

Concept note on the establishment of
THE COLLABORATIVE ON QUALITY CARE FOR PREGNANCY AND CHILDBIRTH



The QCPC Collaborative

*Prepared by the QCPC Collaborative core planning group**

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Executive Summary

This concept note introduces and seeks support for a new Collaborative among the constituency of technical experts, programme implementers and organisations concerned with improving the quality of care for pregnancy and childbirth. The proposed name for the initiative is the **QCPC Collaborative**.

The Collaborative addresses a widely-accepted gap and a crucial obstacle to achieving MDG4 & 5. It seeks to add value and complement the work and operations of other relevant groups with a flexible and responsive structure built upon guiding principles of technical excellence, inclusiveness, transparency and country relevance. The QCPC Collaborative will provide a community of practice which cuts across conventional boundaries of expertise, disciplines and professions, and promotes strong linkages between southern and northern institutions and agencies.

The scope of the term “quality of care” adopted by the Collaborative is broad, encompassing the capacities of the health system and specific programmes to deliver quality care, the interactions between caregivers and receivers, and the outcomes in terms of health and satisfaction. The specific objectives of the QCPC Collaborative are to:

- Raise awareness of the importance of and options for monitoring and assuring the quality of care for pregnancy and childbirth;
- Strengthen national and international monitoring of quality of care indicators for pregnancy and childbirth;
- Advise on best practices, including costs & benefits, in the capture and use of data at national, district and provider levels to improve quality of care for pregnancy and childbirth.

Building confidence in and commitment to the proposed Collaborative is best achieved through the conduct of a small number of targeted activities. Three principal tasks are envisaged for the first two-year period (2009-2011), for which funds are currently being sought: 1. consolidating the Collaborative, 2. undertaking quality of care reviews, and 3. offering recommendations on measuring quality of care in the Demographic and Health Surveys. A small and informal planning group, initiated by the WHO Department of Making Pregnancy Safer, has led the consultative process culminating in this concept note and will continue until the core team of the Collaborative is formally constituted.

* For members see Annex 1

1. WHAT IS THE BACKGROUND AND RATIONALE FOR THE COLLABORATIVE?

There is currently an unprecedented commitment at national and international levels to improve the health of mothers and babies in low-income countries. This is matched by a heightened demand for timely and reliable data to inform effective action and to monitor progress.¹ The evidence-base on proven interventions to prevent maternal and perinatal deaths has been strengthened over the last 10 years through the efforts of many agencies and initiatives.²⁻⁴ Similarly, the availability of robust data on the coverage of some of these interventions and of major packages of care for mothers and babies has also improved, again through multiple channels and from district to global levels.⁵ There remain, however, significant gaps in data and monitoring systems to improve the quality of care implemented, both at programmatic and client levels.^{6,7} Addressing these gaps in the run-up to 2015 requires significant technical and financial inputs together with strong partnerships and political commitment. Different constituency groups have complementary contributions to make at this time of heightened demand for sound data to achieve MDG4 & 5. The purpose of this summary concept note is to introduce and seek support for a new Collaborative among the constituency of technical experts, programme implementers and organisations concerned to monitor and assure the quality of care for pregnancy and childbirth. The proposed name for the initiative is the **QCPC Collaborative**.

The prospect of bringing together expertise for monitoring maternal and perinatal health is certainly not new and there have been earlier suggestions to establish an independent technical group along the lines of the Child Health Epidemiology Reference Group (CHERG).^{8,9} Similarly there are several initiatives which seek to strengthen the availability of robust data relevant to MDG4 & 5, such as the Health Metrics Network and Countdown to 2015. Under these circumstances it is crucial to identify explicitly the added value of any new endeavour in terms of defining which clear gaps need to be filled or the different methods of operation. In the case of the proposed QCPC Collaborative both these added-value criteria are met. The focus on monitoring and assurance of the quality of care for pregnancy and childbirth means the Collaborative is addressing a widely-accepted and crucial gap, and so complements the work of other relevant groups. It seeks to do so through a flexible and responsive structure, built around guiding principles of technical excellence, inclusiveness, transparency and country relevance.

The scope of the term “quality of care” adopted by the Collaborative is intentionally and appropriately broad, encompassing the capacities of the health system and specific programmes to deliver good quality care (the structures), the interactions between caregivers and receivers (the processes), and the outcomes in terms of health and satisfaction.¹⁰ Similarly, the Collaborative supports a comprehensive definition of what constitutes “quality” – recognising the six elements¹¹ of effectiveness, safety, timeliness, efficiency, equity and responsiveness to the preferences, needs and values of mothers and their families – as individuals and populations. This scope and definition highlights the need to mobilise a wide range of disciplines, professional expertise and programmatic skills and to create a critical mass to improve the monitoring of quality of care and as an integral part of health systems strengthening. The proposed QCPC Collaborative will provide a community of practice which cuts across conventional boundaries of expertise and promotes strong linkages between southern and northern institutions and agencies, with an explicit aim of effective country level engagement, in contrast with the usual global remit of technical advisory or reference groups.

Establishing the Collaborative is timely given a number of new developments and considering the contemporary health system challenges and vulnerabilities of the target populations of MDG 4 & 5. The emergence of innovative financing arrangements to help address the supply and demand side barriers to care, particularly around delivery, are leading to significant gains in uptake, especially by poor women.¹² The urgent need to also track quality and identify effective assurance mechanisms has been identified by a number of agencies calling for practical indicators for linking quality to results based financing and pay-for-performance schemes. In addition, quality of care is central to assessing private sector services, especially in unregulated systems. In the absence of formal or standardised monitoring mechanisms, poor families and women may pay more for what is perceived as good quality care but sometimes to little effect or even with detriment to their health or livelihood.¹³ This so-called quality gap¹⁴ – the gap between accessing care, as reflected in coverage statistics, and the receipt of care which is effective, safe, timely, efficient, equitable and responsive, is more challenging to measure than the coverage gap between current uptake and a target, such as universal access. There is, however, clear recognition that the neglect of the quality rather the quantity dimension of maternal and newborn programmes is one of the principle bottlenecks to achieving MDG4 & 5 in many countries.¹⁵⁻¹⁷ Evidence is also available from studies showing a two-way link between the coverage and quality gaps, with poor quality a deterrent to uptake. The challenges of achieving good quality vary considerably across the continuum of care and this also affects coverage. Those services or interventions which can be routinely-scheduled and quality more-readily monitored and assured, such as antenatal tetanus toxoid immunization, have often shown increases in coverage over the last 10 years.¹⁸ Conversely, services that must be available around the clock and encompass composite packages of care to meet the different needs of different cases, such as labour and delivery, have generally shown less gains in coverage and represent the major foci for quality improvement in many countries.

2. WHAT ARE THE PROPOSED AIMS AND OBJECTIVES OF THE QCPC COLLABORATIVE?

The ultimate goal of the QCPC Collaborative is to contribute to the achievement of MDG4 & 5 in low income countries. Given this overriding goal, the specific aim is to enable policy-makers and programme managers to use robust data on quality of care to inform their decision-making and resource allocation and so improve program impact on the health of mothers and babies.

The main specific objectives of the QCPC Collaborative are to:

- Raise awareness of the importance of and options for monitoring and assuring the quality of care for pregnancy and childbirth;
- Strengthen national and international monitoring of quality of care indicators for pregnancy and childbirth, encompassing structure, process and outcome;
- Advice on best practices, including costs & benefits, in the capture and use of data at national, district and providers levels to improve quality of care for pregnancy and childbirth.

These objectives acknowledge the importance of fit-for-purpose measurement at multiple levels, differentiating particularly between measuring quality as an end-point or as a basis for service improvement. For instance, in South Africa efforts to close the quality gap in pregnancy and childbirth services involve measuring staffing,

supplies, training and attitudinal obstacles.¹⁴ Improvements in quality of care should follow an evidence cycle which connects understanding the burden, to identifying effective service and care interventions, to tracking coverage and assuring improved quality of implementation, and so on to judging progress by repeating the measurement of burden. While focusing primarily on strengthening data and monitoring systems to improve quality of care, the QCPC Collaborative will also liaise and coordinate with groups enhancing the evidence base on health burdens and interventions related to pregnancy and childbirth. This second area of work will enable the Collaborative both to flag neglected issues, such as the equity and economic dimensions of the burdens, and to collaborate with these other groups.

3. WHAT ARE PROPOSED INITIAL ACTIVITIES OF THE QCPC COLLABORATIVE?

Building confidence in and commitment to the QCPC Collaborative is best achieved through the conduct of a small number of key activities, conducted over an initial two year period (2009-2011). At the end of this period and subject to good performance, an expanded work plan will be developed and additional funding identified up to 2015. The conceptualisation and work plan for the Collaborative were catalysed by the Making Pregnancy Safer Department of WHO, which convened two meetings (Nov 2007 & Oct 2008) of independent experts to examine the need, alternative scopes and operations. These deliberations led to the creation of a small informal Core Planning Group (see Annex 1) to develop this concept note, consulting with a variety of stakeholders at country and international levels and involving participants from the initial planning meetings (see Annex 2).

Three main activities are envisaged for the first two years: 1. consolidating the Collaborative, 2. undertaking quality of care reviews, and 3. offering recommendations for measuring quality of care in the next round of the Demographic and Health Surveys.

3.1 Consolidation of the QCPC Collaborative

As an independent technical group, the proposed Collaborative will not be mandated by specific agencies but hold itself accountable against a rolling work-plan and report to the funders of its activities. The Collaborative will seek to function through a responsive governance structure with guiding principles of technical excellence, inclusiveness, transparency and country relevance. To ensure the Collaborative remains flexible and efficient the operating model is likely to be a “hub-and-spokes” set-up. A core of 10-12 technical institutions or agencies will be assembled with a small number of individuals with the relevant expertise, and accompanied by a varying number of sub-groups (or spokes) comprised of working groups focused on specific time-bound activities. Each spoke is likely to be based around an institution or agency but will reach out to engage relevant expertise for the task at hand from the wider constituency of the Collaborative.

The underlying purpose of the Collaborative is to bring together a community of practice to tackle the substantial challenges to monitoring and improving quality of care for pregnancy and childbirth. Success will thus depend in large part on its ability to identify, mobilise and sustain engagement from a global base covering many disciplines and professions at multiple levels and institutional contexts including, for example, programme planners and managers, health professionals, civil society representatives, legislators, media, insurance bodies, health researchers and information scientists. This

“Faculty of Skills” of the QCPC Collaborative will need to tap into existing technical and professional associations, agencies and networks and to offer them opportunities to interface and knowledge share with other technical constituencies. The guiding principles of technical excellence, inclusiveness, transparency and country relevance are key to the evolution of the Faculty of Skills. Fostering such a diverse and large community of practice requires operating arrangements at three mutually supportive levels:

3.1.1 Internal Functioning

While the informal Core Planning Group (CPG) made progress in the initial shaping of the QCPC Collaborative, funds are now needed to establish the interim secretariat, develop communication channels and begin to build-up the constituency. These essential operational activities will continue to be directed by the CPG until the Collaborative core team is formally and transparently established later in 2009. One function of the secretariat will be to periodically update a ‘map’ detailing the major groups, initiatives and agencies active in monitoring and assuring quality of care, specifically relating to pregnancy and childbirth. This will be built through active searches and open calls for information through the QCPC Collaborative website. It is envisaged that most interaction within the Collaborative overall will be through web and email contact, through tele-conferences and by taking advantage of other major events. Regular face-to-face meetings are proposed for the core team who will meet twice a year, and the sub-groups undertaking time-bound tasks are also likely to meet.

3.1.2 Country Engagement

The QCPC Collaborative will be informed by prior experiences of how to best facilitate technical cross-learning, peer support and reflective practice across countries.¹⁹ This will entail changing how technical assistance, toolkits and training efforts are normally viewed. Evidence and experience from other fields²⁰ suggest that a mixture of passive (“pushing” information and tools through open access and other initiatives) and focused active engagement in specific countries is most effective. Country level engagement will initially start with two priority countries in sub-Saharan Africa and Asia, identified through an open and transparent process, where the level of maternal and newborn mortality does not appear to be falling. A scoping exercise will be undertaken to identify relevant constituencies and an initial stakeholder consultation held involving direct contact with the Ministry of Health, liaison through United Nations country offices, linkages through professional associations and non-governmental organisations, and engagement of local research groups. The engagement options will then be tailored specifically to the country. Alternative models would be assessed on the basis of a number of different variables, such as awareness of the Collaborative, signing-up to join the constituency, use of materials generated from time-bound activities, and active participation in online discussion groups or offers to contribute to activities.

3.1.3 International Partnerships

The underlying purpose of the Collaborative is to bring together a community of practice. Such a role cannot be undertaken in isolation and a number of key partnerships have already been identified and nurtured by the Collaborative Core Planning Group. The CHERG and the WHO Department of Reproductive Health and Research (RHR), for example, are already undertaking major data driven activities on maternal and newborn health, and identifying areas and issues where the QCPC Collaborative can collaborate and complement is an ongoing process. Other linkages with relevant partnerships, technical agencies and convening initiatives also need to be established. The major professional bodies and societies, for instance, at national and international levels – FIGO, ICM and IPA – represent key influences on quality at the provider level, and the Collaborative will seek their endorsement and active participation. Similarly, the PMNCH could provide an essential platform for the Collaborative to engage and respond to the needs of a variety of constituency groups, and direct linkages will also be sought with major UN agencies and departments therein, such as UNFPA, UNICEF and at WHO with MPS, RHR, HMN and the Global Alliance on Patient Safety. The new Maternal Health Task Force supported by the Bill & Melinda Gates Foundation is a key initiative with which the Collaborative will seek to liaise and engage, along with major international non-governmental agencies and with evidence-based groups, such as the Cochrane and the Campbell Collaboration.

3.2 Quality of care reviews

The QCPC Collaborative will act as a knowledge resource, not only providing a web-portal to access relevant published materials and groups, but also helping to fill knowledge gaps through synthesizing evidence. Two specific sets of activities will be undertaken within the first two years. Firstly and to help raise awareness of the need and challenges of monitoring and assuring quality of care for pregnancy and childbirth, a task team will be set-up to prepare a commentary for publication, provisionally entitled “Where is the ‘Q’ in MCH?” to mirror the seminal paper by Rosenfield and Maine,²¹ and helping to publicise the aims and objectives of the QCPC Collaborative. The second activity is to undertake up to three systematic reviews of specific priority conditions or interventions (“tracers”) selected to illuminate different aspects of quality of care in pregnancy and childbirth. A tracer approach provides a way to streamline and focus the field of enquiry, illuminating not only the elements of quality of care specific to the selected tracer but also issues and measurement relevant to other related conditions or interventions. Each review would be a self-contained and time-bound activity, but the series phased so each review informs the next. A methodology paper summarising the review process and steps involved will also be prepared and discussions held with a major journal to publish a series dedicated to quality of care. The three conditions or intervention areas will be selected to reflect various critical stages along a continuum from pregnancy through to the postnatal period and are likely to be chosen from among: abortion care, PMTCT, maternal anaemia, normal delivery, caesarean section, and puerperal and neonatal sepsis. The Collaborative does not see these as simply desk-based reviews, but will seek engagement of the larger membership in interpreting the findings and sharing lessons for monitoring and assuring quality of care at country levels.

3.3 DHS recommendations

The Demographic and Health Surveys continue to be the major source of population-based data related to reproductive, maternal, perinatal and child health in many developing countries. The next phase (III) of surveys will be co-ordinated by MEASURE DHS for the period 2009-2014. It is thus timely to draw together relevant technical expertise to review the experiences of the previous rounds, the scope and nature of data gathered, the analytical and presentational formats used, and the constraints on country capacity to analyse and use the data with specific regard to maternal and perinatal health and services. This would provide a sound basis for identifying realistic and prioritised changes and options to improve the measurement of quality of care by the DHS. The QCPC Collaborative will co-ordinate the independent review process through a task team who will complete the process by mid-2009 in order to provide timely recommendations to MEASURE DHS.

4. INTERIM OPERATIONAL ARRANGEMENTS AND BUDGET

These start-up and early activities will be undertaken emulating the governance arrangements, guiding principles and operational model proposed for a fully-functioning Collaborative. As noted earlier, the informal CPG (see Annex 1) will continue to act as the core team in the immediate term. A number of options and phases have been identified for launching the QCPC Collaborative, subject to funding, and may include, for example, a keynote address at the upcoming Perinatal Priorities conference in South Africa in early March. The interim secretariat will be based in the Impact unit at the University of Aberdeen, United Kingdom, where the CPG Acting Chair is located.

Funds are now being sought to support the early activities, jointly or individually. Each activity will have clearly defined deliverables, milestones and timelines, and reporting arrangements which reflect the requirements of the funder and the governance arrangements of the QCPC Collaborative. Indicative budgets are available on request.

5. CONTACT DETAILS

For further information on the QCPC Collaborative and this concept note, please contact the Core Planning Group through: info@qcpcollab.org

6. REFERENCES

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ANNEX 1: Names and affiliations of the Core Planning Group for the Collaborative

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ANNEX 2: Names and affiliations of attendees at initial planning meeting. Geneva – October 7-10th 2008

Collaborative Planning Group

Invited attendees:

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Invited but could not attend:

Robert E. Black, Johns Hopkins Bloomberg School of Public Health, USA
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Lynn Freedman, Columbia University, USA
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