement in policies, programmes, interventions and plans.

Stakeholders – Stakeholders are persons, groups, or institutions that are interested in or can influence QoC in an MNCH policy or programme, or who may be directly or indirectly affected by the process or outcome.[10] Stakeholders comprise multiple individuals and groups that could include community members, patients, health professionals, policy-makers, civil society, opinion leaders and the private sector.[11]

Community – These are "groups of people who share common interests, concerns or identities in settings that are defined by geography, culture, administrative boundaries or geopolitical region or that are identified with joint activities, such as work or recreation".[12] "Community" may be conceptualized differently depending on the context and discipline. Examples are the "global health community" or the "MNCH community", mostly referring to people who share a field of work. In literature on health service delivery, "community" is often ill defined, sometimes referring to groups of people living in a health facility catchment area or another administrative entity such as a county or district. In the field of community health, "community" often refers to women, men, family and community members (who are, in turn, ill defined). What matters in this module is that communities, or individual members of communities, may be stakeholders (or not). The guidance in this module aims to invite QI teams to break down the concept of "community" and identify communities that have a stake in QI initiatives.

Stakeholder and community engagement – This is "a process of developing relationships that enable stakeholders to work together and gain access to processes for assessing, analysing, planning, leading, implementing, monitoring, and evaluating actions, programmes and policies to address quality of MNCH services".[13]

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7 Standards for improving quality of maternal and newborn care in health facilities. Geneva: World Health Organization; 2016.

8 Ibid.

9 Implementation guide for national, district and facility levels.

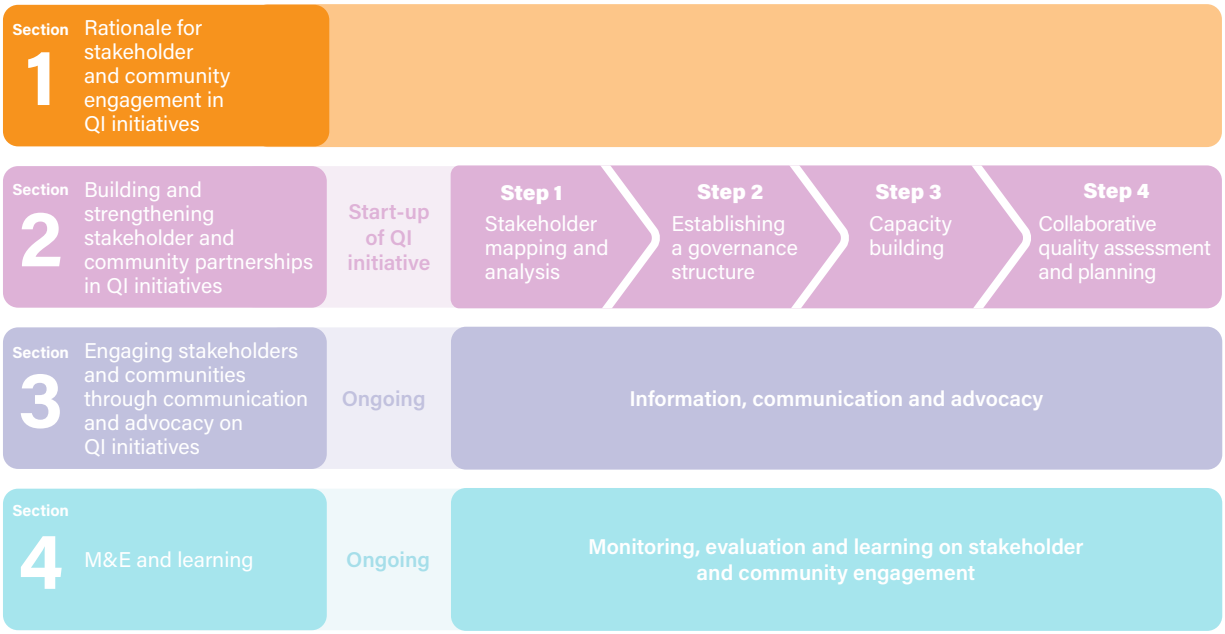
10 Stakeholder mapping guide for WHO MEC/SPR. Geneva: World Health Organization; n.d. (https://www.who.int/reproductivehealth/stakeholder-mapping-tool.pdf).

11 Adapted from: Glossary, Implementation guide for national, district and facility levels; and Spencer J, Gilmore B, Portela A. A mapping and synthesis of tools for stakeholder and community engagement in quality improvement processes for Sexual, Reproductive, Maternal, Newborn and Child Health, forthcoming. N

12 Marston C, Hinton R, Kean S, Baral S, Ahuja A, Costello A, et al. Community participation for transformative action on women's, children's and adolescent's health. Bull World Health Organ. 2016;94(5):376–82.

13 Adapted from Glossary, Implementation guide for national, district and facility levels; and A mapping and synthesis of tools for stakeholder and community engagement in quality improvement processes for Sexual, Reproductive, Maternal, Newborn and Child Health

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



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

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

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

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

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

15 Handbook for national quality policy and strategy.

16 Handbook for national quality policy and strategy.

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

18 Handbook for national quality policy and strategy.

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

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

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

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

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

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

22 Handbook for national quality policy and strategy.

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

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

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

Degrees of stakeholder and community engagement

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

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

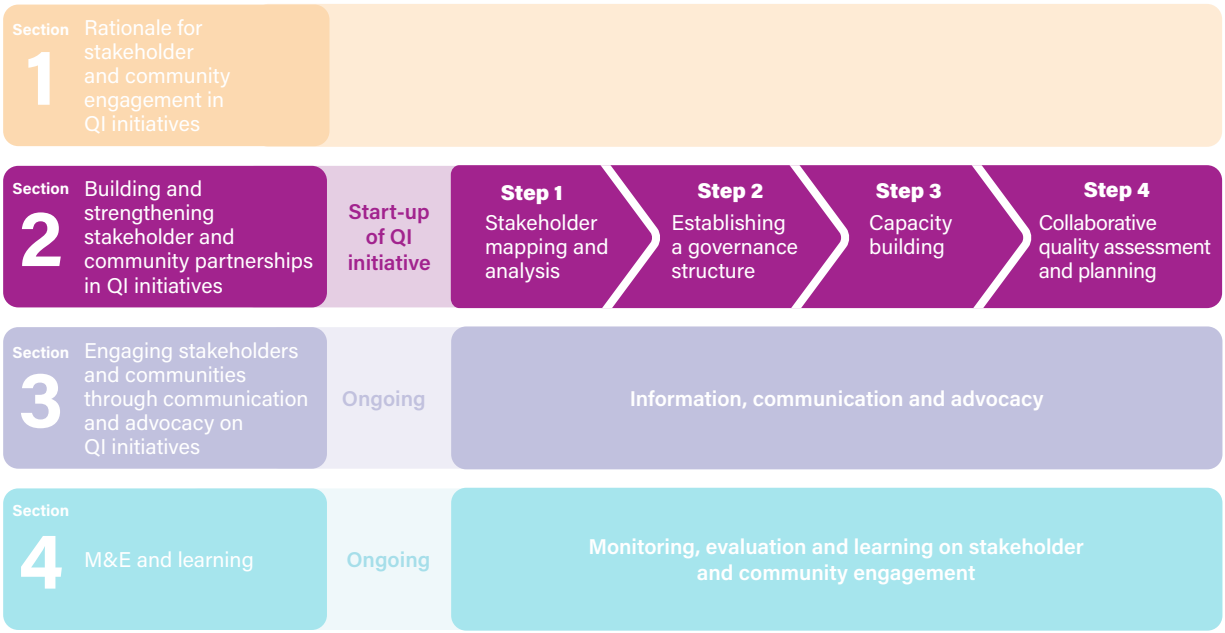
26 Examples of a continuum: Informing, consultation, co-production, delegated control, community control. In: Popay J (2006). Community engagement and community development and health improvement: a background paper for the National Institute for Health and Care Excellence (NICE). Outreach, consult,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

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

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

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

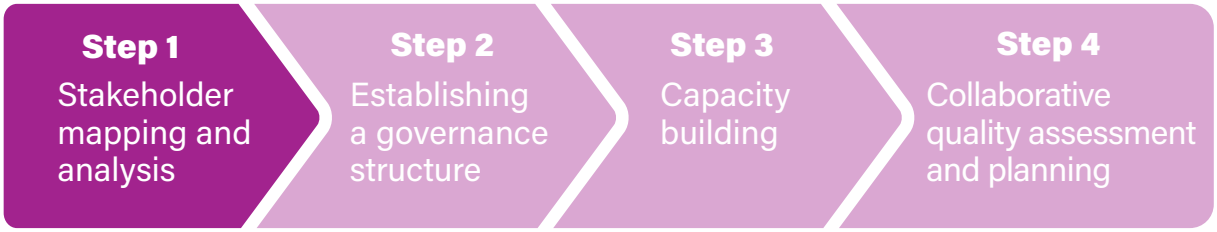
SECTION 2. BUILDING AND STRENGTHENING STAKEHOLDER AND COMMUNITY PARTNERSHIPS IN QUALITY IMPROVEMENT INITIATIVES



For QI initiatives to be effective, meaningful and sustainable, stakeholder and community engagement is crucial across the start-up and implementation phases and across the health-care system at the national, district and facility levels. This section outlines four steps to take, with corresponding activities relevant to each step. Engagement for policy-making, programming and service delivery should follow similar steps, though the types of stakeholders may vary by country and level. At the national level, for example, engagement will mostly refer to stakeholder groups relevant for that level, with users and communities being represented by intermediary structures such as civil society organizations. At the facility level, engagement may be with representatives too but also more directly with groups of women and community members, depending on the engagement approach. The approaches presented in this section will be common to all levels but include such specificities where relevant.

Step 1. Stakeholder mapping and analysis

Given the rationale outlined above, policy-makers and planners need to conduct a careful stakeholder mapping and analysis to ensure that the right individuals and organizations are contributing commitment, knowledge and resources to QI initiatives. Such mapping will take into account differences in stakeholders' experiences, influence and power, and facilitate effective engagement. It also helps to define the roles that stakeholders can play in the programme, and the resources (information and knowledge, funding, technical assistance, alliances, advocacy) they can bring to bear. The result – a stakeholder engagement strategy – should be part of the QI initiative, strategies and operational plans.



1. Specify the issue at stake
2. List stakeholders
3. Conduct a stakeholder analysis
4. Identify potential roles

Stakeholder mapping and analysis is often done informally, in an ad hoc way, and not systematically updated. As a result, it may only include stakeholders who already agree with the policy or programme or only invite participants from selected organizations that are directly involved in the implementation. Such approaches may miss important interest groups that could contribute valuable insights, influence or resources to the programme. Omitting their voices may threaten the embedding and sustainability of the programme.[27]

Stakeholder mapping and analysis can be broken down into four activities. These can be tailored during any stage of the QI initiative (planning, implementation and M&E), although it is most beneficial at the early stages of programme design, prioritization and preparation. At that stage, a stakeholder analysis will avoid overlooking important or influential individuals or organizations.

Box 2 (found on page 19) at the end of this section lists resources available to support stakeholder and community mapping and analysis.

Activity 1. Specify the quality issue at stake

The issue or problem needs to be carefully delineated. If it is stated very broadly ("QoC in MNCH"), it will be hard to identify relevant stakeholders. It may be useful to break down the analysis; for example, by focusing on one QoC dimension or standard at a time (see Table 2)[28] or a quality issue that affects particular groups (e.g. adolescents or unmarried women or health workers in rural areas).

27 Stakeholder engagement tool. Chapel Hill: Measure Evaluation; 2011 (https://www.measureevaluation.org/resources/publications/ms-11-46-e).

28 Standards for improving quality of maternal and newborn care in health facilities (p. 16).

Table 2. WHO quality of care framework

Dimension and intervention area for improvement	Standards
Provision of care	1. Evidence-based practices for routine care and management of complications
	2. Actionable information systems
	3. Functioning referral systems
Experience of care	4. Effective communication
	5. Respect and preservation of dignity
	6. Emotional support
Resources	7. Competent, motivated personnel
	8. Availability of essential physical resources.

The quality issue at stake may be informed by existing quality assessments or may be predefined by the improvement aims set by national-level QoC policies. When there is an opportunity to conduct a new or more comprehensive (i.e. addressing all dimensions of QoC) quality assessment at national, district, or facility level, this could become a stakeholder and community engagement process in itself. Guidance on such processes is provided in Section 3.

Activity 2. List the names of stakeholders relevant to the quality dimension at stake

These include persons; groups such as health professionals, councils or organizations; and research institutions with interests in the defined issue, quality gap or improvement programme, or who may be directly or indirectly affected by the process or outcome. List organizations, groups, or individuals and categorize them by their location (national, district, facility) and sector. Table 3 presents examples of stakeholders for different levels.

An obvious start may be to identify existing QI efforts and start with mapping stakeholders who have already been involved in these programmes. District offices are often well placed to map these, to identify gaps that need to be filled, and to avoid duplication. Good starting references may also be health governance and health systems policies.

Make sure to include stakeholders who are directly affected by QoC issues, including representatives of women using MNCH services and marginalized groups. Also include representatives of health providers, especially midwives and nurses, and managers through their professional associations or societies. Their voices and perspectives on quality of care and challenges and solutions as well as their support to the process is instrumental to the success or failure of any QI strategy.[29]

Activity 3. Conduct a stakeholder analysis. For each stakeholder identified, describe, per level, their stake in the QoC issue, namely:

- **Experience** with QI initiatives in MNCH. People who can bring in success factors, lessons learned from interventions or from challenges around QoC in MNCH. For example, those who have experience in:
  - QoC policy-making, implementation, documentation and scale-up;
  - advocacy for improved QoC in MNCH or other sectors, such as adolescent care;
  - creating an enabling environment for improved QoC in MNCH;
  - community engagement;
  - evaluating QoC and QI initiatives.

29 Handbook for national quality policy and strategy.

- Expertise and **knowledge** of the quality issue identified (e.g. people who have information about the challenges, about community structures and preferences, or information about stakeholders).
  - Determine their level of interest **and commitment** (support or oppose; why).
  - Distinguish between stakeholders with a short-term interest (e.g. in piloting the learning initiative) and those that can play a role in the scale-up of the intervention.
- Level of **responsibility and accountability** for QoC in MNCH (see guidance on mapping responsibilities).[30] National health governance policies can be used for this exercise.[31]
- Available **resources** (staff, funding, tools, information, influence in decision-making).
- **Influence** on other stakeholders: people whose opinions are respected and who have some influence over public and stakeholder opinion, and who can foster participation in and generate support for your initiative.

Table 4 provides an example of a stakeholder analysis at the district level which aims to identify stakeholders that should be engaged in defining improvement activities to enhance experience of care for adolescent women. This table can be used as a template.

30 Handbook for national quality policy and strategy (p27).

31 For example: Guidelines for governance and management structures. Kampala: Republic of Uganda Ministry of Health; 2013 (http://www.health.go.ug/docs/GMS.pdf).

Table 3. Examples of stakeholders

Level → / Sector↓	National	District	Facility
Government	Health and other line ministries; representatives of public administration at national level (including council of traditional chiefs if existing, etc.); regulatory agencies	District health and other line ministries; nutrition programmes, HIV programmes, water and sanitation programmes; public administration representatives; district regulatory agencies	Traditional chiefs, prefects, local government officer
Political	National assembly, sub-committees	District assembly, health or MNCH sub-committees	Village councils, development committees, local assembly, sub-committees
Health service organizations	Government, NGO, private, faith-based, traditional	Government, NGO, private, faith-based, traditional	Government, NGO, private, faith-based, traditional
Health facility management governance	National-level facility governance structure (e.g. national association of health committees)	District representatives of health committees	Health committees, board, management team
Professional (trained workforce)	Leadership of nurse and midwives associations, medical associations and professional bodies, medical schools, nursing and midwifery schools, association of community health workers	District representatives of nurses and midwives associations, professional bodies, district medical schools, nursing and midwifery schools, association of community health workers	Community health workers, midwives, nurses, obstetricians, paediatricians, facility managers
Outreach and other health workforce	Representatives of health workforce	Representatives of health workforce	Hospital attendants, assistants, drivers, guards, health promotors, pharmacists, cleaners, staff in the stockroom, hospital administrators
Nongovernmental	Leadership of insurance agencies, service providers, health promotors, community empowerment programmes	District representatives of insurance agencies, service providers, health promotors, community empowerment programmes	Community-based health insurance; community empowerment programmes; civil society (human rights groups, social accountability initiatives); media, including tv, radio, social media and local communication channels
User groups, communities, community-based organizations (CBOs)	Representatives of service users, women and men, patient groups, community development groups, traditional leaders, youth groups	Representatives of service users, women and men, patient groups, community development groups, traditional leaders, youth groups	Representatives of cooperatives, women's groups, safe motherhood groups, MNCH groups, patient groups, faith-based organizations, social and sports clubs, savings groups, youth groups and organizations
Service users	Platforms of user groups, MNCH networks	District platforms of user groups, MNCH networks	Women of childbearing age, pregnant women, male partners/husbands, family members, children; marginalized groups, including those that do not have access to or do not use MNCH services
Media and advocacy organizations and campaign	(Social and traditional) media, MNCH networks, advocacy organizations, national MNCH campaigns, social accountability initiatives	District-level (social and traditional) media, MNCH networks, advocacy organizations, national MNCH campaigns, social accountability initiatives	Local media (radio, tv, social media and local communication channels), MNCH networks, advocacy organizations, national MNCH campaigns, social accountability initiatives
Donors	International and national donors	Representatives of donor organizations	Foundations, charities, representatives of donor organizations

Table 4. Stakeholder analysis matrix (example)

- QoC issue: Provision to and experiences of care for adolescent women – district level.
- Standards: Improving communication; respectful and dignified MNCH care.

Stake → Sector↓	Stakeholder	Description (purpose, no. of members or staff, funding)	Experience, Knowledge	Interest and influence QoC issue	Responsibility and accountability	Resources (staff, financial, influencers)	Potential role in improvement initiative
Government	District health team		Knowledge of local systems, services and populations		Coordination	MNCH Supervision	*Knowledge, partner.* Data on quality indicators, identification of gaps
	National MOH		Policy issues, QoC regulation	Alignment with national policy	Approval of QI initiative	MNCH QoC department head	*Knowledge* from review of QI initiatives – *inputs/ review* to the plan *Regulation*
Political	District assembly – health committee			Interest in implementing youth strategy			QoC *champion*
Health service organizations	Faith-based clinics Government clinics Private clinics		Experience with participatory approaches and dialogue on barriers to reaching target population	Implementation influence (adoption or rejection of the guidance)			*Input* into selection of QI initiatives *Partner* in decision-making *Piloting* QI actions
Health facility management/ governance	District representatives of health committees		Experience with facility management and monitoring	Adoption of new QI tools		Tools for facility management	
Professional (trained workforce)	District representatives of nurse-midwives associations		Health providers' perspectives and experiences	Interest in improving working conditions and QoC		Training modules on QoC	Continuous feedback loops; *dissemination* among members
	Community MNCH workers		Presence in remote communities	Better engagement with adolescent women		Trusted in the community, communication channel	*Partner* Identify gaps in quality and training needs

Stake → Sector↓	Stakeholder	Description (purpose, no. of members or staff, funding)	Experience, Knowledge	Interest and influence QoC issue	Responsibility and accountability	Resources (staff, financial, influencers)	Potential role in improvement initiative
Nongovernmental	"Save our mothers" health promotors		Presence in remote communities				*Resources* that can be mobilized for implementation
User groups, communities, CBOs	Male MNCH champions groups; youth groups, including young women and girls groups						*Contribute* to quality assessment and planning *Partner* in decision-making
Service users	Sexual, reproductive health and rights district network						
Media and advocacy organizations and campaign	City radio FM health programme						*Input* into selection of target groups based on knowledge of quality for adolescents and teenage pregnancy
Donors	Representatives of donor organizations			Budget influence			Resources that can be mobilized for implementation

Activity 4. Identify stakeholders' potential active role in the QI initiative

In the last column of Table 4, the potential role of stakeholders can be identified. Examples of roles are: partner in the QI team (needs to be involved in decision-making), influence/advocacy champion, informant, funder, knowledge provider, regulator, reviewer, expert consultant, beneficiary, etc.

Box 2 contains a list of resources that can be used for stakeholder and community mapping and analysis.

Box 2. Resources supporting stakeholder and community mapping and analysis

Tools and references for stakeholder mapping and analysis – national and district level

- The Partnering Initiative (2011). **The partnering toolbook**: an essential guide to cross-sector partnering. See example of a resource map on p14.
- Wageningen University and Research (2019). **Stakeholder characteristics and roles matrix**.
- Wageningen University and Research (2019). **Stakeholder analysis: Importance/influence matrix**.
- Measure Evaluation (2011). Tools for data demand and use in the health sector: stakeholder engagement tool. **Examples of stakeholder analysis matrix and stakeholder engagement plan**.
- WHO reproductive health **sample stakeholder mapping grid**.

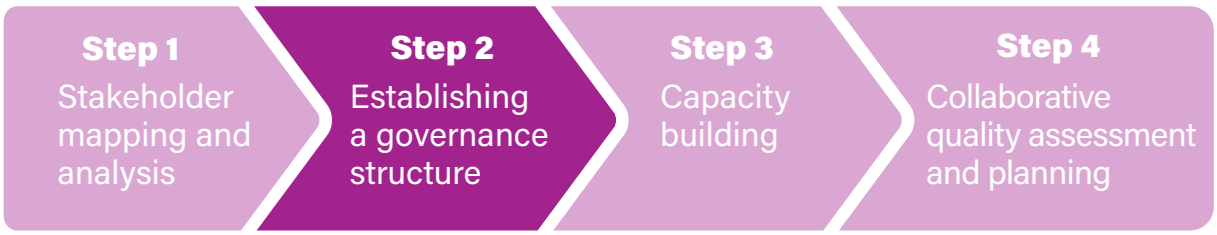
Tools and references for stakeholder mapping and analysis – facility level

Facility and community level

- World Vision International (2016): Local context analysis, including a country and local analysis of governance structures, policy development and processes, implementation and budgeting, opportunities for citizen participation, stakeholder analysis, public and social accountability mechanism, and civil society and sector analysis. (WVI, 2016, pp. 28–30). **Citizen Voice and Action Field Guide.**
- Management Sciences for Health (2012): **Community-based participation and initiatives.**
- Centre for Community Health and Development (2019): **How to identify and involve influential people.**

Step 2. Establishing a Quality Improvement governance structure

The stakeholder analysis will have facilitated the identification of core stakeholders that need to be actively involved in the QI initiative. This next step helps to identify the forums in which these stakeholders can be engaged and through which governance mechanism they will be enabled to contribute and provide input in decision-making.



5. Exploratory interview
6. Identifying the governance structure and members
7. Developing partnership agreements

Activity 5. Conduct exploratory interviews

Review the information entered into the stakeholder analysis table and discuss the relative priority of stakeholders to involve in the QI initiative. Exploratory interviews with key stakeholders from different sectors can help confirm their interest and gather input for the engagement strategy. Such consultation can help to further specify the objectives of stakeholder and community engagement in QoC in MNCH. The interviews can also ask the previously identified relevant stakeholders how they would prefer to be engaged as core members of the QI governance structure. Exploratory interviews can cover questions such as:

- What issues are important for you (or your group)?
- Do you actively contribute to addressing the issue? Would you like to actively contribute to addressing the issue? If so, how?
- What do you need to engage in a way that is meaningful to you?
- What factors would help or hinder you in becoming actively involved with the QI team?

The earlier in the process people are consulted and listened to, the more likely they are to be supportive and to contribute. Hence, such interviews also help to build stakeholder support in the early stages, even if the stakeholders do not become part of the governance structure. As already mentioned, it is important to take additional measures to ensure women's voices and vulnerable groups are not overlooked in these consultations.

Box 3 (found on page 22) lists resources identified to support the establishment of a governance structure.

Activity 6. Identify the governance structure

A group or a team that oversees a plan, project or intervention can go by a number of names which are often used interchangeably: task force, QI team, quality committee, oversight group, coordination team, etc. The QOC Network implementation guide[32] refers to ***QI teams*** as "the focal point for working on specific improvement aims". Smaller facilities may have one QI team that works on different MNCH aims. Larger facilities may have multiple QI teams. Sometimes, QI teams may exist but lack an MNCH focal person or committee. At the national level, the guide refers to technical working groups (TWG). Many district health systems will already have an existing MNCH TWG that can be a good platform to start establishing a partnership. It will usually be necessary, however, to review the composition of any existing district platform to ensure participation by relevant partners and community stakeholders.

Decision-making on the composition and functioning of the governance structure depends on:

- the needs and priorities of the organizations and individuals involved (as obtained through the exploratory interviews);
- the level of input required;
- the amount of time members will need to put in; and
- what the group is actually going to do (oversee, coordination, implementation of the initiative).

For the QI governance structure, there needs to be enough people to perform the roles, but not so many as to make collaboration impractical. Implementation (TWG, QI) teams usually consist of 8–10 members, while an advisory body or steering committee may consist of a broader set of stakeholders up to 20 members. The composition of the team is not fixed and will change depending on the focus of the partnership (whether focusing on developing a holistic QI plan for MNCH or on sub-aspects of QoC) and the selected QI aim.

32 Implementation guide for national, district and facility levels

Stakeholders can be engaged as:

- TWG member (national) or QI team member (district and facility)
- subcommittee or working group member (e.g. committee that works on defining, contextualizing QoC standards, developing and testing quality assessment tools)
- member of a (national or district-level) steering committee or advisory board.

Criteria for QI team membership.

Ideally, QI team members are:

- keen to work on QoC or QoC issues in MNCH and have the time and energy to invest in it;
- able to regularly attend meetings, especially for the implementing team (for advisory bodies this may be less important);
- representative of a cross-section of the sectors (see Table 3); and
- select representatives of a cross-section of service users and community members in terms of gender, socioeconomic status and expected roles.

There may be stakeholders who cannot be directly engaged as QoC team members or members of advisory boards, but who need to be involved at different moments because they can make a particular contribution. Such stakeholders can be engaged as:

- audience receiving the information
- resource person, expert, reviewer
- participant in a focus group discussion
- participant in a stakeholder meeting
- participant of a working group (e.g. on quality assessment, audit and review of stillbirths and neonatal deaths).

Activity 7. Develop partnership agreements

Ideally, identified stakeholders are involved in establishing the roles and procedures of QI teams, TWG or advisory boards. They need an understanding of the process that they are being invited to join, what is required from them, and how long it is going to take, before they will commit to taking part. A start-up workshop can help to clarify expectations and questions, and begin engaging stakeholders in co-developing collaboration principles and establishing processes of communication, coordination, decision-making and leadership. It is recommended that partnership agreements – or more specifically, QI team Terms of Reference – are jointly drafted. Box 3 describes the resources available for supporting the establishment of a governance structure.

Box 3. Resources supporting the establishment of a governance structure

Tools and references for establishing a governance structure

- WHO (2017). **Guidance on establishing district QOC teams or coordinating mechanisms** (WHO guide for individuals, families and communities [IFC], section 3.4).
- UNICEF (2016). **Every Mother Every Newborn (EMEN) quality Improvement guide for health facility staff.**

Step 3. Capacity-building and coordination of training programmes

8. Developing a capacity strengthening plan for stakeholders and communities
9. Developing a capacity strengthening plan for health professionals
10. Facilitating partnerships
11. Consolidating of stakeholder engagement strategy

The implementation guide suggests several actions to foster a positive environment for improving QoC. From the perspective of stakeholder and community engagement, this translates to actions aimed at strengthening the capacities and ability of stakeholders, communities and providers to engage with each other and work in partnership in the QI initiative in MNCH.

Activity 8. Develop a capacity strengthening plan for stakeholders and communities

In order for partners in a QI initiative – such as representatives of women, their families and the communities – to be effectively involved, they will need certain capabilities that facilitate their interaction with health providers and managers, and that also increase their ability to understand, participate in, and influence QI processes. Some community members may already have skills and experiences in these processes; others may not. Building these capabilities requires time and commitment, and the related activities need to be included in the QI initiative. Specific capabilities will also be contextually defined and may differ between the "core" stakeholders (active partners in the QI team) and stakeholder and communities in a broader sense. Equally important is building the capacities of community and civil society structures to understand quality issues and to monitor QoC.

Activity 9. Develop capacity strengthening of health professionals

Formal sector health professionals play a key role in facilitating the process of stakeholder and community engagement in QI initiatives in MNCH. To fulfil these roles effectively and to create productive partnerships at different levels, health managers and providers must develop engagement capacities including strengthened interpersonal communication skills. Specifically, they require the skills to:

- communicate with different stakeholders and members of the community and establish relationships with people, including with community leaders, women's groups, marginalized groups and health workers;
- listen well and learn from the stakeholders and the community;
- share skills and experiences with the community;
- respect people's ideas and skills;

- promote equity in male–female representation and in representation of the various social, economic and age groups in local decision-making bodies;
- be aware of and respect the social practices, traditions and culture of the community;
- foster collaboration with other projects, organizations and services; and
- promote a holistic or integrated approach to QoC in MNCH (integrating dimensions of provision and experience of care, as well as intersectoral aspects).

It is important to view health professionals not only as facilitators of the QI process but important stakeholders in the process. Health providers will provide important views on barriers to achieving quality care and what support and systems are needed.

Activity 10. Facilitate partnerships

In a number of QI initiatives, collaboration between health facility management, providers, stakeholders and communities will be a new experience. Working in partnership involves listening to different perspectives and managing varying power dynamics. Skilled facilitators are needed to make sure partners can participate and contribute effectively. Facilitators need to guide partners in the processes of:

- shared assessment and analysis of the situation;
- the design of context-specific approaches;
- shared agenda setting and planning;
- defining roles and responsibilities.[33]

Within the QI team there may be someone with the necessary skills, or an external facilitator or coach may be involved, in particular, at the start-up phase when the QI teams or groups are set up, but also during QI team planning and M&E meetings. A facilitator may use team-building exercises to develop the partnership at different stages. Abilities a facilitator needs to possess are: knowing how to ask clarifying questions; active listening; being able to encourage everyone to share; relating discussions to people's realities; and managing differences of opinion.[34]

The **district and national levels** have a role in facilitating stakeholders, communities, health authorities and providers to engage in a partnership. An important requirement is the training of the health workforce as well as community representatives in skills and capacities to effectively communicate, listen, and engage in joint decision-making and planning. If multiple facilities participate in the QI initiative, districts can explore efficient ways of building capacities in collaboration with other district-level organizations.

33 WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/259280/WHO-HIS-SDS-2017.15-eng.pdf).

34 Partnership defined quality for youth: A process manual for improving reproductive health services through youth-provider collaboration. Washington (DC): Save the Children; 2008 (https://www.savethechildren.org/content/dam/global/reports/health-and-nutrition/pdq-y-manual.pdf).

Activity 11. Consolidate the stakeholder and community engagement strategy

If there is an existing national/district/facility operational plan for improving MNCH QoC, the stakeholder and community engagement strategy and governance structure should be integrated. The engagement plan is flexible and should be reviewed at various points throughout the programme. The engagement strategy should identify who is responsible for this as well as for coordinating stakeholder engagement at different levels (facility, district or national level). Determine who in the TWG (national level) or QI team (district and facility level) can oversee the plan implementation and review. Box 4 lists the resources that can be used to support capacity strengthening.

Box 4. Resources supporting capacity strengthening

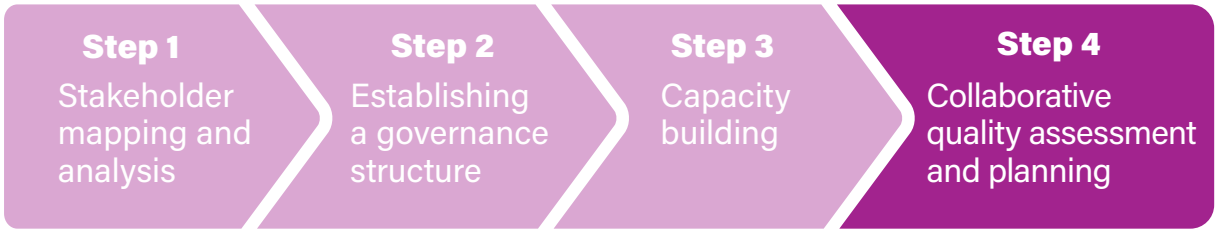
Tools and references for capacity-building and empowerment of communities

- Identification of needs and available community resources through focus group discussions and preparation of user-friendly information packages on MNCH quality policies, quality measures and indicators and facility processes.
- Learning Network (2014): **Health committee learning circles**. Increasing understanding of National Core Standards, the importance of quality health care, and how clinic health committees can participate in standards of QoC, responsibilities and QI plans.
- World Vision International (2016): **Capacity-building of health-focused community groups** that are empowered to coordinate and manage activities leading to improved overall community health and strengthened civil society.
- Health facilities can make visible and accessible the rights of women and children and the responsibility of the health facility in providing MNCH, as well as display important information on health facilities, such as services provided, hours of operation, staff timetables, and fees for services (if any). Example: Display of patients' and/or health workers' charter or other charters such as the **Charter on Respectful Maternity Care**, including the Seven Universal Rights of Childbearing Women.

Tools and references for enhanced access to information and capacity-building of health professionals

- Identification of needs and available community resources of different categories of health workers: This can be conducted through focus group discussions and preparation of user-friendly information packages on national community participation policies, local governance and decentralization. Example from Sierra Leone: **Facility management committee operational guideline.**
- Marshall and Mayers (2015): **Community engagement for quality care: a health workers training manual.** This training manual aims to strengthen interpersonal respect, compassion and professionalism in health care as a quality component. It assesses patients' rights and responsibilities as well as health workers' rights and responsibilities, and includes methods and tools to develop people-centred care.
- Population Council (2015): **Promoting respectful maternity care: a training guide for facility-based workshops.**

Step 4. Collaborative quality assessment and comprehensive Quality of Care planning



12. Identifying goal and scope of QoC assessment
13. Specifying the information needed
14. Specifying the methods and tools
15. Preparing the QI plan

After having defined the governance structure and QI team composition and procedures, the next step is to conduct a collaborative quality assessment to identify gaps and improvement aims. Such assessments provide an opportunity to collect, aggregate and compare data on all dimensions of QoC and to develop a comprehensive operational plan. This step describes activities for the **district and facility** levels.

What are collaborative quality assessments?

Collaborative quality assessments are approaches in which different groups (service users, marginalized groups, health providers, managers, etc.) evaluate the QoC; for example, through the use of rating methods (scorecards, checklist with a grading scale) or group discussions. The criteria for quality are first defined separately by the groups or sub QI teams. This is followed by an interface meeting where the groups jointly review the criteria and results, compare different perspectives and identify improvement aims. Out of this assessment, the core group (QI team) prepares a QI plan.

Besides identifying improvement aims, a collaborative quality assessment is an important strategy for community and stakeholder engagement that can achieve multiple additional goals: enhance transparency and mutual understanding; mobilize relevant support for a QI initiative; encourage acceptable and respectful MNCH services; improve experiences of care; increase accountability to service users; and empower health providers, communities, families and women in the longer term. Such an assessment is usually led by the QI team but may involve the delegation of particular assessment areas to sub-teams or groups.

As observed by the QOC Network, certain areas of quality assessment remain undeveloped, particularly with regard to experience of care.[35] Many QI teams may be new to assessments of processes of care from the perspectives of women and communities, and to identifying improvement initiatives focusing on experiences of care. Also, many assessment methods overlook health workers' perspectives of QoC. While there are many assessment and problem

35 Implementation guide for improving quality of care for maternal newborn and child health. Working document. Lilongwe: Network for improving quality of care for maternal newborn and child health; 2017 (https://www.who.int/maternal_child_adolescent/topics/quality-of-care/quality-of-care-brief-implementation.pdf). See also: Handbook for national quality policy and strategy.

analysis methods, this section focuses on community-based monitoring, tools for collecting women's perspective on and experiences of care, and methods to assess health providers' perspectives on QoC.

Activity 12. Identify the goal and scope of collecting perspectives from communities, women and health providers[36]

The specific goal identified for capturing the QoC perspectives and experiences of communities, women and health providers is what determines the methods used to collect information, report findings and make improvements. In the planning phase, discuss the following questions:

- What guidelines exist and which actors have experience related to collecting information on experiences of care of communities, women and health providers?
- Why do we collect information about views of QoC from communities, women and health providers? Is it for **information** (understanding experiences of care), **involvement** (identifying opportunities for QI) or **collaboration** (joint planning and implementation of QI initiatives)?
- How might the assessment itself also contribute to capacity strengthening, **empowerment** and **accountability**?
- What organizational level are we considering: health clinics, outreach services, maternal health clinics, individual health workers, teams, particular services (such as antenatal care, vaccines, etc.)?

Activity 13. Specify the information needed

It is important to review what information already exists and to identify where the gaps are before collecting additional information:

- What information (data, studies, reports) do we already have regarding experiences of care? Where do we lack information and knowledge?
- Consider the following information sources:
  - Women who use(d) services, or their representatives (for example, when certain data already exist): pregnant women, women who have given birth, women of childbearing age, male partners/husbands, caregivers, family
  - Women who do not (yet) use services and their families and others who influence decisions to use services
  - All women or a specific group of women (e.g. particular age group, urban/rural, with certain medical conditions, marginalized groups)
  - Community leaders and community-based groups, etc.
  - Vulnerable groups of women
  - Providers – specify types
  - Communities – specify who in local communities need to be consulted.
- Consider the outputs:
  - Anonymous information
  - Results comparing groups of women, communities, providers or facilities.

36 National Quality and Risk Managers Group. Guide for developing a consumer experience framework. Wellington: Health Quality and Safety Commission; 2012.

Activity 14. Specify the methods and tools

While considering which method to use to gather information, also think about who will be gathering the information and their respective skills; different methods are associated with different levels of engagement: information, involvement, or collaboration. A combination of methods is likely to achieve multiple objectives. Some factors to bear in mind are:

- Consider whether the assessment is for planning purposes only or for ongoing feedback (i.e. can the assessment be used for subsequent collection of feedback).
- The quality assessment must be appropriate for finding areas of improvement and potentially for keeping track of improvements. The type of data and questions to be addressed should determine the data collection methods. These include:
  - methods that do not require interaction (e.g. surveys, questionnaires, suggestion boxes);
  - methods that allow for gathering of more in-depth information on the what, how and why of experiences (e.g. in depth-interviews);
  - methods that allow interaction between members of the same group (e.g. women, health providers) or participants (e.g. focus group discussions, discussion forum).

For such assessments to be meaningful for health providers, women and communities, they have to go beyond one-off events. Identify methods to bring together data from the individual assessments (e.g. interface meetings, stakeholder meetings) and to facilitate continued interaction. Community-based monitoring and social accountability approaches support such interactions (see Box 5).

Activity 15. Prepare the QI plan

The QoC team can use the outcomes of collaborative quality assessments to design or finalize the QI plan, with regular feedback to participants of the assessment. The QoC team uses the data from all groups to identify the gaps, improvement aims, and approaches and actions that are appropriate to solve the identified gaps in the short term and in the long term. QoC teams should also keep an open mind and try new things if they learn about other successful strategies to improve care, including strategies to improve experiences of care (see Box 5 for examples). Further guidance on developing QI operational plans is provided in detail in several guidelines for different levels.[37]

37 For example:

- Implementation guide for national, district and facility levels and A mapping and synthesis of tools for stakeholder and community engagement in quality improvement processes for Sexual, Reproductive, Maternal, Newborn and Child Health - forthcoming,
- CQI for respectful maternity (Ethiopia)
- Implementation guide for improving quality of care for maternal newborn and child health
- Handbook for national quality policy and strategy.Implementation guide for improving quality of care for maternal newborn and child health. (Working document.)
- Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care. Geneva: World Health Organization; 2018.

Box 5. Resources supporting collaborative quality assessments

Tools and references for partnership-led quality assessment and QI planning

Partnership-led quality assessment and improvement planning (QoC in general):

- Save the Children (2003). **Partnership defined quality**: a toolbook for community and health provider collaboration for quality improvement.
- Quality of Care Network (2017). **Monitoring framework** proposes measurements to assess all aspects of quality of MNCH care.
- WHO (2017). WHO IFC Toolkit. **Participatory community assessment (PCA)** is a tool that district health services can use to assess the maternal and newborn health (MNH) situation and needs in a participatory manner, through collaboration within the health sector and with other sectors (such as education and transport), with district authorities, NGOs, religious organizations and other community groups. Using the results of the PCA, partners can then plan actions together to help create an enabling environment for care of the mother and newborn in the home and in the community, and to increase access to quality MNH services.

Maternal and perinatal death surveillance and response with community engagement components:

- Bayley et al. (2015). **Community-linked maternal death review (CLMDR)**: An assessment of the value of involving communities in investigating and responding to local maternal deaths. Collaborative analysis resulted in the development of community-planned actions, district hospital and health centre actions.
- Biswas et al. (2018). **Social autopsy for maternal and perinatal deaths**: A tool for community dialogue and decision-making. A tool to engage family members of the deceased, senior community members, community leaders, religious leaders, teachers, and members from the local government.

Tools and references for community-based monitoring and social accountability

- Tools such as community scorecards and maternal health report cards may facilitate community–provider collaboration, and relevant data can be used by districts for planning purposes as well as for engaging stakeholders at the district level; for example, through organizing district-level **public hearings** or through the publication of aggregated analysis and organizing district feedback meetings.
- CARE (2013). Tools to enhance provider accountability by using community-driven assessment and monitoring: **The Community Score Card (CSC)**: A generic guide to implementing CARE's Community Score Card process to improve quality of services.
- World Vision International. **Citizen Voice & Action field guide developed by World Vision International.**

Tools and references for the assessment of health provider perspectives on quality of care

- Save the Children. **Health worker defined quality.** Exercises to be conducted in a 1- to 2-day workshop (PDQ-Youth guide, pp. 30–35).
- Merriel et al. (2018). **Ten low-cost recommendations** to improve working lives of maternity health-care workers, based on a case study in Malawi.

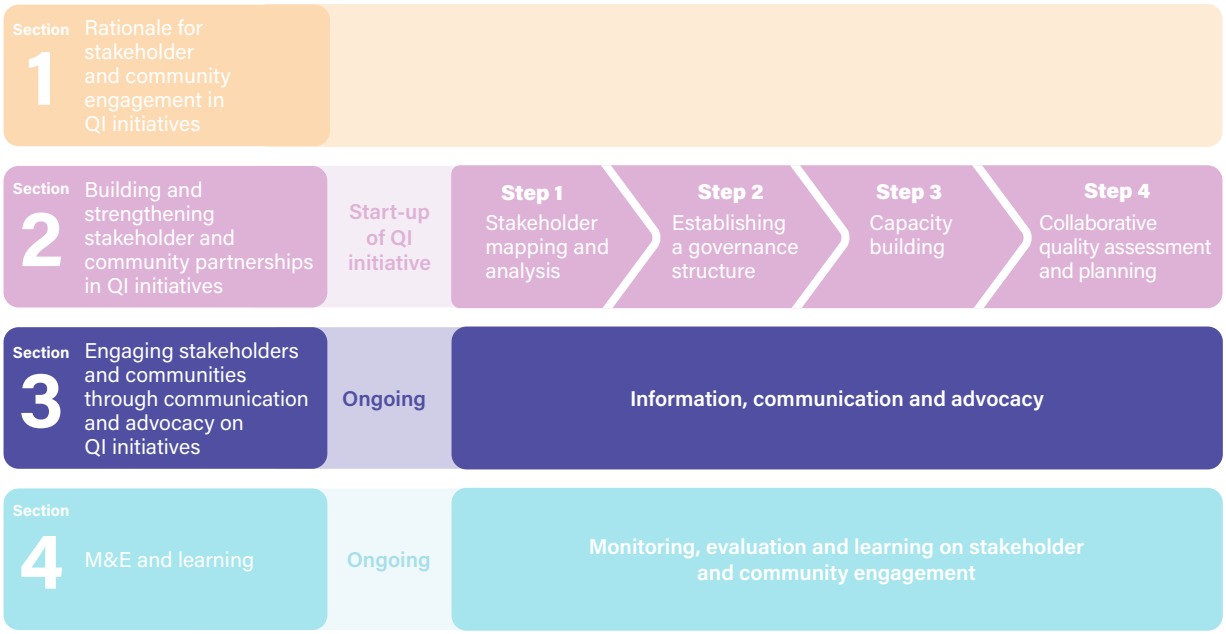
Tools and references to assess women's experiences of care

- Bohren et al. (2018). Tools to measure how women are treated during facility-based childbirth: **labour observation and community survey.** The implementation of these tools can inform the development of more women-centred, respectful maternity health-care services.
- JSA Studies Series – India (2015). **Maternal health report card**: collecting data on the quality of care among women using colour codes – referred to in George, A.S., Mohan, D., Gupta, J. et al. Can community action improve equity for maternal health and how does it do so? Research findings from Gujarat, India. Int J Equity Health 17, 125 (2018). https://doi.org/10.1186/s12939-018-0838-5
- WHO Ethiopia: Facility-led respectful maternity care checklist for continuous quality improvement. (CQI for respectful maternity – Ethiopia.)

Examples of QI initiatives focusing on experiences of care:

- **The Strengthening community and health systems for quality PMTCT** [prevention of mother-to-child transmission] (Pathfinder) project supported the creation of formal community-provider platforms to help health centres address cultural barriers to institutional childbirth. Traditional rites and ceremonies were an important part of birth for many families in Ethiopia, and were exclusively administered by TBAs at the community level. To support facilities' integration of these rites, the project facilitated collaboration between facility staff and TBAs, training providers to safely integrate TBAs into delivery ward procedures and conducting outreach to TBAs to build their awareness of pregnancy risk signs and support for HIV-positive women's institutional deliveries.
- Population Council (2015): **Respectful maternity care: a training manual for facility-based workshops.**

SECTION 3. STRATEGIES FOR INFORMATION, COMMUNICATION AND ADVOCACY



Ongoing engagement with national/district/facility-level stakeholders is crucial to maintaining commitment, ensuring accountability, and creating or strengthening a positive environment to improve and scale up QoC in MNCH in the long term. This section provides a set of approaches and tools for **information, communication and advocacy strategies and activities** geared towards stakeholders who are not directly part of the partnership or member of the TWG or QI team.

Information strategies around the QI initiative

At which points do core stakeholders, other groups and the general public need to be informed about the QI initiative? Think through the types of information different stakeholders and community members need. What mechanisms will be put in place for information sharing?

Recommended information activities – national level

- Launch of an MNCH QoC report or other relevant outputs
- Creating momentum and organizing events around key dates (e.g. International Women's Day) or organizing a side event to a conference (e.g. health summit)
- Presentation of programmes and reports at medical schools to raise awareness and collect feedback from students.

Recommended information activities – district level

- Presentation of the stakeholder mapping results in a district development forum, asking for inputs and feedback
- Creating momentum and organizing events around key dates (e.g. International Women's Day) or organizing a side event to a conference (e.g. health summit)
- Presentation of programmes and reports during health provider training or at medical schools to raise awareness and collect feedback from students.

Communication and advocacy strategies to promote QoC in the MNCH agenda

Goals of communication and advocacy

Communication and advocacy can help raise awareness on QoC in MNCH and accelerate action by stakeholders. For example:

- Develop stakeholders' understanding of the underlying reasons for low QoC and push for the need to address these.
- Increase stakeholders' commitment to the initiative itself or for QoC in MNCH care more generally.
- Call for investments in necessary infrastructure, skilled health workforce, medical supplies, appropriate information systems, and standards and guidelines, as well as effective systems of regulation and accountability to support QoC in MNCH.
- Call for action on the social, political, economic and environmental determinants of QoC in MNCH.
- Build trust for contracting with accreditation or insurance agencies

When to develop a communications and advocacy strategy?

A communications and advocacy strategy complements the stakeholder engagement strategy by conducting more in-depth analyses of the position of stakeholders towards a QI initiative and their preferred information sources and channels. Communications and advocacy activities can be planned and implemented at different stages of the QI initiative. They are, however, more likely to be effective and consistent when developed at the early stages of the process.

Who should develop a communication and advocacy strategy?

A communications and advocacy strategy complements the stakeholder engagement strategy; therefore, ideally, the group that developed the stakeholder engagement strategy also develops the communications and advocacy strategy. The stakeholder mapping and analysis will also help to identify partners (e.g. NGOs or civil society organizations, media, existing MNCH campaigns) that have existing QoC or MNCH advocacy campaigns that can be built upon. For example, White Ribbon Alliance has launched advocacy campaigns on safe and respectful childbirth in several countries. Box 6 describes some resources supporting information, communication and advocacy.

Box 6. Resources supporting information, communication and advocacy

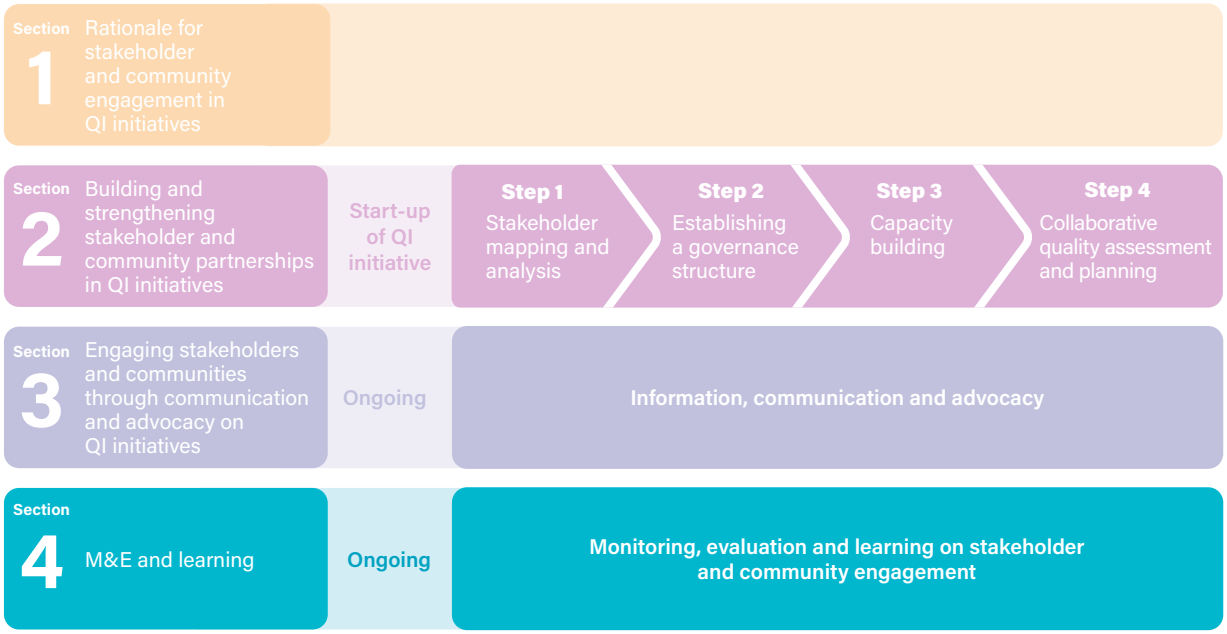
Tools and references for communication and advocacy – national level

- WHO (2014). Every Newborn advocacy toolkit. This document provides a repository of quick references and examples to show how to undertake advocacy and communication in various national and local contexts. It includes examples of the use of basic facts in advocacy messaging and ways in which "calls to action" can be written for different audiences: policy-makers, health managers, health providers, parents and families. The guide includes examples of letters to policy-makers, briefs, press releases, social media content and other relevant materials to make the case for improving QoC. The guide suggests steps on how to develop a communications and advocacy strategy. The UNICEF list of "key elements to consider before developing advocacy activities" is a useful complementary source – it helps think through advocacy objectives for different stakeholders, possible advocacy activities and tools. https://www.unicef.org/cbsc/files/Advocacy_Toolkit.pdf
- White Ribbon Alliance (2013). Guide for advocating for respectful maternity care.

Tools and references for information and communication – facility level

- Save the Children (2008). Thinking through motivational messages to interest partners in the QOC programme (PDQ-Youth guide, p. 28).
- Community Toolbox. Developing a community communication plan.
- Community Toolbox. Information and consultation: making community presentations.
- The IAP2 Public Participation Toolbox provides a reference guide on 45 techniques for sharing information. Some of the communication techniques covered are press releases, newspaper inserts, television programming, briefings, in-person surveys, focus groups and open houses.
- WHO (2014). Every Newborn advocacy toolkit: Developing communication materials for health workers, community and religious leaders, NGOs; includes examples of communication channels to reach pregnant women, husbands, families and community leaders in MNCH (pp. 28–30).

SECTION 4. M&E, LEARNING AND DOCUMENTATION OF STAKEHOLDER AND COMMUNITY ENGAGEMENT AND QUALITY IMPROVEMENT PARTNERSHIPS



Some initiatives may have, for the first time, integrated stakeholder and community engagement more systematically in their programme, based on a stakeholder and community mapping and analysis and after going through a process whereby collaborative forms of engagement were sought. It is important to monitor, evaluate and document the process and impact of this engagement, to learn what worked and what didn't, and to establish evidence of the impact of stakeholder and community engagement on the effectiveness of the QI initiative. Existing evidence is mixed and experiences of QI teams will greatly contribute to understanding the benefits of and barriers to engagement.

Partnership assessment

When new partnerships are formed in the context of a QI initiative or when a multi-stakeholder TWG has been established, it is useful to conduct a partnership assessment: this is a planning, M&E tool that defines the features of a successful partnership. It can provide feedback on the current status of the partnership, suggest areas that need further support and work, and help to evaluate how well the collaboration is going.

Monitoring and documentation

During implementation of the QI initiative, document positive, negative, or unexpected contributions of stakeholders in decision-making, planning and M&E of the QI initiative. Where possible, include other resources for validation (policy memos, meeting minutes, etc.). Insights can be continuously shared and enriched by organizing network meetings and learning events across initiatives and settings.[38]

Evaluation of stakeholder and community engagement

Before engaging in an evaluation exercise, reflect on the purposes and needs of the evaluation:

- What are the results you would like to obtain from the evaluation?
- What specifically will you learn? What will others learn from this if you do it?
- What do you really need to know?
- What data do you need to understand processes and outcomes? What data do you need to understand why your partnership does or does not function effectively?

Goals and benefits of engagement will differ per programme or intervention, and hence the scope of the evaluation will differ. In the spirit of partnership building, evaluation should be collaborative by eliciting stakeholders' voices – including that of women and communities – in the design and implementation of the evaluation. There are a few generic questions and indicators QI teams can use to assess the process and impact of their engagement activities. They are presented in Table 5.

38 Implementation guide for improving quality of care for maternal newborn and child health.

Table 5. Example of questions for process and impact evaluation of stakeholder and community engagement strategies[39]

Process evaluation **To better understand the components of the engagement activities in the QI initiative.**	**Impact evaluation** **To determine whether the engagement strategy and activities contribute to the desired outcome.**
What were the objectives of stakeholder and community engagement (i.e. engagement strategy, information, involvement, collaboration)?	What were the outcomes from stakeholder and community engagement? For example: ▪ Communities' access to new skills and knowledge regarding QoC in MNCH; relationship between service users or their representatives and health providers; continued commitment to contribute to QoC; accountability of health services towards the public. ▪ Health managers' and providers' attitudes and skills to facilitate community inputs and feedback.
What activities did we implement to achieve these objectives?	How do these outcomes contribute to the improved quality of MNCH services?
What happened in practice?	Examples of questions to guide the evaluation of process and outputs of community engagement[40]
What were the gaps between the plan and the reality?	
What worked well?	
What were the challenges?	
What did we learn?	
How can we adapt our processes of engagement?	
How do we measure the effectiveness/impact of the engagement?	

It is important to provide feedback to the stakeholders and communities on the process and results of both the QI initiatives and the stakeholder and community engagement. If this is not done, it can lead to individuals and groups being reluctant to be further engaged or to engage in the future.

The QI team should document how they are improving the QoC, what challenges they are facing, and the results of their improvement efforts. Such documentation can be shared with other facilities, stakeholders and community members at facility and district levels.

Documentation and sharing should lead to the formulation of concrete recommendations to improve and adapt processes of engagement in QI initiatives in the future. Recommendations can be formulated with the support of the recommendations outlined in Table 6. Box 7 lists some resources supporting M&E.

39 Evaluating participation: a guide and toolkit for health and social care practitioners. Glasgow: Scottish Health Council; 2013 (http://scottishhealthcouncil.org/publications/research/evaluation_toolkit.aspx#.XjLa6C17FQI).

40 UNICEF. Minimum quality standards and indicators for community engagement. Forthcoming, standards, pp. 44–52. https://www.unicef.org/mena/reports/community-engagement-standards

Table 6. Recommendations for improvement of stakeholder and community engagement in QI initiatives

Elements of stakeholder and community engagement	Strengths	Weaknesses	Recommendations for improvement
Coordination of the stakeholder and community engagement process			
Who did we engage with?			
What did we engage them on?			
How did they engage?			

Box 7. Resources supporting M&E

Tools and references for M&E of stakeholder and community engagement

- VicHealth (2016). Evaluation of partnerships: partnership checklist (p. 5–7). **The partnership analysis tool.**
- Jansen et al. (2018). **Checklist for stakeholder participation** (p. 975). The TWG can use the checklist at the planning stage to identify important stakeholders and to review partnership processes. It supports the identification of strategies for improvement of stakeholder engagement.
- Save the Children (2008). **Team effectiveness questionnaire:** simple tool to discuss the functioning of multi-stakeholder QI teams (PDQ-Youth guide, p. 109).
- UNICEF Minimum quality standards and indicators for **community engagement** [in development] provides guidance on how to collect quantitative and qualitative measures of community engagement processes and outputs. The tool can be applied to situations of comprehensive community engagement, such as in a partnership approach described in this module, at the evaluation stage, and also at the community engagement planning stage.
- Network for improving quality of care for maternal newborn and child health (p. 14). Indicators to assess the **accountability of a QI programme.**

Notes

Notes

World Health Organization

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