Quality Improvement Task Team
Terms of Reference
January 2019

1. Justification

The need for the improvement of quality in humanitarian health response has been a continuous goal for the humanitarian community as it is acknowledged in many responses that there are clear gaps. Quality of care is also a key component of the right to health and critical to the achievement of universal health coverage (UHC) iterated in Sustainable Development Goals[1]. Globally, poor-quality health care causes harm to human health, with between 5.7 and 8.4 million deaths occurring annually in low- and middle-income countries due to inadequate care.[2] Improving quality of health care may also improve health system resilience, allowing adequate response to any further health shocks, e.g. outbreaks or conflict, during an existing crisis. It is also a key opportunity to support one aspect of the humanitarian development nexus.

The development of international standards for humanitarian contexts has galvanised for example with Sphere, the Inter Agency Field Manual for Reproductive Health in Emergencies and IASC Guidelines for Mental Health and Psychosocial Support (MHPSS) in Emergency Settings etc, being widely used and accepted. Implementation of standards vary including those which agencies may voluntarily align to and be independently certified e.g. the Core Humanitarian Standards or where agencies need to achieve mandatory criteria and verification prior to approval for deployment by national authorities such as with the Emergency Medical Teams (EMT) initiative.

However, monitoring adherence to standards during a humanitarian response and corrective actions taken to improve or ensure quality varies considerably between countries and context. Existing mechanisms may include individual agencies self-implementing quality control mechanisms, local health authorities assessing quality, or assurance mechanisms performed by third parties. However, there is no common framework for country health clusters to utilise and there is a recognition that core aspects of quality assurance/improvement need to be aligned to ensure predictable and effective response. Previous Global Health Cluster (GHC) discussions on quality, (most recently, the GHC partner meeting in Brussels[3]), the 'Quality and Capacity Forum' hosted by ECHO[4], and the Health Cluster Forum[5] reconfirmed the interest and commitment among partners to determine systems for quality improvement.

The GHC Strategic Advisory Group (SAG) has thus decided to create a new Task Team on quality for direct relevance to the cluster but also placing this within the wider scope of work being done on quality by WHO Health Systems and the other networks such as EMT and GOARN. Quality is one of the common themes across all partner networks, so collaboration is important from the outset. The Task Team should also have strong participation by country health clusters.

2. Considerations

There are many aspects in the development of a quality framework that need to be considered

- The objective of the framework

[1] Sustainable Development Goal Target 3.8: "*Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all*"
[2] National Academies of Sciences, Engineering and Medicine. 2018. Crossing the Global Quality Chasm: Improving Health Care Worldwide. Washington, DC: The National Academies Press.
[3] GHC Partners meeting, April 2018.
[4] ECHO forum on Quality and Capacity, April 2018.
[5] Health Cluster Forum, June 2018.

- Should country level mechanisms include quality control, quality assurance, quality improvement or quality management[6]

- The scope
  - Should it measure health care programming at community and facility levels, organisational quality, or the wider health care system (e.g. healthcare workforce, medical supplies, information systems etc), and performance of the humanitarian health response including QoC, coverage, utilisation rates, mortality rates
  - Determine which organizations should utilise the framework and in which contexts
  - The desired impact over what time period e.g. focussing on small quick impact gains gradually expanding interventions
  - The feasibility of such a mechanism to be implemented during a humanitarian crisis, making the best use of available resources and recognising constraints
  - Recognise complex humanitarian terrains and the need to adhere to protection principles and to 'do no harm' both in service delivery as well as when implementing the quality improvement mechanism to mitigate re-enforcing existing conflict dynamics or creating further marginalisation
- The definition of quality itself.
  - Currently the general WHO definition of **quality of care** is "*the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred."*
  - The Committee on Economic, Social and Cultural Rights (CESCR)[7] states that the right to health contains the essential elements of availability, accessibility, acceptability and quality[8]. Quality is defined as *"... health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation".*
  - Other definitions such as the Bellagio Declaration[9] regarding **high-quality health systems**, as "*systems that consistently deliver services that improve or maintain health, are trusted by people, and can adapt to changing needs and health shocks."*
- The mechanisms for quality assurances and/ or improvement
  - Define what to measure e.g. quality of essential package of health care services, organisational quality, health system performance
  - Standards to align against (e.g. Sphere, Minimum Initial Service Package (MISP), EMT quality standards, Core Humanitarian Standards, disease specific standards, or national MOH standards and guidelines, partner clinical guidelines, Good Manufacturing Practice and Good Distribution Practice for medicines and medical products etc.)
  - Tools to be used that allow collation of data from existing health information, such as from medical records, HMIS, HERAMs, perceived needs analysis surveys, household surveys, or new tools to be designed e.g. Health Facility Performance Assessment Tool (currently being developed by EPHS Task Team).

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[6] *National Quality, Policy and Strategy Handbook* (WHO 2018), by WHO Service Delivery and Safety, uses definitions *"**Quality control:** Operational techniques and activities that are used to fulfil requirements for quality. **Quality assurance:** All the planned and systematic activities implemented within the quality system, and demonstrated as needed, to provide adequate confidence that an entity will fulfil requirements for quality. **Quality improvement:** An organizational strategy that formally involves the analysis of process and outcomes data and the application of systematic efforts to improve performance. **Quality management:** All activities of the overall management function that determine the quality policy, objectives, and responsibilities, and implement them by means such as quality planning, quality control, and quality improvement within the quality system*

[7] *The Right to the Highest Attainable Standard of Health,* The Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14, 11 August Doc. E/C.12/200/4 (2000).

[8] *"…Availability: Health facilities, goods and services must be available in sufficient quantity; accessibility: Health services must be accessible to everyone without discrimination; acceptability: health services must be respectful of medical ethics, culturally appropriate and gender sensitive…."*

[9] *Bellagio Declaration on high-quality health systems,* The Lancet (2018)

- Assurance, improvement (e.g. basic improvement cycles, EFQM Excellence Model for organisational self assessment[10]), or regulation measures to be implemented and by whom (e.g. by individual agencies, Ministry of Health, third parties or Health Cluster)
- Governance of quality mechanisms in different contexts and the roles and responsibilities of partners. This may also include any support that may need to be provided from the global level by partners and cluster

- The barriers to and enablers of such a mechanism
  - Opportunities for localisation and the development of local and national capacities through quality improvement mechanisms vis a vis strict regulatory mechanism excluding local actors
  - Contexts or factors that may leverage quality assurance and regulation e.g. country clusters with country based pooled funding (currently implemented in 18 out of 23 country clusters)
  - The level of input required to implement such measures including financial and human resources
- The impact of implementing a quality improvement framework including un-anticipated synergies or consequences such as increased /decreased local capacities, funding demands, range of services able to be implemented, healthcare coverage, humanitarian space

3. Purpose and strategic objectives

The **purpose** of the work of the Quality Improvement Task Team[11] (QITT) will therefore be to determine the GHC position regarding quality and support the development of a quality improvement framework, with strategies and tools for Health Cluster Coordinators and country partners to utilise.

In 2018-9 the **Specific Objectives** of the Task Team will be to:

SO1 Determine existing quality assurance and improvement mechanisms in humanitarian contexts, understanding good practice as well as constraints and limitations

SO2 Develop, finalise, publish and disseminate practical operational guidance / quality improvement framework to be used at country level adaptable to different contexts.

SO3 Support the roll out of the quality framework in country health clusters

SO4 Develop a mechanism to monitor the outcomes of implementing the quality framework at country level, capture lessons learned and good practice

1. Activities

1.1 Develop and monitor a workplan for the project.

1.2 Oversee a review examining quality assurance and improvement frameworks in humanitarian settings documenting evidence of good practice as well as constraints and challenges

1.3 Participate in expert review workshop *(optional step)* examining findings and agree upon scope of work of final quality improvement framework

2.1 Oversee development of draft Quality Improvement Framework

2.2 Oversee a pilot of the draft Quality Improvement Framework in one country *(optional step, to be determined by TT)*

2.3 Participate in expert review workshop to finalise framework *(optional step)*

3.1 Oversee and contribute to the roll out and implementation of quality framework and mechanism in countries where a cluster / IASC response is activated

3.2 Contribute to dissemination of framework such as participating in webinars, workshops, and promote within own organisation and across networks

4.1 Contribute to the development of a tool and mechanism to measure the implementation of the quality framework at country level, determining success and challenges

4.2 Oversee the monitoring of the quality framework.

[10] *The EFQM Excellence Model,* EFQM (2013)

[11] For the purpose of this draft ToR the term *"quality improvement"* will be used, but may be changed depending on scope of the framework etc as decided by the Task Team

4. Deliverables (with planned timeframe)

- The Task Team deliverables in 2019 are in the Work Plan and Budget which will form a part of this TOR.
- The deliverables are dependent on the availability of funding and resources and subject to change and readjustment.

5. Membership

- The GHC Quality Improvement Task Team will include representation from partners including NGOs, academic institutions, UN organisations, GOARN, EMT, WHO Health Systems and Health Cluster Coordinators. Partners are encouraged to volunteer to join the Task Team, and to take the lead in specific activities in the work plan which corresponds to their expertise, capacity and interests.
- To ensure the Task Team is a manageable size and has broad representation from Partners and Stakeholders the maximum number of members will be 15.
- Representatives of other clusters, regional and national sectoral coordination groups, and external partners may also be asked to participate in meetings and teleconferences where relevant. The cost of this participation will be covered by their organisations.

6. Roles and responsibilities of the Task Team

- Lead and drive action specific work identified in the Quality Improvement Task Team Work Plan
- Consult appropriately with the wider Global Health Cluster, networks and technical experts as needed.
- Provide quarterly progress reports on activities and deliverables to the Strategic Advisory Group via the Global Health Cluster Unit.
- As soon as an activity is completed, present the finished product to the SAG and Global Health Cluster Unit with recommendations for the way forward.
- Ensure harmonisation with other Global Health Cluster Task Teams.
- Secretariat support will be provided by the Global Health Cluster Unit.

7. Frequency of meetings

- The Task Team will meet quarterly (with at least two face to face meetings, the remainder by teleconference) organised by the Global Health Cluster Unit
- Where possible meetings will take place face to face before GHC Partner meetings
- Task Team members commit to attend all meetings.