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Acknowledgements

- **DRAFTING NOTE:**
  - Need to highlight the foundational work carried out on the implementation guide by MNCH colleagues through the QED network.
  - Need to highlight the role of Taskforce working group members.
  - Need to mention the contribution of thinking from NQPS contributors.
  - Need to mention the role of the wider WHO quality taskforce.
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AMR</td>
<td>antimicrobial resistance</td>
</tr>
<tr>
<td>DHMT</td>
<td>district health management team</td>
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<tr>
<td>NQPS</td>
<td>national quality policy and strategy</td>
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<tr>
<td>QI</td>
<td>quality improvement</td>
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<tr>
<td>QoC</td>
<td>quality of care</td>
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<tr>
<td>SDG</td>
<td>sustainable development goals</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<tr>
<td>WASH</td>
<td>water, sanitation and hygiene</td>
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</table>
Quality Implementation Guide - at a glance

Key activities at each level

**National**
- Map existing national quality efforts
- Establish national commitment to improve quality
- Develop national quality policy and strategy
- Select and prioritize package of quality interventions
- Develop operational and resourcing plan alongside key stakeholders

**District**
- Align district commitment to national QoC goals and priorities
- Develop district QoC structures and operational plan, and where they already exist, update district QoC operational plans based on learning from health facilities
- Orient health facilities to district and national-level QoC goals and priorities
- Respond to facility needs in reaching selected aims and ensure support systems to support QoC
- Maintain engagement with the national level on QoC
- Adapt quality interventions package to district-level context.

**Facility**
- Ensure all activities are aligned with district and national plans and ensure facility leadership demonstrate active support for establishment of quality improvement programme in the facility.
- Engage with stakeholders and community representatives during all stages of the QI implementation, with a focus on social accountability.
- Develop improvement aim(s) and operational plan including processes for data collection and use, gap analysis and review cycles.
- Establish mechanisms to review results, share learning and set new improvement aims as part of sustainability and refinement of strategies.
- Ensure facility leadership support for institutionalizing successful actions to ensure sustainability of improvement.
- Continue all improvement activities, including sharing lessons learned and participating in learning activities (with other facilities).

Foundational requirements for system-wide quality initiatives
Introduction
This document provides practical guidance for the implementation of activities for the delivery of quality health care services. A wide body of theory already exists related to quality of health care services and has informed the content presented here.

Why quality?
Quality of health care services is critical to achieving universal health coverage (UHC). The success of UHC depends on its ability to provide quality services to all people, everywhere. Overall, between 5.7 and 8.4 million deaths are attributed to poor-quality care each year in low- and middle-income countries, which accounts for up to 15% of overall deaths in these countries (1). Improving access to health services must go hand in hand with improving the quality of these services. Further, poor quality care can jeopardize people’s trust in the health system. Indeed, there is an urgent need to place quality at the centre of national, district and facility-level actions to progress towards UHC.

What do we mean by quality?
While there is no single universally accepted definition of “quality”, there is a commonly shared understanding of basic concepts and dimensions. There is growing acknowledgment that quality health services across the world should be (2):
- effective: providing evidence-based health care services to those who need them;
- safe: avoiding harm to people for whom the care is intended; and
- people-centred: providing care that responds to individual preferences, needs and values.

In addition, to realize the benefits of quality health care, health services must be
- timely: reducing waiting times and sometimes harmful delays for both those who receive and those who give care;
- equitable: providing care that does not vary in quality on account of age, sex, gender, race, ethnicity, geographic location, religion, socio-economic status, linguistic or political affiliation;
- integrated: providing care that is coordinated across levels and providers and makes available the full range of health services throughout the life course; and
- efficient: maximizing the benefit of available resources and avoiding waste.

In 2018, three publications shone a spotlight on quality of health care services (1, 2, 3). The WHO, the World Bank and the OECD; the National Academies of Sciences in the United States of America; and the Lancet Global Health Commission all covered aspects of the quality of health systems in the context of UHC and the sustainable development goals (SDGs). Authors of each of these reports call for quality to be a core UHC consideration. As summarized by the WHO Director-General, without quality, UHC remains an empty promise (4). To capitalize on this global focus, action is clearly required.

To support the necessary action, answers are needed to some of the burning questions of our time on quality health services. Questions such as: what do health leaders across all levels of the system need to do? How will they take the necessary action? What are the linkages between national, district and facility level action to enhance quality of health services? What principles need to be considered?
What is required to support such endeavours? What are some of the first steps? What are the ongoing activities that need to be sustained? These are some of the questions that this document aims to address.

**Purpose of this document**

This document focuses on action required at the national, district and facility levels to enhance quality of health services. It provides practical guidance on implementing necessary activities at each of these levels, aimed at saving lives and improving experience of care. It highlights the need for a health systems approach to enhance quality of care, with a common understanding on the activities needed by all stakeholders.

This implementation guide sits alongside more detailed guidance for specific population groups, in particular quality of care (QoC) for maternal, newborn and child health. It articulates the key actions required to improve health service quality for the entire population. It recognizes that the path varies for each country, district and facility – so stimulates the reader to consider multiple factors and entry points for action. National, district and facility-level authorities are encouraged to act based on whichever evidence-based approaches they determine to be the most appropriate for their context and to be open to adapting based on what they learn.

**Who is this document for?**

This implementation guide is for staff working at all levels of the health system (national, district, facility) who have a role in enhancing the quality of health care services. It is also relevant to all stakeholders initiating and supporting action at facility, district and/or national levels.

**BOX X – Targets for three level action**

**National** level is used in this document to refer to the leadership, stewardship and planning function of the national health authority for achieving quality health services.

**District** is used to refer to a network of organizations and health facilities that provides equitable, comprehensive and integrated health services to a defined population.

**Health facility** is used in this document to refer to any primary, secondary or tertiary health facility where patients receive health care services.

**Navigating the document**

Subsequent parts of this document cover each of the three levels. Part 1 addresses the national level; part 2 the district level; and part 3 the facility level. Each part builds on and is linked to the other. The success and sustainability of quality focused efforts is dependent on the integration between these levels and the need for leaders at each level to understand the activities required not just within their own area but at all levels. In some countries, there will be an array of sub-national levels to consider (e.g. states, regions, provinces or counties). In these cases, the guidance for national or district level needs to be adapted according to their roles in health planning and implementation.
Improving quality occurs along a continuum and often does not have a defined start and end point, usually moving in a continual cycle of planning, implementation and monitoring. However, for the purposes of this guide activities within each level are divided into start-up activities and ongoing activities. The approach outlined in this document emphasizes the need to avoid undue delay in implementing improvement activities. Activities that can be conducted during the initial stages of improvement and that will help make progress faster are listed as start-up activities. Activities that either take a longer time to carry out or are needed on an ongoing basis for sustainability are listed as ongoing activities. This is a slightly artificial delineation and many activities are required at both start up as well as on an ongoing basis.

**BOX X– What do we mean by start-up and ongoing activities?**

**Start-up activities** are efforts usually needed in the initial stages of improving health care quality e.g. to begin roll-out of quality efforts. These activities can begin straightaway.

**Ongoing activities** are efforts needed to ensure sustainability and involve continuous follow-up to optimize improvement efforts as the quality initiatives progresses.

**Foundational requirements & guiding principles**

Five foundational requirements for quality health services, relevant to each of the three levels, are proposed. First, **on-site support** is required to ensure staff working to improve quality receive the necessary coaching, mentoring and clinical skills support. Second, **measurement** mechanisms are required to track the delivery of quality health services and promote accountability. Third, **sharing and learning** is required to enable exchange of experiences in improving quality between and across health system levels. Fourth, **stakeholder and community engagement** is required to ensure regular, active and meaningful engagement of the community in efforts to enhance quality. Finally, **management** is required to ensure activities to improve quality are carried out within a functional support architecture. The actions described in this guide at each of the three levels are closely linked to whether these requirements are in place.

While quality of care is predominantly expressed at the level of the interaction between the provider and receiver, it takes place within a much broader, **complex health system**, and this context should also be considered as central by those planning quality efforts at each of the three levels. The six
WHO health system building blocks framework is often used by countries to examine quality efforts with different parts of the health system within their specific context (5). This can help to ensure that health systems components that underpin action on quality are in place, and that their influence on delivery of quality care is accounted for.

For example, *service delivery* in many countries may be based on traditional hierarchical provider-patient relationships. Reorienting care around the needs, preferences and engagement of the people served by health providers can be a powerful step to institutionalize quality of care. High turnover of *health workforce* may provide a challenge to maintenance of institutional quality efforts and may itself result from working environments that are not conducive to quality care. *Health information systems* must be able to provide the data providers and health workers need to drive improvement. Adherence to evidence-based quality standards requires reliable access to *essential medicines and commodities*, and thus endeavors to enhance quality of service provision require examination of supply chains and quality of medicines. Applying a quality lens to *health financing* reforms can help ensure that in expanding access to services other domains of quality, such as equity and efficiency of service provision, are not compromised. *Leadership and governance* are critical to the success of national quality policy and strategy that is fully aligned with overall national health policy and planning. To avoid such efforts becoming a vertical, standalone initiative requires strong advocacy for and building capacity on quality among existing health system leadership at all levels. These system considerations are critical for the sustainability of the actions taken to enhance quality. All the above point us to some guiding principles that underpin the guidance that is described in this document (Box X).

**BOX X: GUIDING PRINCIPLES FOR SYSTEM-WIDE EFFORTS TO IMPROVE QUALITY**

1. **Start fast.** The only way to reduce mortality and improve experience of care is to change what is happening at facilities and communities; therefore, the focus should be on initiating improvement activities as soon as possible. Planning is most effective when it is informed by implementation.

2. **Build on existing structures and functions.** Improving quality is a fundamental activity of the health system. The responsibility for quality must lie with system leadership, managers and frontline staff. Sustainability of quality activities is dependent on how aligned they are to existing structures and functions.

3. **Support health workers.** Health workers often work in conditions that are difficult, under-resourced and that hinder excellence. Systemic conditions – such as poor organization of care, unclear goals, wasteful rules, inadequate information flows – prevent health workers from carrying out their tasks successfully. Thus, a clear focus is required to support health workers.

4. **Improve care for people.** All efforts to improve service delivery must be directed towards improving clinical outcomes and patient experience of care. Effective and compassionate care for patients and the community should be central to all activities. Changes in systems and processes of health-care delivery should aim to put people at the centre of care.

5. **Learn, adapt and share.** We need to learn what different levels of the system need to do to enhance quality. Activity plans should be adapted based on evidence from implementation. There is always room for doing things better. It is only when we identify problems that they can be addressed. Good ideas should be shared across the system to enable faster improvements in care.
Culture of quality
This leads to another area that requires special attention when planning to improve quality of care – developing and institutionalizing a **culture of quality** in organizations and across the health system as a means to sustainable and meaningful change. There is no one definition of what a culture of quality entails, but it is generally understood to mean that, at all levels of a health system, there is an inherent and explicit recognition of the value of efforts to improve the quality of care provided, and such efforts are systematically promoted within an enabling environment that encourages engagement, dialogue, openness and accountability. Some of the features of a culture of quality are outlined in box x.

There are also important considerations around how the culture of teams responsible for implementation across the health system can impact its success. Delivering reforms to health care provision that are inclusive, equitable, and promote a culture of improvement, requires that clinical and managerial teams responsible for implementation reflect these principles in their own approach and values. This is central to sustainability of efforts to enhance quality.

### How is this document linked to other resources?

This document provides an outline of proposed activities at the national, district and facility level to enhance quality health care services. Other foundational resources and detailed implementation guidance is sign-posted to ensure that this document remains focused on core content requiring consideration by all those involved in enhancing quality health services at all levels of the system.

This document builds on the existing body of work on quality of health care by WHO and others. It does not seek to replicate already available information and guidance. Where applicable, the appropriate external resources that can be used in conjunction with this guidance have been referenced, such as the implementation guide for quality of care for maternal, newborn and child health, the WHO Handbook for national quality policy and strategy (6) and the multiple practical implementation manuals that WHO has produced on different technical areas such as infection prevention & control (7).

<table>
<thead>
<tr>
<th><strong>Culture of quality: key features</strong></th>
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<tbody>
<tr>
<td>▪ Leadership for quality at all levels</td>
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<tr>
<td>▪ Openness &amp; transparency</td>
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<tr>
<td>▪ Emphasis on teamwork</td>
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<tr>
<td>▪ Accountability at all levels</td>
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<tr>
<td>▪ Learning embedded in system</td>
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<tr>
<td>▪ Active feedback loops for improvement</td>
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<tr>
<td>▪ Meaningful staff, service user &amp; community engagement</td>
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<tr>
<td>▪ Empowering individuals while recognizing complex systems</td>
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<tr>
<td>▪ Alignment of professional and organizational values</td>
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<tr>
<td>▪ Fostering pride in care</td>
</tr>
<tr>
<td>▪ Valuing compassionate care</td>
</tr>
<tr>
<td>▪ Coherence of quality efforts with service organization &amp; planning</td>
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National-level activities for improving quality of care

Introduction - the role of national actors in delivering quality health care services

To improve health outcomes, we must improve health care delivery at the point of care. National-level leadership, ownership and action are required to guide, support and sustain such improvements. This section describes activities required by national level health leadership (also referred to as national stakeholders) to support improvement efforts across the system. The exact roles or organizations responsible for each activity will vary depending on country context, but in general those involved will include the ministry of health team responsible for coordinating national quality efforts, senior health system and political leaders, steering committees or technical working groups, and other key quality-related bodies active at the national level (for example professional councils, disease or population-focused quality programmes, national health insurance funds, and external evaluation bodies).

Central to the national level efforts is a clearly articulated national direction on quality health care services as described by the WHO Handbook for National Quality Policy and Strategy (6). The focus is to promote leadership and ownership of quality by national health authorities, ensuring integration with broader national health planning and with disease or population specific programmes. Particular attention is placed on eight core and inter-dependent elements to set national quality direction (Figure 1): identifying and aligning with national health priorities; a context-specific definition of quality; stakeholder mapping and engagement; situational analysis; governance and organizational structures at all levels of the health system; application of improvement methods & a package of interventions; health management information systems & data systems; and quality indicators & core measures (6). Emphasis is also placed on ongoing refinements to national directions on quality based on feedback loops from other levels of the system.
While this implementation guide presents activities required at different levels to improve quality of care, health outcomes can be maximized through strong collaboration across all levels of the health system. In this way, activities at each level can combine to promote development of a culture of quality. It is also recommended that stakeholders at each level understand the activities taking place in other parts of the system, so those at the national level are encouraged to read and unpack the other sections of this guide to help develop a fuller picture of how the system can work together to promote quality at the point of care.

The focus of this section
The purpose of this section is for national level stakeholders, in particular those with responsibility for developing and implementing national quality programmes, to understand both the key activities required at the national level and how they can support delivery of quality health services across all levels of health system. Although strategic planning is critical, planning alone is not sufficient. Instead of aiming for a perfect plan, countries can initiate improvement activities alongside the planning process, learn from the implementation experiences, and use these to update and strengthen their strategic approach accordingly. Whatever level of human and financial resource is available, there is always somewhere to start. The activities described here represent important starting points to promote system-wide action on quality.

This section, alongside those on district and facility-level activities, is presented in terms of both start up and ongoing activities.
National start-up activities
This section describes the initial activities to improve quality of services. Stakeholders at the national level are responsible for a range of activities that are focused on mapping efforts; establishing commitment; developing national direction; selecting interventions; and developing an operational plan & resourcing strategy.

1. Map existing national quality efforts
It is important that any new or renewed national effort to improve quality of care should build on and align with any related initiatives already underway. Understanding the current quality landscape is necessary for the team leading national efforts.

Key activities
• Review relevant national health and quality documentation (for example existing quality policy/strategy, national health strategic plans)
• Engage with stakeholders responsible for existing quality-related programmes, for example disease/population programmes or prominent facility QI programmes.
• Consider options for integration of existing quality programmes throughout national quality planning process (6).
• Map existing quality related interventions taking place throughout the health system.

2. Establish national commitment to improve quality
A critical early step is for national level leadership to commit to improve quality of care, for example through high-level official political or policy statements.

Key activities
• Senior health leadership/ national government commits to improve quality of care and to allocate appropriate domestic resource
• National government/ Ministry of Health commits to develop national direction on quality
• Ministry of Health commits to:
  - create an enabling environment, including ensuring adequate resources to improve QoC, supporting development leadership across the health system, and promoting a culture of quality
  - provide regular public updates on progress in improving QoC
  - meaningful engagement of patients, families, communities & health workers in design and implementation of national efforts
  - respond to district needs in reaching selected QoC goals and priorities
  - facilitate sharing of learning (successes and failures) within and across countries
  - coordinate and align development and technical partner activities with the national QoC agenda
• Other key national level stakeholders supporting quality activities commit to align with national direction on quality and contribute to its development.
• Consider development of an advocacy and communications plan to support efforts to secure buy-in and engagement from stakeholders across the system.

3. Develop national direction on quality
Country efforts to improve QoC should be based on a clear national direction on quality, often articulated in a national quality policy and strategy (2). Countries that do not have national policies or strategies for quality of health care services should initiate multi-stakeholder efforts to develop these. The WHO Handbook for National Quality Policy and Strategy (NQPS) (6) provides further guidance on this, based on eight inter-dependent elements for national direction on quality: national health goals and priorities; local definition of quality; stakeholder mapping & engagement; situational analysis; governance & organizational structure; interventions for improvement; health management information systems & data systems; and quality indicators & core measures.

Although developing national direction may take time, this should not delay the initiation of further QoC activities across the system; in fact, such activities can help inform efforts to set a national direction on quality. While this process will be led by national-level stakeholders, development and implementation of national direction on quality relies upon active engagement of stakeholders from across all levels of the health system. This will be a key activity for developing a shared understanding of quality across national, district and facility levels.
Key activities

- Strengthen or develop a National Quality Policy and Strategy to support quality of care efforts in the health sector (6).
- Clarify the function and governance of existing quality structures, ensuring they are placed at an appropriate level within the ministry of health, to ensure coordination and provide technical leadership.
- Strengthen or establish a government-led, multi-stakeholder steering group/technical working group to guide and coordinate efforts to improve QoC (8).
- Develop a quality roadmap based on review of existing QoC activities, partners and resources, linked closely to the stated national direction and national goals and priorities (7).
- Align national direction setting for quality with broader health planning and budgeting processes, ensuring budget lines for key quality activities.
- Develop a plan to assess and improve national systems required for measuring, monitoring and reporting on QoC (6).
- Develop a pragmatic national quality indicators framework.
- Engage key sub-national/district stakeholders in further planning for implementation of national direction.

4. Select package of quality interventions

It is important to develop an agreed practical package of quality interventions at the national level, working closely with districts and facilities. Implementation of most interventions will require action at multiple levels of the health system; there is no simple delineation of national, district and facility interventions. This document uses the list of illustrative quality interventions list outlined in the WHO NQPS Handbook and the WHO-World Bank-OECD Report on Delivering Quality Health Services (6).

Quality interventions can be broadly categorized as serving the following purposes:

- to create a system environment that supports QoC (e.g. training, professional regulation, external evaluation, clinical governance, public reporting, benchmarking, ethical performance-based financing, medication regulation);
- to reduce harm (e.g. safety protocols & checklists, facility inspection, adverse event reporting);
- to improve facility-level clinical care (e.g. clinical standards & protocols, clinical decision support tools, audit and feedback, morbidity and mortality reviews, QI cycles);
- to engage and empower patients, families and communities (e.g. health literacy, peer support, shared decision-making, self-management programmes).

The list is not exhaustive, and there may be other quality interventions that are being applied in various countries. However, none of these are simple to implement, and they should not be viewed in isolation – these interventions are interrelated and can have greater impact when implemented in combination. In general, the national level will have a key role in considering the full package of interventions to be applied across the system, while district and facility leaders will determine how best this same package can be adopted and adapted at their levels. The national level will also often have a specific role in implementing many of the system environment interventions. It is important to note that many districts and facilities will commence quality improvement activities before there is a validated national direction; where this is happening, efforts should be made to ensure the learning from the implementation experience is fed into the process of setting national direction and selecting interventions.
Underpinning many interventions is quality measurement, which must be given particular attention as any national quality programme is implemented. Effective measurement supports improvement efforts across the system, including:

- monitoring for adherence against standards and guidelines
- feedback to providers on quality improvement activities
- transparency and accountability to the public
- benchmarking to understand comparative performance
- strategic or value-based purchasing and contracting
- monitoring the effectiveness of quality interventions

**Key activities**

- Collect and review local evidence of successes and challenges in implementing quality interventions. This should provide an opportunity for technical partners, district stakeholders and facility health workers to shape the emerging package of interventions based on the local implementation experience.

- Select and prioritize an initial package of proposed interventions, taking into account:
  - Existing quality infrastructure and available resource
  - National quality goals and priorities
  - Local and global evidence/consensus on quality interventions
  - Need for action at different levels of the health system
  - Health worker and service user views on what is required to ensure quality care
  - Need for action across quality planning, control and improvement.
  - Foundational requirements to support quality improvement
  - On-site support
  - Measurement
  - Sharing and learning
  - Community and stakeholder engagement
  - Management
  - Need for work on basic infrastructure, water, sanitation and hygiene (WASH) and infection, prevention and control (IPC)
  - Agreed selection criteria such as feasibility, value for money, estimated impact on national health goals

- Develop monitoring and evaluation plan to gather lessons from initial implementation phase to be used in ongoing strategic planning and refinement of interventions package.

- Develop plan for supporting national learning system. Initial steps might include engagement of local academic institutions, identification and training of learning focal points in districts and facilities, and partner collaboration on learning events.

5. **Develop an operational plan & resourcing strategy**

To ensure national strategic direction is translated into actions that improve care, the national level has a key role in pragmatic operational planning. A national operational plan describes what is needed to achieve progress towards the stated goals and priorities of the policy/strategy, including resources, timeline, and arrangements for monitoring.

Operational planning needs to consider resourcing requirements. While quality efforts across a health system can be expected to result in more cost-effective care and less waste of resources, there will clearly be initial resource implications as activities are commenced. Teams responsible for the national direction on quality should plan for how the strategic approach, governance structures and interventions can be adequately and pragmatically resourced.

**Key activities**

- Agree process for developing operational plan. This may be a discrete planning process for the national initiative on quality or there may be an opportunity to combine with broader national health planning or existing financial planning cycles. Those developing operational plans should consider:
  - where to begin (for example, whether to start in particular districts or with a nationwide programme)
- the need for operational planning at different levels of the health system, including resource considerations to support sub-national scale up of quality interventions
- timing and plan for nationwide spread and scale-up
- how to involve key stakeholders in operational planning

- Develop draft operational plan, and share with key stakeholders for consultation
- Prioritize interventions list taking into account additional cost, expected impact, feasibility and importance in reaching key quality aims. In the startup phase, consider a focus on “best buys” or “quick wins” to accelerate initial progress on quality, focusing on those interventions that will give maximum impact for limited additional cost
- Engage with ministry of finance, donor organizations, technical partners and related technical programmes to understand resource required for each quality intervention and clarify how this need will be met, ensuring existing structures and systems are built upon where possible
- Finalize operational and resourcing plan and agree process for progress review as part of broader governance arrangements
- Identify priority resourcing gaps. Carefully consider the benefits and risks associated with roll-out of some activities in only selected geographical areas.
- Where required, develop a formal resource mobilization plan to address critical gaps and allow future scale up.

National ongoing activities

While the activities described above will need early attention by national teams, there are several further activities that will require ongoing attention to ensure the sustainability of efforts. As well as ongoing advocacy and coordination of national programmes, the national level should help address health systems constraints on delivery of quality care that are not easy to resolve at a facility or district level, for example strengthening or adapting human resources, commodities, infrastructure and financing.

Key activities:

- Assess and maintain existing quality infrastructure and systems, ensuring adequate resource, oversight, and integration with related national efforts.
- Ongoing sensitization of political and health system leadership to the state of quality and progress of national efforts
- Put in place mechanisms to use data on quality emerging from the health information system and take action to improve, identifying where national level intervention brings added value to improvement efforts
- Respond in a timely manner to district needs in reaching selected improvement aims
- Support ongoing needs across all health system levels for leadership development
- Develop and maintain mechanisms to facilitate effective coordination between different stakeholders, including technical and development partners
- Instigate regular multi-stakeholder review of quality work across all levels to improve and refine operational planning. This process should bring together learning from national and sub-national levels, and can be used to reappraise available resource, evaluate emerging implementation experience and plan for scale-up of the strategic approach, for example where this has been initially implemented through a specific technical programme or in a particular geographical area.
- Demonstrate accountability using existing periodic review mechanisms

For more information on operational planning, visit the relevant section in the NQPS tools and resources compendium.
- Publicly report progress on implementation (including data on state of quality)
- Continue to engage communities, civil society, health providers and health workers in ongoing strategic planning
- Identify steps to sustain progress and institutionalise a culture of quality, for example:
  - Review of factors promoting quality culture (6).
  - Development of Ministry of Health/Health Services values statement and/or patient charter
  - Commitment to publicly release data on progress on quality of care
  - Leadership engagement and development activities to develop appropriate leadership culture across health system
  - Engagement with regulatory and professional bodies
- Ensure engagement with global learning mechanisms/networks (9 10) and connect with counterparts in peer countries to share progress and learning.

Driving foundational requirements for quality from the national level
Foundational requirements for quality at the point of care relies upon several actions at the national level. The below table below outlines key considerations for national level stakeholders as they look to develop and sustain these foundational requirements for quality.

<table>
<thead>
<tr>
<th>Foundational Requirement</th>
<th>National-level key considerations (non-exhaustive)</th>
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| **Onsite support**        | - How can national quality teams strengthen on-site support mechanisms through national planning?  
                            - How can health care and health management training be improved to increase capacity across the system in quality improvement?  
                            - What human and financial resources are required to enable effective on-site support and how should initial efforts be prioritized? |
| **Measurement**           | - What sources of data on quality of care exist? (for example, disease/population programmes, health facility assessment, patient surveys etc.)  
                            - How can the national team responsible for quality access the measurement expertise needed to generate the required data?  
                            - How can measurement capacity and information systems be strengthened across the health system?  
                            - How can transparency of data on health system performance be achieved?  
                            - What is required for health data to be able to monitor effectiveness of quality interventions? |
| **Sharing and learning**  | - What support can the national level provide to initiate and sustain a learning system?  
                            - How can the emerging learning be fed meaningfully into national direction setting for quality?  
                            - How can health system leaders engage in global learning on quality? |
| **Community and stakeholder engagement** | - What role can national quality teams play in designing and applying a community engagement approach to ensure that care provided in facilities meets the needs and preferences of patients, families and community members? (7) |
How can these approaches be used to ensure meaningful engagement of communities in broader national dialogue on health system planning?

How can the activities of partners be best coordinated and aligned to maximize impact on quality?

Management

- What additional management capacity and training is required at all levels to support quality of care efforts, and how can this be achieved?
- What upstream planning is required at the national level to enhance management of quality programmes and support at the district and facility level?
- What practical steps can be taken to promote a culture of quality throughout the system?

Action checks – National level

Improving quality of health services requires several critical actions at the national level. After reading this chapter you should know how to address the following interconnected actions

<table>
<thead>
<tr>
<th>Actions</th>
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<tbody>
<tr>
<td>1. Map existing national quality efforts</td>
<td></td>
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<tr>
<td>2. Establish national commitment to improve quality</td>
<td></td>
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<tr>
<td>3. Develop national quality policy and strategy</td>
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<td>4. Select and prioritize package of quality interventions</td>
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<td>5. Develop operational and resourcing plan alongside key stakeholders</td>
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District-level activities for improving quality of care

Introduction – the focus of this section

Before starting this section, consider review of the introductory and national level sections.

The health district is an essential element of a national health system. Activities at the district-level influence implementation of quality of care activities at the facility and community levels and should be carefully considered in national-level strategic setting on quality. District management is the key interface between the health facilities and higher levels and is responsible for operationalization of national policies and programmes. It is at this level that planning, implementation, monitoring and supervision of activities to improve QoC in facilities and communities are carried out.

This section describes activities that staff at the district level (particularly district health leadership and teams) can do to improve quality of care. Activities at the district-level should be coordinated and collaborated with national and facility-level authorities to ensure coherence and strengthening in the delivery of quality health services designed for the needs of people.

The action checks [insert name & page] in the national-level section provide a useful reminder of activities and responsibilities at the central level that will impact your work in improving quality of care at the district-level. Similarly, the action checks [insert name & page] in the facility-level section provide a useful reminder of activities and responsibilities at facility level to be considered when planning and implementing district level activities.

Who is taking action at the district level?
District management leadership and teams facilitate and ensure that quality of care activities are prioritized, supported and delivered at the point of care. Engagement of other stakeholders at the district-level, including providers of health services, civil society and communities, academic and professional associations, cooperating partners and other decentralized services such as water, sanitation and hygiene and housing authorities, is critical for QoC. Further, stakeholders involved in the national health sector planning process should be attentive to activities at the district-level.
District-level start-up activities
This section describes a range of activities to improve quality health care services that can be initiated more readily by district-level actors. These activities are clustered around district commitment; structures and operational planning; and orientation of facilities.

1. District commitment to national QoC goals and priorities
The district-level should commit to deliver on national QoC goals and priorities by developing, aligning and implementing operational plans with clear actions for district-level actors, that aim to improve the quality of care that is delivered at the sub-national level.

Key activities
- Internalize and commit to the district QoC aims and targets in support of the overall national goals and priorities
- Commit structural system and human resources to support the needs of healthcare facilities
- Commit to creating an enabling environment for QI, reflecting on elements captured in culture for quality
- Commit to and facilitate documentation and sharing learning within and across districts and with national level
- Facilitate sharing of national direction, goals and priorities to facilities and relevant programmes
- Ensure effective grounding of national quality directions in health service realities encountered at the district level
- Ensure effective dialogue with the national level and facilities in planning and coordination

2. District QoC structures and operational plan
District level structures and operational plans play an important role in setting out implementation of quality of care activities. District-level structures help clarify governance and implementation arrangements for quality. Operational plans at the sub-national level help to identify and prioritize tasks, timeline, responsible stakeholders, resource requirements and measurement/monitoring parameters.

Key activities
- Review and map existing QoC activities, partners and resources
- Examine district-level health care quality data to set priorities and guide process of selecting aims
- Identify district aims in support of national level goals and priorities
- Establish appropriate structures and mechanisms to support quality of care activities at the facility-level
- Build capacity for quality improvement support among district staff
- Introduce QoC programme to district, facility and community stakeholders
- Work with facilities in identifying improvement aims to support the district-level QoC goals and priorities (aligned with the overall national quality goals).
- Develop and share district operational plan outlining activities, timelines, budget and responsible actors.
- Establish coordination and collaboration mechanisms with other programmes working on QoC

3. Orient facilities on key quality concepts and activities
Quality of care happens in health facilities and communities. Any new or renewed effort to improve quality of care requires that facility staff and leadership are brought on board to understand their roles in improving care. Orientation of health facilities and health workers to improve health care quality is therefore an essential component to strengthen capacity and build interest to deliver safe, effective and people-centred care.

Key activities
- Identify who will be involved in the orientation.
• Based on the emerging national direction, operational plan and interventions package, develop a district orientation package for facilities.
• Identify other activities to be done alongside the orientation.
• Deliver the orientation and continuously refine based on feedback.
District-level ongoing activities

This section describes activities that may be currently ongoing at the district level or long-term processes to support quality of care programmes. A number of these areas also contribute to start-up of quality of care activities at the district-level. These activities at the operational district-level inform and contribute to overall policy or strategy direction put forth by national authorities and serve as a support to health facilities in rolling out QoC activities aligned with the district-level QoC aims and objectives.

1. Respond to facility needs in reaching selected aims

A key function for district leadership, the district-level supports health facilities in achieving its stated aims for QoC.

**Key activities**

- Identify ways the district level can help in reaching selected aims at the facility level
- Identify what type of support may be needed from the district level, informed by the key questions on foundational requirements for quality at the district-level (see page x)
- Map out existing capacities at the district level to respond to facility needs.

2. Ensure functioning mechanisms to support QoC

District-level leadership should ensure that the foundational requirements to support QoC (on-site support, measurement, sharing and learning, stakeholder and community engagement, and management) are functional. Where lacking, district leadership should provide support to build this. On-site support and management are needed to build and sustain a culture of continuous quality improvement. District managers overseeing QoC activities need data to determine whether planned activities to improve QoC are happening and whether they are leading to better care. Learning within the district can be either collaborative – bringing a multi-disciplinary team, from different health facilities to work through an improvement aim and improve systems performance or, working with one individual facility to improve a weak area identified by district and facility-leadership. Stakeholder and community engagement is pivotal to build trust within the health system.

**Key activities**

**Onsite support**

- Ensure that coaches are assigned to specific facilities to provide refresher trainings/orientation to facility staff and support overall QI efforts
- Support coaches to build QI skills
- Keep track of QI support visits and help facilities problem-solve
- Collect data on facility QI projects, review to identify successes and identify facilities needing support
- Incorporate mentoring and supportive supervision as part of activities to improve health worker performance.
- Based on identified gaps at facility-level, address problem, or coordinate with national level to get necessary support.

**Measurement**

- Collect data pertaining to patient outcome measures and patient process measures at the facility-level
- Collect district-level performance measures based on aggregate data from facilities
- Analyze data emerging from the facility and district-level and use emerging data to inform facility-level support.
- Share emerging data on QoC into national level reporting systems

Learning
• Establish exchange visits between health facilities and between health districts to understand how improvement activities were conducted.
• Develop tools and resources to facilitate sharing of data and stories.
• Include capacity building on data collection and story writing/sharing as part of regular supervision visits to enable health workers capture key elements of improvement.
• Host peer-to-peer learning opportunities. Examples at the district-level can include district review meetings, quarterly sharing meetings, district newsletters or bulletin and other routine meeting opportunities.
• Include a measure on learning in periodic assessments and feed emerging information to the national-level.

Stakeholder and community engagement
• Engage relevant stakeholders and the community in the design, planning, implementation and evaluation of district-level QoC activities
• Co-plan and co-produce quality of care activities with relevant stakeholders and communities.

Management
• Ensure and build management capacity for quality improvement at the district and facility-level
• Hold regular management meetings to ensure coordination of QoC efforts
• Communicate effectively between district staff, relevant stakeholders and communities
• Ensure resources to support QoC activities are in place

3. Update district QoC operational plans and activities based on learning
District leadership should periodically review operational plans against emerging learning from facilities and the district as a whole and adjust as needed.

Key activities
• Regular review of QoC activities.
• Based on learning from facilities, refine district-level plans.
• Participate in national level learning activities and learn from experiences in other districts

4. Maintain engagement with national level
A cross-cutting function across all levels of the health system, district management should interact regularly with the national level to convey their progress and outline how district-level goals and priorities are contributing to the overall national strategic direction on quality. Engagement between national, district and the facility levels and fostering a positive environment are prerequisites for success of implementation.

Key activities
• Share data on progress with national level
• Identify specific problems that the district needs help with
• Share any key learnings about how best to organize such an effort at a district level.
• Identify periodic meetings with national level leadership

5. Foster positive environment for QoC
A key role of the district-level is to cultivate an environment for improving quality of care. Supporting and sustaining a culture for everyday quality is key to improving health outcomes. District leadership can influence how quality is perceived and acted upon by cultivating and institutionalizing quality across all governance structures within the district.

**Key activities**

- Recognize and celebrate successes of health facilities.
- Provide health facility staff forums to share learning.
- Develop strategies to build motivation to improve QoC.

**6. Adapt QoC interventions at the district-level**

Quality of care interventions can vary greatly depending on the context and surrounding health systems environment at the district level. At the national level, authorities are responsible for prioritizing a set of quality interventions to guide improvements to drive health systems towards the stated national level objectives for quality of care. At the district-level, district health teams may adapt these prioritized QoC interventions to achieve the desired district-level goal in support of the national level objective.

**Key activities**

- Identify and map existing quality interventions which aim to improve the health systems environment; reduce harm; improve clinical care and engage patients, families and communities.
- Prioritize quality interventions to use at the district level
- Align the district level package of interventions to the national level interventions package
- Learn from application of quality interventions and refine district-level intervention package
- Identify foundational requirements that are needed to support application of the quality intervention at the district level.

**Key questions to consider when adapting QoC interventions at the district-level:**

- What quality interventions are currently being applied at the district-level?
- Of these interventions, which ones have yielded positive results?
- What interventions from the national-level package need to be prioritized and adapted to fit the district-level context?
- What is new from the district-level to support quality interventions?
- What resources are required from the district and the national-level to adapt and implement the prioritized interventions?
- What foundational requirements are needed to support implementation of QoC activities at the district level?

For practical tools and resources on district health management, visit Chapter 6, page 30 of the WHO Recovery Toolkit.

**Further considerations for adapting QoC interventions at the district-level**

For systems environment interventions, district leadership have the role of managing and ensuring allocation of adequate human and financial resources – both quality and quantity, as well as adapting processes of care emerging from the national level. Foundations of care, including governance and accountability structures; health workforce; essential medicines, tools and commodities; and health management information systems; are essential to have in place and is central to how quality of care is delivered at the facility-level (3). As an example, district leaders are responsible for public reporting and comparative benchmarking to facilitate sharing of information between health facilities and promote transparency and accountability in reporting. In addressing health workforce competence, supervision, coaching and mentoring to health facility QI teams can promote health system leadership and build local capacity to lead and sustain efforts for quality. District leadership can improve facility readiness by ensuring that health workers and health facilities/institutions meet the minimum criteria when conducting periodic
assessment visits as part of wider registration/licensing of health workers and the external evaluation and accreditation of health facilities.

**Reducing harm** to both the patient, health worker and community should be at the core of every health care delivery service and a key pillar of any district level operational support. Key activities that can be considered for district level leadership can include inspection of institutions for minimum safety standards to ensure there is baseline capacity and resources to maintain a safe clinical environment. This includes, ensuring that minimum requirements for water and sanitation infrastructure; infection, prevention and control and energy are available and maintained. Considering the differences between districts – for example urban and rural – adaption and capacity building of safety protocols and checklists may be required for sustained uptake of safety interventions.

Support will be needed from the district level leadership to facilitate *improvements in clinical care*. Types of support that can be considered at the district-level include:

- Adaption of clinical standards, pathways, guidelines and protocols to fit local district context.
- Clinical skills mentoring, coaching and skills development.
- Periodic assessment of health facilities for appropriate implementation of standards.
- Development of locally appropriate tools and resources (electronic or print/paper-based) to support decision-making processes at the facility-level.
- Co-development of feedback mechanisms on clinical practice with health facilities.
- Periodic learning reviews with health facilities and with other districts.

**Engaging and empowering patients, family and communities** at the district-level can increase participation in district-level planning and ensure that activities proposed at the district-level are tailored to the needs of the community. Representation of community and patient representatives on district health boards can create the open space needed to feed emerging community needs into district planning and increase community participation in district-level health outreach programmes. A strong link between community and district leadership creates the dialogue needed to ensure that emerging national policy/plans/strategies are grounded in community needs and can in turn help operationalize emerging policy and plans at district level.

District leadership is well-placed to tap into the wisdom of relevant stakeholders (facilities, partners, civil societies, communities, professional bodies etc.) to improve health care quality. Each stakeholder will need to be engaged within the planning cycle of the district as well as continued implementation of district level plans. As part of this engagement, key insights and learning from frontline experiences need to be harvested collaboratively, fed into a locally developed learning mechanism to improve QoC efforts and best practices shared to ensure uptake of proven interventions. As part of the convening power of district leadership, emerging issues relating to resources, clinical, administration and quality improvement can be discussed, and actions identified in periodic learning fora. This collaborative approach can improve communication between district-level stakeholders, promote coordination and harmonization of efforts to support quality of service delivery.
Box X: Spotlight - Implementing QoC to reduce Perinatal Mortality in Nwoya district, Uganda

Uganda’s maternal and neonatal mortality rates are high at 336/100,000 live births and 27/1000 per deliveries respectively (Uganda Demographic and Health Survey 2016) despite ANC attendance (90%) and institutional delivery (60%) (Annual Health Sector Performance Report 2017/18). The delayed access to emergency obstetric services between and within health facilities has been highlighted as a contributing factor of death. WHO recommends a focus on the quality and experience of care to reduce preventable maternal and perinatal deaths. In 2016, Nwoya district in Northern Uganda piloted the WHO QoC standards on maternal health at five health facilities. The district has registered 44% (27 to 15/1000 deliveries) and 54% (8.6 to 3.9/1000 deliveries) reduction in perinatal mortality and fresh stillbirth rates respectively through the simultaneous engagement of the national, district and facility levels to undertake specific roles.

At the national level, the QoC framework was adopted, partners rallied to integrate QoC in the MNCH activities and maternal perinatal death surveillance and response (MPDSR) guidelines rolled out.

At the district, stakeholders were engaged through performance review, mentors trained and provided tools for on-site supervision and mentorship. The Assistant District Health Officer (in charge of MNCH) rejuvenated the maternal and perinatal death reviews (MPDRs) committees and collaborated with MoH to address health system challenges such as lack of fuel for emergencies through budget advocacy.

At the health facility, QI teams were oriented on QoC standards, provided training on EmoC, essential newborn care and newborn intensive care management, supported through monthly visits and quarterly peer to peer learning to build their skills to address the quality gaps. Teams were oriented on MPDSR guidelines and supported to continuously identify and address quality gaps. The QI focal areas were to reduce delays in 1) inter-facilities referral and 2) accessing emergency C-Section at the hospital when appropriate.
Driving foundational requirements for quality from the district-level

Foundational requirements for quality at the point of care relies upon several actions at the district level. The table below outlines key considerations for district actors as they look to develop and sustain these foundational requirements for quality.

<table>
<thead>
<tr>
<th>Foundational Requirement</th>
<th>District-level key considerations (non-exhaustive)</th>
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</table>
| **On-site support**      | • What is required from the district level for the QI on-site support system?  
                           | • How can district leadership support facilities in moving forward on QoC?  
                           | • What resources are required from the national and district-level to support facility-level improvements? |
| **Measurement**          | • What sources of data and tools are used at the district level for QoC?  
                           | • What data should be collected from the facility-level and district-level?  
                           | • How should the QoC data be reported and used?  
                           | • What measures are needed to manage QoC activities?  
                           | • How can the district-level support data quality and transparency?  
                           | • How can district-level leadership support measurement capacity building in facilities and across the district health management team?  
                           | • What is required for health data to be able to monitor effectiveness of quality interventions at the district level? |
| **Sharing and learning** | • What tools and resources are available at the district-level to support learning around QoC activities?  
                           | • How should learning on QoC be documented?  
                           | • What information is needed to support learning on QoC?  
                           | • How should data emerging from the facilities be shared within and beyond the district?  
                           | • How should learning opportunities be organized within the district? |
| **Stakeholder and community engagement** | • What relevant stakeholders need to be engaged in district-level planning and implementation for QoC?  
                           | • How can stakeholders be engaged within planning and implementation efforts on QoC at the district-level?  
                           | • What existing mechanisms are being used for community engagement within the district?  
                           | • What are the ways the community can be engaged at the district level in improving QoC? |
| **Management**           | • What does the management system for QoC look like at the district level?  
                           | • What is required to support management for QoC?  
                           | • What additional resources are needed to support district level QoC aims and goals? |
Improving quality of health services requires several critical actions at the district-level. After reading this chapter you should know how to address the following interconnected actions.

<table>
<thead>
<tr>
<th>Actions</th>
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<tbody>
<tr>
<td>1. Align district commitment to national QoC goals and priorities</td>
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<tr>
<td>2. Develop district QoC structures and operational plan, and where they already exist, update district QoC operational plans based on learning from health facilities and emerging national direction</td>
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</tr>
<tr>
<td>3. Orient health facilities to district and national-level QoC goals and priorities</td>
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<tr>
<td>4. Respond to facility needs in reaching selected aims and ensure functioning support systems to support QoC</td>
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<tr>
<td>5. Maintain engagement with the national level on quality of care</td>
<td></td>
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<tr>
<td>6. Adapt quality interventions package to district-level context.</td>
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Facility-level activities for improving quality of care

Before starting this section, consider review of the introductory, district-level and national-level sections.

Introduction – the focus of this section

The ultimate aim of quality improvement efforts is to deliver quality at the point of care in health care facilities. This section focuses on health care facilities and describes the activities that facility health personnel can do to improve the QoC and patient outcomes. Not all QI challenges can be addressed at the facility level. In some cases, facility-level quality of care activity and progress is influenced by what happens nationally and in districts. For example, a national aim to reduce waiting times for a specific surgical procedure can provide a strong mandate for facility level action. On the other hand, a facility may be more motivated to work on problems that are identified locally, by both health care providers and the local community. Both of these approaches have advantages and disadvantages, which are explained in more detail throughout this section.

Who is taking action at the facility level?

Facility leadership and facility QI teams drive activity and ensure relevant stakeholders are engaged. The facility leadership includes the overall facility chief or administrator. The QI team includes the team working on specific improvement aims. Both of these may be called by different names in various countries. The QI team is the focal point for guiding the QI process within the facility. Smaller facilities may have one QI team that works on different aims. Larger facilities may have multiple departments working on a range of QI-related issues and a central coordinating QI team. The facility leadership and QI teams should work with all facility health personnel – across all clinical and non-clinical cadres – to ensure everyone understands and is engaged in improving quality of care. Quality is everyone’s business.

Fundamental success factors

In the previous sections we learned about the five foundational requirements that are considered necessary to support change at all levels and facilitate sustainability.

Take a few moments to review the foundational requirements and guiding principles in the introduction of this document (page X). These help to lay the foundations for success.
Many additional structural and process factors will influence implementation of QoC activities at the facility level. These will differ from facility to facility depending on the local reality but may include one or more of the following:

Of note are the **essential structures required for quality**. The facility leadership should ensure these essential structures are in place to enable the delivery of quality health services. These include but are not limited to the elements related to the physical environment in which care is provided e.g. WASH and safe waste disposal infrastructures; reliable electricity; supplies of safe and effective medicines; medical devices and technologies; and evidence-based guidelines and standards e.g. minimum standards for infection prevention and control. Liaison may be required with the district and national level to meet critical gaps in these essential structures.

**Facility-level activities:**

This section describes the actions that facility leadership and QI teams can take to improve QoC. It is based on an iterative improvement approach to systematically address implementation and refine it over time (figure x).

The above diagram is not intended to represent a QI methodology; rather, it is a representation of a broader improvement process that links with the national and district approaches.
Facility-level start-up activities
The table below summarizes activities to improve QoC that can be initiated more readily by facility personnel (see figure X above).

**1. Commit to district QoC aims & identify clear facility improvement aim(s)**
A critical early step is for facility leadership to commit to district and/or national QoC aims. Informed by these, one of the first activities is to identify and define the overall facility quality aim(s) to be achieved. In the absence of national or district aims, the facility has to select their aim locally. This can motivate health personnel to work on problems that are important to them and meet local need. Working on national or district aims allows to start fast, and to learn from and share learning across districts and facilities.

**Key activities**
1) For facility leadership:
- With the support of district officials, introduce the district QoC aims and targets to relevant health workers, e.g. hold a meeting with health workers and community representatives to review and discuss district aims. It is important to secure commitment from those who will be most affected by the programme.
- Commit to creating an enabling environment for QI including the key features of culture of quality (page 10) and fundamental success factors described above.
- Identify approaches and tools/resources needed to support QI efforts in collaboration with the district.

2) For QI team:
- Identify and define the overall quality aim(s) for the facility and develop a clear statement of purpose describing the targets to achieve and the timeframe, e.g. “This facility aims to reduce the surgical site infection rate by 50% for patients undergoing elective surgery by 2021.”
- Commit to achieving the standards of quality of care set by the district and national level.
- Identify facility champion(s) (or quality focal point) to create a coalition of quality champions including senior health-care professionals, partners, civil society and communities to promote the initiative and mobilize support for implementation.

3) For both leadership and QI teams:
- Commit to and facilitate documentation and sharing of learning within the facility and the district – e.g. weekly or monthly newsletters, regular communications with district counterparts.

**2. Establish, organize and support QI teams – preparing for action**
During this preparatory phase, QI team is established, organised and supported to guide the QI process and work on specific improvement aims. One of the key roles of QI team in the early stages of implementation is the intentional and systematic engagement of stakeholders and community representatives to participate in planning and action. Community feedback helps identify gaps, monitor performance and use resources strategically to improve services. Community members can also help solve problems and contribute towards improving care. This is vital to ensure social accountability.

**Key activities**
1) For facility leadership:
- Establish and support a multidisciplinary QI team comprised of all cadres of personnel involved in the selected aim. This will differ from facility to facility but should include, for example, people with effective communication skills, and those with interest, knowledge and the ability to address administrative problems. Representatives from community or patient groups should also be included.

2) For QI team:
- Agree upon QI team functions: a) set improvement aims, b) review facility data on selected improvement aims, c) take continual action to improve QoC, d) share learning and e) keep facility leadership informed about QoC activities.
- Agree upon how the QI team will function including developing clear roles and responsibilities, frequency of meetings, mode and purpose of communication etc.
• Introduce QoC programme to facility health personnel, community representatives and other stakeholders e.g. holding quality briefings, learning or orientation sessions for clinical and nonclinical personnel (e.g. cleaners, administrative workers, technicians).
• Use practical examples to illustrate how QoC encompasses technical areas such as infection prevention and control and antimicrobial resistance.

3. **Conduct situational analysis/baseline assessment to identify gaps**

The importance of facility situational analysis is to understand the current “state of quality” within the facility before starting the implementation. While important to align facility aims with district and national ones, facility aims are more specific and grounded in the local data. Through situational analysis the QI team gathers detailed information on different aspects of quality such as infrastructure, availability of policies, guidelines, standards and related resources in the facility. This is key to identifying gaps and needs for improvement.

**Key activities**
- Conduct facility situational analysis to identify priority areas for action and inform facility aims.
- Use recent assessment results where available.
- Based on the results of the assessment, undertake a gap analysis to identify where to take action.

4. **Adopt standards of care**

Informed by the results of the baseline assessment, QI teams should ensure relevant standards of care that are set by national or district level are applied.

**Key activities**
- Orient all personnel on relevant national standards (if available) and on the results of the baseline assessment.
- Identify gaps in quality based on the standards.
- Set goals for improving performance.
- Report to the district health management on critical resources that are needed to achieve improvements in quality.

5. **Identify QI activities (develop roadmap and operational plan)**

Based on the overall facility quality aim, the QI team identifies one or two specific clinical components of care for improvement to start with. After they fix these, they can improve other components of care. The QI team coordinates the planning of QI activities by developing a roadmap and operational plan.

**Key activities**
- Decide upon specific improvement aims with a defined target and time frame, based on the result of the situational analysis. Look for quick wins initially – aims that are a) considered relatively easy to achieve, b) easy to measure or c) would have the highest impact – early success is a strong motivator.
- Identify specific QI interventions to be implemented to achieve the specific aims, informed by the national QI package of system environment, reducing harm, improvement in clinical care, patient, family and community engagement interventions.
- If the facility is already implementing interventions from the national QI intervention package (e.g. clinical mentorship, clinical audits) consider establishing mechanisms to strengthen the capacity of QI teams
- Develop a road map or operational plan that lists all the actions to be taken to implement the intervention(s), including start and end dates, the person(s) assigned to perform the action and required resources.
- Liaise with the district for implementation support.

6. **Implement QI roadmap and operational plan**

The facility QI teams test and implement the roadmap and operational plan. Periodic measurement will determine whether the actions are helping to reach the aims. The support of facility leadership is important to help make successful actions routine. New ways of working may then form new facility policies and protocols to support institutionalizing successful actions.

**Key activities**
- Test the proposed operational plan on a small scale for a limited time first.
- Review data to determine effective actions and progress, and refine the operational plan as needed.
• Consider the best ways to share good practices e.g. with peers, facility leadership and other facilities during peer-to-peer sharing meetings, exchange visits, online webinars and other virtual and in-person forums.

• Reflect on 1) system interventions that are implemented nationwide and how these may affect your health facility and 2) how different programs may implement specific QI interventions towards their specific goals and how linkages might be made throughout a health facility to support learning of lessons.

7. Undertake continuous measurement of quality and outcomes

Measurement of outcome and in particular continuous monitoring of QI tracers and feedback is an important activity of QI teams. It enables tracking whether QI interventions are being implemented effectively. Measurement is also critical for team-based learning.

Key activities

• Define measures related to the identified QoC aims and set up the measurement process for data collection and use
• Consider whether the QI team requires additional facilitation or coaching/supportive supervision to conduct measurement e.g. district level/partner support.
• Establish training for measurement
• Develop job aids to support measurement

Facility-level ongoing activities

This section describes activities that may be currently ongoing, or may require ongoing action at the facility level to support quality of care. A number of these areas also contribute to start-up of quality of care activities at the facility level. These activities inform and feed in to overall policy or strategy direction from national and district authorities.

8. Continuous improvement – sustaining the improvement and refining operational plans

Quality improvement is not a one-off static process but rather a continuous dynamic effort. Support from facility leadership is needed throughout the process to reach the selected aims. Once an aim has been achieved, the QI team should continue activities by selecting new improvement aims and developing a new road map and operational plan accordingly. A basic principle underlying continuous quality improvement is learning – identifying what works – and sharing this knowledge within and across facilities and districts. To enable this, the facility leadership should foster a culture of quality described earlier in this document (page X).

QI benefits from shared leadership involving everyone. Facility leadership and QI team should ensure good quality care is sustained and the new way of working is made the norm in the facility. Additionally, stakeholders should actively be engaged if sustainability is to be achieved.

Key activities

1) For facility leadership:

• Secure continuous support for QoC efforts
  o Work with the district leadership to make sure the QI team receives adequate support such as coaching and clinical mentorship.
  o Support the QI team in involving community representatives in all stages of the process.
  o Ensure QI team are able to collect and use measurement data to determine effectiveness of the interventions and progress.
  o Provide quick resolutions to emerging problems including those addressing processes, resources, infrastructures and clinical skills.
  o Foster a positive environment for QI.
  o Put in place health workforce development mechanisms (career paths, professional development)
  o Ensure improvement gains are institutionalized e.g. revision of standard operating procedures, structural and process changes.

• Share learning
  o Facilitate continuous learning by sharing experiences and results e.g. incorporating discussions in relevant routine facility meetings, peer to peer learning across QI team.
  o Ensure facility personnel participate in learning activities to share their firsthand experience in relation to QI efforts.
  o Prioritize learning by:
    ▪ Forming a collaborative with other health facilities to discuss and compare indicators and quality improvement activities and facilitate joint learning.
- Participating in exchange visits between health facilities and between health districts according to direction from the district level.
- Sharing data and stories using district generated tools and resources.
- Building capacity on data collection and story writing/sharing as part of regular supervision visits from the district level to enable health workers capture key elements of improvement.
- Participating in peer-to-peer learning opportunities e.g. district-level review meetings, quarterly sharing meeting, district newsletters or bulletin and other routine meeting opportunities.
- Including a measure on learning in periodic assessments and feeding emerging information to the district-level.

- **Recognize and reward quality improvement**
  - Recognize and celebrate success e.g. through awards or other acknowledgements including the opportunity to present at conferences/seminars.

- **Ensure engagement and accountability mechanisms**
  - Maintain engagement with the district and community as part of their on-going demonstration of accountability (including social accountability).

2) For QI teams:

- **Share learning** on challenges and successes both internally and with community members, e.g. through social media, local mechanisms and digital platforms.

- **Ensure engagement and accountability mechanisms**
  - Maintain engagement with facility leadership – this is important when the facility leadership are not members of the QI teams e.g. provision of regular updates on progress and requests for support
  - Engage the community and patients and collect patient experiences for identifying new improvement aims; analysing gaps and proposing and testing solutions. Ensure individual, family and community engagement mechanisms are functional and used e.g. regular meetings with stakeholders.
  - Consider how other facilities are engaging stakeholders and communities during exchange visits and peer-peer learning events.

- **Continue improvement activities**
  - Select new improvement aims in discussion with district and coaches aligned with national and district aims.
  - Orient new health personnel to the QI efforts to cascade benefits into the future.

---

**An example of sharing learning and recognising and rewarding QI in Ethiopia**

In 2012 the Federal Ministry of Health of Ethiopia created a network of hospitals to improve quality of care. The network, called EHIQAQ – Ethiopian Health Institutions Alliance for Quality - brings together all hospitals in the country. The network is now on its 3rd round, each round having a specific theme. The 1st round in 2012 was all about finding the best performing hospitals in the country, based on mortality data and patient satisfaction. Ten lead hospitals made the cut and were matched to a group of five to ten hospitals located nearby to lead by example, share their lessons and best experiences and drive quality improvement in their cluster. The second round in 2014-2016 focused on maternal, newborn and child health. Fifteen hospitals met the criteria for best performers. The third round started in 2017, on the theme ‘save life through safe surgery’ and this time 31 hospitals came out as leaders of the pack. For each round, the best performing hospitals received a cash award from the Federal Ministry of Health based not on performance but on quality improvement.

“Learning is a key driver in EHIQAQ, fostered by knowledge sharing, and the incentive of an award, but also thanks to strong peer pressure among health workers and the power of interpersonal relations among physicians”

Seman Jakob, CEO of St Peter’s hospital in Addis Ababa
Improving quality of care requires several actions at the facility level. After reading this chapter you should know how to address the following inter-dependent actions.

### Actions

1. Facility leaders commit to district QoC aims & identify clear facility improvement aim(s)
2. Establish, organize and support QI teams – prepare for action
3. Conduct situational analysis/baseline assessment to identify gaps
4. **Adopt standards of care**
5. Identify QI activities – develop roadmap and operational plan
6. Implement QI roadmap and operational plan
7. Undertake continuous measurement of quality and outcomes
8. Focus on continuous improvement – sustain improvements by refining operational plans
Bringing it together

The purpose of this guidance document is to support country teams in taking required action at the national, district and facility levels to enhance quality of health care services. The practical guidance on implementing necessary activities at each of these levels cannot be seen in isolation and are clearly inter-dependent. As stated in the introduction, the success and sustainability of quality focused efforts is dependent on the integration between these levels and the need for leaders at each level to understand the activities required not just within their own area but at all levels. While this is a reasonably obvious statement it is emphasized again here to encourage a systems approach to enhance quality of care. Such a systems approach has several implications. Five stand out.

First, the foundational requirements relevant to each of the three levels – on-site support; measurement; sharing & learning; stakeholder & community engagement; and management – provide a clear linkage point between levels. Second, each of the health systems levers needs to be considered when taking action for quality at each of the three levels. Third, the culture of quality percolates all levels – without careful attention to this glue that binds things together sustainable and meaningful systems wide change is unlikely. Fourth, implementation of quality interventions occurs at all three levels – while it is tempting to recognize and focus only on the visible facility-based interventions at the point of care, multiple interventions require focused attention at national and district level. Finally, a diversity of priorities is the natural state within a health system – a shared vision for quality health services based on facility and district-based realities and driven by long term national aspirations can drive improvement.

As the reader will know, the litmus test for any health system is the quality of health services that are delivered at the point of care and the health outcomes that the system achieves for its populations. This implementation guide hopefully helps organize thinking on the urgent action required for quality and in response to that litmus test at the point of care. A lot remains to be done and to be learned in health services across the world.
Annex 1 – Driving foundational requirements for quality across the health system

A number of key questions need to be considered when planning for quality health services. Delivering quality health services relies upon several interlinked foundational requirements working together to consistently deliver the right care, at the right time to the right patient. A non-exhaustive list of questions to be considered is presented in Table X. This is intended to guide ministries of health, district health management teams and facility health personnel as they undertake improvements in health service quality.

### Key considerations for foundational requirements (non-exhaustive questions)

<table>
<thead>
<tr>
<th>On-site Support</th>
<th>Measurement</th>
<th>Sharing and Learning</th>
<th>Stakeholder and community engagement</th>
<th>Management</th>
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<tr>
<td><strong>National</strong></td>
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<td>• How can national quality teams strengthen on-site support mechanisms through national planning?</td>
<td>• What sources of data on quality of care exist? (for example, disease/population programmes, health facility assessment, patient surveys etc.)</td>
<td>• What support can the national level provide to initiate and sustain a learning system?</td>
<td>• What role can national quality teams play in designing a community engagement system to ensure that care provided in facilities meets the needs and preferences of patients, families and community members, and is to their satisfaction?</td>
<td>• What additional management capacity and training is required at all levels to support quality of care efforts, and how can this be achieved?</td>
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<tr>
<td>• How can health care and health management training be improved to increase capacity across the system in quality improvement?</td>
<td>• How can the national team responsible for quality access the measurement expertise required to generate the required data?</td>
<td>• How can the emerging learning be fed meaningfully into national direction setting?</td>
<td>• How can these systems be used to ensure meaningful engagement of communities in broader national dialogue on health systems planning?</td>
<td>• What upstream planning is required at the national level to enhance management of quality programmes and support at the district and facility level?</td>
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<tr>
<td>• What human and financial resources are required to enable effective on-site support and how should initial efforts be prioritized?</td>
<td>• How can measurement capacity and information systems be strengthened across the system?</td>
<td>• How can health system leaders engage in global learning on quality?</td>
<td>• How can the activities of partners be best coordinated and aligned to maximize impact on quality?</td>
<td>• What practical steps can health system leadership take to promote a culture of quality?</td>
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<td>District</td>
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<td>• What is required for QI on-site support at the district-level?</td>
<td>• Are there opportunities to participate in peer-to-peer learning activities e.g. district-level review meetings, quarterly sharing meeting, district newsletters or bulletin?</td>
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<td>• How can district leadership support facilities in moving forward on QoC?</td>
<td>• Are there opportunities for participating in exchange visits between health visits and health districts?</td>
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<td>• What resources are required from the district-level to support facility-level improvements?</td>
<td>• Are district generated tools and resources available to support sharing experience and stories among facilities?</td>
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<td>• What sources of data and tools are used at the district level for QoC?</td>
<td>• How can district level actors support the facility in documentation and sharing of lessons learned? Is learning addressed during periodic assessments?</td>
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<td>• What data should be collected from the facility-level and district level?</td>
<td>• Are mechanisms in place to ensure learning feeds into the district-level?</td>
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<td><strong>accreditation</strong></td>
<td>A formal process by which a recognized body, usually a nongovernmental organization, assesses and recognizes that a health-care organization meets applicable predetermined and published standards. An accreditation decision about a specific health-care organization is made following a periodic on-site evaluation by a team of reviewers.</td>
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<td><strong>benchmarking</strong></td>
<td>A strategy often used to increase transparency and accountability on issues of quality and cost in the health-care system by providing consumers, payers, health-care organizations and/or providers with comparative information on performance.</td>
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<td><strong>coaching</strong></td>
<td>Regular hands-on support to motivate and help quality improvement teams at health facilities to use quality improvement methods in improving the quality of care at the health facility and/or in the community.</td>
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<td><strong>community</strong></td>
<td>The minimum social unit that is locally relevant just above the level of the household (e.g. neighbourhood, canton, precinct, parish, town, village). It can also include non-geographically centered social networks of interaction, interchange and inter-dependency. Such networks may have direct local inputs into the transfer of health, educational, social, informational, economic, cultural and political resources (e.g. diaspora networks, rural–urban networks, peer group or social networks, kinship networks).</td>
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<td><strong>community and stakeholder engagement</strong></td>
<td>A process of developing relationships that enable stakeholders (including a wide range of traditional, community, civil society and opinion leaders) to work together and gain access to processes for assessing, analysing, planning, leading, implementing, monitoring and evaluating actions, programmes and policies to address health-related issues and promote well-being to achieve positive health impact and outcomes.</td>
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<tr>
<td><strong>data</strong></td>
<td>Facts and figures as raw material, not analysed.</td>
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<td><strong>equity (in health)</strong></td>
<td>(i) The absence of systematic or potentially remediable differences in health status, access to health care and health-enhancing environments, and treatment in one or more aspects of health across populations or population groups defined socially, economically, demographically or geographically within and across countries; (ii) a measure of the degree to which health policies are able to distribute well-being fairly.</td>
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<td><strong>evaluation</strong></td>
<td>The systematic and objective assessment of the relevance, adequacy, progress, efficiency, effectiveness and impact of a course of action, in relation to objectives and taking into account the resources and facilities that have been deployed.</td>
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<td><strong>evidence</strong></td>
<td>Any form of knowledge, including, but not confined to research, of sufficient quality to inform decisions.</td>
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<td><strong>health</strong></td>
<td>The state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.</td>
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<td><strong>health facility</strong></td>
<td>Any place where patients receive health care services. It includes hospitals, clinics, outpatient care centres, specialized care centres such as birthing centres and psychiatric care centres and doctor’s offices.</td>
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<tr>
<td><strong>Health care facility leadership</strong></td>
<td>The overall facility chief or administrator.</td>
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</table>
**health system**
(i) All the activities that have as their primary purpose to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill health through a variety of activities that have the primary intent of improving health.

**health system building blocks**
A framework used by WHO to describe health systems, disaggregating them into six core components: leadership and governance (stewardship); service delivery; health workforce; health information system; medical products, vaccines and technologies; and health system financing.

**health system performance**
(i) The level of achievement of the health system relative to resources (ii) the degree to which a health system carries out its functions (service provision, resource generation, financing and stewardship) to achieve its goals.

**improvement aim**
A defined aspiration to improve selected components of patient care and/or experience within a given time frame; often with clear targets specified.

**indicators**
Quantifiable characteristics of a population that are used as supporting evidence for describing the health status of a population or the progress of a programme.

**infection prevention and control**
A scientific approach and practical solution designed to prevent harm caused by infection to patients and health workers.

**input**
A quantified amount of a resource put in a process. (see process)

**intervention**
An activity or set of activities aimed at modifying a process, course of action or sequence of events, in order to change one or several of their characteristics such as performance or expected outcome.

**management system (for quality of care)**
Consists of management processes and leaders and managers in the health system with defined roles and responsibilities for ensuring that the efforts to improve quality of care continuously happen, the systems to support this goal are functional, and any issues related to health system building blocks that affect quality of care are addressed.

**measure**
Quantifiable characteristic of a population that is used as supporting evidence for describing the health status of a population or the progress of a programme.

**monitoring**
The continuous oversight of an activity to assist in its supervision and to see that it proceeds according to plan; involves the specification of methods to measure activity, use of resources, and response to services against agreed criteria.

**on-site support system (for quality of care)**
Involves visits to the facility to provide support for improving quality of care, including: (a) coaching by a visiting quality improvement coach who supports the facility staff in implementing the selected quality interventions, and (b) clinical skills support by a clinical skills mentor who provides on-the-job clinical skills training and skills building.

**operational plan**
Describes the activities and timeline for actions to improve quality of care, including how to initiate activities.

**outcome**
Those aspects of health that result from the interventions provided by the health system, the facilities and personnel that recommend them, and the actions of those who are the targets of the interventions.
<table>
<thead>
<tr>
<th>Ownership</th>
<th>The effective leadership and coordination by countries of their development policies, strategies and development actions.</th>
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<tbody>
<tr>
<td>Patient Safety</td>
<td>The absence of preventable harm to a patient during the process of health care, including the coordinated efforts to prevent harm caused by the process of health care itself from occurring to patients.</td>
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<tr>
<td>People-Centred Health Services</td>
<td>An approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways; requires that people have the education and support they need to make decisions and participate in their own care; organized around the health needs and expectations of people rather than diseases.</td>
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<tr>
<td>Performance-Based Financing</td>
<td>Payment or funding conditional upon taking a measurable action or achieving a predetermined performance target.</td>
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<tr>
<td>Process</td>
<td>Actions that are taken in health care, including those taken by both health-care staff and patients.</td>
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<tr>
<td>Quality</td>
<td>Satisfying the wants and needs of customers (i.e. patients) for products and services, while at the same time achieving the technical standards for public health practice.</td>
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<tr>
<td>Quality Improvement</td>
<td>An organizational strategy that formally involves the analysis of process and outcomes data and the application of systematic efforts to improve performance.</td>
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<td>Quality Improvement Team</td>
<td>The team working on specific improvement aims; may be called by different names in various countries.</td>
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<tr>
<td>Quality Intervention</td>
<td>A method or approach aimed at modifying a process, course of action or sequence of events in health-care systems, services or suppliers for the purpose of increasing the likelihood of optimal clinical quality of care for individuals and populations. Examples include: quality improvement cycles, morbidity and mortality reviews, clinical decision support tools, clinical audit and feedback, etc. (Note that for the purposes of this document, the term does not refer to specific evidence-based clinical practices.)</td>
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<tr>
<td>Quality Measure</td>
<td>Criterion for assessing, measuring and monitoring the quality of care as specified in a quality statement.</td>
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<tr>
<td>Quality of Care (QoC)</td>
<td>The extent to which health-care services provided to individuals and patient populations improve desired health outcomes; health care must be safe, effective, timely, efficient, equitable and people-centred.</td>
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<tr>
<td>Quality Planning</td>
<td>Activities that establish the objectives and requirements for quality and for the application of quality system elements.</td>
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<tr>
<td>Regulation</td>
<td>The imposition of external constraints upon the behaviour of an individual or an organization to force a change from preferred or spontaneous behaviour.</td>
</tr>
<tr>
<td>Roadmap</td>
<td>A strategic direction to achieve good quality care by bringing together information on the current situation of quality of care, existing activities and available technical and financial resources in a country.</td>
</tr>
<tr>
<td>Scale-Up</td>
<td>Deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis.</td>
</tr>
<tr>
<td>Social Accountability</td>
<td>Active participation of civil society or citizens – including those most marginalized by society – in holding governments responsible for meeting their obligations, such as monitoring how resources are allocated and how</td>
</tr>
</tbody>
</table>
services are delivered, demanding that their needs are taken into account, and mobilizing for change.

<table>
<thead>
<tr>
<th><strong>stakeholder</strong></th>
<th>An individual, group or organization that has an interest in the organization and delivery of health care.</th>
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</thead>
<tbody>
<tr>
<td><strong>standard</strong></td>
<td>An established, accepted and evidence-based technical specification or basis for comparison.</td>
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<tr>
<td><strong>standards of care</strong></td>
<td>General statement about what is expected to be provided to ensure high-quality care.</td>
</tr>
<tr>
<td><strong>strategy</strong></td>
<td>A series of broad lines of action intended to achieve a set of goals and targets set out within a policy or programme.</td>
</tr>
<tr>
<td><strong>Supportive supervision</strong></td>
<td>Supportive supervision is a process of helping staff to improve their own work performance continuously.</td>
</tr>
<tr>
<td><strong>sustainability</strong></td>
<td>The potential for sustaining beneficial outcomes for an agreed period at an acceptable level of resource commitment within acceptable organizational and community contingencies.</td>
</tr>
<tr>
<td><strong>target</strong></td>
<td>An intermediate result towards an objective that a programme seeks to achieve, within a specified time frame; more specific than an objective and lends itself more readily to being expressed in quantitative terms.</td>
</tr>
<tr>
<td><strong>universal health coverage (UHC)</strong></td>
<td>The concept that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.</td>
</tr>
</tbody>
</table>
References