National Strategy for Reproductive, Maternal, Newborn, Child and Adolescent Health Quality of Care in Nigeria

I. Maternal and Neonatal Health

Acknowledgements

Preface

Acronym and Abbreviations

ACSI-CCCD	Africa Child Survival Initiative- Combating Childhood Communicable Diseases
AIDS	Acquired Immune Deficiency Syndrome
APIN	AIDS Prevention Initiative in Nigeria
BEmNOC	Basic Emergency Obstetric and Newborn Care
BEmOC	Basic Emergency Obstetric Care
CEmNOC	Comprehensive Emergency Obstetric and Newborn Care
CEmOC	Comprehensive Emergency Obstetric Care
CIHP	Centre for Integrated Health Program
COPE	Client-Oriented, Provider-Efficient
DFF	Decentralized Facility Financing
DFID	Department for International development
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
FMoH	Federal Ministry of Health
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICPD PoA	International conference on population and development Programme of action
IMNCH	Integrated Maternal, Newborn and Child Health
LGA	Local Government Area
LMICs	Low and Middle Income Countries
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MCSP	Maternal Child Survival Program
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MNH	Maternal and Neonatal Health
MSS	Midwife Service Scheme
NAFDAC	National Agency for Food and Drug Administration and Control
NDHS	Nigeria Demographic and Health Survey
NPHCDA	National Primary Health Care Development Agency
NURHI	Nigeria Urban Reproductive Health Initiative
PFB	Performance-Based Financing
PHC	Primary Health Care
PLA	Participatory Learning and Action
QIC	Quality Improvement Committee
QoC	Quality of care
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCH	Reproductive, Maternal and Child Health
SBM-R	Standards-Based Management and Recognition
SDGs	Sustainable Development Goals
SDI	Service Delivery Indicators
TBAs	Traditional Birth Attendants
TLTL	Too Little, Too Late
TMTS	Too Much, Too Soon
TSHIP	Targeted States High Impact Project
TWG	Technical Working Group
UNFPA	United Nations Population Fund
USAID	United State Agency for International Development
WHO	World Health Organization

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Executive Summary

Background

Quality of care is globally recognized as a critical aspect of the Reproductive, Maternal, Child and Adolescent Health (RMNCAH) agenda. Quality of care is critical to the reduction of preventable maternal and newborn death, and improving the health and well-being of mothers, newborn, and adolescents. Poor quality of care (QoC) has significantly compromised the potential achievements that could have been realized with the level of investments in RMNCAH globally; among others, the significant increase recorded in the coverage level for skilled birth attendants globally in the Millennium Development Goal (MDG) era has not translated to commensurate reduction in the level of maternal and newborn mortality.

Nigeria has the second highest burden of maternal mortality in the world, and contributes about 15% of the annual total global maternal deaths and the country's neonatal death rate ishigh (37/1,000 live births). The burden of infant mortality, under-5 mortality, and adolescent morbidity and mortality is also high in Nigeria. The leading causes of both maternal and childhood deaths as well as adolescent mortality and morbidity in Nigeria are preventable or easily treatable conditions. Overall, the RMNCAH status in Nigeria is poor, and poor QoC has been identified as a major factor associated with the RMNCAH situation in the country, and lack of significant progress in Nigeria's RMNCAH indicators over the MDG period. Nigeria has now prioritized the improvement in RMNCAH QoC, and she is currently one of the 10 first phase countries to be part of the"Network to Improve Quality of Care for Mothers, Newborns and Children" led by the World Health Organization (WHO).
Nigeria's high commitment to improving RMNCAH QoC is rooted in her agenda for improved health and well-being for women, children, and adolescents, and her aspiration towards achieving the Sustainable Development Goals (SDG), especially the health-focused goal (SDG 3).In this respect, there is the need for a coordinated strategy for improving RMNCAH QoC in Nigeria. This strategy document focuses specifically on quality of care relating to maternal and newborn health (MNH), and is the first in the series of national strategy documents on RMNCAH. The document provides a platform for harnessing MNH quality of care initiatives across the country, and serves as an entry point into RMNCAH QoC, as well as a roadmap for addressing key quality challenges in the Nigerian health system as a whole. This document has been developed through a highly iterative and collaborative process that involved the active participation of many stakeholders across the health development domain – government agencies, international development partners, civil society organizations, and the academia.

Concept and framework for MNHQoC in Nigeria

Quality is a multi-faceted construct and multi-dimensional concept; as such, there is no universally accepted definition for quality of care. WHO in its working definition of quality has identified six areas or dimensions of quality: safe, effective, timely, efficient, equitable and people-centered. WHO, in its articulation of a vision of quality of care for pregnant women and children, defines quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centred." WHO has further proposed a QoC framework for maternal and newborn health with two inter-linked elements – the provision of care, and the experience of care. Together, these two dimensions consist of eight domains, which should be the focus of the assessment, improvement and monitoring of care within the health system for improved outcomes in MNH. Three of the domains relate to "provision of care" – (i) Evidence based practices for routine and emergency care; (ii) Actionable information systems, and (iii) Functional referral systems; three domains relate to "experience of care" – (iv) Effective communication, (v) Respect and dignity, and (vi) Social and emotional support, while the other two domains are cross-cutting – (vii) Competent and motivated human resources; and, (viii) Essential physical resources. Nigeria has adopted the WHO Quality of Care Framework for this MNH QoC Strategy.

Vision, Core Values, Goal, and Objectives

Vision: The vision of this strategy is "A Nigeria in which every pregnant woman receives quality care throughout pregnancy, childbirth and the postnatal period, and every newborn receives quality care for optimal health, development and well-being.

This vision is underpinned by the core values of quality, equity and dignity.

Goal: The goal of this National Strategy is improved maternal and newborn outcomes in Nigeria

Targets: To have achieved the following targets relating to mortality, avoidable morbidity and experience of care over a five-year period:

- reduction in level of maternal deaths in health facilities by 50%
- reduction in level of newborn deaths in health facilities by 50%
- reduction in intra-partum stillbirths by 50%
- reduction in the incidence of severe post-partum haemorrhage by 50%

- reduction in neonatal sepsis by 50%
- reduction in the proportion of women of reproductive age who report the attitude of health workers as barriers to healthcare services by half

Strategic Objectives

The approach to improving quality of care for mothers and newborns is structured around four strategic objectives, summarised by four key words: leadership, action, learning and accountability

- Strategic Objective 1: LEADERSHIP - Build and strengthen national institutions and mechanisms for improving quality of care in the health sector.
- Strategic Objective 2: ACTION - Accelerate and sustain implementation of quality of care improvements for mothers, new-borns, children and adolescents.
- Strategic Objective 3: LEARNING - Facilitate learning, share knowledge and generate evidence on quality of care.
- Strategic Objective 4: ACCOUNTABILITY - Develop, strengthen and sustain institutions and mechanisms for accountability for quality of care

Implementation Framework

A national ministerial-level multi-sectoral QoC Steering Committee and a Technical Committee has been established by the Federal Ministry of Health to drive the national RMNCAH QoC agenda nationally. Similar structures will also be established at state and LGA levels while Quality Improvement Committee (QIC) will be established at Facility level, with membership including representatives of the community.

Monitoring and Evaluation Systems

Appropriate functioning of the monitoring and evaluation system, encompassing monitoring, evaluation and research, is critical to ensuring the impactful implementation of Nigeria's RMNCAH QoC agenda. In this respect, quality data will be regularly collected, synthesised, and analysed to strengthen accountability and to inform programmatic and policy decisions on the implementation of the QoC agenda. Research will provide further support to monitoring and evaluation activities in generating data that can strengthen programme implementation and decision-making by policy-makers, programme managers as well as health workers

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1. Background

1.1. Introduction

The last two decades has been a period of significant focus on reproductive, maternal, newborn, child and adolescent health globally and nationally. The International Conference on Population and Development held in Cairo, Egypt, in 1994, was a watershed in global health development, with the emergence of "Reproductive Health", as a new paradigm. As the ICPD Programme of Action (PoA)[1]articulates, Reproductive Health (RH) encompasses, among others, safe motherhood, family planning, adolescent sexual and reproductive health, elimination of harmful practices against women and girl-child, as well as the prevention and management of chronic condition of the reproductive tract. As a paradigm, RH has a life cycle approach, and interconnects women's health, adolescent health, gender and women empowerment, and human rights. Since the late 1990s, governments and international development partners all over the world, including Nigeria, have intensely invested in policies, plans and programmes aimed at ensuring the realization of the reproductive health and well-being of the human population. RH in a significant way, lays the foundation for the targets of the health-related Millennium Development Goals, and is an agenda that remains relevant for now and the future as the United Nations General Assembly affirmed in 2015[2].

A key focus of the RH agenda is to significantly improve the access of the population to quality sexual and reproductive health services, as a pathway to reducing mortality and morbidity, and improving health and well-being. Explicitly, the ICPD PoA expressed and championed the ambitious goal of achieving universal access to reproductive health services by 2015. The ICPD PoA also aims to improve maternal health and reduce maternal mortality globally. For Nigeria, the ICPD agenda provided an impetus for strengthening safe motherhood programme to reduce mortality and morbidity among mothers and their newborn babies. The ICPD also provided the foundation for building national adolescent health programmes, and advancing efforts to address the challenge of Human Immunodeficiency Virus (HIV) and other sexually transmitted infections in Nigeria.

The Millennium Development Goals (MDGs), which lapsed in 2015, builds on the ICPD agenda with the fourth and fifth goals aimed at significant reduction in child and maternal mortality, and the eighth goal aimed at halting and reversing the epidemics of Acquired Immune Deficiency Syndrome (AIDS). The MDG era amplified the trend of improving coverage of, and access to essential services

with potentials for impacting significantly on maternal and child mortality statistics globally. The realization of the importance of integration of services and the life cycle approach in the efforts to improve the health of women and their children had led to the recognition of RMNCAH as an entity, with interconnected elements that reinforces one another. Consequently, the Global Strategy on Women's, Children's and Adolescents' Health has now replaced the earlier Global Strategy on Women's and Children's Health, and a new National Integrated Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAH+N) Strategy has been recently developed to replace the previous Integrated Maternal,Newborn and Child Health Strategy.

Yet, for all the global and national attention, focus and investment in RMNCAH, a crucial gap exists that was largely unaddressed – the quality of care. Poor quality of service and care has significantly compromised the potential achievements that could have been recorded with the level of investments so far made in RMNCAH in low- and middle-income countries (LMICs).Available evidences indicate that the significant increase globally recorded in the coverage level formaternal and child health services has not been attended by commensurate level of decrease in the level of maternal and newbornmortality. According tothe World Health Organization, "While the rate of skilled birth attendance has increased in many high burden countries due to focused advocacy and investment, many women and their babies still die, or suffer from life-long disabilities, even after reaching a health facility, due to poor care practices." The WHO Multi-country Survey on Maternal and Newborn Health[3], with data on more than 300 000 women attending 359 health care facilities in 29 countries including Nigeria, for example, showed a poor correlationbetween coverage of "essential interventions" and maternal mortality in health facilities. Thus, increasing the coverage of essential interventions, despite their potentials as high-impact and cost-effective actions, is insufficient to reduce maternal and newborn mortality and morbidityin the absence of good quality of the services offered in the context of those interventions.

Indeed, poor quality of services and care also contribute substantially to the current unacceptable RMNCAH+N statistics in Nigeria. The leading causes of both maternal and childhood deaths in Nigeria are preventable or easily treatable condition. For maternal deaths the leading causes are obstetric haemorrhage, infection, hypertensive disorders of pregnancy, unsafe abortion and obstructed labour. For neonatal and child death the leading causes are largely infections (neonatal sepsis, malaria, pneumonia and diarrheoa), followed by preterm and asphyxia. As a meeting of RMNCAH+N national stakeholders held in December 2016 noted in the review of the implementation of the National IMNCH Strategy, poor quality of service is likely to have played a

major role in the lack of progress in Nigeria's RMNCAH+N status over the 2007-2016 period covered in the review. Quality care is not only important for good clinical outcomes, but is also integral to ensuring the rights of individuals to health, equity and the preservation of their human dignity.

As such, globally, there is a renewed call for "quality revolution in global health"[4] to address the challenge in the quality chasm. There is also a concomitant drive in Nigeria for improved quality of care[5], and Nigeria has committed herself to that agenda, and is one of the 9 first phase countries to join the "WHO Network to Improve Quality of Care for Mothers, Newborns and Children"[6] alongside Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Kenya, Malawi, and Uganda. As noted by the WHO, "these countries were invited on the basis of being well-positioned to make rapid progress, as evidenced by a high degree of political will and commitment to support and resource maternal and newborn health services from government, and strong, funded commitment and support from partners (funders and technical)".The vision of the WHO network is that "every pregnant woman and newborn infant receives good quality care throughout pregnancy, childbirth and the postnatal period", with the goal of "halving mother and newborn death rates in health facilities within five years"6. Nigeria is committed to realizing the goal and vision of the "Network to Improve Quality of Care for Mothers, Newborns and Children" as part of her larger vision of ensuring reproductive, maternal, newborn, child, and adolescent health quality of care.

1.2. Rationale for Strategy

Quality of care is increasingly recognized internationally as a critical aspect of the unfinishedagenda in the RMNCAH+Nfield, particularly in relation to maternal and newborn care around the vulnerable periods of labour, delivery, and the immediate postnatal period. Quality care is critical to the reduction of preventable maternal, newborn, child and adolescentdeath, and improving the health and well-being of mothers, newborn, and other population groups. According to WHO, based on evidence from studies, "giving birth in a health facility with a 'skilled' attendant is not sufficient to reduce maternal and newborn deaths and severe morbidity. Many women and their babies die from poor care practices, even after reaching a health facility. Improving quality of care and patient safety are therefore critical if we want to accelerate reductions in maternal and newborn mortality**Error! Bookmark not defined.**." This strategic plan focuses specifically on the maternal and newborn health (MNH) component of RMNCAH QoC. The strategy plan for the other components of the RMNCAH QoC – child health and adolescent health Qoc – will be developed subsequently.

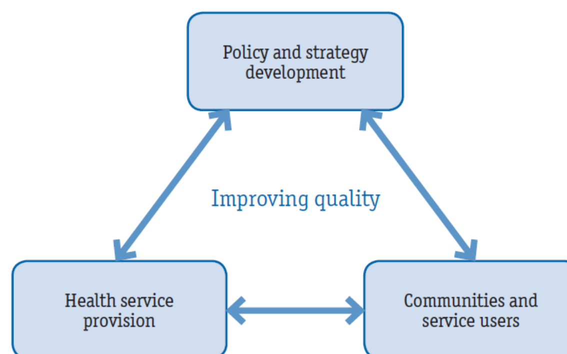
Currently, Nigeria has the second highest burden of maternal mortality in the world, and contributes about 15% of the annual total global maternal deaths. Furthermore, Nigeria's progress in reducing maternal mortality ratio (MMR) has been too slow. The Nigeria Demographic and Health Surveys show no significant difference between the MMR for 2008[7](545 maternal deaths per 100,000 live births and 95% Confidence interval [C.I.] of 475-615/100,000) and 2013 (576/100,000 and 95% C.I. of 500-652/100,000)[8], while the United Nations indicated a reduction of 37.9% in Nigeria's MMR between 1990 and 2015 (Uncertainty interval: -5 to 56.3%)[9] as against the target of 75% reduction. With neonatal death rate of 37/1,000 livebirths, infant mortality rate of 69/1,000 live births, and under-five mortality rate of 128/1,000 as reported by the 2013 NDHS, Nigeria's childhood mortality burden is also unduly high. Furthermore the country also has a high burden of adolescent health challenges[10]. Thus, overall, Nigeria has a huge burden of RMNCAH, and poor quality of services contributes significantly to that burden. Yet, Nigeria has committed herself to the Sustainable Development Goals (SDGs), of which significant reduction in maternal and child mortality are part of the targets under Goal 3. If the situation with the MDGs, where the nation fails to meet the health-related MDGs is not to repeat itself, it is imperative that a national focus be brought to the issue of quality of care – and efforts be dedicated to ensuring high quality of care for all clients and patients that access healthcare facilities.

Quality care requires appropriate use of evidence-based clinical practices and non-clinical interventions, strengthened health infrastructure and optimum skills and a positive attitude of health providers. Quality care, thus, is a matter of deliberate planning, and strategic choices in health care investments and actions[11], and involves specification, monitoring, and enforcement of standards – as quality of care is a normative concept, and measuring quality, or improvements in quality, demands a set of standards to gauge the impact of quality improvement efforts. To end preventable maternal and newborn morbidity and mortality, for example, every pregnant woman and newborn should have skilled care at birth with evidence-based practices delivered in a humane, respectful, and supportive environment. Providing such desired service and service environment to engender quality care takes deliberate and painstaking effort. More important is the fact that not only must good quality services be provided, but it must be provided consistently. In the context of a national health system, the issue even goes beyond some health facilities being capable of providing quality care and consistently so; it is also critical that the entire health system – across the country – be geared towards meeting specific quality standard, and the necessary mechanisms are put in place for the implementation of such quality standards. Thus, there is the need for a coordinated strategy

for improved RMNCAH QoC in Nigeria. This strategy documents focuses specifically on maternal and newborn health – as the first in the series of national strategy documents in RMNCAH.

Policy and strategy development is critical to defining and pursuing a national vision on quality of care, and its interaction with health service provision, service users and communities provide the key pillars for improving the quality of care. This strategy document focuses specifically on maternal and newborn QoC: it provides a platform for harnessing quality of care initiatives in the area of maternal and newborn health across the country, and serves as an entry point into improving RMNCAH QoCas well as a roadmap for addressing key quality challenges in the Nigerian health system as a whole.

Figure 1: The role of policy and strategy development in improving quality of care



Source: WHO. Quality of care: a process for making strategic choices in health systems.2006, p. 11

1.3. Process of Developing the Strategy

There has been a growing concern among stakeholders on the need to improve quality of health services, and particularly the quality of care in maternal and newborn health (MNH) due to the high vulnerability to mortality and morbidity at the peri-delivery and neonatal period, and Nigeria's unacceptably high RMNCAH burden. That concern has manifested in a number of individual initiatives by different international development partners, as well as some broad reform agenda and initiatives by the government. The 2015 publication of the WHO Quality of Care Framework for maternal and newborn health[12]catalyzed the discussion among partners in Nigeria on the need to harmonize a common approach started in-country. The initiative of the Honourable Minister of Health in signaling Nigeria's interest in August 2016 to be one of the first wave of countries to participate in the WHO-led"Network to Improve Quality of Care for Mothers, Newborns and Children" finally served as the lynchpin for in-country articulation of common agenda for QoC in

MNH, which was later broadened to embrace RMNCAH given Nigeria's interest in an integrated RMNCAH approach.

Consequently, and at the request of the Honourable Minister, a landscaping analysis was carried out by the Federal Ministry of Health, which provided a quick snapshot of the QoC situation in Nigeria and highlights major strengths and gaps. Following this, the Federal Ministry of Health (FMoH)convened a meeting of stakeholders on the 10th and 11thof November, 2016. The 2-day meeting featured the participation of national stakeholders (from the Federal and States health agencies, regulatory bodies, professional associations, international development organisations, and civil society organisations) as well as technical officers from the WHO country office, Inter-Country Support team in Ouagadougou, Burkina Faso, and WHO Headquarters. The stakeholders' meeting produced a draft quality of care framework analysis, based on the tools and models from WHO.

This stage was followed by the engagement of two independent consultants to develop the draft National Strategy for RMNCAH Quality of Care in Nigeria document (with specific focus on Maternal and Newborn Health), which was reviewed by the National RMNCAH Quality of Care Technical Committee at a two-day meeting in early February 2017. The draft document was presented at the launch of the Global Network for improving quality of care for mothers, newborns and children's health that took place in mid-February 2017 in Lilongwe, Malawi with Nigeria among the first nine wave countries participating. The National RMNCAH Quality of Care Technical Committee finalised this National Strategy document at a 3-day meeting in April 2017, as well as developed a road map for its implementation.

2. Concept and Framework for MNH Quality of Care in Nigeria

2.1. Concept of Quality of Care in the Context of the National Strategy

Quality is a multi-faceted construct and multi-dimensional concept. Historically, quality has been defined at a clinical level and the development of standards for health care settings, focusing on offering technically competent, effective, safe care that contributes to the client's well-being[13][14], and Donabedian's seminal work of over four decades on structure-process-outcome model remains one of the dominant frameworks in the quality of healthcare field[15]. Over time, quality has been defined, discussed and measured from various angles, and multiple models currently exists in the literature[16]. The perspective model, for example, focuses on the quality of care as perceived by different constituencies: patients, healthcare providers and healthcare managers. The characteristic model, on the other hand, focuses on the list of desired elements and features of the care, while systems model put quality care, as a product of the structure of healthcare services, and the process of health care delivery.

As such, there is no universally accepted definition for quality of care. However, a number of definitions available in the literature provide useful insight into the nature, elements, and characteristics of quality of care. One of the widely acknowledged definitions is that of The Institute of Medicine (IOM) of the United States of America, thatdefinesquality care as "care that is safe, effective, patient-centered, timely, efficient and equitable"[17].

Box I: Dimensions of quality of care

- ***Safe*** – delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors
- ***Effective*** – providing services based on scientific knowledge and evidence-based guidelines
- ***Timely*** – reducing delays in providing and receiving health care
- ***Efficient*** – delivering health care in a manner that maximizes resource use and avoids waste
- ***Equitable*** – delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status
- ***People-centred*** – providing care that takes into account the preferences and aspirations of individual service users and the culture of their communities

Source: Tuncalp et al, 2015.

This definition encompasses three key components of quality:clinical (safe and effective), interpersonal (patient-centered)and contextual (timely, efficient and equitable).WHO,in its working definition of quality,has identified six areas or dimensions of quality: safe, effective, timely, efficient, equitable and people-centered[11,12].

Specifically in relation to maternal care, Hulton[18] has defined quality of care as "the degree to which maternal health services for individuals and populations increase the likelihood of timely and appropriate treatment for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and uphold basic reproductive rights", and proposed a framework with two dimensions – provision of care, and experience of care. The first dimension – "provision of care" – include the quality of the human, infrastructural, and information systems and clinical appropriateness of care, while the second dimension – "experience of care" – refers explicitly to the relationship that women and their families had with health services. The WHO in its recent articulation of a vision of quality of care for pregnant women and children defines quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centred." Building on the foundation of other works, WHO has further proposed a framework with two inter-linked elements – the provision of care, and the experience of care.

The WHO definition is adopted for this document. In that respect, the quality of MNHcare is the degree to which MNH services increase the likelihood of timely,appropriate care for the purpose of achieving desired outcomes that are both consistent withcurrent professional knowledge and take into account the preferences and aspirations ofindividual clients and their families.

2.2. Framework for Quality of Care in the Context of the National Strategy

This Strategy adopts the WHO Quality of Care Framework for pregnant women and newborns in health facilities. The

Box 2: Eight domains of MNH QoC

A. Provision of care

1) Evidence based practices for routine and emergency care;
2) Actionable information systems
3) Functional referral systems

B. Experience of care:

4) Effective communication
5) Respect and dignity
6) Social and emotional support

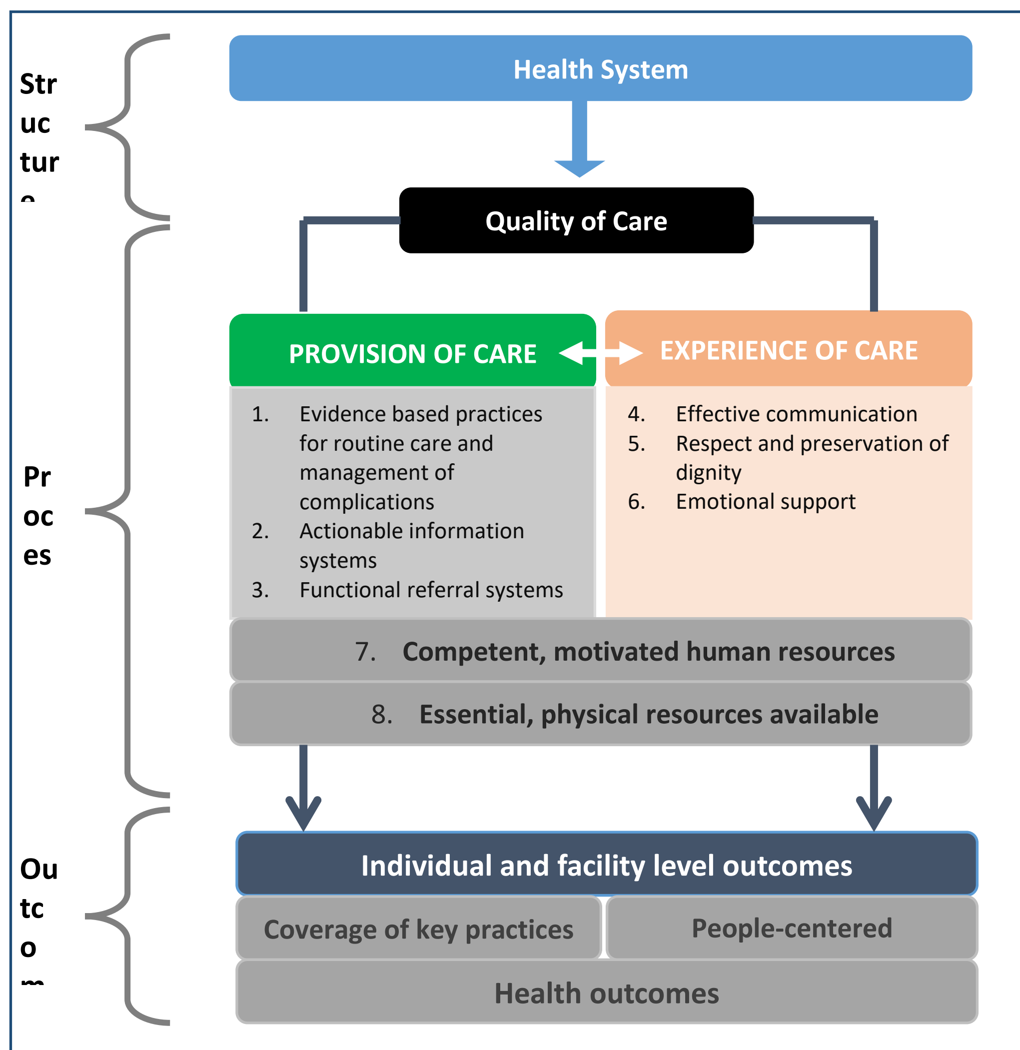
C. Cross-cutting:

7) Competent and motivated human resources
8) Essential physical resources

Source: Tuncalp et al, 2015

WHOframework presents dimensions of quality of care which can be targeted for improvement. The overarching structure is the health system. Within this structure, the process of care takes place across two inter-linked dimensions – the provision of care, andthe experience of care. Together, these two dimensions consist of eight domains, which should be the focus of the assessment, improvement and monitoring of care within the health system for improved MNH outcomes. Three of the domains relate to "provision of care" – (i)Evidence based practices for routine and emergency care; (ii)Actionable information systems, and (iii) Functional referral systems; three domains relate to "experience of care" – (iv) Effective communication, (v) Respect and dignity, and (vi) Emotional support, while the other two domains are cross-cutting – (vii) Competent and motivated human resources; and, (viii) Essential physical resources.

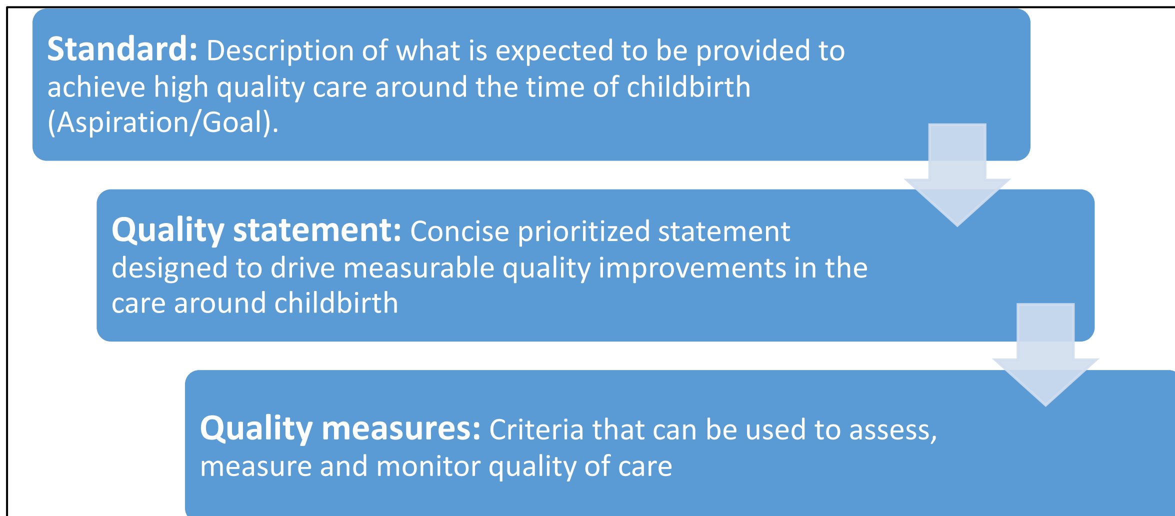
Figure 2: WHO Quality of Care Framework for Maternal and Newborn Health



Source: Tuncalp et al., 2015 (Quality of care for pregnant women and newborns – the WHO vision. Br J Obstet Gynaecol 2015;122:1045–1049).

Further to the development of the framework, WHO has formulated a **standard** for each of the eight domains to define the priorities for quality improvement[19]. Each standard is assigned **quality statements** that are prioritized statements designed to drive measurable quality improvements in the care around childbirth (Figure 6). For each quality statement a set of **quality measures** (input, output and outcome) were developed for use as part of quality improvement in facilities. The primary intention of these quality measures is to improve quality of care at the facility level. Secondary use may be for reporting and further use of the data. Data reporting and linkages to the national health information system is an important priority. Nigeria will be reviewing these standards, quality statements and quality measures, and adapting them as necessary in developing her own criteria.

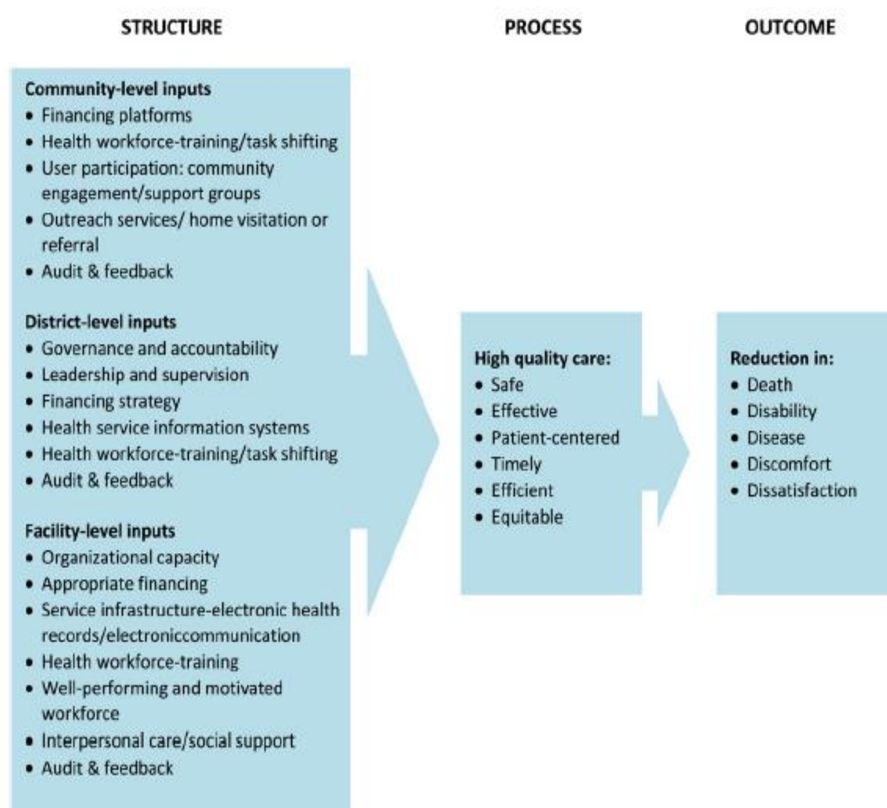
Figure 3: Relationship between Standards, Quality Statements, and Quality Measures in Quality of Care



3. Situation Analysis

The analysis of MNH QoC situation in Nigeria highlights the state of MNH care as well as efforts to address quality issues, to provide a foundation for the proposal of specific strategic actions.The MNH QoC framework developed by Austin et al.[20]was adopted as a guide for reviewing the situation of MNH QoC situation in Nigeria (Figure 4). The framework, which was "developed as an easy-to-use and conceptual guide to understand the drivers of quality in facility-based maternal care", integrates a modified form of the classical Donabedian causal chain framework with that of Hulton (from which the WHO QoC framework was adopted), and that of other scholars. Thus, the framework fully embraces the domains of the WHO MNH QoC, but more expansive, and many existing published works fit more readily into its structure, particularly because of the frontline nature of the Donabedian approach in the healthcare quality field over decades. Overall, the framework by Austin et al. "outlines the interconnected inputs, required at different levels of health system that lead to the delivery of quality care and result in positive health outcomes."[20]

Figure 4: Guiding Conceptual Framework for the Situation Analysis



Source: Austin et al, 2014 (Approaches to improve the quality of maternal and newborn health care: an overview of the evidence. Reproductive Health 2014, 11(Suppl 2):S1: 1-9).

Structure refers to the context in which healthcare isprovided; Political, legal, professional and organisationalresources (human, materials, and financial) needed to ensure that quality care is deliveredat the community and all levels of the healthsystem. Process refers to whether or not good medical practices are followed, and quality care, as defined by the IOM is delivered; Outcome, in this framework embraces the traditional clinical outcomes of improved health status as well as positive user-experience, resulting in increased demand, and the timely utilization of healthcare services is also incorporated.

This analysis draws from peer-reviewed literature, programme assessments and studies, as well as policy-related documents. It also draws from the findings of the country landscape carried out by the Federal Ministry of Health, which utilized a WHO tool to undertake a quick assessment of RMNCAH-related QoC issues, and with government agencies as well as selected international development partners completing the tool.

3.1. The State of MNH QoC in Nigeria

In assessing the state of MNH QoC in Nigeria, the literature reviewed covered the most recent five year period (2012 – 2016) so as to provide an up-to-date picture. The analysis focus on maternal care, which is where the preponderance of the work on QoC in MNH and RMNCAH have been carried out. In the context of this analysis, maternal care serves as a “window” into the MNH and the larger RMNCAH field and paints an overall picture that all the other less-researched RMNCAH QoC issues in Nigeria can easily relate to.

3.1.1. Structure

Several studies have shown that most Nigerian health facilities lack the critical input they need, including human resources, equipment, commodity and supplies, and infrastructure. In a study on the the role of supply-side factors, particularly health facility readiness and management practices for provision of quality maternal health services across states, Gage and colleagues reported that “basic amenities for antenatal care provision, readiness to de liver basic emergency obstetric and newborn care, and management practice supportive of quality maternal health services were suboptimal in health facilities surveyed” and did not change significantly over a five-year period[21]. In another study, involving 231 sampled basic emergency obstetric and newborn care (BEmONC) and

comprehensive emergency obstetric and newborn care (CEmONC) facilities in six northern Nigerian states, Hulton and colleagues reported that only 35%-47%of facilities met minimum quality standards in infrastructure, while 49%-73% met the minimum standards for human resources[22]. The Service Delivery Indicators (SDI) survey, a product partnership of the World Bank, the African Economic Research Consortium and the African Development Bank, carried out between June, 2013 and January 2014 in 12 states of Nigeria (two states per geographical zone) and covering 2,479 facilities also reported that the availability of minimum infrastructure was generally poor across all the states, ranging from a minimum of 9.7% of facilities in Kogi State to a maximum of 41.3% in Imo State[23]. As expected, the infrastructure is generally poorer in PHC facilities compared to secondary facilities except in Anambra State.In a study published in 2016, and involving 42 tertiary hospitals in Nigeria over a year period, non-availability of blood was reported, alongside late presentation of the client at the health facility and lack of health insurance, as the most frequent problems associated with deficiencies in women with carelife-threatening maternal complications[24]. Consequently, the overall mortality index recorded for life-threatening maternal conditions was high (40.8%).

A systematic review ofbarriers and enabling factors in the provision of emergency maternal care undertaken by Hussein et al. and published in 2016 also reported that lack of safe blood transfusion services, alongside delays in Caesarean section and non-availability of magnesium sulphate, are the three elements with the highest contributions to maternal deaths in Nigeria[25]. Findings from a qualitative study carried out around nine midwives service scheme (MSS) facilities across three states indicate that lackof essential drugs and equipment and the absence of staff, particularly at night as some of the major reasons why many pregnant women continue delivering at home[26].Uneke et al, in 2014, also identified inadequate human resource for health, inadequate funding, inadequate drugs and supplies (out-of-stock syndrome), inadequate infrastructure, and poor staff remuneration as implementation challenges for the Free Maternal and Child Health Care Programme in Ebonyi State[27].

With regards to life-saving commodities, the UNFPA-supported 2015 Facility Assessment for Reproductive Health Commodities and Services in Nigeria[28] has also reported that just over 50% of all facilities had a combination of seven (including two essential) life-saving maternal/RH medicines out of a list of 17essential commodities available. While all of tertiary facilities (100%) had at least seven life-saving medicines available, only 66% of secondary level facilities and 30% of primary level facilities had the same availability.

The RMNCH Rapid Health System Assessment undertaken by the USAID-supported Maternal Child Survival Program (MCSP) in Kogi and Ebonyi States in October 2015 also indicated significant challenge with human resources, including staff shortages and absenteeism (especially among clinical staff providing primary health care), low staff capacity, and low staff motivation[29]. Reasons for the human resources shortages, as described by the study participants, include: “(i) staff retirement without a strategy for replacement; (ii) difficulty recruiting and retaining staff due to low and/or delayed salary payments; (iii) inadequate distribution of staff across urban and rural areas; (iv) absenteeism due to lack of supervision, worker professionalism and motivation, and workers being posted far from their homes; (v) promotion of the most experienced clinicians into managerial roles (leaving younger workers to provide services); and (vi) too few new graduates due to low capacity at training institutions.”The report of the 2013 Nigeria Service Indicators Survey also reflect the low capacity of the Nigerian health worker: when the ability of health workers to manage maternal and newborn complications were assessed using a case of haemorrhage and neonatal asphyxia, Only one-fifth of health workers were able to adequately manage the maternal and neonatal complications presented to them, including, 33.2% of doctors, 23.9% of nurses and midwives, 13.6% of CHEWs and 12.4% of para-professionals were able to adequately manage maternal and neonatal complications. Approximately 40% percent of the five tracer cases were correctly diagnosed by all the health workers in all the states

Emergency obstetric care services are critical in reducing maternal mortality and morbidity, as their availability and utilisation largely account for the differences in maternal death statistics among countries, communities, and populations. In general, studies have shown that the availability, utilization, and quality of EmOC services in Nigeria, are suboptimal. For example, in a cross-sectional study of 20 general hospitals and 39primary healthcare centers providing delivery services in Bauchi, analysis of data on the performance of emergency obstetric care (EmOC) services between June2011 and May 2012 showed that only 10.2% of the 59 facilities met the United Nations requirements for EmOCcenters[30]. Also, none of the three senatorial zones in Bauchi state had the minimumacceptable number of five EmOC facilities per 500 000 population[30].A study published in Nnewi, Anambra State, similarly reported that none of the four primary health care facilities assessed had the minimum equipment package, essential drugs,orhuman resources required to provide essential obstetric care (EOC) services[31].

Another assessment of 121 healthcarefacilities in Nigeria reported that most of the primary healthcare facilities were unable to provide the full list of the BEmOC signal functions, and in

general, theylacked the required clinical staff,ambulances and uninterrupted electricity supply whenever there were obstetricemergencies. Secondary healthcare facilities were noted to fare better than PHC, but most of them were also found to lack neonatal care infrastructure[32]. The November 2016 report of the Nigeria Health Facility Baseline Survey, supported by the World Bank and which covered a total of 791 facilities in the result-based financing (RBF) intervention states (Adamawa, Nasarawa and Ondo) and 270 facilities in control states (Benue, Ogun and Taraba), indicated that almost half of the surveyed facilities depend on supply grid for electricity: in Taraba only 10% of the facilities are connected to national electricity grid[33]. Most facilities reported experiencing some form of power failure and or interruption for both solar and electric power supply systems. Most of the facilities do not have access to pipe-borne water, but depend on protected well and protected spring or borehole as the main source of water supply. However, at least a fifth of the facilities surveyed did not have any source of water.

In a study that was conducted in 378 health facilities in Nigeria as well as in Kenya, Malawi, Sierra Leone, Bangladesh and India between2009 and 2011, Ameh et al. reported that only 23.1% of facilities aiming to provide CEOCwere able to offer the nine required signal functions of CEOC and only2.3% of health facilities expected to provide BEOC provided all seven signalfunctions. Furthermore, the authors noted that none of the districts assessed in the six countries met minimum UN coverage rates for EOC[34].The MCSP study in Kogi and Ebonyi States also reported facility infrastructural challenges, poor supervision and accountabilityas well as inadequate storage, distribution, quality andinventory monitoring with regards to pharmaceutical management – all of which negatively impact the ability of the health workers to offer quality MNH services[29].

The Nigeria Health Facility Baseline Survey has documented that more than half of referral facilities were located 10 miles away from referring facilities, thus needing emergency transportation but only about 12% of facilities reported having means of transportation. The Service Delivery Indicators (SDI) survey also reported that significant gaps exist in the availability of emergency ambulance services among facilities by rural-urban and primary-secondary disaggregation. Availability of ambulance services is significantly lower among primary facilities than secondary facilities across all the states. Only 7.8% of all rural facilities and 28.2% of urban facilities have access to emergency ambulance services. The Nigeria Health Facility Baseline Survey, in comparing facilities in the Performance-Based Financing (PBF) initiative, the Decentralized Facility Financing (DFF) initiative and those in the control areas – documented that drug availability was relatively low in all areas and a very low percentage of facilities in all the areas had at least 80% of all surveyed general equipment

available and functioning. Overall, the study documented that the average score achieved by the facilities was less than 50% of the maximum score achievable based on the index developed to assess quality and with no significant difference between the three groups of facilities– thereby indicating poor quality of services in general.

On the whole, as the studies have shown most health facilities in Nigeria have significant challenges with staffing, infrastructure, equipment, and essential lifesaving supplies and are, thus, not in a position to adequately and effectively respond to and manage women with obstetric complications, or offer quality services that will ensure good MNH or RMNCAH outcomes. Poor political will, resulting in poor prioritisation of the health sector and health issues, lies at the root of the problems relating to the inadequacy of the critical input needed in the Nigerian health facilities to deliver qualityMNH services[35]. As participants in the MCSP study noted, budget decisions and funds release are often subjected to “bureaucratic delays and driven by ad hoc political decisions” by the political actors[29].

3.1.2. Process

Nigerian health facilities, as studies have shown, have significant gaps in the process of care. On the one hand, there are gaps in technical performance or meeting the expectation of stakeholders as a study that used a Performance Needs Assessment framework has shown from the Osun State example[35]. On the continuum of maternal health care, two extreme situations exist, as Oladapo and colleagues indicate: toolittle, too late (TLTL) and too much, too soon (TMTS)[36]. “TLTL describes care withinadequate resources, below evidence-based standards, or care withheld orunavailable until too late to help. TMTS describes the routineover-medicalisation of normal pregnancy and birth. TMTS includes unnecessary use of non-evidence-based interventions, as well as use of interventions that can be life-saving when used appropriately, but harmful when applied routinely orover-used.”

The available data suggests that TMTS and TLTL co-exist in Nigeria: the low coverage rate of caesarean section (<10%) indicates TLTL, while high level of inequity between the use of maternal care services between the high and the low wealth quintiles suggest TMTS for wealthy women. Delay in the use of Caesarean section has been identified as one of the three leading contributors to Nigeria’s unacceptably high maternal ratio[24]. Gaps in technical performance of MNH services are often associated with a failure to adhere to—or absence of—clear evidence-based guidelines at theindividual or facility levels[36].In a 2016 published research, Kabo and colleagues reported from their work in Bauchi State that at the baseline assessment in 2010, focal facilities achieved only 4%

of set performance standards for MNH on the average, but this has increased to 86% in 2013[37]. Another area of gap in technical process of care is that of referral. As Adeoye and colleagues have documented in a prospectivecase control study relating to near-miss maternal events in a multi-centre tertiary hospital in Osun State, late referral of the women was one of the main factors associated with severe maternal morbidity[38]. The MCSP study in Kogi and Ebonyi State has also documented ineffective referralsystems as one of the challenges in quality MNH and RMNCH service delivery.

Studies have also documented poor attitude of health workers, and associated disrespectful treatment and abuse of women in maternal care. Idris and colleagues, for example, reported that and negative attitude of service providers constitute a leading barrier to the use of facilities for delivery and postnatal care in Nigeria[39]. However, some studies conducted in primary health care facilities in Anambra State, indicated that the clients were satisfied with the attitudes of the health workers[40,41]. Few studies had focused on the issue of respectful maternity care and mistreatment of clients in Nigeria in the context of MNH services. One of the few studies in this area, published in 2016, was based on qualitative research work in Abuja. The findings showed that both the clients (women who presented for MNH care) and service providers have witnessed physical abuse of clients, “including slapping, physical restraint to a delivery bed, and detainment in thehospital and verbal abuse, such as shouting and threatening women with physical abuse.” Clients may not be provided with bed in the facility, resulting in their giving deliveries on the floor, and may not be attended to on time or adequately by service providers. Three main factors were identified in the study to be contributing to mistreatment of MNH clients: poor provider attitudes, women'sbehavior, and health systems constraints[42].

3.1.3. Outcome

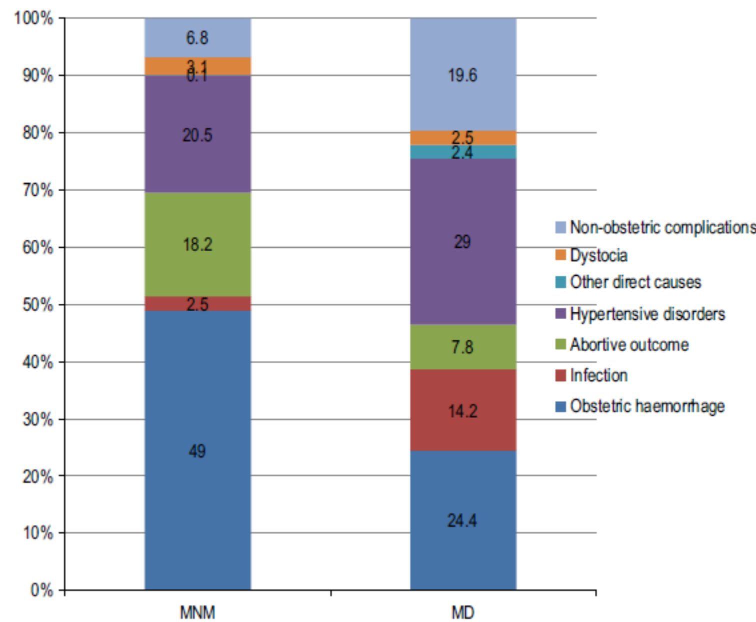
With the inadequacies in input and process of services, the MNH status of the Nigerian is predictably poor. Poor quality of care has been shown by a number of studies to be associated with poor MNH outcomes. A correlation was shown, for example, between compliance with set performance standards and maternal and neonatal deaths level in health facilities in a study in Bauchi State. Nigeria currently has one of the highest maternal and neonatal health burden in the world.The institutional neonatal mortality rate was documented to have decreased from 9 to 2 deaths per 1000 live births, while the institutional maternal mortality ratio dropped from 4113 to 1317 deaths per 100, 000 live births with the implementation of SBM-R between 2010 and 2013[60]. In another study, which covered four states – Kaduna, Kano, Ondo and the Federal Capital Territory – the

institutional maternal mortality ratio was recorded to have generally and strikingly decreased between 2008 and 2013 following the introduction of a quality assurance process. In Kaduna, for example, the institutional MMR was reported to have reduced from 1,380/100,000 live births to 360/100,000[43].

Overall, Nigeria has the second highest burden of maternal deaths in the world, with an estimated 45,000 maternal deaths annually. Currently, Nigeria contributes only about 2 percent of the global population, but about 15% of the global maternal deaths. Whereas the 2013 Nigeria Demographic and Health Survey reported Nigeria's maternal mortality ratio (MMR) as 576 in 20138, the United Nations reports Nigeria's MMR as 814/100,000 live births (80% uncertainty interval [UI]: 596 – 1180)[44]. The Nigeria's MMR figure as given by the United Nations is much higher than the regional average for sub-Saharan Africa (546/live births; UI 511 to 652) and the global average (216/100,000 live births; UI 207 to 249). The leading causes of maternal mortality in Nigeria are largely preventable or easily treatable, but no current national data is currently available. According to the 2007 data from the Federal Ministry of Health, haemorrhage (23%), infection (17%), malaria (11%), unsafe abortion (11%), obstructed labour (11%), and eclampsia (11%) are the leading causes of maternal mortality in Nigeria[45].

A study of deliveries in 42 public tertiary hospitals over a one-year period (2012 – 2013) provides some recent insights into levels and causes of maternal morbidity, maternal mortality and stillbirth in Nigerian tertiary facility setting. Stillbirths constituted 6.1% of the total of97,634 births recorded during the study period, and a total of 2,449 severe maternal outcomes (2.7% of live births) – 998 maternal deaths and 1451 maternal near-misses – were recorded[46]. Thus, maternal deaths (MD) and maternal near-miss (MNM) constituted 1.1% and 1.6% of live births in the study. Obstetrichaemorrhage (39.0%) and hypertensive disorders (24.0%)were the most frequent groups of complications resulting in severe maternal outcomes. Specifically for maternal deaths, the leading obstetric causes were hypertensive disorders (29%), obstetric haemorrhage (24%), infections (14%), and abortive outcomes (8%) (Figure 5).However, it is important to note, strictly speaking, that the results of this study apply primarily to tertiary facility settings, and not likely to be representative of the national situation or the population level data.

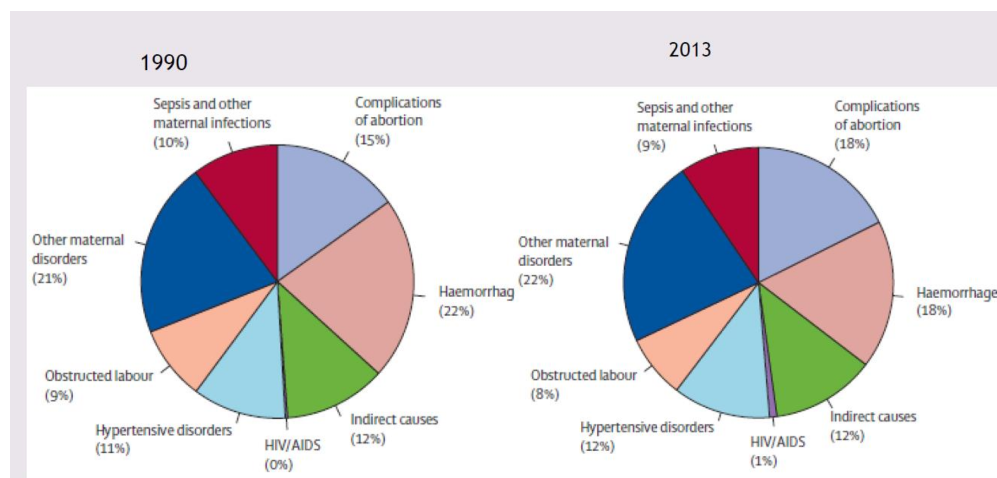
Figure 5: Relative contribution of key groups of complications to severe maternal outcomes (maternal deaths and maternal near miss) in tertiary facilities in Nigeria between 2012 and 2013.



Source: Oladapo et al, 2016. When getting there is not enough: a nationwide cross-sectional study of 998 maternal deaths and1451 near-misses in public tertiary hospitals in a low-income country. BJOG 123:928–938.

On the global scale, recent estimates indicate that the picture regarding the causes of maternal mortality may be changing: while direct causes of maternal mortality still remain the dominant group of associated factors, a slight decrease has occurred in the proportion of maternal deaths attributable to obstructed labour, sepsis and haemorrhage but an increase recorded in the proportion attributable to hypertensive disorder, HIV/AIDS, and complications of abortion (Figure 6)[47].

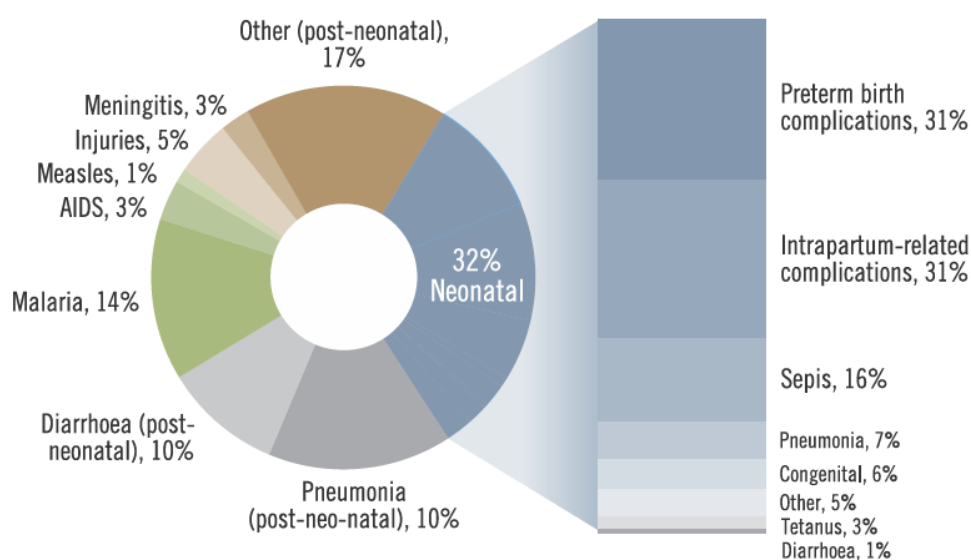
Figure 6: Causes of maternal mortality globally: 1990 versus 2013



Source: Graham et al, 2016.Diversity and divergence: the dynamic burden of poor maternal health. Lancet 2016; 388: 2164–75

Preventable or easily treatable conditions also account for most neonatal and child deaths in Nigeria. On the one hand, almost a third of all childhood deaths are of neonatal origin, and is followed by malaria (14%) and diarrhoea (post-neonatal) as the leading cause of deaths among under5 children in Nigeria (Figure 7). On the other hand, the leading causes of neonatal deaths are preterm birth complications (31%), intra-partum related complications (31%), sepsis (16%), and pneumonia (7%).

Figure 7: Causes of neonatal and child mortality in Nigeria



Source: Federal Ministry of Health, 2016.Nigeria every newborn action plan: a plan to end preventable newborn deaths in Nigeria. Abuja; Federal Ministry of Health.

3.2. Quality Improvement Responses and Efforts

Several efforts have been made towards improving the quality of care provided by the Nigerian health services, including MNH and RMNCAH. One of the best known national efforts by the government is the public service delivery reform called Service Compact with All Nigerians (SERVICOM). SERVICOM, which was officially launched by the Federal Government in 2004, is not health sector specific, but relates to every facet of public service delivery in Nigeria including the health sector. SERVICOM is a social contract between the Federal Government and the people of Nigeria, and is based on quality services designed around consumers' requirements. The essence of

SERVICOM is to ensure that the basic services to which each citizen is entitled is provided “in a timely, fair, honest, effective and transparent manner[48,49]. As part of the implementation process, SERVICOM Unit has been set up in every government establishment (including ministries, agencies, parastatals and other government departments), and SERVICOM charter made available to the public in all government agencies wherever services are provided. The charterinforms the public on what to expect in terms of service delivery, how to expect it, and provides clear process of grievance redress in case of service failure.

The Federal Ministry of Health in 2004 initiated the health sector reform agenda as a sector-wide initiatives to improve the performance of the Nigerian health system, including the quality of services, and MNH is one of the main areas of emphasis of the reform. The strategic thrusts of the reform include to: improve the performance of the stewardship role of government; strengthen the national health system and improve its management; improve availability of health resources and their management; improve the access (including physical and financial) to quality health services; and, increase consumers’ awareness of their health rights and health obligations[5051]. More recently, the Federal Ministry of Health initiated the 5S-Continuous Quality Management System-Total Quality Management (5-CQI-TQM) with the support of the Japanese International Cooperation Agency (JICA). The 5-CQI-TQM was initiated in 2013 and implemented in some facilities in the Federal Capital Territory and Lagos State.

The federal government, through the National Primary Health Care Development Agency (NPHCDA), has also implementedspecific MNH-focusedQoCinitiatives, particularly the Midwives Service Scheme (MSS)[52] and the Subsidy Reinvestment and Empowerment Programme on Maternal and Child Health (SURE-P MCH)[53]. TheMSS focused on the supply side of MCH services by providing midwives to selected 1,000 facilities, but the SURE-P MCH focused on both the supply of and demand for MCH services in targeted 1,000 primary health centers (PHCs) and their catchment areas across Nigeria. The key supply-side interventions included improvement of PHC facilities’ infrastructure, provision of midwives, and ensuring steady supplies of drugs, consumables, and other commodities for theprovision of quality MCH.

Several QoC initiatives have also been implemented in the area of MNH in Nigeria with the support of development partners over the years. These include efforts in the areas of family planning (FP) QoC by the Population Council using the situation analysis approach[54] and the Client-oriented, provider-efficient services (COPE®) approach implemented by EngenderHealth focusing onFP and

MCH. EngenderHealth implemented COPE in several states in Nigeria with the support of the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA). The Africa Child Survival Initiative-Combating Childhood Communicable Diseases (ACSI-CCCD) Project, and the Partnership for Reviving Routine Immunisation in Northern Nigeria – Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) also included significant elements of Qoc in their programme implementation. The Partnership for Transforming Health Systems, Phase 1 and Phase 2 (PATHS1 and PATHS2) focused on health systems strengthening, with significant focus on QoC.

Some of the key recent current policy and programmatic initiatives relating to QoC in the MNH field in Nigeria are described below.

3.2.1. Policies and structures for quality improvement agenda in healthcare

The National Health Act[55] provides that individuals, governments or organisations must obtain a Certificate of Standards from appropriate body of government before health facility can be established and health services provided. In the case of tertiary institutions the appropriate authority shall be the National Tertiary Health Institutions Standards Committee, acting through the Federal Ministry of Health. The Act has several other provisions regarding the quality of healthcare services in Nigeria: the Section 19, for example, specifies that:

- all health establishments shall comply with the quality requirements and standards prescribed by the National Council on Health.
- the quality requirements and standards stated in subsection (1) may relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety and the manner in which users are accommodated and treated.
- the National Tertiary Health Institutions Standards Committee shall monitor and enforce compliance with the quality requirements and standards stated in subsection(l) as it relates to Tertiary Hospitals.

However, there are also gaps in the provisions: as the National Health Policy (2016)[56] notes, for example, “There is a lack of institutional framework that regulates quality and standards. While the National Health Act provides that facilities are required to obtain a certificate of standards, the requirements for this certificate are not provided in the Act. Regulations that would provide these requirements have not yet been enacted.”

A Technical Working Group (TWG) has been constituted by the Federal Ministry to drive the process of the operationalization of the National Health Act, with five sub-committees, including a sub-committee on "Healthcare Quality and Performance" and with a Quality Assurance Steering Group established.An independent National Standards, Performance and Certification Body is being established, and two small groups established by the FMoH are already working on Certificate of Standards, and Accountability Framework for the implementation of the Act. Other groups have also been formed to focus on: infrastructure/equipment/products& technologies/utilities; human resources for health; service delivery and patient safety, Standards and conformity – accreditation, inspections and monitoring; and, health records data and e-health.

In terms of implementation of the QoC in healthcare agenda, Nigeria currently has some structures in place regarding national and sub-national structures, but several gaps exist (Table 1). The Inspectorate Division in the Department of Hospital Services of the Federal Ministry of Health is charged with monitoring the quality of services provided in tertiary hospital, but the degree to which the Division is performing the task regularly, effectively and efficiently is questionable. There is no coordinated mechanism among all stakeholders to follow a harmonized approach to QoC nationally. Quality Committees are not in existence at the sub-national levels (states and LGAs) as part of the health management teamexcept in some few states where some international development partners with focus on QoC are working. To operationalize the RMNCAH QoC agenda, the Minister of Health inaugurated the National Reproductive, Maternal, Newborn, Child and Adolescent Health Quality of Care Steering Committee and the Technical Committee on the 6th of February 2017.

Regarding data systems, the national health information system has some quality of care indicators including availability of commodities,referral system, coverage of interventions, morbidity and mortality. However, there is no established mechanism or system for reporting on quality of care in health facilities, and there are no systems in place at the state and LGA levels for reporting on quality of care in health facilities. There is no established system for sharing and reviewing the QoC performance at national or sub-national levels.

Table 1: Availability of structures, strategies and systems for QoC in Nigeria's health care system

Structures, Strategies and Systems for QoC	**Yes**	**Yes, but not functional**	**No**	**Comments**
I. Availability of national and district structures				

Structures, Strategies and Systems for QoC	Yes	Yes, but not functional	No	Comments
a. MoH has an established Directorate/Division/Unit/Section responsible for quality of health services	X			Inspectorate Division in the Department of Hospital Services of the Federal Ministry of Health has the responsibility to monitor quality of services provided in Tertiary hospitals
b. MoH has an established Quality Assurance Unit/Section/Department			X	
c. MoH has an established Quality Steering Group		X		Quality assurance steering group established as one of the subcommittees to operationalise the National health Act
d. There is a broad Technical Working Group for QoC including broader partners	X			The Technical Working Group on RMNCAH was newly inaugurated on 6 February 2017, alongside the Steering Committee on RMNCAH QoC
e. There is a strong coordinated mechanism among all stakeholders to follow a harmonized approach to QoC			X	
f. LGAs have a Quality Committees or are part of the District Health Management Teams			X	Exist only in few states supported by development partners
g. LGAs have a Focal person for Quality of Care			X	Exist only in few states supported by development partners
h. Hospitals or big health facilities have a person or team responsible for quality of care	X			Exist in some tertiary hospitals
II. National Quality of Care Strategies and Plans				
a. National Quality of Health Services Strategy is available			X	
b. There are national standards of care for health service delivery	X			
c. There is a national QoC implementation plan or guidelines			X	
d. There is a national mechanism or system for regular assessment and accreditation of health facilities	X			National level tertiary facilities - accreditation is carried out by Postgraduate Medical Colleges, and other-training related bodies. Some states have agencies that assess and accredit health facilities
e. The national RMNCAH strategy/implementation plan has quality of care improvement component	X			Explicitly stated under the service delivery objective
f. There are national maternal, newborn and child standards of care	X			existing standards need to be harmonized and updated

Structures, Strategies and Systems for QoC	Yes	Yes, but not functional	No	Comments
g. There are opportunities for revision of existing Policies in which quality can be integrated (If yes, please comment)	X			Existing National Policies and strategies are being planned for review in 2016 -2017
III. Availability of data systems				
a. The national health information system has quality of care indicators that are regularly reported	X			Availability of commodities, referral, coverage of interventions, morbidity and mortality
b. There is an established mechanism or system for reporting on quality of care in health facilities			X	
c. There is state and LGA level system or mechanism for reporting on quality of care in health facilities			X	
d. There is an established system for sharing and reviewing the QoC performance at national level			X	
e. There is an established system for sharing and reviewing the QoC performance at state and LGA levels			X	

3.2.2. Programmatic Actions

The Federal Ministry of Health, under its “Saving One Million Lives” Initiative,is currently partnering with PharmAccess Foundation to pilot a health-care quality improvement projectin 40 PHC facilities in rural communitiesacross five states (Anambra, Bauchi, Cross River, Ekiti, and Kebbi States). The project involved the use of a set of quality standards and improvement methodology called SafeCare[57].

USAID and the United Kingdom Department for International Development (DFID) are playing lead roles in supporting a number of MNH-related QoC initiatives in Nigeria. Within the USAID-supported projects, six quality improvement strategies have broadly been implemented – Accreditation, Clinical In-Service Training, Client-oriented, provider-efficient services (COPE®), Improvement Collaborative, Standards-Based Management and Recognition (SBM-R), and Supportive Supervision. The six strategies have much in common, including an interdisciplinary grounding, the use of assessments to identify problems, and benchmarking to measure progress[58]. Virtually all the USAID-supported projects have focused on MNH issues, including the Maternal and Child Health Integrated Program

(MCHIP) that was implemented in the Northwest zone of the country, the Nigeria, and the Targeted States High Impact Project (TSHIP) implemented n Bauchi and Sokoto States by Jhpiego. Both the MCHIP and the TSHIP which involved the use of the Standards-Based Management and Recognition as quality improvement approach[59,60]: the SBM-R adopts four main elements of the continuous quality improvement cycle (plan, do, study, act) to standardize, do, study, and reward.

The Maternal and Child Survival Program (MCSP), a multi-partner project supported by the USAID as a follow-up to the MCHIP, focuses on Reproductive, Maternal, Newborn and Child Health with Ebonyi and Kogi as focal states. MCSP is working towards equity in access to quality and respectful care at both the community and facility levels. In this regard, quality improvement approaches in the intrapartum period in the context of MCSP focus on "respectful, quality care for normal births as well as for obstetric complication, and are engaging the community for increased accountability[61]." "Quality improvement at the facility level focuses on simplified models to measure and track progress in Qoc and to link improvements to health outcomes. To this end, MCSP expands work begun under MCHIP to introduce an 'audit/feedback' cycle for key maternal health interventions[62]." MCSP is also improving performance through enhanced clinical governance and targeted capacity building at the facility level.

MNCH2, a country-led programme supported by UK government, is one of the leading programmes currently focusing on MNH QoC in Nigeria. The programme aims at "saving lives and improving the quality of life for women and children through the empowerment of communities and the strengthening of health systems in Northern Nigeria". MNCH2 focuses on "improving the quality, coverage and demand for integrated maternal, newborn and child health, routine immunisation services, and healthy timing and spacing of pregnancy in six northern states (Kaduna, Kano, Katsina, Jigawa, Yobe, and Zamfara) to accelerate reductions in maternal, newborn and child death: the project has developed a QoC strategy[63] based on the framework of Hulton and colleagues**Error! Bookmark not defined.**, and recognizes seven elements in all: human resources; infrastructure; equipment, supplies and medicines; clinical practice; respect, cognition and equity; evidence and information; and, referrals and network of care. MCHS2 has also developed tools and training manuals relevant to QoC.

Table 2: Quality of care improvement activities recently/currently being implemented in Nigeria

Quality of care improvement activities	**Yes**	**No**	**Implementing organisations**
a. Leadership and organisation management	X		MNCH2, MCSP, PATHS2, WHO, PLAN-Health

Quality of care improvement activities	Yes	No	Implementing organisations
b. Mentorship activities	X		WHO, PLAN-Health, PATHS2
c. Supportive Supervision	X		MNCH2, MCSP,PATHS2, WHO, APIN, SuNMaP
d. Capability building (including clinical training)	X		Various technical partners and public sector health services
e. Audit and feedback	X		MCSP
f. Improving data systems	X		MEASURE Evaluation Project
g. Learning networks/systems including collaboratives	X		CIHP, WHO
h. Performance based financing	X		World Bank
i. Policy/Strategy development support	X		WHO
j. Accreditation	X		Postgraduate Medical Colleges, other training-related regulatory bodies, and the Society for quality Health care in Nigeria. Some states also have accreditation agencies for health facilities
k. Client-Oriented, Provider Efficient (COPE) Client-Oriented, Provider Efficient (COPE)	X		EngenderHealth
l. Standards-Based Management and Recognition	X		MCHIP, TSHIP, MCSP
m. Others	X		FMoH (5S-CQI-TQM); NPHCDA and partners (SafeCare); World Bank (SDI); CIHP (CQI/Breakthrough Series Intervention)

4. Vision, Core Values, Goal, and Objectives

4.1. Vision

The vision of this National Strategy is “A Nigeria in which every pregnant woman receives quality care throughout pregnancy, childbirth and the postnatal period, and every newborn receives quality care for optimal health, developmentandwell-being”.

4.2. Core Values

This vision is underpinned by a number of core values of quality, equity and dignity.

- *Quality*: many morbidities, disabilities and deaths of mothers and infants can be preventedby effective, scalable and sustainable improvements in care.
- *Equity*: receiving quality care is a basic human right; it addresses the needs of thereproductive health focal populations in a holistic manner and minimizes inequities between the rich and poor, marginalized or otherwise disadvantaged. For the most disenfranchisedfamilies and communities, quality of care needs to be complemented with specific policies toincrease access to care.
- *Dignity*: Dignity for women in childbirth is not just a luxury added-on. Dignity reduces stress.Many studies have shown that stress and isolation impair the progress of labour and increasethe risk of complications. Conversely, social support, a companion in labour, a friendly,supportive midwife calm,welcoming environment can make a huge difference to the clients’ experience of care and also reduce their risks of complications.

4.3. Goal

The goal of this National Strategy isimproved health maternal and newborn outcomesin Nigeria

4.4. Targets

To have achieved the following targets relating to mortality, avoidable morbidity and experience of careover the next five years (by 2022):

- reduction in level of maternaldeaths in health facilities by 50%
- reduction in level of newborn deaths in health facilities by 50%
- reduction in intra-partum stillbirths by 50%
- reduction in the incidence of severe post-partum haemorrhage by 50%
- reduction in neonatal sepsis by 50%

- reduction in the proportion of women of reproductive age who report the attitude of health workers as barriers to healthcare services by half.

4.5. Strategic Objectives

The approach to improving quality of care formothers and newborns is structured around four strategic objectives, summarised by four key words: leadership, action, learning and accountability

- Strategic Objective 1: LEADERSHIP - Build and strengthen national institutions and mechanisms for improving quality of care in the health sector.
- Strategic Objective 2: ACTION - Accelerate and sustain implementation of quality of care improvements for mothers, new-borns, children and adolescents.
- Strategic Objective 3: LEARNING - Facilitate learning, share knowledge and generate evidence on quality of care.
- Strategic Objective 4: ACCOUNTABILITY - Develop, strengthen and sustain institutions and mechanisms for accountability for quality of care

5. Strategic Actions and Outputs

5.1. Strategic Objective 1: LEADERSHIP

Build and strengthen national institutions and mechanisms for improving quality of care in the health sector

Output	Strategic Actions	Lead Ministry	Key Agencies and Partners
Output 1: National, strategy and operational plan for improving RMNCAH QoC developed and funded.	a. Develop National RMNCAH QoC Strategy b. Develop costed National RMNCAH QoC operational plan c. Communicate and disseminate national plan to states and development partners d. Advocate for budget line and government funding in support of the national implementation plan e. Mobilise additional funding for the full implementation of the national operational plan from the private sector and development partners	Federal Ministry of Health and her relevant agencies	• States Ministries of Health (SMOHs) and State Primary Health Care Development Agencies (SPHCDAs) • Development Partners
Output 2: QoC governance structures established/strengthened and functioning at all levels.	a. Establish and ensure functioning of the National RMNCAH QoC Steering Committee b. Advocate and support the establishment and functioning of State and LGA RMNCAH QoC Steering Committees c. Develop guidelines for the establishment and functioning of Facility QoC Committees d. Establish coordination mechanism between National , State, LGA, and Facility QoC committees	Federal Ministry of Health and her relevant agencies	• SMOHs and SPHCDAs • Development Partners • Professional Associations • Regulatory Agencies
Output 3: National advocacy and social mobilisation strategy for QoC is developed and implemented	a. Develop, implement and monitor National advocacy and social mobilization strategy andplan in support of the RMNCAH QoC agenda. b. Mobilise stakeholders – professional associations, academics, civil society, international development partners, the private sector, and	Federal Ministry of Health and her relevant agencies	• SMoHs • Development Partners • Professional groups

Output	Strategic Actions	Lead Ministry	Key Agencies and Partners
	community leadership – to support the RMNCAH QoC initiative		

5.2. Strategic Objective 2: ACTION

Accelerate and sustain implementation of quality of care improvements for mothers and newborns

Output	Strategic Actions	Lead Ministry	Key Agencies and Partners
Output 1 National evidence-based standards of care for RMNCAH developed and disseminated.	a. Adapt WHO MNH standards of care and disseminate b. Develop non-existing (RCAH) standards of care and protocols by adapting WHO and other relevant Stakeholders standards of care. c. Incorporate the national standards and protocols into the National Quality of Care assessment tools d. Disseminate updated national standards, protocols and assessment tools to all relevant stakeholders for use Develop and disseminate implementation guideline of QoC	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations • Academic and Research Institutions • Regulatory bodies • Traditional leaders • Religious leaders
Output 2: National package of quality improvement interventions is developed and disseminated	a. Continuously assess the quality of care situation and identify "best practices" based on the national standards of care b. Develop national package of quality improvement interventions to address identified quality gaps (based on WHO model) c. Regularly disseminate the findings from review of standards, and the national package of quality improvement intervention	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations • Academic and Research Institutions
Output 3: Clinical and managerial capabilities to support quality improvement are developed, strengthened and sustained	a. Establish and ensure the functioning of national and regional resource centres, with tools to improve capabilities of health care providers and managers. b. Identify and train national and state pools of master trainers and facilitators with expertise in quality improvement c. Develop protocols and tools for documenting and disseminating quality improvement activities, and lessons learned at various levels d. Include quality improvement in pre-service training curriculum e. Conduct monthly meetings for participatory learning on quality	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations • Academic and Research Institutions

Output	Strategic Actions	Lead Ministry	Key Agencies and Partners
	improvement (QIT) at facility and community level and quarterly meetings at the LGA and state levels f.		
Output 4: Quality improvement interventions for MNH are implemented	a. Identify demonstration sites for the implementation of RMNCAH QoC national package of improvement interventions b. Document RMNCAH QoC best practices and QI packages. c. Adapt the package of improvement interventions to State and LGA context d. Provide resources and technical support to implement the package of improvement interventions in the demonstration sites in the context of their States and LGAs of location e. Monitor, evaluate and document the results of the demonstration projects and lesson learned f. Refine the package of effective and scalable QoC interventions and identify optimal implementation approach from the experiences of the demonstration sites g. Expand the implementation of the refined package of QoC interventionsto new States and LGAs	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations • Academic and Research Institutions

5.3. Strategic Objective 3: LEARNING

To facilitate learning, share knowledge and generate evidence on quality of care

Output	Strategic Actions	Lead Ministry	Key Agencies and Partners
Output 1: Data systems are developed/strengthened to integrate and use quality of care data for improved care	a. Develop and validate a national minimum set of RMNCAH QoC indicators aligned with the core global indicators and include in the NHMIS . b. Standardise data collection, synthesis and reporting, and regularly monitor data quality c. Strengthen capacity for data collectionsynthesis and use at h national and sub-national levels d. Develop system for collection and reporting of case studies, and best practices from the field. e. Promote the use of score cards and dashboards in the quarterly dissemination meetings and institute performance reward approaches f. Provide updates during quarterly review meetings g. Use of ISS system to generate information and promote learning Share key data with stakeholders to inform decision-making, and planning h. Promote research on QoC and,in collaboration with relevant institutions in the utilization of research findings for learning and decision making i.	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations • Academic and Research Institutions
Output 2: Mechanisms to facilitate learning and share knowledge through a learning network are	a. Establish dedicated website to facilitate access to national and international resources on RMNCAH QoC b. Establish and support virtual and face-to-face learning networks and communities of practice at all levels taking into account local	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations

Output	Strategic Actions	Lead Ministry	Key Agencies and Partners
developed and strengthened	languages c. Establish learning collaboration between health facilities at LGA State levels, and National Levels d. Identify focal point(s) at the FMoH as well as zonal centres and states to coordinate and sustain national and zonal learning networks e. Disseminate relevant protocols, standards and guidelines on RMNCAH QoC f. Promote participatory peer learning and exchange programs both nationally and internationally		• Academic and Research Institutions • Society for Quality of Care in Nigeria.
Output 3 Data and practice are analyzed and synthesized to generate an evidence base on quality of care improvement.	a. Regularly analyse and synthesise data to identify successful interventions at least on a quarterly basis b. Identify, document and disseminate information on "best practices" nationally and internationally c. Publish research findings and best practices in local and international journals, bulletins and other publications. d. Establish knowledge management and QoC units in institutions of learning.	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations • Academic and Research Institutions

5.4. Strategic Objective 4: ACCOUNTABILITY

Develop, strengthen and sustain institutions and mechanisms for accountability for quality of care

Output	Strategic Actions	Lead Ministry	Key Agencies and Partners
Output 1: National framework and mechanisms for accountability for QoC are established and functioning	a. Develop and regularly update and publish quality indicator dashboards to track progress at facility, LGAs, State and National levels b. Track and regularly report and discuss on inputs and outputs in the national operational plan for QoC in national fora c. Conduct periodic independent assessments of progress to validate routinely reported results (DQA) d. Conduct regular multi-stakeholders dialogue to monitor progress and resolve issues e. Conduct periodic analysis of progress to validate routinely reported results f. Establish mechanism for tracking resources (financial, human and material) and g. Strengthen public accountability that improves citizens' engagement in policy design and implementation	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations • Academic and Research Institutions (ARI)
Output 2: Progress of the National Networkon RMNCAH quality of care is regularly monitored	a. Develop and disseminate annual progress report on RMNCAH QoC activities b. Organise annual review meeting on the RMNCAH QoC initiative c. Develop and disseminate other materials to document and share the experiences and lessons from the RMNCAH initiative, including case studies, policy briefs, and peer-reviewed materials d. Recognise and rewards States, LGAs, facilities, and individuals who excel in the implementation of RMNCAH QoC	Federal Ministry of Health and her relevant agencies	• Development Partners • Professional associations • Academic and Research Institutions
Output 3: Impact of the National initiative on RMNCAH quality of care	a. Develop and build consensus on evaluation designs for the RMNCAH QoC initiative b. Conduct evaluation on QoC (Baseline, Midterm and Endline)	Federal Ministry of Health and her relevant agencies	• Development Partners

Output	Strategic Actions	Lead Ministry	Key Agencies and Partners
is evaluated			• Professional associations • Academic and Research Institutions

6. Implementation Framework

6.1. Implementation Structure at National Level

The MNH QoC agenda needs to be implemented at every level – federal, state, LGA, Health facility, and community – to ensure its success, in an integrated way. The structure and responsibilities described in this section are geared towards ensuring that the QoC agenda has adequate focus.

A national inter-ministerial-level QoC Steering Committee and a Technical Committee have been newly established by the Federal Ministry of Health. The membership of the Steering committee include:

- Honourable Minister of Health
- Honourable Minister of State for Health
- Honourable Minister of Women Affairs and Social Development
- Honourable Minister of Finance
- Honourable Minister of Agriculture
- Honourable Minister of Education
- Honourable Minister of Water Resources
- Honourable Minister of Environment
- Honourable Minister of Information and Culture
- Honourable Minister of Transport
- Honourable Minister of Power

Other members of the Steering Committee include: Permanent Secretary, Federal Ministry of Health; Director, Department of Hospital Services, FMoH; Director, Family Health Department, FMoH; Director, Health Planning Research and statistics, FMoH; Director, Public Health, FMoH; Executive Director, National Primary Health Care Development Agency; Executive Secretary, National Health Insurance Scheme; Director-General National Agency for Food and Drug Administration and Control (NAFDAC), the Special Technical Assistant to the Honourable Minister of Health; the Technical Adviser to the Honourable Minister of Health; the Special Technical Assistant to the Permanent Secretary, FMoH, and the WHO Representative.

The Terms of Reference of the Steering Committee are as follow:

- To provide high level leadership for coordination of Quality of care (QoC) interventions for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in Nigeria
- To oversee partners and donors mapping, identify and mobilize resources from Global and local partners for implementation of the national RMNCAH QoC roadmap and operational plan
- To provide high level support to the WHO-led RMNCAH QoC network and implementation of the operational plan at country level
- To approve action plans for the implementation of the national quality of care presented by the quality of care technical committee on RMNCAH
- To conduct high level advocacy on the improvement of quality of care in health facilities to all states of the federation
- To provide overall guidance for implementation of the quality of care plan
- To define accountability metrics, roles and responsibilities of different stakeholders in the RMNCAH QoC Network and ensure timely monitoring and reporting of national progress

The membership of the Technical Committeeconsists of:

- Director, Family Health Department, FMoH
- Director, Hospital Services Department, FMoH
- Director, Health Planning Research and Statistics, FMoH
- Director, Food and Drug Services, FMoH
- Director, Public Health Department, FMOH
- Head, Child health Division, FMoH
- Head, Reproductive Health Division, FMoH
- Head, Safe motherhood, FMoH
- Head, Newborn Branch , FMoH
- Head, Gender, Adolescent, School Health, and the Elderly (GASHE) Division, FMoH
- Head, Health Promotion Division, FMoH
- Head, Nutrition, FMoH
- National Coordinator, HIV/AIDS Division, FMoH
- National Coordinator, National Malaria Elimination Programme, FMoH
- Assistant Director, MNCH Branch
- Representative of other government Ministries and Agencies
    - National Primary Health Care Development Agency.

    - National Health Insurance Scheme
    - Ministry of women and Affairs and Social Development
- Representatives of professional bodies
    - President, Society of Obstetrics and Gynaecology of Nigeria
    - President, Nigerian Society of Neonatal Medicine
    - President, Association of Public Health Physicians of Nigeria
    - President, National Association of Nigerian Nurses and Midwives
- Regulatory bodies
    - Medical and Dental Council of Nigeria (MDCN)
    - Nursing and Midwifery Council of Nigeria (NMCN)
    - Community Health Practitioners Registration Board of Nigeria (CHPRBN).
- Civil society organisations
- Development partners
- Representatives of states (1 per geo-political zone)

The Terms of Reference of the Technical Committee are as follow:

- To contribute to the development of a national quality of care strategy of health services and develop an action plan/road map to improve national quality of care of health services for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in Nigeria
- Provide technical support for implementation of WHO-led RMNCAH QoC network action plans in the country
- To develop strategies to link health facilities to communities and vice-versa to improve quality of care for women, children and adolescents
- To facilitate and work hand-in-hand with quality of care teams in health facilities
- To provide technical support for monitoring progress of RMNCAH QoC at regular intervals and put together country reports

6.2. Implementation Structure at Sub-national Level

Similar structures will also be established at state and LGA levels while Quality Improvement Committee (QIC) will be established atFacility level, with membership including representatives of the community. The roles of the QICs will include overseeing monitoring and implementation of the QoC operational plan at their levels.

6.3. Quality of Care Improvement Approaches and Steps

6.3.1. Implementation approaches

In order to achieve quality improvement for MNH, the following implementation approaches need to be ensured at all levels;

1. Integrated approach to Planning, improvement and control of quality
2. Establishment of Quality improvement Teams/Committees at all levels
3. Mainstreaming of Quality into Universal Health Coverage (UHC)
4. Strengthening data system for feedback to support quality improvement actions

Implementation of QoC should involve iterative process of 'Plan-Do-Study Act'(PDSA) cycle model based on evidence synthesis, best practices and experience. Tested packages that have proven to be effective will be widely disseminated and its implementation will be supported.

6.3.2. Steps for introduction of quality of Care at Facility Level

An Action Plan with timelines, resources needed and responsible persons should be developed at each facility level to guide the quality of care activities. Key actions in the plan should include the following:

- Identify quality of care champions in the facility
- Constitute Quality Improvement Teams (QIT) in the facility
- Development and/or adaptation of assessment tools
- Undertake baseline assessment of the facility
- Acquirenational/state-adapted MNH and QoC guidelines and protocols
- Organize facility based quality of care training for champions and facilitators
- Stepdown QoC training to members of the QIT
- Identify services to be improved
- Conduct causal analysis of identified quality and performance gaps
- Develop quality improvement interventions that address the root causes of the identified gaps
- Mobilisation of resources and leverage support for the implementation of the interventions
- Implement interventions
- Supervise and monitor health workers and facility performance

- Monitorselected quality MNH indicators for improvement
- Review and share results with other staff periodically e.g. monthly and identify new services to be improved

7. Monitoring and Evaluation Systems

Appropriate functioning of the monitoring and evaluation system, encompassing monitoring, evaluation and research, is critical to ensuring the impactful implementation of Nigeria's MNH QoC agenda. In this respect, quality data will be regularly collected, synthesised, and analysed to strengthen accountability and to inform programmatic and policy decisions on the implementation of the QoC initiative. Research will provide further support to monitoring and evaluation activities in generating data that can strengthen programme implementation anddecision-making by policy-makers, programme managers as well as health workers.

To provide the appropriate framework for monitoring and evaluation, Nigeria will define relevant standards, quality statements, and quality measures. The quality measures will capture inputs, the process of care or service provision, and where, appropriate the outcome of care. Relevant national quality indicators will be developed, based on the review of the WHO MNH quality indicators as well as other international accountability instruments and in-country measures and instruments vs-a-vis the Nigerian RMNCAH QoC vision and goal. Furthermore, Nigeria will work systematically to include and integrate the MNH and other RMNCAH QoC indicators in the national health information system so as to avoid creating a parallel system.

7.1. Monitoring

Monitoring, as the concept implies, will go on continuously in the programme. Generation of quality facility-based and service data is quite important to this process, and as such the routine health information system will be strengthened. Regular data quality assessment will be undertaken to ensure the integrity and validity of the data being generated and engender users' confidence in the data system and the QoC programme.

7.2. Evaluation

An evaluation of the initial implementation at specific demonstration sites will be done at the end of one year period, to allow lessons learned to be applied in expanding to sites. An evaluation will also be carried out at the end of the three years of project implementation.

7.3. Research

A national MNH and RMNCAH QoC research agenda will be developed and implemented to generate important information that can strengthen the policy decision and programme operations. The agenda will cover diverse types of research – qualitative and quantitate, operations research, implementation research and other forms of research. The research agenda will be reviewed every two years. To implement the research agenda, an annual call for concept paper/research proposal will be produced, announced publicly, and widely disseminated to academic and research institutions as well as other stakeholders.

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