

Full compilation of messages. For background on the project, see:

www.hifa.org/patientsafety

HIFA Spotlight: Patient safety and NCDs

This HIFA Spotlight, organised in collaboration with WHO around World Patient Safety Day 2026, brought together clinicians, patient-safety experts, researchers, health managers, community practitioners, patient advocates and people with lived experience from a wide range of countries and settings. The discussion was hosted in English on the HIFA forum over 7 days.

There were 74 contributions from 26 contributors in 15 countries (Cambodia, Canada, Democratic Republic of the Congo, Egypt, Guinea, Honduras, India, Italy, Morocco, Oman, Switzerland, Uganda, United Arab Emirates, United Kingdom, United States).

Spotlight: Patient safety and NCDs (1) Introduction: Charles Vincent, United Kingdom

11 September, 2026

Hello HIFA Colleagues

I have recently joined HIFA as a member of the steering group for the HIFA forum on safe care for non-communicable diseases. [www.hifa.org/patientsafety]

I trained as a clinical psychologist a long time ago but I have spent most of my career working on risk management and patient safety. I have been based at universities in the UK, but worked in many clinical settings, including running a research group in a department of surgery and cancer. In the early years, when the term patient safety didn't even exist, we developed methods of analysing clinical incidents and carried out studies of the scale of error and harm. Later we carried out research on teamwork in the operating theatre, the measurement and monitoring of safety, managing risk under pressure and other safety related topics. I have also had a longstanding concern with the impact of error and harm on patients, families and staff and how we can best support people in the aftermath of harm.

In recent years, now based in Oxford, I have worked with a global health group who collaborate on research to support care in Africa and run training programmes on improvement and implementation in global health. We have learned that many safety concepts and methods, originally developed in other industries or in richer systems, can be effectively used in low resource settings and have seen many really impressive projects to improve the safety of care.

I am looking forward to the discussion on the forum next week and to learning about the experiences of HIFA members in both understanding and improving the safety of care in different settings

With best wishes

Charles Vincent

HIFA profile: Charles Vincent trained as a clinical psychologist and worked in the British NHS for several years. Since 1985 he has focused on conducting research on the causes of harm to

patients, the consequences for patients and staff, and methods of improving the safety of healthcare. charles.vincent AT psy.ox.ac.uk

Spotlight: Patient safety and NCDs (2) Introduction: Degutla Karthik Chary, India - Anaesthesia and perioperative care

11 September, 2026

[*Note from HIFA moderator (NPW): As we prepare for our Spotlight next week 14-20 September (www.hifa.org/patientsafety) I invite all HIFA members with an interest in patient safety and/or NCDs to introduce yourselves by sending email to hifa@hifaforums.org]

Dear HIFA colleagues,

I'm an anaesthesiologist based in Hyderabad, India, and a new HIFA member. Thank you to Dr. Meena Nathan Cherian and Dr. Neil Pakenham Walsh for the warm welcome.

My clinical background is in anaesthesia and perioperative care. Outside the OT, I run medical education platforms for anaesthesia trainees and practising clinicians across India and beyond, and I've recently been focused on how AI tools are being introduced into clinical workflows including where they're helping and where they're creating new patient safety concerns.

I'm looking forward to learning from this community, particularly around patient safety in low and middle-income settings.

Warm regards,

Dr. Degutla Karthik Chary

MBBS, MD Anaesthesia

Hyderabad, India

HIFA profile: Degutla Karthik Chary is an Independent Anaesthesiologist & Medical Educator, based in India. Professional interests: Anaesthesiologist (MBBS,MD), Independent medical educator, NEETPG Faculty at Charaka app by Apollo.edu. Independent medical educator running anesthesianotes app and educational pages on instagram (195k+ followers), Youtube (85k+ subscribers). Currently focused on artificial intelligence in healthcare, learning and teaching AI literacy to healthcare professionals in India. I have been associated with IJA (Indian Journal of Anaesthesia) for 3 years as a social media ambassador. Interested in safe and appropriate deployment of AI tools in clinical settings with ethical and patient safety as priority. kd95.work AT gmail.com

Spotlight: Patient safety and NCDs (3) WHO and World Patient Safety Day 2026 Goals

11 September, 2026

Dear HIFA colleagues,

Below is the text from the WHO campaign page: <https://www.who.int/campaigns/world-patient-safety-day/2026>

'The 2026 edition of World Patient Safety Day focuses on addressing one of the major health concerns affecting billions of people and accounting for 74% of deaths worldwide, namely

noncommunicable diseases (NCDs). Noncommunicable diseases are long-term conditions, such as cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, that can affect people of all ages and often require ongoing care throughout life. Addressing NCDs is a global priority, reflected in the United Nations political declaration on NCDs and mental health, which calls for strengthened prevention and long-term management of NCDs. Achieving these commitments requires access to safe and quality care.

'Globally, 1 in 10 patients is harmed during health care, with around half of this harm being considered preventable. People living with NCDs are particularly vulnerable to harm due to the long-term nature of their conditions, ongoing treatment needs and frequent interactions with health systems. This repeated exposure increases the likelihood of harm over time. With some conditions, such as cancer, up to 1 in 3 patients experience adverse events during care. Many people also live with multiple chronic conditions, further increasing the risk of harm.

'World Patient Safety Day 2026 is, therefore, focusing on safe care for noncommunicable diseases, under the slogan 'Safe care for life!'. It calls for multisectoral and multi-stakeholder action to ensure that no one is harmed while receiving care for NCDs.'

We learned today that WHO is proposing WORLD PATIENT SAFETY DAY GOALS 2026 relating to NCDs.

<https://www.who.int/campaigns/world-patient-safety-day/2026/goals>

'On the occasion of World Patient Safety Day 2026, with the theme "Safe care for noncommunicable diseases", WHO is proposing a set of Goals to facilitate action for improvement at the point of care. These goals highlight priority areas where health facilities, organizations, health care leaders, managers and health practitioners can make tangible changes to reduce avoidable harm and improve safety for people living with noncommunicable diseases..

The World Patient Safety Day 2026 Goals are:

Goal 1: Partner with people with lived experience and civil society

Goal 2: Strengthen prevention and risk assessment

Goal 3: Provide early detection, accurate diagnosis and integrated management

Goal 4: Secure access and safe use of medicines and medical devices

Goal 5: Strengthen care coordination, continuity and transitions of care

'If you are a health practitioner, health care facility manager, patient safety or quality professional, or otherwise involved in the design and delivery of NCD care, sign up to the Goals and help turn awareness into action for safer NCD care.'

I have signed up on behalf of Global Healthcare Information Network (the non-profit that administers HIFA)

You can sign up here: <https://extranet.who.int/dataformv6/index.php/833423?lang=en>

WHO also provides a document that describes the goals in more detail:

<https://iris.who.int/server/api/core/bitstreams/42b8b81f-2f55-4e58-8953-...>

For example, on Goal 4:

'Many people living with NCDs need long-term treatment, often involving multiple medicines and medical devices in health care settings as well as at home. This increases exposure to medication and device-related risks. Medication-related harm may result from stockouts and interruptions in treatment, medication errors, polypharmacy, inappropriate prescribing or use, inadequate monitoring and poor communication. Harm associated with medical devices may result from inappropriate selection, unsafe operation, inadequate maintenance, device malfunction or insufficient user training. Reducing medication- and device-related harm calls for coordinated action by health care providers, pharmacists, biomedical engineers, health care facility managers, regulators, supply chain stakeholders, people living with NCDs and their caregivers. This includes ensuring equitable access to appropriate, quality-assured and affordable medicines and medical devices, together with systems that support their safe prescribing, dispensing, administration and use, and the safe selection, operation, maintenance and monitoring of medical devices. The third WHO Global Patient Safety Challenge, entitled "Medication Without Harm", calls for action across the medication-use process, with particular attention to polypharmacy, transitions of care and high risk situations.'

We welcome your comments on the World Patient Safety Day 2026 Goals.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (4)

11 September, 2026

I was interested to read this perspective article in The Lancet.

Tim Baker: bringing systems change to acute health-care provision

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(26\)01823-4/fulltext?dgcid=raven_jbs_etoc_email](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(26)01823-4/fulltext?dgcid=raven_jbs_etoc_email)

Here are extracts:

'In 2025 Baker and colleagues' African Critical Illness Outcomes Study (ACIOS) on the prevalence of critical illness in 22 African nations was published. "Before ACIOS there was very little data on the size of the problem, or what's happening to these patients", says Baker. "It's a much larger problem than usually thought. Often, when people think of critical illness, they

assume these patients are in ICUs, and as there are only a few ICU beds, it appears to be a minor issue. But ACIOS found that one in eight inpatients are critically ill and less than half of them receive essential emergency and critical care. They need oxygen, they need fluids, they need basic airway management, and they're not getting this care. And they're scattered through the hospital. They're not on ICUs. They're on the paediatric ward. They're on the maternal ward. They're on the surgical ward. They're all over the place."... if Essential Emergency and Critical Care was provided to all patients who need it, 1 million deaths each year could be averted'.

The paper does not mention patient safety, but clearly it is a major patient safety issue if less than half of critically ill patients in hospital are receiving essential care.

Patient safety is about so much more than correcting errors. Poor quality care is unsafe care.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (5)

12 September, 2026

We're looking forward to our Spotlight discussion this week on patient safety and NCDs, 14-20 September.

Here are further details: www.hifa.org/patientsafety

Our guiding questions are:

1. What is unsafe care and what is its local and global impact?
2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?
3. What can be done to better understand and improve health systems for safer care for people living with NCDs?
4. How can we better support patients and primary and facility-based health workers to deliver safe care?

Please feel free to contribute a message on any of the above, or indeed any aspect of patient safety and/or NCDs.

The Spotlight working group includes Meena Cherian, Ashwarthy Sunil, Charles Vincent, Diana Zandi and myself and we look forward to your participation.

We are especially interested to hear examples from your own experience, whether professional or personal. Email to: hifa@hifaforums.org

We aim to develop a concise learning brief for publication on the WHO Health Services Learning Hub (HLH), reflecting experience in different contexts and countries.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (6) Welcome!

13 September, 2026

Welcome to our Spotlight on Patient safety and noncommunicable disease. Thanks to sponsorship from WHO we shall focus on this topic for seven days, from 14-20 September inclusive.

We propose four guiding questions:

1. What is unsafe care and what is its local and global impact?
2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?
3. What can be done to better understand and improve health systems for safer care for people living with NCDs?
4. How can we better support patients and primary and facility-based health workers to deliver safe care?

We invite you to share your experience, expertise and thoughts by email to: hifa@hifaforums.org

We shall then collate, edit, and synthesize discussion contributions as a concise learning brief for publication on the WHO Health Services Learning Hub (HLH).

For more information see our landing page: www.hifa.org/patientsafety

With thanks,

Neil Pakenham-Walsh

On behalf of the Spotlight working group: Meena Cherian, Diana Zandi, Charles Vincent, Ashwarthy Sunil, NPW.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (7) Q1: What is unsafe care and what is its local and global impact?

13 September, 2026

Dear HIFA colleagues,

Hello, on behalf of the Spotlight working group I would like to introduce the first guiding question in our discussion:

Q1. What is unsafe care and what is its local and global impact?

WHO defines patient safety as 'the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum'. By extension, unsafe care involves the presence of avoidable, preventable harm or the failure to reduce the risk of unnecessary harm during healthcare delivery. Fact sheet: <https://www.who.int/news-room/fact-sheets/detail/patient-safety>

WHO estimates that 'Around 1 in every 10 patients is harmed in health care and more than 3 million deaths occur annually due to unsafe care. In low-to-middle income countries, as many as 4 in 100 people die from unsafe care'. <https://www.who.int/news-room/fact-sheets/detail/patient-safety>

We encourage you to look at the above WHO fact sheet which provides an overview of patient safety and its impact, including common sources of patient harm, factors leading to patient harm, system approach to patient safety, and the WHO response.

We also refer to the Global Patient Safety Action Plan 2021–2030, which provides a framework for action for key stakeholders to join efforts and implement patient safety initiatives in a comprehensive manner. The goal is “to achieve the maximum possible reduction in avoidable harm due to unsafe health care globally”, envisioning “a world in which no one is harmed in health care, and every patient receives safe and respectful care, every time, everywhere”. <https://www.who.int/teams/integrated-health-services/patient-safety/poli...>

In terms of local impact, we especially encourage all of us to share any personal experience of unsafe care or patient harm, whether in primary, secondary or tertiary health care. This could be from your perspective as a health worker or as a patient or family member. As health workers we have almost certainly had experience of unsafe care. We are all patients and, as described above, at least 1 in 10 of us will have been harmed by unsafe care. In a previous Spotlight on Group B Strep, for example, we heard the moving testimonies of mothers whose babies had died or were severely damaged by unsafe care. (www.hifa.org/gbs)

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (8) Personal experience (1) A missed diagnosis of epiglottitis

13 September, 2026

Dear HIFA colleagues,

This is not an easy message to write - I have not written about it publicly before. I hope that by sharing my experience it may help us understand the impact of unsafe care and that it will encourage you to share your experience.

In 1986 I was working as a junior hospital doctor doing my first job as a senior house officer in paediatrics.

One evening my registrar and I were, as usual, covering all paediatrics in five areas of the hospital: paediatric A&E, general paediatrics ward, labour room, postnatal ward and intensive neonatal care unit. I got a call to A&E to assess a 23-month-old child. The child looked moderately well but miserable with a fever. There was slight tachycardia and slight tachypnoea; no stridor or recession. I also noted slight neck stiffness. I made a presumptive diagnosis of a viral illness and recommended the child be admitted for observation. In view of the neck stiffness I could not rule out early meningitis and I called my registrar to ask him to review the child as soon as he could.

I continued working flat-out, covering the five clinical areas. An hour and a half later I received a call from the paediatric ward saying that the patient had arrived and looked very unwell. I ran to the ward, saw the child to be very ill and called my registrar to ask him to come urgently. I asked him if I should proceed with lumbar puncture in the meantime and he said go ahead - I tapped turbid CSF, appearing to confirm meningitis. The registrar arrived a few minutes later. We established a venous line and gave intravenous antibiotics, but meanwhile the child's condition deteriorated and he had a cardio-respiratory arrest. At this point laryngoscopy by the registrar revealed epiglottitis and he was unable to pass the endotracheal tube. The anaesthetist in the 'crash team' arrived and was finally able to pass a tube. The child lived but tragically had substantial brain damage.

This is the most powerful experience I have had as a doctor and it was deeply upsetting. I blamed myself for missing the diagnosis and felt ashamed. I still think about it.

So how is this a patient safety issue?

1. At first sight, it appears to be a missed diagnosis and the 'fault' lies with the health professional (me) who missed the diagnosis.
2. I subsequently learned that epiglottitis is notoriously difficult to diagnose, with as many as 80% of cases missed on first assessment.
3. Epiglottitis is very uncommon. It's the only case I saw in 2 years of paediatrics.
4. The child deteriorated greatly between when I saw him and when he arrived at the ward. The time to transfer him from A&E to the ward was abnormally long - I am not sure of the reasons for the delay but assume the people accompanying him (his parents and a nurse? or a porter?) were unable to recognise his deterioration or act accordingly.

There are wider contributory factors.

1. In the 1980s junior hospital doctors, including me, were often required to work up to 100 hours a week without days off in-between. We were often physically and mentally exhausted.
2. The level of staffing at night and weekends was inadequate to provide safe care. For example, the registrar had been unable to review the child as I had requested because he himself was tied up with urgent care in the intensive neonatal care unit.
3. NHS health policy at the time did not yet include routine Haemophilus influenzae vaccine, which was available and would likely have protected the child. In 1986 the incidence of epiglottitis in the UK was 20-30 per 100,000 per year. Routine H influenza vaccine was introduced in the UK in 1992. The disease is now exceptionally rare: less than one case per 100,000 per year.

Although I can now see the many systems factors, and recognise that epiglottitis is notoriously hard to diagnose, this was not made clear to me at the time and I was offered no counselling. All I remember was being told 'Don't blame yourself. It was bad luck. It could have happened to anyone'. This was little comfort and the experience has stayed with me.

I hope that case studies such as this can help us to understand the impact of unsafe care and how it might be improved.

I would like to invite HIFA members to share any experience you may have of unsafe care. Have you ever been involved with the care of a patient when something went wrong, something that might have been avoided? Or have you ever been on the receiving end of unsafe care, either for yourself or your family? We look forward to hear from you. Please send your contributions to: hifa@hifaforums.org

With thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries,

interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (9) Patient Safety and Noncommunicable Diseases in West Africa

14 September, 2026

Q1. What is unsafe care and what is its local and global impact?

Unsafe care occurs when patients are exposed to preventable harm through errors, delays, misdiagnosis, inappropriate treatment, poor communication, medication errors, infection risks, inadequate referral, or failures in follow-up. Globally, patient harm is a major public-health problem, particularly in low- and middle-income countries. In West Africa, the consequences are amplified by weak health infrastructure, shortages of skilled personnel, fragmented services and financial barriers. For people living with NCDs — such as hypertension, diabetes, cardiovascular disease, > cancer and chronic respiratory diseases — unsafe care can result in avoidable complications, disability, premature death, catastrophic household

expenditure and loss of confidence in health services.

Q2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?

Major causes include late diagnosis, inadequate screening, medicine stock-outs, polypharmacy, poor continuity of care, weak referral systems, limited diagnostic capacity, insufficiently trained health workers, overcrowded facilities and poor patient-provider communication. Reliable health information is a fundamental determinant of safety. Patients need understandable information about symptoms, medicines, warning signs, appointments, lifestyle changes and when to seek urgent care. Health workers likewise need accurate, current clinical guidance, patient records and reliable diagnostic information. Misinformation, fragmented records and low health literacy can directly increase unsafe decisions.

Q3. What can be done to better understand and improve health systems for safer NCD care?

Countries should establish stronger patient-safety surveillance and incident-reporting systems, conduct routine quality-of-care audits, map NCD care pathways, strengthen referral and counter-referral, and use patient and community feedback. Primary healthcare should be strengthened as the foundation for prevention, early detection, treatment and long-term follow-up. Digital health records, decision-support tools and interoperable information systems can improve continuity and reduce errors.

Q4. How can we better support patients and health workers?

Patients should be empowered through health-literacy programmes, culturally appropriate information, self-management education and meaningful participation in care decisions. Health workers need continuous training, practical guidelines, adequate staffing, essential medicines and diagnostics, supportive supervision and safe working environments. Ultimately, safer NCD care requires a whole-system approach in which informed patients, competent

health workers, reliable information and accountable institutions work together to prevent avoidable harm.

HIFA profile: Dr. Uzodinma Adirieje is a leading voice in health education, community health, and advocacy, with decades of experience advancing people-centered development across Africa and beyond. His approach to health education emphasizes participatory learning, knowledge transfer, and behavior change communication, ensuring that individuals and communities gain the skills and awareness to make informed decisions about their health. He develops and delivers innovative health promotion strategies tailored to local realities, particularly in resource-limited settings. In community health, Dr. Adirieje has championed integrated primary health care, preventive medicine, and grassroots health initiatives. Through Afrihealth Optonet Association (AHOA), which he leads, he connects civil society, community groups, and health institutions to strengthen healthcare delivery, tackle health inequities, and improve access to essential services for vulnerable populations. His work addresses infectious diseases, maternal and child health, nutrition, climate and health, environmental health, and emerging public health challenges. As a passionate advocate, Dr. Adirieje works with governments, NGOs, and international organizations to influence health policy, mobilize resources, and promote sustainable development goals (SDGs). He amplifies community voices, ensuring that health systems are inclusive, accountable, and responsive. His advocacy extends beyond health to governance, environment, and social justice, positioning him as a multidisciplinary leader shaping healthier and more equitable societies. afrepton AT gmail.com

Spotlight: Patient safety and NCDs (10) Q2. What are the main causes of unsafe care for people living with NCDs?

14 September, 2026

Hello HIFA colleagues,

I'm Meena Nathan Cherian (former WHO staff) and a HIFA Steering Group and Spotlight Group member who has prepared this discussion. I would like to introduce Question 2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?

NCDs, including heart disease, stroke, cancer, diabetes, and chronic lung disease, are collectively responsible for 74% of all deaths worldwide (WHO).

i. One of the main causes of 'unsafe care' for people living with NCDs is 'lack of access to reliable healthcare information' for both patients and healthcare providers. Patients may not be aware of evidence-based scientific knowledge on prevention, early detection, and appropriate, timely treatment. Health providers at the primary and community level often lack access to scientific updates to guide and communicate to patients on early detection, diagnoses, and to make treatment and follow-up decisions. Lack of updated evidence-based standard protocols at health facilities for treatment and for avoiding medication, diagnostic, and equipment errors is also one of the causes of 'unsafe care'. Health facilities with constrained resources due to limited financial support, poorly maintained equipment, and lack of trained health providers and caregivers lead to 'poor quality, harmful and unsafe care'.

ii. Lack of access to reliable healthcare information is a crucial determinant of unsafe patient care, leading to poor quality of care and poor outcomes at all levels of health facilities.

Best wishes

Dr. Meena Nathan Cherian, MBBS, MD (Anaesthesia)

(Former WHO Lead Emergency and Essential Surgical Care Program, Geneva, Switzerland).

Director, Global Health New Challenges: Geneva Foundation for Medical Education & Research, Switzerland.

<<http://www.gfmer.ch/surgery/cancer.htm>> www.gfmer.ch/surgery/cancer.htm (NSA-WHO)

Senior Advisor, Global Action International Society of Geriatric Oncology

<<https://siog.org/about-us/governance/leadership/permanent-committees/>> Permanent Committees - SIOG

Senior Advisor, International College of Surgeons-Global Affairs.

<<https://icsglobal.org/>> <https://icsglobal.org/> (NSA-WHO)

Adjunct Prof., The Chinese University of Hong Kong, Shenzhen, China.

<<https://med.cuhk.edu.cn/en/teacher/371>> <https://med.cuhk.edu.cn/en/teacher/371>

WHO-HIFA Essential Health Services; mHEALTH-INNOVATE.

<<http://www.hifa.org/>> www.hifa.org (NSA-WHO).

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HIFA profile: Meena Nathan Cherian was a professor of anaesthesiology from Christian Medical College Hospital, Vellore, India. She trained, worked, and taught in several countries, USA (Johns Hopkins Hospital), Southeast Asia and Africa. She worked at the World Health Organization Headquarters, Geneva, Switzerland, as the Emergency and Essential Surgical Care Program Lead where she created the 'surgical care' program resulting in the first World Health Assembly Resolution on 'Emergency and Essential Surgical Care and Anaesthesia in the context of Universal Health Coverage'. Currently she works as the Director, Global Health New Challenges program, Geneva Foundation for Medical Education and Research, Geneva, Switzerland; Adjunct Prof. The Chinese University of Hong Kong, Shenzhen, China; Senior Advisor, Global Action, International Society of Geriatric Oncology, Switzerland; she is a member of the HIFA Steering Group; HIFA Partnerships and Projects Working Group; and HIFA mHEALTH-INNOVATE Working Group. cherianm15 AT gmail.com

Spotlight: Patient safety and NCDs (11) A missed diagnosis of epiglottitis (2) James Reason and system factors

14 September, 2026

Dear HIFA colleagues

On Monday this week a doctor shared a tragic safety episode of a time early in their career in 1986 when a missed diagnosis of epiglottitis (a very rare condition) had a tragic outcome. They told us that the memory of this event can still distress them decades later and reflected with hindsight on the many systems factors that contributed to the problems that occurred. They received no real support after the event and were expected to treat it as 'one of those things'. This was indeed the understanding of error and harm that was common at that time when I was

working on errors in medicine as a researcher in an emergency department. We now understand that the great majority of events that harm patients have a much more complex set of causes and contributory factors.

The person who helped me and many others understand the nature of error was James Reason, a British Psychologist who wrote widely on human error and safety. This elegantly written quotation beautifully summarises one of his key insights:

"Rather than being the main instigators of an accident, operators tend to be the inheritors of system defects created by poor design, incorrect installation, faulty maintenance and bad management decisions. Their part is usually that of adding the final garnish to a lethal brew whose ingredients have already been long in the cooking."

People of course play a part when things go wrong, but they are simply the final link in the chain, the final garnish to a lethal brew as Jim Reason memorably says. Clinical staff are often 'set up to fail' by the systems they work in, as the story of the missed diagnosis showed us.

There is also now, thankfully, a great deal more understanding of the impact of error and harm on patients, families and healthcare professionals though blame and recrimination are still far too common. Some organisations have active programmes to support all concerned after serious events.

People sometimes write and say that we are making little progress on patient safety. We are certainly not making us much progress as many people hoped. However, when I think back to the attitudes and understanding of the 1980s and compare that with today, it is clear that our understanding and approach to safety in healthcare has completely transformed.

I thank the person concerned for sharing their story with us this week, for teaching us about safety through their story and offering hope and support to the many, many other HIFA colleagues who will have had similar experiences.

Charles Vincent

HIFA Spotlight on Patient Safety and NCDs

HIFA profile: Charles Vincent trained as a clinical psychologist and worked in the British NHS for several years. Since 1985 he has focused on conducting research on the causes of harm to patients, the consequences for patients and staff, and methods of improving the safety of healthcare. charles.vincent AT psy.ox.ac.uk

Spotlight: Patient safety and NCDs (12) Q1. What is unsafe care and what is its local and global impact? (2)

14 September, 2026

WHO defines patient safety as 'the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum'. By extension, unsafe care involves the presence of avoidable, preventable harm or the failure to reduce the

risk of unnecessary harm during healthcare delivery. Fact sheet: <https://www.who.int/news-room/fact-sheets/detail/patient-safety>

WHO estimates that 'Around 1 in every 10 patients is harmed in health care and more than 3 million deaths occur annually due to unsafe care. In low-to-middle income countries, as many as 4 in 100 people die from unsafe care'. <https://www.who.int/news-room/fact-sheets/detail/patient-safety>

In previous discussions on HIFA we have noted that poor-quality care is estimated to account for 5 million deaths in 2016 [1]. This figure applies to LMICs. Clearly, if all countries were included, the number would be higher. Furthermore, we contacted the authors and established that the numbers only include facility-based care. They do not include home care or care by community health workers. The actual number of deaths caused by low quality care is certainly much higher than 5 million.

What is the difference between 'low-quality care' and 'unsafe care'? Some have argued that 'unsafe care' is a subcategory of low-quality care. However, I would argue that any low-quality care that results in death is by definition unsafe.

I would be interested to hear your thoughts on this.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

[1] Kruk ME, Gage AD, Joseph NT, Danaei G, García-Saisó S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. *Lancet*. 2018 Nov 17;392(10160):2203-2212. doi: 10.1016/S0140-6736(18)31668-4. Epub 2018 Sep 5. Erratum in: *Lancet*. 2018 Nov 17;392(10160):2170. doi: 10.1016/S0140-6736(18)32337-7. PMID: 30195398; PMCID: PMC6238021.

Spotlight: Patient safety and NCDs (13) A missed diagnosis of epiglottitis (3) James Reason and system factors (2)

14 September, 2026

Dear Charles,

Thank you for your message where you wrote "On Monday this week a doctor shared a tragic safety episode of a time early in their career in 1986 when a missed diagnosis of epiglottitis (a very rare condition) had a tragic outcome..."

Just to confirm, I was the senior house officer who saw that child in 1986.

Back then it was never explained to me that "clinical staff are often 'set up to fail' by the systems they work in, as the story of the missed diagnosis showed us". Indeed, there was probably little awareness of system factors per se. There were multiple system factors in my case.

It is encouraging that "our understanding and approach to safety in healthcare has completely transformed" compared to the 1980s, and yet I imagine this is true for only a few countries. Worldwide, I suspect that "blame and recrimination are still far too common"?

Thanks again for your input Charles. We are fortunate to have you as one of the world's leading experts on patient safety.

(Incidentally, for the past 40 years until this week, I had not been aware that epiglottitis is notoriously difficult to diagnose, with as many as 80% of cases missed on first assessment. I wish I had understood this at the time.)

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (14) Reinventing the wheel or duplicating other platforms

15 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-5>]

I am thinking that perhaps we should be cautious about reinventing a wheel or duplicating other platforms and ongoing work that have been addressing this important concern. What resources are already available; where are the gaps? How can HIFA forum add value and/or extend dissemination? For example, via partnering or following up via activities of the WHO integrated health services/patient safety initiative and Global Patient Safety Action Plan 2021–2030; ISQua, etc.

Jo Anne Bennett, PhD, RN

Institut National de Santé Publique

*Direction Nationale de la Lutte contre la Maladie *

Ministère de la santé – République de Guinée

*+224 626 95 17 28

HIFA profile: Jo Anne Bennett, PhD, RN works at the Institut National de Santé Publique, Direction Nationale de la Lutte contre la Maladie, Ministère de la santé – République de Guinée. joannebenn AT gmail.com

Spotlight: Patient safety and NCDs (15) Q3: What can be done to better understand and improve health systems for safer care for people living with NCDs?

15 September, 2026

Dear HIFA colleagues,

I'd like to introduce Question 3. What can be done to better understand and improve health systems for safer care for people living with NCDs?

Unsafe care for people living with noncommunicable diseases (NCDs) remains a major and often preventable cause of harm worldwide. We now have a good understanding of how harm occurs. However many health systems still struggle to provide safe, coordinated, and reliable care for conditions such as diabetes, hypertension, cardiovascular disease, chronic respiratory disease, and cancer. These challenges affect millions of people every day, especially those in low-resource settings.

When patients come to harm because of failures in their healthcare it is still all too common to blame individual staff. This is seldom warranted and is a seriously misguided approach to safety. We have learned over many years that the real causes lie in weaknesses in healthcare systems. Lack of resources plays an important part of course. However, even in poor systems, many vulnerabilities in systems can be identified which are not resource related and are putting patients at risk. There are opportunities everywhere to improve safety often with relatively simple interventions.

Unsafe NCD care is rarely due to a single failure and isolated human errors are relatively uncommon. Unsafe NCD care emerges from systemic gaps in primary care, information access, coordination, training, supply chains, equity, and governance. Understanding these gaps is the first step toward designing safer, more resilient systems.

Gaps include (among others) weak primary health systems resulting in misdiagnosis, mismanagement, communication failures among healthcare providers, limited access to reliable information, stockouts of medicines, insufficient training, excessive workload, lack of digital health support, lack of national or facility-level policies for patient safety.

We invite HIFA members to share their experience, insights, and examples from practice, research, policy, or community engagement. In particular, we welcome reflections on:

1. Any examples of unsafe care in your personal experience, whether as a patient or healthcare provider. What happened, what were the causes, how was it dealt with (blame? improved processes?)
2. Key health system gaps that contribute to unsafe care
3. Successful approaches that have improved safety or continuity of care

Your contributions will help us build a clearer picture of what works, what doesn't, and what is needed to ensure safer care for people living with NCDs everywhere.

We look forward to your thoughts and experiences.

With best wishes

Charles Vincent

HIFA profile: Charles Vincent trained as a clinical psychologist and worked in the British NHS for several years. Since 1985 he has focused on conducting research on the causes of harm to patients, the consequences for patients and staff, and methods of improving the safety of healthcare. charles.vincent AT psy.ox.ac.uk

[*note from HIFA moderator (NPW): See overview and questions here: www.hifa.org/patientsafety ; to contribute to the discussion, send email to hifa@hifaforums.org]

Spotlight: Patient safety and NCDs (16) Q1. What is unsafe care and what is its local and global impact? (3)

15 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-12-q1...>]

In my previous message I raised the question of whether poor-quality health care leading to death should be categorised as unsafe care. If so, then the global impact of unsafe care is probably at least 6 million rather than the 3 million that is commonly quoted in patient safety circles.

We have noted that global descriptions of poor-quality and unsafe care are selective - they do not typically include care in the home or community.

Question 1 also invites us to reflect on national and local impacts.

In which countries are patients most likely to receive unsafe care? It would be interesting to see a visual world map. What countries provide the most and least safe care and what are their commonalities?

We may anticipate that people living in LMICs carry the greatest burden, due primarily to an overworked and undersupported health workforce. A world map that also provides information on causality would be very helpful.

At which level of the health system is unsafe care most likely: in the home or community? among outpatients and the family doctor's clinic? in the emergency room? among inpatients in district or referral hospitals?

An additional factor is socioeconomic: those with the highest income are able to afford higher-quality care, while those without are dependent on stretched public health systems.

There are also considerations around medical needs. For example, I understand that people living with disabilities have a higher risk of unsafe care. People living with NCDs are also at higher risk for reasons we shall explore.

I look forward to learn more about the distribution of unsafe care, by country, by level in the health system, and by medical need.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (17) IAPO Webinar: World Patient Safety Day 2026: What can we do to make NCD care safer? (3)

15 September, 2026

Below is a reminder for the IAPO webinar, 16 September 2026. We encourage HIFA members to participate (free) and share your observations with us.

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Dear all,

Last chance to join us!

Our global webinar to mark World Patient Safety Day 2026 is taking place TOMORROW!

"Partners in Safe Care: Lived Experience and Collective Action for Safety in Noncommunicable Diseases"

Date: Wednesday 16 September 2026

Time: 11:00-12:30 CEST

Online via Zoom

Register

here https://us06web.zoom.us/webinar/register/WN__UZ8dt1lT7Oe9lkeGPps1w#/regi...

Join the below distinguished panel to explore how we can work together to make care safer for everyone living with NCDs:

?? Dr Blerta Maliqi (opening address), Head of the Patient Safety and Quality of Care Unit at World Health Organization HQ

?? Dr. Ratna Devi (Moderator) - IAPO Board Member and CEO of DakshamA Health

?? Klaus B Von Pressentin - Chair of the World Organization of Family Doctors (WONCA) Working Party on Quality and Safety

?? Ferdinand M. Sonyuy - CSEM for UHC2030 in Cameroon, and President/CEO of Reconciliation and Development Association (RADA)

?? Lydia E Makaroff - CEO of Multiple Sclerosis International Federation (MSIF)

?? Ikram Esegir - Member of the Our Views, Our Voices Advisory Committee, representing the NCD Alliance, and Founder/President of NABD-BC2 Association (Best Care for Breast Cancer) in Morocco

We hope to see you there!

The IAPO team

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HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (18) Introduction: Diana Zandi, Switzerland - WHO Quality of Care and Patient Safety

15 September, 2026

Dear colleagues,

I am currently a Technical Officer in the Quality of Care and Patient Safety team at the World Health Organization. With 20 years of experience working with the organization, I bring extensive expertise in the use of digital technologies for health and their potential to support and improve the quality, safety, and delivery of health care.

I have a strong interest in the ethics and safety of digital technologies, their responsible use within health systems, and how digital solutions can be leveraged to address health system challenges and improve patient outcomes.

Regards,

Diana Zandi

HIFA profile: Diana Zandi is a technical officer for eHealth at the World Health Organization, Geneva. zandid AT who.int

Spotlight: Patient safety and NCDs (19) Q2. What are the main causes of unsafe care for people living with NCDs? (2) The continuity gap in rural primary care (Dominican Republic)

15 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-10-q2...>]

Dear Neil and colleagues,

Thank you for convening this Spotlight. I write from Somos Amigos Medical Missions, which has run a free primary medical and dental clinic in El Naranjito, high in the mountains above San José de las Matas, Dominican Republic, since 1997. We serve 32 rural communities, and hypertension and diabetes are among the conditions we see most often. On Question 2 — the causes of unsafe NCD care and the place of reliable information within it — I would like to offer the view from one small clinic rather than add to the excellent general points already made.

In our setting, the most common form of unsafe NCD care is not a dramatic clinical error. It is a quiet failure of continuity. An elderly woman's dangerously high blood pressure is revealed on a routine visit to our clinic. She is prescribed appropriate medications and advised to return in ninety days. But the clinic is a long, costly journey on the mountain's rough roads; she is the caretaker of her young grandchildren and she also looks after an incapacitated neighbor who depends on her for his meals. The follow-up visit does not happen. Her 90-day supply of anti-hypertensives has run out, and while she would only reluctantly admit it, she has shared some with her neighbor. No one knows any of this until she returns months later, having obviously suffered a stroke, or she does not return at all. Nothing in that sequence would appear in any incident report, yet each gap is a safety event in the life of someone living with a lifelong condition. "No news" is too easily mistaken for good news.

Reliable information sits at the center of this, and it fails in two directions. The patient needs to understand — in plain Spanish, and often without relying on the written word — what her diagnosis means and why a medicine still matters on the days she feels perfectly well. And we, as a small and mostly volunteer-supported clinic, need her information to travel with her care: a record the next clinician can pick up, a medication list the pharmacy and the prescriber both work from, a way to know whether a referral down the mountain was ever completed. When that information is fragmented, safe management of a chronic disease becomes almost impossible, however skilled the individual clinician.

Turning to Question 4 — what has helped us is to treat these gaps as the safety problem, and to design against them with the modest means we have. We try to make the screening-to-follow-up step a deliberate hand-off rather than an outcome left to chance; to keep a simple register of our highest-risk patients so they are actively recalled rather than passively awaited; and to invest in clear, reusable patient-education materials, so that whether a patient understands her own condition does not depend on how much time a particular clinician happened to have that day. None of this requires sophisticated technology. It requires deciding that continuity is itself a safety practice, and organizing and staffing around that belief.

I would gladly share more with anyone working in similar settings, and I am learning a great deal from this discussion.

With best wishes,

Frank Brightwell

Founder and Executive Director

Somos Amigos Medical Missions

Dominican Republic

HIFA profile: Frank Brightwell is Executive Director at Somos Amigos Medical Missions, in the United States. Email: frank AT somosamigos.org

Spotlight: Patient safety and NCDs (20) Global Patient Safety Action Plan 2001-2030 (1) The role of reliable healthcare information

15 September, 2026

<https://www.who.int/teams/integrated-health-services/patient-safety/poli...>

The Global Patient Safety Action Plan 2021-2030 'provides a framework for countries to develop their respective national action plans on patient safety, as well to align existing strategic instruments for improving patient safety in all clinical and health-related programmes'.

'The purpose of the action plan is to provide strategic direction for all stakeholders for eliminating avoidable harm in health care and improving patient safety in different practice domains through policy actions on safety and quality of health services, as well as for implementation of recommendations at the point of care.'

The plan defines patient safety as "A framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely and reduce the impact of harm when it does occur."

The plan has seven strategic objectives:

1. Policies to eliminate avoidable harm in health care
2. High-reliability systems
3. Safety of clinical processes
4. Patient and family engagement
5. Health worker education, skills and safety
6. Information, research and risk management

7. Synergy, partnership and solidarity.

I have not had a chance to read the 100 pages in detail, but it seems that the plan does not acknowledge lack of availability of reliable healthcare information as a patient safety issue. This seems to be a major gap in the plan.

Strategic objective 5 talks of health worker, skills and safety solely in terms of awareness of patient safety principles. I could see nothing about clinical knowledge and access to reliable healthcare information.

Strategic objective 6 talks of measurement, surveillance, health data. Again I could see nothing about clinical knowledge and access to reliable healthcare information.

Over two decades, HIFA has consistently highlighted how a failure to meet health workers' needs, particularly their needs for reliable healthcare information, undermines quality of care and patient safety just as much as technical mistakes do. Over this period, we have been encouraged to see that patient-safety thinking has moved from "fix the errors" to "support the people who deliver care."

Failure to translate evidence into policy and practice is a glaring cause of poor-quality and unsafe care and should surely be considered in a global patient safety action plan.

I look forward to hear from anyone who was involved in the development of the plan. What if anything can we do to integrate access to reliable healthcare information as part of patient safety considerations?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (21) Reinventing the wheel or duplicating other platforms (2)

15 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-14-re...>]

Dear Jo Anne,

Thank you for your message.

You say "I am thinking that perhaps we should be cautious about reinventing a wheel or duplicating other platforms and ongoing work that have been addressing this important concern. What resources are already available; where are the gaps? How can HIFA forum add value and/or extend dissemination? For example, via partnering or following up via activities of the WHO integrated health services/patient safety initiative and Global Patient Safety Action Plan 2021–2030; ISQua, etc."

Please can you say a bit more about this so that I can understand your concerns better?

In terms of duplicating other platforms, HIFA is primarily a community of practice. The most important community of practice for patient safety is the Global Patient Safety Network, which is run by the WHO department that sponsored this HIFA Spotlight. I would strongly recommend for all with an interest in patient safety join this community. You can read more about it here: <https://www.who.int/teams/integrated-health-services/patient-safety/netw...>

I would agree that if HIFA was primarily about patient safety, this would be duplicative. However our primary lens is not patient safety, but evidence-informed policy and practice. One of the key points that has been made this week is that a failure of evidence-informed practice is a hugely important but unrecognised cause of unsafe care. I noted in a message earlier today that the Global Patient Safety Action Plan appears to ignore this aspect, and have invited HIFA members to comment.

We work in official relations with WHO and we prepared this HIFA Spotlight with WHO patient safety staff. We agreed that HIFA can bring value that complements the Global Patient Safety Network, if only for one week (14-20 September). Namely, the HIFA community can bring additional experience and understanding around the four guiding questions for this discussion:

1. What is unsafe care and what is its local and global impact?
2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?
3. What can be done to better understand and improve health systems for safer care for people living with NCDs?
4. How can we better support patients and primary and facility-based health workers to deliver safe care?

The original remit for this Spotlight was to look specifically at the role of reliable healthcare information in patient safety. We were very fortunate to have one of the world's leading experts on patient safety, Charles Vincent, join our working group in the later stages. He suggested we broaden the remit of this Spotlight to include core patient safety issues in addition to the role of access to reliable healthcare information. We recognised that knowledge and understanding of patient safety issues can be considered part of HIFA's goal to ensure that every person and every health worker needs to be aware of these issues (in addition to clinical knowledge) in order to protect their own health and the health of others. And we agreed to broaden the remit as represented by the four questions above.

There are several other initiatives in patient safety:

- Global Patient Safety Collaborative (GPSC)
- Africa Patient Safety Initiative
- WHO Patients for Patient Safety Network
- African Partnerships for Patient Safety (APPS)

There are also several WHO Collaborating Centres with expertise in patient safety.

HIFA does not currently have links with these initiatives (apart from WHO and the Global Patient Safety Network). If any HIFA members can help us to establish links, we would be grateful.

I agree, Jo Anne, the key is not to duplicate but to collaborate.

To collaborate, and to share our individual experience and expertise. I invite you and others to continue sharing by email to: hifa@hifaforums.org

With thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (22) Introduction: Charles Vincent, United Kingdom (2)

15 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-1-int...>]

Dear Charles,

Thank you for your introduction message. You said:

"In recent years, now based in Oxford, I have worked with a global health group who collaborate on research to support care in Africa and run training programmes on improvement and implementation in global health. We have learned that many safety concepts and methods, originally developed in other industries or in richer systems, can be effectively used in low resource settings and have seen many really impressive projects to improve the safety of care."

Please can you say a bit more about the effective use of patient safety concepts and methods in low resource settings? What are the similarities and differences as compared with high resource settings? Has your experience been mainly with hospitals or are you (or others) looking at patient safety in the home, in the community and/or at primary health centres. You also

mention 'many really impressive projects'. It sounds like there is a lot of good experience to share.

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (23) A missed diagnosis of epiglottitis (4)

16 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-8-per...>]

Dear Neil, I've read this several times and I think you are being too harsh on yourself. In fact, if you read your piece as if it were written by one of your juniors you would agree with me. You answer your charge: inexperience, unusual condition, too busy, slow system. That counselling you should have been offered is not too late, I seriously think you should seek an appropriate older, sympathetic, skilled physician to talk to. I'm sure it doesn't help (& probably shouldn't) to tell you I could share much greater physician errors that I've witnessed in my career. Nursing ones exist too, but usually different.

Warmest regards, Christine

HIFA profile: Christine Hancock is Founder and Director at C3 Collaborating for Health, which tackles the three major risk factors – tobacco use, poor diet and lack of physical activity - which cause the majority of cardiovascular disease, diabetes, many cancers and chronic lung disease. <https://www.linkedin.com/in/christinehancockc3/>

Spotlight: Patient safety and NCDs (23) Reflections on the IAPO-WHO Patient Safety webinar today

16 September, 2026

Dear HIFA colleagues,

Last week I shared reflections from a WHO webinar on Patient safety and NCDs. <https://www.hifa.org/dgroups-rss/reflections-who-patient-safety-webinar-...>

Today I attended another webinar on Patient safety and NCDs. This one was hosted by WHO in association with the International Alliance for Patient Organisations.

The speakers included Blerta Maliqi, head of the patient safety team at WHO, and Ratna Devi of IAPO.

Panellists included Ferdinand Sonyuy CSEM UHC2030), Iram Esegir, Klaus Von Pressentin (WONCA), Lydia Makaroff

Blerta Maliqi gave a keynote presentation outlining the impact of patient safety and NCDs. She noted that 74% of deaths worldwide are due to NCDs, and that people living with NCDs are especially vulnerable to unsafe care, for several reasons: repeated contact with health services over prolonged periods of time, exposure to devices, multiple medications. There are problems with failure to implement interventions, misdiagnosis, poor communications. She mentioned 'Safer care in every health facility and community', which points to the need to look at patient safety outside of the hospital environment. She also spoke of the importance of supporting health workers to understand and strengthen safety practices. A systematic review is in progress which will be published in April 2027. Preliminary findings suggest that 1 in 6 patients preventable harm while receiving NCD care, and perhaps 1 in 3 for those receiving cancer care. (I'm not sure what the denominator is for this - are we talking 1 in 6 per hospital contact? hospital admission? per year?)

She finished with a call to action: How can patient safety be more integrated into policy and practice?

Panellists emphasised that patient safety is about much more than reducing mistakes, validating that HIFA has consistently highlighted how a failure to meet health workers' needs, particularly their needs for reliable healthcare information, undermines quality of care and patient safety just as much as technical mistakes do. It is encouraging to witness that patient-safety thinking over recent decades has moved from "fix the errors" to "support the people who deliver care.". Patient safety can be compromised at every stage in the journey, from prevention to presentation, referral and diagnosis. Through to multiple aspects of treatment and management. Communication and language are determinants of unsafe care also, including when the healthcare provider is not fluent in the language of the patient. There are safety issues with overworked, understaffed facilities (which was a factor even in the UK hospital where I saw the child with epiglottitis). They also noted the importance of regulation, which to me includes evidence-informed policymaking at large. If the NHS had introduced Haemophilus influenzae vaccine into routine schedules earlier (the vaccine was already available) then the child I saw would have been protected.

Panellists also drew attention to the distress caused to patients by uncertainty, waiting for diagnosis and results of tests. Better communication and information is needed. A leaflet is not enough. (I suspect most patients worldwide do not even get a leaflet or its equivalent.) Patients have to repeat their history multiple times to different health workers.

This made me think of the work of HIFA member Richard Fitten who is advocating for universal access to electronic health records. If this can be achieved, it would have a major impact on patient safety. As Richard has said, the murderer GP Harold Shipman would not have been able to kill so many of his patients if their records had been universally available.

Patient organisations are vital to ensure lived experience is heard, to equip people with tools for advocacy, and to help navigate complex treatment choices. Services include discussion forums and helplines. Helpline. Global organisations provide connection and support for national organisations.

Throughout we heard about the importance of access to reliable healthcare information. Panellists also asked: How can people be better informed to make safe decisions?

Did you participate in the webinar today?

Or do any of the above points resonate with you? Please send a few words to the HIFA forum by email to: hifa@hifaforums.org

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (24) Summary of the discussion so far

16 September, 2026

Dear HIFA colleagues, We have had 22 messages exchanged so far and below is a brief summary. You can see all the messages in full on our website: www.hifa.org/read

You are encouraged to pass this on to your contacts and invite them to join us for the rest of the discussion.

Most important, please do share *your* experience of unsafe care, whether personal or professional. I shared my story of a missed diagnosis of epiglottitis with the hope that you might share yours. I am convinced that we have a huge amount to learn from this exchange. More so than, for example, reading an academic paper or a report.

SUMMARY

The discussion brings together clinicians, researchers, WHO staff, and community health practitioners to explore unsafe care for people living with noncommunicable diseases (NCDs). Contributors emphasise that unsafe care is widespread, often preventable, and deeply rooted in systemic weaknesses rather than individual failings.

Several messages introduce participants and set the context for the Spotlight week, highlighting WHO's 2026 World Patient Safety Day theme ("Safe care for life!") and the five global goals for safer NCD care. Contributors stress that people with NCDs are particularly vulnerable due to long-term treatment needs, polypharmacy, frequent interactions with health systems, and fragmented care pathways.

A major theme is the central role of reliable healthcare information. Multiple contributors argue that lack of access to up-to-date, evidence-based information — both for patients and health workers — is a critical and under-recognised cause of unsafe care. Messages note that WHO's Global Patient Safety Action Plan 2021–2030 insufficiently acknowledges this issue.

The discussion includes powerful personal testimony. One contributor recounts a missed diagnosis of epiglottitis in 1986 that led to severe harm, illustrating how exhausted staff, inadequate staffing, delayed transfers, and lack of system awareness contributed. Charles Vincent expands on this case using James Reason's human factors theory, emphasising that clinicians are often "set up to fail" by system defects.

Contributors from West Africa and the Dominican Republic describe unsafe care in low-resource settings, where weak infrastructure, medicine stock-outs, poor continuity, limited diagnostics, and financial barriers heighten risks. A vivid example from rural Dominican

Republic shows how missed follow-up and fragmented information—rather than dramatic clinical errors—drive harm for patients with hypertension and diabetes.

Across messages, unsafe care is framed as a whole-system problem: failures in primary care, referral pathways, continuity, communication, training, supply chains, and governance. Several contributors call for stronger surveillance, incident reporting, digital health records, patient education, and community engagement.

The discussion closes with calls for shared learning, better integration of patient safety concepts in low-resource settings, and recognition that poor-quality care leading to death is, by definition, unsafe care.

Six verbatim, though-provoking points:

“Poor quality care is unsafe care.”

“Clinical staff are often ‘set up to fail’ by the systems they work in.”

“Unsafe NCD care is rarely due to a single failure.”

“Reliable information sits at the center of this.”

“Blame and recrimination are still far too common.”

With thanks and best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (25) Introduction: Jacob Oommen, Oman - Hospital administration and patient safety

16 September, 2026

Dear HIFA members,

Thank you for welcoming me to HIFA. I am Jacob Oommen, Group Chief Operating Officer at Badr Al Samaa Group of Hospitals, Oman's largest private healthcare group.

I have over 30 years of experience in hospital administration, healthcare finance, and multi-branch clinical operations. My work focuses on healthcare operations, quality and patient safety, and healthcare finance.

I look forward to learning from and contributing to the HIFA community.

You can also find me on LinkedIn: <https://linkedin.com/in/jactvm>

Best regards,

Jacob Oommen

HIFA profile: Jacob Oommen is Group Chief Operating Officer at Badr Al Samaa Group of Hospitals, Oman. Professional interests: Healthcare Operations, Quality and Patient safety, Healthcare Finance jactvm AT gmail.com

Spotlight: Patient safety and NCDs (26) Reflections on the IAPO-WHO Patient Safety webinar today (2)

16 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-23-re...>]

Re. Reflections on the IAPO webinar

Just attended the IAPO webinar. All Presenters were equally engaged yet focused mostly on the theme of “Safe care for NCDs” and not much on its critical intersections with “Safe care for Life”!

In high risk industries, the model of the discipline of Patient Safety, the "black box" model, refers to a system where the *inputs* are known, but the internal processes and mechanisms that transform the inputs into outputs are not directly examined or are opaque.

Based on decades of “lived experience “ of caregiving and engaging with healthcare professionals/ providers, in addition to my own *nonformal *research I realize that EQUITY represents this black box of Patient Safety, where “Safe Care for Life” of NCD patients continue to be invisible in relevant legislation and ethical norms of clinical decision making.

The WHO resources on *Intention to Action* series provide a global model for integrating LE expertise focused on ethical and just representation, which can integrate the WPSD theme with its critical slogan. Even though the IAPO session did not have time to respond to my question(s), I believe that a systematic approach to share and communicate relevant *information* through nonformal participatory learning could translate this vision into reality.

Esha Ray Chaudhuri
Calgary, Canada

HIFA profile: Esha Ray Chaudhuri is an Equity Analyst, in Canada. Professional interests: Equity Issues in Health and Health Care with particular focus on interface of Local and Global contexts. She is affiliated to Patients for Patient Safety Canada-Healthcare Excellence Canada, and is a member of the GLL4QUHC at WHO.

Spotlight: Patient safety and NCDs (27) Reflections on the IAPO-WHO Patient Safety webinar today (3)

16 September, 2026

Kindly note that even though HIFA SPOTLIGHT on Patient Safety and NCDs emphasize on four different aspects of the Theme, the summary below attempts to integrate them into one single commentary.

Quality care is Informed care. A relational process where Caring is achieved through informed efficient, timely communication, centering on the patient as a person for achieving equity and sustaining safety. Unsafe care is uniformed care, lacking the relational aspect and thereby being deprived of the quality measures that are essential for achieving safety.

The WPSD theme “Safe Care for NCDs – Safe Care for Life!”, marks a milestone in the field of Patient Safety. It enhances the individual concepts of both patient and safety using equity as an overarching principle for guiding the field’s path forward. The equity focus sets a transformative point of view that patient safety should consider not only information on individual medical challenges during treatment, but also relevant lifestyle and environmental risk factors, where health equity is determined by ‘the conditions in which people are born grow, live, work, play and age’ (WHO, Health equity and its determinants, 2021). Within this equity based transformative approach, information on patients emphasizing their agency and safety is acknowledged to be a sustainable social and ethical human right.

According to the World Health Organization (WHO, Invisible numbers, 2022), Globally, NCDs are not only the major cause of premature and preventable deaths, but they also threaten the progress of countries to achieve the health and wellbeing objectives of the 2030 Agenda for Sustainable Development. The long-term nature of medically treating NCDs requires access to multiple social and economic resources, which challenges safe care of vulnerable patients, particularly from socially disadvantaged communities. However, equity analysis of health and economic benefits indicate that simple and affordable initiatives to address NCDs, including interventions as part of WHO’s “best buys” (WHO, Saving Lives, spending Less, 2025), lead to better population health outcomes than isolated clinical medical efforts for curing the illness (OECD, Health and Economic Benefits of Tackling NCDs, 2026).

In Canada, NCDs are a major public health challenge and require an integrated approach to address root causes of diverse risk factors such as air pollution, diet and nutrition, tobacco and alcohol use, income and physical activity (OECD, Health and Economic Benefits of Tackling NCDs: Canada, 2026). This is supported by the WPSD objective of integrating “patient safety principles across NCD-related legislation, policies, strategies and programmes, with an emphasis on strengthening PHC-oriented health systems

Information related to NCDs need to be communicated within an integrated approach .Recognition of “Safe Care for NCDs” integrated with “Safe Care for Life!” indicate the most pressing issues facing healthcare often relate to (a) addressing the impact of upstream social factors on individual health and (b) acknowledging the interdependence of health systems and other sectors of Ethical, Legal and Social Issues (ELSI). These challenges are seldom addressed within an individual disease-based patient safety approach. Information on intersectional factors of sustainable well-being of NCD patients and integration of their lived experience insights in design, implementation and evaluation of Care approach can respond to persisting inequities within the healthcare and social systems enhancing the value of informed quality care.

Esha Ray Chaudhuri PhD
Patient Advocate / Health Equity Analyst
Calgary, Canada

HIFA profile: Esha Ray Chaudhuri is an Equity Analyst, in Canada. Professional interests: Equity Issues in Health and Health Care with particular focus on interface of Local and Global contexts. She is affiliated to Patients for Patient Safety Canada-Healthcare Excellence Canada, and is a member of the GLL4QUHC at WHO.

Spotlight: Patient safety and NCDs (28) Introduction: Mostafa Shakshak, Egypt - Patient Safety, Emergency Public Health & Humanitarian Response

16 September, 2026

Dear HIFA Members,

Thank you to Dr. Neil and Dr. Meena for the warm welcome.

I am delighted to join this esteemed global community.

My name is Mostafa SHAKSHAK, and I am a global public health and humanitarian emergency response professional.

Currently, I serve as the Migration Health Officer with the UN Migration Agency (IOM) in Bangui, Central African Republic, where I manage migration health operations and emergency responses.

My field experience spans across the Middle East and Africa, focusing on emergency coordination, health cluster management, and health system strengthening in complex environments. Previously, I had the privilege of working with WHO as a Field Coordination Specialist during the crisis in Sudan, as well as holding public health and human-centered design roles with IOM in Djibouti and UNICEF in Egypt.

My professional and academic interests are deeply aligned with HIFA's mission to promote reliable healthcare information.

I recently completed my Master's in Global Public Health, with my research focusing on access to care for Non-Communicable Diseases (specifically Chronic Kidney Disease) in conflict-affected regions of Sudan. Working on the ground in these low-resource settings has shown me firsthand how critical robust health data systems and access to reliable information are for patient safety and saving lives.

I look forward to learning from all of you, sharing insights from the field, and exploring ways we can collaborate to improve health access for vulnerable populations.

I would be very happy to connect with you all on LinkedIn : Mostafa SHAKSHAK

<https://www.linkedin.com/in/mostafashakshak/>

Best regards, Mostafa

HIFA profile: Mostafa Shakshak is a Global Health Professional - Emergencies, United Nations Migration Agency - IOM. He is based in Egypt. Professional interests: Global health, humanitarian medical missions, expanding access to reliable healthcare information, and patient safety in low-resource settings. Mos.shakshak AT gmail.com

Spotlight: Patient safety and NCDs (29) Reflections on the first 3 days of our discussion

17 September, 2026

Dear HIFA colleagues,

Today is World Patient Safety Day and the theme this year is "Safe care for noncommunicable diseases".

HIFA is marking this week with a global online discussion in collaboration with WHO

www.hifa.org/patientsafety

Thank you to all who have made contributions on this subject in the past few days, and welcome to the many new members who are joining us each day.

You can read a summary of the discussion so far here: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-24-su...>

and all the messages in full here: www.hifa.org/read

If you have not yet sent a message, please do so. To send a message, simply send a brief email to: hifa@hifaforums.org and we'll ensure it is distributed.

I can see at least four gaps in our discussion so far (perhaps you can see others):

1. Personal experience. I sent a message about my experience of missing a diagnosis of epiglottitis. I am sure that we can learn a lot from such experiences and I urge you to say a few words about your experience of unsafe care, whether you were personally involved as a health professional or indeed as a patient or relative. Email hifa@hifaforums.org
2. Patient safety and NCDs. NCDs is the focus of our discussion but paradoxically we have not said much about patient safety issues in relation to NCDs. We have noted that people with NCDs have a much higher risk of harm, for several reasons. It would be great if you would like to say more about this, perhaps with examples?
3. Patient safety in low resource and conflict settings. Again, we have not discussed this aspect in any depth. I have noticed that in the past few days we have welcomed new members with specific experience in these areas, including health professionals working with agencies such as ICRC in humanitarian and conflict settings such as Sudan. What approaches work to improve quality of care and patient safety in such challenging circumstances?
4. Most of our discussion has been around patient safety in hospitals and health facilities, but we have said little about patient safety in the home and community. Can anyone fill the gap? In what ways, for example, can self-care and care by relatives and by community health workers be made more safe?

These questions come to mind in addition to the original four guiding questions for this discussion.

1. What is unsafe care and what is its local and global impact?
2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?
3. What can be done to better understand and improve health systems for safer care for people living with NCDs?
4. How can we better support patients and primary and facility-based health workers to deliver safe care?

With best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries,

interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (30) A missed diagnosis of epiglottitis (5)

17 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-22-mi...>]

Dear Christine,

Thank you for your kind message. It was hard to write the original message. My intention was to give an example of a patient safety incident from my own experience, and thereby encourage other HIFA members to share their experience. We haven't yet heard any other personal experiences yet, whether from a health worker or patient/family perspective. I am convinced that such sharing can help us to understand the impact of unsafe care and its causes.

You say "I could share much greater physician errors that I've witnessed in my career". It would be interesting to hear more about these, from you and from others. Please email to:

hifa@hifaforums.org

I am sure we could identify hundreds of examples from the literature but communication is more powerful and educational when it is personal.

"That counselling you should have been offered is not too late..." Yes, I am sure it would have been very helpful at the time. More so, it would have been helpful to have a hospital review of the case, which I believe would have made it clear to me that the primary factors were systems-related rather than 'my fault'. Although I submitted my own account I did not see an overall account of the case. I was left to 'get on with it'. As Charles Vincent said in his response, 'This was indeed the understanding of error and harm that was common at that time when I was working on errors in medicine as a researcher in an emergency department. We now understand that the great majority of events that harm patients have a much more complex set of causes and contributory factors.'

<https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-11-mi...>

Preparing and sending my account to HIFA has turned out to be cathartic and healing for me. I reviewed my own statement from 1986 and came to realise more fully that I was indeed 'set up to fail' by the systems I was working in. Looking back objectively, I provided reasonable care (and so did my registrar). The factors that contributed to the death were primarily health system factors.

Over 40 years I had felt some responsibility to have 'missed' the diagnosis of epiglottitis at the first assessment. Only while preparing my account did I read that epiglottitis is notoriously difficult to diagnose and that 80% of cases are not diagnosed at first assessment. It's curious that I did not learn this at the time - that would have been very helpful. In effect, now I realise that I did what any other junior doctor in paediatrics would have done.

Out of curiosity, I asked Copilot 'how many patient safety incidents occur in a doctor's career?' and it answered 'a typical doctor will be involved in hundreds to thousands of patient-safety incidents over a full career. Only a minority of these are due primarily to an error by the doctor.'

Most incidents arise from system failures, workload, communication breakdowns, equipment problems, or team-level issues, not from a single clinician's mistake.'

If other HIFA members are willing to share an experience of unsafe care, we can all learn from this, as I hope you have from my example. Email: hifa@hifaforums.org

All the above begs a further question: How best to support a health worker who HAS made a serious error, perhaps resulting in disability or death. And how to prevent such errors.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (31) Improving patient safety in low-resource settings

17 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-22-in...>]

Dear HIFA Colleagues

Neil suggested I say a bit more about understanding and improving safety in low-resource settings (Aim 3). Clearly increasing resources is the most important long-term objective. However, it is also possible to improve the safety and quality of care using some methods that are applicable to any healthcare setting, indeed to any safety-critical industry. My own approach would be to focus on the safety of care in the first instance essentially targeting care that is very poor quality or even dangerous and which may leave patients in a worse state than before they entered treatment.

Many well-intentioned interventions do not gain traction because they do not give enough attention to initial 'system diagnosis', which is discovering the strengths and weaknesses of the existing system. Sending donations of equipment into a setting for instance will fail if there is no capacity for maintenance of that equipment. Implementing guidelines from well-resourced systems may simply put impossible strain on a lower resource setting.

There are a variety of techniques that can be used to assess the system. These include process mapping, incident analysis, interviews, observation and ethnography. These are research methods, but can be used in a simpler form to make a rapid assessment of strengths and weaknesses. This is a very revealing process even for experienced clinicians who may have worked in the setting for a long time.

There are also a range of approaches to improving safety. Targeting critical safety processes, like hand washing and patient identification, may be a good first step leading on to wider changes to the system, such as through improved communication and organisation of teams. Some risks

can be controlled by restricting the care that is provided, limiting the use of complex techniques that cannot be managed in the setting.

Some Oxford and Kenyan colleagues and I made an initial attempt to summarise these approaches in these open access publications. Each of the papers has references to useful practical resources

<https://adc.bmj.com/content/106/4/326>

<https://adc.bmj.com/content/106/4/333.abstract>

This is also a really useful short paper led by Albert Wu about using low-tech solutions to cope with safety issues in low-resource settings. Doing more with less.

<https://journals.sagepub.com/doi/full/10.1177/25160435261445192>

I hope these papers and links might be of some help to HIFA colleagues. There are many more available. Health Information must of course focus on providing up to date and relevant information on clinical issues. However, we also need to share information about improving health systems if we are to improve the safety of care.

Best wishes

Charles

HIFA profile: Charles Vincent trained as a clinical psychologist and worked in the British NHS for several years. Since 1985 he has focused on conducting research on the causes of harm to patients, the consequences for patients and staff, and methods of improving the safety of healthcare. [charles.vincent AT psy.ox.ac.uk](mailto:charles.vincent@psy.ox.ac.uk)

Spotlight: Patient safety and NCDs (32) A missed diagnosis of epiglottitis (6)

17 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-13-mi...>]

Thank you Neil for sharing that the missed diagnosis of epiglottitis was your own story. I had not realised that when I wrote my response discussing the wider issues that your story illustrated.

I think that the sharing of such stories is very helpful, particularly to younger people working in healthcare, who may feel very alone when such things happen.

These stories are also a wonderful way of teaching people about safety as one can carry out analyses and uncover all the system factors that played in to the final outcome

Best wishes

Charles

HIFA profile: Charles Vincent trained as a clinical psychologist and worked in the British NHS for several years. Since 1985 he has focused on conducting research on the causes of harm to patients, the consequences for patients and staff, and methods of improving the safety of healthcare. charles.vincent@psy.ox.ac.uk

Spotlight: Patient safety and NCDs (33) Reflections on the first 3 days of our discussion (2)

17 September, 2026

Dear HIFA colleagues,

It's a great opportunity for all of us to voice our opinions and concerns about 'unsafe care' and 'Patient safety in NCDs'. I already responded to Q 1 and 2 of the 4 guiding questions in my previous HIFA global discussion forum.

[see: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-10-q2...>]

1. What is unsafe care and what is its local and global impact?
2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?
3. What can be done to better understand and improve health systems for safer care for people living with NCDs?
4. How can we better support patients and primary and facility-based health workers to deliver safe care?

In response to Q3. What can be done to better understand and improve health systems for safer care for people living with NCDs?

Addressing Patient Safety requires a multisectoral approach; therefore, investing in strengthening the health systems is crucial.

NCDs require a long-term care strategy, from empowering patients with reliable information on risk factors to prevent NCDs, seeking care, awareness of their treatment, follow-up after treatment, and multiple referrals (specialities and/ or to a higher level health facilities).

In response to Q4. How can we better support patients and primary and facility-based health workers to deliver safe care?

Several decades ago, I served in a rural, remote mission hospital which, due to a shortage of doctors, required multi-skilled responsibilities. I performed surgeries in obstetrics, gynaecology, and anaesthesia.

I now realise why so many women came to the hospital at late stages of breast and cervical cancer, because, in those days, digital/media communication on advances in scientific research was inadequate.

With recent advancements in digital technology, are we better informed with reliable health information or misinformation or disinformation?

In health facilities in LMICs even today, we see patients with delays in seeking care, late diagnosis, inappropriate treatment, and often inadequate follow-ups, referrals, and medication errors at home.

Therefore, it's crucial to provide updated evidence-based protocols and patient-health provider communication skills at the primary and community level of health facilities.

Best wishes

Dr. Meena Nathan Cherian, MBBS, MD (Anaesthesia)
(Former WHO Lead Emergency and Essential Surgical Care Program, Geneva, Switzerland).
Director, Global Health New Challenges: Geneva Foundation for Medical Education & Research,

Switzerland. <<http://www.gfmer.ch/surgery/cancer.htm>> www.gfmer.ch/surgery/cancer.htm (NSA-WHO)

Senior Advisor Global Action International Society of Geriatric Oncology Permanent Committees - SIOG <<https://siog.org/about-us/governance/leadership/permanent-committees/>>

Senior Advisor, International College of Surgeons-Global Affairs. <<https://icsglobal.org/>> <https://icsglobal.org/> (NSA-WHO)

Adjunct Prof.The Chinese University of Hong Kong,Shenzhen,China.

<<https://med.cuhk.edu.cn/en/teacher/371>> <https://med.cuhk.edu.cn/en/teacher/371>

WHO-HIFA Essential Health Services; mHEALTH-INNOVATE. <<http://www.hifa.org/>> www.hifa.org (NSA-WHO).

Geneva, Switzerland. <mailto:+41%20763837253> +41 763837253(m);
cherianm15@gmail.com

HIFA profile: Dr Meena Nathan Cherian was a professor of anaesthesiology from Christian Medical College Hospital, Vellore, India. She trained, worked, and taught in several countries, USA (Johns Hopkins Hospital), Southeast Asia and Africa. She worked at the World Health Organization Headquarters, Geneva, Switzerland, as the Emergency and Essential Surgical Care Program Lead where she created the 'surgical care' program resulting in the first World Health Assembly Resolution on 'Emergency and Essential Surgical Care and Anaesthesia in the context of Universal Health Coverage'. Currently she works as the Director, Global Health New Challenges program, Geneva Foundation for Medical Education and Research, Geneva, Switzerland; Adjunct Prof. The Chinese University of Hong Kong, Shenzhen, China; Senior Advisor, Global Action, International Society of Geriatric Oncology, Switzerland; Member of the WHO-HIFA Working Group on Essential Health Services and COVID-19; and HIFA mHEALTH-INNOVATE Working Group. She is a member of the HIFA Steering Group.
<https://www.hifa.org/support/members/meena> cherianm15 AT gmail.com

Spotlight: Patient safety and NCDs (34) Reflections on the first 3 days of our discussion (3)

17 September, 2026

Dear HIFA colleagues

It's interesting to read all the messages to date please click: www.hifa.org/read

Best wishes

Dr. Meena Nathan Cherian, MBBS, MD (Anaesthesia)

(Former WHO Lead Emergency and Essential Surgical Care Program, Geneva, Switzerland).

Director, Global Health New Challenges: Geneva Foundation for Medical Education & Research, Switzerland. <<http://www.gfmer.ch/surgery/cancer.htm>> www.gfmer.ch/surgery/cancer.htm (NSA-WHO)

Senior Advisor Global Action International Society of Geriatric Oncology Permanent Committees - SIOG <<https://siog.org/about-us/governance/leadership/permanent-committees/>>

Senior Advisor, International College of Surgeons-Global Affairs. <<https://icsglobal.org/>> <https://icsglobal.org/> (NSA-WHO)

Adjunct Prof.The Chinese University of Hong Kong,Shenzhen,China.

<<https://med.cuhk.edu.cn/en/teacher/371>> <https://med.cuhk.edu.cn/en/teacher/371>

WHO-HIFA Essential Health Services; mHEALTH-INNOVATE. <<http://www.hifa.org/>>

www.hifa.org (NSA-WHO).

Geneva, Switzerland. <mailto:+41%20763837253> +41 763837253(m);
cherianm15@gmail.com

HIFA profile: Dr Meena Nathan Cherian was a professor of anaesthesiology from Christian Medical College Hospital, Vellore, India. She trained, worked, and taught in several countries, USA (Johns Hopkins Hospital), Southeast Asia and Africa. She worked at the World Health Organization Headquarters, Geneva, Switzerland, as the Emergency and Essential Surgical Care Program Lead where she created the 'surgical care' program resulting in the first World Health Assembly Resolution on 'Emergency and Essential Surgical Care and Anaesthesia in the context of Universal Health Coverage'. Currently she works as the Director, Global Health New Challenges program, Geneva Foundation for Medical Education and Research, Geneva, Switzerland; Adjunct Prof. The Chinese University of Hong Kong, Shenzhen, China; Senior Advisor, Global Action, International Society of Geriatric Oncology, Switzerland; Member of the WHO-HIFA Working Group on Essential Health Services and COVID-19; and HIFA mHEALTH-INNOVATE Working Group. She is a member of the HIFA Steering Group.

<https://www.hifa.org/support/members/meena> cherianm15 AT gmail.com

Spotlight: Patient safety and NCDs (35) Reflections on the IAPO-WHO Patient Safety webinar today (4) Recording of IAPO-WHO webinar

18 September, 2026

Dear HIFA colleagues,

IAPO has just announced that the recording of their webinar on 16 September is now available on YouTube: <https://youtu.be/de8Q1zJu5vk?si=keSuoMjTVQRSUrB->

Below is their message:

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Happy World Patient Safety Day 2026!

Yesterday's global webinar, co-hosted by IAPO and NCD Alliance, with moderation by Dr @SITA RATNA DEVI DUDDI and an opening address by Dr @Blerta Maliki, had an amazing turnout. Thank you to everyone who joined us!

The panel brought together representatives from the NCD Alliance's Our Views, Our Voices initiative, the Civil Society Engagement Mechanism for UHC2030, the Multiple Sclerosis International Federation, and the WONCA Working Party on Quality and Safety for a rich discussion that sparked strong engagement and comments from participants.

In case you missed it, the recording is now available on IAPO's YouTube channel — follow us and share it within your networks. Join us in raising awareness for safer NCD care for all!

<https://youtu.be/de8Q1zJu5vk?si=keSuoMjTVQRSUrB->

==

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of

universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (36) The role of reliable healthcare information (2)

Introduction: Archana Seahwag, India

18 September, 2026

Dear HIFA colleagues,

Greetings from India.

I am Dr Archana Seahwag (MBBS, DTMPH, MSc International Health), a physician and global public health professional with over 15 years of experience across clinical medicine, epidemiology, health systems, maternal and newborn health, infectious diseases and international health.

My professional experience includes working with the World Health Organization (WHO) Headquarters in Geneva, where I contributed to programmes spanning life-course health, maternal and newborn health, health emergencies, and research and development initiatives. I have also worked with government, academia and international development partners, including on country-level health profiles and public health programmes across multiple countries.

I have a particular interest in the intersection of health information, health literacy, evidence-informed decision-making and equitable access to quality healthcare. My experience across different health systems has reinforced my belief that reliable, accessible and actionable health information is itself an important determinant of health — and that translating evidence into information that people, communities and health workers can understand and use remains a critical global challenge.

I am therefore very pleased to join the HIFA community and look forward to learning from fellow members and contributing to discussions around universal access to reliable healthcare information, health systems strengthening, maternal and newborn health, and the effective translation and dissemination of evidence.

I would also be very interested in exploring potential collaborations with HIFA members and partners where my experience in global public health, WHO programmes, epidemiology and health systems may be useful.

I would be happy to share my CV or a more detailed professional profile if useful in exploring potential collaborations.

I look forward to engaging with the HIFA community and learning from you all.

Warm regards,

Dr Archana Seahwag
MBBS | DTMPH | MSc International Health
Global Public Health & Health Systems
India

HIFA profile: Archana Seahwag is an International Health & Tropical Medicine professional, self-employed, India. Professional interests: Global Public / International Health archanaseahwag AT gmail.com

Spotlight: Patient safety and NCDs (37) The role of reliable healthcare information (3)
Videos on locating and removing non-palpable contraceptive implants (2)

18 September, 2026

Dear HIFA colleagues,

We have just heard from Deborah van Dyke about the new Global Health Media Project videos on locating and removing non-palpable contraceptive implants. Thank you Deborah for keeping us updated on your excellent work.

I have watched the first of these and the central message is clear: removal should not be attempted unless the precise location of the implant is known, whether by palpation or ultrasound.

I did a quick google search on complications of contraceptive implant removal and found that these are uncommon compared with other surgical procedures but can be serious. Here is a case study and a comment from me below.

==

'A 21-year-old woman presented to our hand and peripheral nerve clinic 4 months after attempted Nexplanon® removal from her left arm. The patient reported that neither she, nor her nurse practitioner (NP), was confidently able to feel the Nexplanon® before the attempted removal. ***Imaging studies to confirm location of the Nexplanon® were not performed*** [my emphasis] The patient remembered a small incision being made at the site of insertion after local anesthetic was injected. The provider was not immediately able to find the Nexplanon®, but after exploring the local area, did grasp another structure in her arm. The patient felt an “electric shock” sensation that radiated down to her medial elbow as the NP pulled. No further attempts to remove the Nexplanon® were undertaken.

'Immediately after the removal attempt, the patient had complete numbness in her small and ring fingers. She returned for follow up to her NP. As months progressed, the numbness did not improve, and she began to notice wasting of her hand muscles and weakness in her grip. At almost 4 months after the attempted removal, her NP ordered a nerve conduction study which showed 50% loss of ulnar nerve function.

'On presentation to the office, she had classic signs of severe, chronic ulnar nerve injury: wasting of the ulnar nerve-innervated intrinsic muscles of the hand, a claw position of the ring and small fingers, and dense numbness in an ulnar sensory nerve distribution (Fig. 1). On examination of her arm, there was a well-healed incision with surrounding scar tissue from the extraction attempt. The Nexplanon® was not palpable. X-rays showed the radio-opaque Nexplanon® at the junction of the proximal and middle thirds of the humeral shaft with the most distal end 16.5 cm proximal to the medial epicondyle.'

'At 7 months after nerve reconstruction, the patient had weak grade 2/5 function of ulnar innervated muscles. She still had dense numbness in an ulnar nerve distribution. She did have an advancing Tinel's sign on physical exam and reported intermittent paresthesias in an ulnar

nerve distribution in her hand.... our case strongly supports the manufacturer's recommendation that extraction should not be attempted without knowing the exact location of the device...'

==

COMMENT (NPW): We are not told whether the health professional who tried to remove the implant was unaware of the rule never to attempt removal without precise location, or if they 'knew' this but ignored it. It would have been interesting to read the internal case report from a patient safety perspective to assess the determinants of this unsafe care episode.

The case underlines that 'uninformed care is unsafe care'. In a previous message I pointed out that the WHO Global Patient Safety Action Plan appears to ignore this determinant. 'Over two decades, HIFA has consistently highlighted how a failure to meet health workers' needs, particularly their needs for reliable healthcare information, undermines quality of care and patient safety just as much as technical mistakes do. Over this period, patient-safety thinking has moved from "fix the errors" to "support the people who deliver care."' I have not been able to read the whole plan in detail, but it seems to me that the plan seems stuck in information and awareness about patient safety principles rather than clinical knowledge as a determinant of unsafe care.

If other HIFA members accept this point, I would suggest that clinical knowledge as a determinant of unsafe care should be specifically integrated into the current Global Patient Safety Action Plan. Our current discussion can serve as a starting point.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (38) Too many doctors spoil the broth

18 September, 2026

My message below is in response to Dr Neil Pakenham-Walsh's request for HIFA members to share their experiences relating to patient safety.

There is an old joke in which an engineer, an architect and a doctor are arguing about which profession is most common. The architect and engineer make their cases, citing population statistics, facts and figures. The doctor leans back and quietly states that he has been suffering from headaches lately. Immediately, the engineer suggests stress, the architect recommends painkillers, and another friend suggests an eye test. The doctor laughs: "You see? Everyone is a doctor!"

The serious aspect of the joke came to mind as I reflected on the experience (from some years ago) of a relative in a low-income country, where access to private healthcare was increasing among the middle classes.

After returning from a holiday, people commented that one of her eyes appeared smaller than the other. They encouraged her to consult one of the country's leading ophthalmologists, who found nothing obviously wrong but prescribed eye drops. When these made no difference, a relative who'd had Bell's palsy suggested she see another doctor. The doctor agreed it was Bell's palsy and prescribed steroids – but these made no difference.

Meanwhile, other relatives had noticed that she was walking differently and that her balance seemed poor. This was attributed to an old toe injury and ageing. She was eventually seen by a well-known orthopaedic surgeon, who performed a minor procedure on the toe. Her walking did not improve – in fact, it became worse. Her hearing impairment, which she had had since childhood, also seemed to be deteriorating; this too was attributed to age.

Eventually, a family member persuaded her to seek assessment overseas. There, she was diagnosed with a large acoustic neuroma (vestibular schwannoma). Although benign, it was sufficiently large and close to the brainstem to be potentially life-threatening. Most of the tumour was removed, but she has been left with lasting problems.

Looking back, I see two main patient-safety issues.

First, there was fragmentation. Different symptoms were considered separately, there was apparently no one putting them together, and when initial treatments did not help, there was not always effective follow-up or reassessment. Several symptoms were attributed to pre-existing problems or ageing rather than prompting a broader review. The eventual delay in diagnosis resulted in significant and lasting harm.

Second, there was the “everyone is a doctor” problem. Family members and other non-medical people were understandably trying to help, but were making medical suggestions that influenced the patient's decisions. This highlights another important aspect of patient safety: people need access to reliable, understandable health information so that they can recognise concerning symptoms, know when and how to seek appropriate care, and distinguish informed advice from plausible-sounding speculation.

Perhaps the lesson is that patient safety requires much more than just having more doctors available. It requires continuity within healthcare, a robust system through which disjointed health professionals can communicate, centralised records, effective follow-up, an understanding by patients of “trusted” sources and, of course, access to reliable health information.

Best wishes

Julie

HIFA profile: Julie N Reza is a UK-based specialist in communications for biosciences, global health & international development (www.globalbiomedia.co.uk). She predominantly works with NGOs and not-for-profit organisations. Previously she was the senior science editor at TDR, based at the World Health Organization (WHO) in Geneva; prior to this she worked at the Wellcome Trust, UK, leading educational projects on international health topics including trypanosomiasis and trachoma. She has a PhD in immunology and a specialist degree in science communication. She also has several years research and postgraduate teaching experience. She is a member of the HIFA Steering Group and HIFA Social Media Working Group.

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Spotlight: Patient safety and NCDs (39) BBC news: Twenty women had breasts removed needlessly, says NHS trust

18 September, 2026

Dear Neil & HIFA colleagues,

I am sure the following news story reported by the BBC has caught the attention of many UK HIFA members, but I'm sharing it here as no doubt there are problems/issues highlighted that also affect other countries. <https://www.bbc.co.uk/news/articles/c9qrn3y72dxo>

A few quotes that caught my attention:

"....outsourcing patient appointments had created financial incentives which were potentially "a risk to clinical standards"."

"Concerns were also raised last year ... that breast cancer cases had not been discussed properly in multi-disciplinary team meetings (MDTs)."

"... decisions about patients' cases were being made based on the unchallenged opinion of individual surgeons..."

"...patients were potentially treated by locum consultants who were not competent..."

"... repeatedly raised concerns about trust delays in obtaining vital diagnostic equipment."

And from the patient's perspective:

"...the apology was "all good and well" but will not bring her breast back."

Best wishes

Julie

HIFA profile: Julie N Reza is a UK-based specialist in communications for biosciences, global health & international development (www.globalbiomedia.co.uk). She predominantly works with NGOs and not-for-profit organisations. Previously she was the senior science editor at TDR, based at the World Health Organization (WHO) in Geneva; prior to this she worked at the Wellcome Trust, UK, leading educational projects on international health topics including trypanosomiasis and trachoma. She has a PhD in immunology and a specialist degree in science communication. She also has several years research and postgraduate teaching experience. She is a member of the HIFA Steering Group and HIFA Social Media Working Group.

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Spotlight: Patient safety and NCDs (40) Introduction: Ikram Esegir, Morocco - The importance of lived experience

18 September, 2026

Dear HIFA colleagues,

Greetings from Morocco.

My name is Ikram Esegir. I am the President of NABD-BC2 Association for breast cancer, a patient advocate, Vice-President of the Moroccan Alliance of Cancer Patient Associations and a member of the NCD Alliance Our Views, Our Voices Global Advisory Committee.

I am pleased to join the HIFA community following the recent IAPO webinar on patient safety and NCDs, where I contributed from the perspective of lived experience.

My work focuses on cancer advocacy, access to care, patient education, supportive care and the meaningful involvement of people living with NCDs in health policies and services. I firmly believe that lived experience constitutes essential evidence for patient safety. People living with NCDs can identify gaps that healthcare systems may overlook, including delayed diagnoses, fragmented referrals, medicine shortages, inadequate communication and unsafe transitions between hospital and home.

I look forward to learning from HIFA members, sharing experiences from Morocco and the wider Eastern Mediterranean region, and contributing to discussions on equitable access to reliable healthcare information and safer NCD care.

Warm regards,

Ikram Esegbir

Ikram ESEGHIR

Patient advocate expert

Founder and president of NABD-BC2

Best Care for Breast Cancer Association

Morocco

Tel: 212 662144509

Email: esegbir.nabdbc2@gmail.com

NABD-BC2 Website <<https://nabdbreastcancer.com/>>

NABD-BC2 - YouTube <<https://www.youtube.com/@NABD.BC2>>

Facebook

<https://web.facebook.com/profile.php?id=100089826341223&_rdc=1&_rdr#>

"NABD-BC2 Association" | Recherche | LinkedIn

<<https://www.linkedin.com/search/results/all/?heroEntityKey=urn%3Ali%3Aor...>>

Association Cartography <<https://nabdbreastcancer.com/map/>>

HIFA profile: Esegbir Ikram is a Patient advocate expert, lived experience, founder and president of NABD-BC2 Association, Morocco. Professional interests: Breast cancer, meaningful engagement of people living with NCDs , advocacy, supportive care, UHC, HTA. Email address: esegbir.nabdbc2 AT gmail.com

Spotlight: Patient safety and NCDs (41) Q1. What is unsafe care and what is its local and global impact? (4)

18 September, 2026

It is widely said in the patient safety community that unsafe care causes 3 million deaths per year.

It is separately estimated (Kruk et al 2018) that poor-quality care leads to 5 million deaths per year. We have shown that this is an underestimate because it only includes care in facilities. It does not include care in the home or community, which we know to be a strong determinant of avoidable death.

If we accept that poor quality care that leads to death must by definition be unsafe, then the actual deaths due to unsafe care are likely to be at least 5 million rather than 2 million.

Unsafe care can lead to death or to minor or major harm. Often it will lead to no substantial harm and will be completely invisible - a matter of luck for the healthcare provider and, especially, the patient.

We have also learned that 'Around 1 in every 10 patients is harmed in health care and more than 3 million deaths occur annually due to unsafe care'. <https://www.who.int/news-room/fact-sheets/detail/patient-safety> We have asked on this forum what this actually means - 1 in every 10 patients per treatment episode? per year? over a lifetime? I have been unable to find a denominator which would make this statistic meaningful.

Also, how do we define 'harm'? At one end of the spectrum is avoidable death, but the other end of the spectrum is unclear. If a patient has a significant but minor side effect from a drug that was given incorrectly or in the wrong dose, is this counted as '1 in 10 patients is harmed'? We wait for answers.

Looking even more broadly, what is the definition of 'unsafe care'? Probably the majority of incorrect decisions and actions made in healthcare do not actually result in harm, but such care remains unsafe.

I was unable to find a definition of unsafe care on the WHO website or in the Global Patient Safety Action Plan.

It could be argued that any decision or action that is not informed by the cumulative available evidence represents 'unsafe care'. In this case every single one of us has most certainly been a recipient of unsafe care at many points in our lives, even if that care did not result in measurable harm.

I look forward to read your thoughts. Email to: hifa@hifaforums.org

Many thanks, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

[...42] Reflection on safe care for NCD in unsafe corners of the world

18 September, 2026

Dear Neil,

Here is a small contribution from my side.

Best, Sanja

Reflection on safe care for NCD in unsafe corners of the world

For over a decade I was deployed in conflict related emergency settings as anaesthetist, mainly in LMICs where most of the conflict were/are happening.

While the main focus of surgical response in such contexts is on trauma and emergency surgery, the safe care for patients requires for surgery not to be seen as a standalone activity, but rather as part of continuum of care, that includes also NCD management.

There cannot be safe surgery & anaesthesia if we are not able to provide also SAFE perioperative care for patients affected by NCDs.

Especially, when knowing that almost three quarter of NCD related deaths are happening in low and middle-income countries, and in times of humanitarian crises this burden becomes even higher. Health priorities shift towards other acute needs and access to healthcare is way more difficult. There is a shortage of medical professionals, disruption in supply of NCDs drugs and diagnostic tools that leads to interruption in treatment, but also missed diagnoses and lack of awareness.

Several efforts over last decade were made to improve NCD management in humanitarian settings. The Interagency working group, led by the United Nations High Commissioner for Refugees, was composed of members of the World Health Organization, Médecins Sans Frontières, the International Committee of the Red Cross (ICRC), the International Federation of the Red Cross, and others in 2018, published a report "Operational Guidelines of NCD management in humanitarian settings". Subsequently, the ICRC has adapted this report to provide operational guidance to address and address the burden of NCDs in emergency settings through integrated approach that combines ICRC's overall activities throughout initial, acute and continuing response phases.

<https://www.icrc.org/en/publication/4456-managing-projects-addressing-no...>

Considering WHO proposed set of Goals to facilitate safe care for NCDs in regards to humanitarian response most efforts will be on Goal 4 (secure access and safe medication) and on Goal 5 (strengthen care coordination, continuity and transition of care). While other three goals are equally important, they might not be fully integrated in the humanitarian response, especially Goal 2 that concerning prevention and risk assessment.

There is still a big gap in addressing NCDs such context but it is great to see that lots of joint efforts a put forward to address these needs.

HIFA profile: Sanja Janjanin is an Anaesthetist with the ICRC, Italy. Professional interests: Patient safety and anaesthesia in LMIC, Global & Environmental health, Conflict & Health. smizlica AT yahoo.com

Spotlight: Patient safety and NCDs (43) Continuity, patient engagement and reliable healthcare information

19 September, 2026

Dear Neil and colleagues,

Thank you for pulling these threads together. They gave me a reason to look back on my own early days of practice and write the reflection below, which I think speaks to several of the questions on the table.

As yesterday was World Patient Safety Day 2026, and coincidentally Thursday, It took me straight back to my early days of practice as a clinical pharmacist, when Thursday meant something very specific at Massawa Zonal Referral Hospital.

Back then, Thursday was NCD day. My colleagues and I would wake around 5 a.m. to see our regular patients until 8, then jump straight into the normal daily routine like nothing had happened. Those mornings were some of the most fulfilling hours of the week. Most of our patients were from the older generation, living with one, sometimes several, NCDs at once. Some had carried that weight for years and made peace with it. Others were still new to it, still trying to understand a diagnosis that had just turned their world upside down.

Seeing those same faces every Thursday gave us a bond you don't get with regular outpatients. It pushed us to do more than expected: to show up fully, provide extra patient education, and run a support group where everyone could feel heard and valued. Healthcare rooted in "quality, safety, commitment, and compassion." Slowly, that earned their trust and that trust fuelled adherence to medication and to advice on lifestyle and nutrition, which showed in better outcomes and quality of life.

As already discussed before, Safe and quality NCD care requires shared action from governments, health systems, professionals, patients, caregivers, communities and civil society.

In low-resource settings like here in Africa, where our people already carry so much just to get through an ordinary day, I believe we owe them that EXTRA MILE now more than ever.

On patient safety and NCDs (Q2) [What are the main causes of unsafe care for people living with NCDs?]: the risk we saw most often wasn't a single dramatic error, it was accumulation. Someone managing two or three conditions at once, on multiple medications, with limited health literacy and no one coordinating the whole picture. A missed follow-up or a misunderstood dosage rarely looked dramatic in the moment, but it compounded over months.

On low-resource settings (Q3) [What can be done to better understand and improve health systems for safer care?]: Massawa is exactly that kind of setting stretched staff, limited resources, patients travelling from far. What worked for us wasn't a system upgrade, it was continuity, protected deliberately rather than assumed. Three things made it hold:

First, a fixed weekly slot. Thursday clinic wasn't fitted around other duties; the day moved around it. Patients knew exactly when to return.

Second, the same faces. We didn't rotate staff, so nothing had to be re-explained, and changes like a new symptom, a slipping routine or a supply problem were noticed because we knew what "normal" looked like for that person.

Third, a low-tech shared record. A simple register that travelled with the patient and stayed with the clinic, so the plan, medications, and last conversation were visible to whoever was on duty. In a setting without a working electronic system, that paper trail was the coordination.

None of this required more money, just protecting a slot, keeping a team stable, and writing things down. In low-resource settings, that kind of continuity isn't a luxury add-on to safe care; it is the safety mechanism, because it catches problems before they compound.

On safety in the home and community (Q4): our support groups existed precisely because so much of NCD management happens after the patient leaves the clinic. Patient education and a

space to ask questions without judgement did as much for safety as anything we did clinically. We also found that family members' understanding of the condition mattered as much as the patient's: where relatives understood the medication schedule and the lifestyle changes involved, adherence was noticeably stronger.

We also organised patients into committees by condition, as diabetes, hypertension, and so on. Each functioning almost like a membership group, with every patient carrying a membership card. The card identified them with a specific group and gave them something tangible between visits, but more importantly it created belonging: patients were no longer managing a condition alone. And the groups became communities that looked after themselves. Patients checked on each other between clinic days, reminding one another about appointments, asking after someone who hadn't shown up, flagging when something seemed wrong. Where we couldn't call every patient every week, that peer vigilance extended our reach and turned safety into something patients themselves helped carry.

On the original guiding questions, particularly what makes care unsafe for people with NCDs and the role of reliable health information: unsafe care for NCDs is rarely one bad decision.

It's fragmentation, one when information, responsibility, and follow-up don't travel with the patient between visits.

Reliable, plainly explained information, for patient and family alike, was often the difference between someone adhering to a plan and someone quietly drifting from it.

#WorldPatientSafetyDay #SafeCareForLife #HIFA

Best regards,

Isaias Yosief

HIFA profile: Isaias Yosief is a Clinical Pharmacist/Medical Researcher at Ministry of Health, Eritrea, Kampala, Uganda. Driven by a mission to end preventable suffering across Africa, I pursue this vision from every angle I can access, integrating Public Health, Pharmacy, Data Science & AI, and Health Finance through continuous research, learning, and collaborative practice. In Public Health, I am actively engaging in epidemiological research spanning vector-borne diseases (malaria, dengue, leishmaniasis), communicable diseases (HIV/TB, cholera, XDR-typhoid), and the silently escalating burden of non-communicable diseases (hypertension, diabetes, mental illness), also interested in women's maternal and child health, refugee healthcare across displaced populations, and expanding Mental Health and Psychosocial Support (MHPSS) for trauma-affected communities. Furthermore, I am exploring how to redesign surveillance systems for marginalized and cross-border populations, quantify climate-driven shifts in disease burdens, and contribute to shaping healthcare policies that translate evidence into culturally adapted, actionable guidelines. In Pharmacy, I am focusing on combating counterfeit and substandard medicines through quality assurance and control, advancing antimicrobial resistance stewardship, and strengthening supply chain resilience with a growing interest in decentralized track-and-trace systems and regional quality control networks. In Data Science, I am actively learning to leverage artificial intelligence and advanced analytics on authentic field-collected data to predict outbreaks, model disease spread, and optimize logistics; I am particularly interested in contributing to Africa's indigenous health AI infrastructure developing locally-trained models and tools that turn community health narratives into actionable intelligence for policymakers. In Health Finance, I am studying

sustainable budgeting, resource management, and financing models tailored for resource-limited settings, exploring mechanisms such as revolving drug funds, currency-hedging buffers, and health-ROI frameworks that can help persuade ministries to prioritize preventive care. Each angle of pursuit converges on a single vision: equipping our people with healthy, balanced, and peaceful lives, and building resilient, equitable health systems that our future generation deserves. isaiasyosief369 AT gmail.com

Spotlight: Patient safety and NCDs (44) Patient safety in conflict setting - South Sudan

19 September, 2026

Dear Neil,
Here is one concrete example from my recent mission.
Best regards,
Sanja

During my recent deployment in South Sudan we had one young male patient who was referred to our clinic due to minor gun shout wound. He was coming from very remote village, where access is difficult, with only poorly functional PHC that is facing severe shortages in skilled staff, medicines and basic diagnostic tools.

Several days after admission he had one episode of tonic-clonic seizures. He didn't not mention on arrival any previous medical condition. After talking to his caretaker and with patient itself about this event he said that he had similar episodes over last years. They just accepted it, minimizing the importance of need for treatment. Partially to avoid stigma, but also as the healthcare facility in his village can offer very limited support.

This is just one of the examples and there are many similar in the country remains complex and volatile context from humanitarian perspectives. South Sudan's fragile public health system is almost entirely dependent on humanitarians/donors. Due to the protracted conflict, the health system is characterized by widespread damage to health structures, closure of many health facilities, low levels of qualified staff, lack of remuneration for health staff and lack of medical materials and drugs. Access to quality health care remains difficult due to insecurity and logistical challenges as communities live isolated, often impossible to reach by road and airlift is the only possibility. With poorly functional primary health care facilities across the country, delay in treatment and secondary health care hardly available. This dire situation is reflecting high levels of avoidable morbidity and mortality from communicable and non communicable conditions. In parallel, a humanitarian assistance and development funding continue to shrink for South Sudan, due to global crises and increase of overall growing humanitarian needs.

Going back to this patient that was started on treatment but the main concerns were around follow up and access to medications. We involved the caretaker in explaining what is epilepsy, the importance of treatment and how to link with local facility for follow up. The other possibilities was to use of phone for follow up, though in that area phone coverage is limited too.

Indeed, patient follow-up can be particularly challenging in humanitarian situations, due to access constraints, lack of functional structures, language barriers and sometimes cultural beliefs, health illiteracy and overall adherence to treatment. Solution that might seem obvious and easy to apply in most of the context here might not be applicable.

HIFA profile: Sanja Janjanin is an Anaesthetist with the ICRC, Italy. Professional interests: Patient safety and anaesthesia in LMIC, Global & Environmental health, Conflict & Health. smizlica AT yahoo.com

Spotlight: Patient safety and NCDs (45) Publish on Patient Safety and Non-Communicable Disease: Challenges and Solutions

19 September, 2026

Hello HIFA community

We are looking for you to publish with us in a special collection of articles in Frontiers of Public Health Impact Factor 4.1 . Please join us.

The following manuscript types are suitable and aligned with the themes of the WHO WPSD: <https://www.who.int/campaigns/world-patient-safety-day/2026>

The concept is a group of curated papers that address the following questions:

- How can we design health services to be safer for people with NCDs?
- What role can the study of health systems play in designing and delivering safer care for people with NCDs?
- How can patients and families themselves be involved in safety initiatives?
- How do we measure outcomes for safer care for people with NCDs?
- What are the barriers and enablers of safer care for people with NCDs?
- How can safer care be made more equitable?
- Application of Implementation Science, quality and safety improvement.
- Safe care across the continuum of care.

You can submit:

- Research on any of the themes on safety for people with NCDs
 - The epidemiology of harm in people with NCDs
 - The application of insights from health systems research and practice to facilitate safer care and their implications for public health policy and system-level governance
 - Policy and practice evaluations of interventions to improve safety for people with NCDs
 - Systematic and narrative reviews, particularly those with a focus on reviewing published interventions that have had impact
 - View points
 - Commentaries
 - Priority-setting and rationale for public health policies addressing patient safety in NCD care
- Link for more details

Link for information <https://www.frontiersin.org/research-topics/85370/patient-safety-and-non...>

Manuscript Submission Deadline 30 June 2027

Patient Safety and Non-Communicable Disease: Challenges and Solutions
frontiersin.org

Thank You

Best regards

Peter Lachman

Guest Editor

HIFA profile: Peter Lachman works with the Patient Safety Movement Foundation, United Kingdom. Professional interests: Paediatrics, Patient Safety, Quality. peter.lachman@gmail.com

Spotlight: Patient safety and NCDs (46) Q1. What is unsafe care and what is its local and global impact? (5) Q1 Discussion highlights

19 September, 2026

Dear HIFA colleagues, Thank you for all your contributions to date. Please keep them coming. Please send by email to: hifa@hifaforums.org

You can review previous messages here: www.hifa.org/read

An overview is here: www.hifa.org/patientsafety

Below I have selected verbatim quotes related to Question 1: What is unsafe care and what is its local and global impact?

“Unsafe care occurs when patients are exposed to preventable harm through errors, delays, misdiagnosis, inappropriate treatment, poor communication, medication errors, infection risks, inadequate referral, or failures in follow-up.”

“Patient safety is about so much more than correcting errors. Poor quality care is unsafe care.”

“Around 1 in every 10 patients is harmed in health care and more than 3 million deaths occur annually due to unsafe care.”

"[What does 1 in 10 actually mean?] 1 in every 10 patients per treatment episode? per year? over a lifetime? I have been unable to find a denominator which would make this statistic meaningful.

"If we accept that poor quality care that leads to death must by definition be unsafe, then the actual deaths due to unsafe care are likely to be at least 5 million rather than 3 million."

“People living with NCDs are particularly vulnerable to harm due to the long-term nature of their conditions, ongoing treatment needs and frequent interactions with health systems. This repeated exposure increases the likelihood of harm over time.”

“For people living with NCDs such as hypertension, diabetes, cardiovascular disease, cancer and chronic respiratory diseases, unsafe care can result in avoidable complications, disability, premature death, catastrophic household expenditure and loss of confidence in health services.”

“With some conditions, such as cancer, up to 1 in 3 patients experience adverse events during care. [What is the denominator?]”

"Globally, patient harm is a major public-health problem, particularly in low- and middle-income countries. In West Africa, the consequences are amplified by weak health infrastructure, shortages of skilled personnel, fragmented services and financial barriers. For people living with NCDs — such as hypertension, diabetes, cardiovascular disease, > cancer and chronic respiratory diseases — unsafe care can result in avoidable complications, disability, premature death, catastrophic household expenditure and loss of confidence in health services."

"I hope that by sharing my experience [of a missed diagnosis of epiglottitis] it may help us understand the impact of unsafe care and that it will encourage you to share your experience."

"WHO defines patient safety as 'the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum'. By extension, unsafe care involves the presence of avoidable, preventable harm or the failure to reduce the risk of unnecessary harm during healthcare delivery."

"I asked Copilot 'how many patient safety incidents occur in a doctor's career?' and it answered 'a typical doctor will be involved in hundreds to thousands of patient-safety incidents over a full career. Only a minority of these are due primarily to an error by the doctor.'"

"In which countries are patients most likely to receive unsafe care? What countries provide the most and least safe care and what are their commonalities?"

"At which level of the health system is unsafe care most likely: in the home or community? among outpatients and the family doctor's clinic? in the emergency room? among inpatients in district or referral hospitals?"

As you can see there are some unanswered questions. Can you help? Further comments are very welcome.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (47) Extension of discussion until Wednesday 23 September

20 September, 2026

Dear HIFA colleagues,

Officially our discussion ends today. Meanwhile I have received a request to extend the discussion and propose we extend to Wednesday 23 September inclusive. This will give an opportunity for those who have not yet contributed to do so, and will further enhance the WHO learning brief that we are preparing for publication on the WHO Health Services Learning Hub (HLH).

An extension will also give us an opportunity to answer some of the many unanswered questions that have arisen during the discussion.

For example, in relation to Q1:

1. It is said that "Around 1 in every 10 patients is harmed in health care and more than 3 million deaths occur annually due to unsafe care." We do not know the denominator for '1 in 10'. Is this annually? The average global lifespan is 74 years (76 for women and 71 for men). If the denominator is annually then almost all of us can expect to be harmed by healthcare, multiple times.

2. But what do we mean by 'harm'? This can range from an unpleasant but transient side effect to an avoidable death caused by a catastrophic error.

3. Also, do we accept that poor-quality care that leads to death is unsafe care? If so then we should be talking about at least 5 million people dying per year and not 3 million.

4. We have noted that “People living with NCDs are particularly vulnerable to harm due to the long-term nature of their conditions, ongoing treatment needs and frequent interactions with health systems. This repeated exposure increases the likelihood of harm over time.” However, I feel that we have only scratched the surface of patient safety specifically in relation to NCDs. Can anyone help? Email: hifa@hifaforums.org

5. We also have a suggestion that 'a typical doctor will be involved in hundreds to thousands of patient-safety incidents over a full career. Only a minority of these are due primarily to an error by the doctor.'

6. We do not have a sense of which countries provide the most and least safe care, other than the broad brush of increased risk in LMICs.

7. We do not know at which level of the health system unsafe care is most likely to occur. Most research on patient safety has been done in hospitals, but what about the home, community, and primary care clinics?

If you would like to comment on any of the above, or any aspect of patient safety and NCDs, email: hifa@hifaforums.org

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (48) 2. What are the main causes of unsafe care for people living with NCDs? (3) Q2 Discussion highlights

20 September, 2026

Dear HIFA colleagues,

Below are some highlights from our discussion relating to Q2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?

Would you like to comment and share your experience? Send email to: hifa@hifaforums.org

"We now have a good understanding of how harm occurs. However many health systems still struggle to provide safe, coordinated, and reliable care for conditions such as diabetes, hypertension, cardiovascular disease, chronic respiratory disease, and cancer. These challenges affect millions of people every day, especially those in low-resource settings."

"Major causes include late diagnosis, inadequate screening, medicine stock-outs, polypharmacy, poor continuity of care, weak referral systems, limited diagnostic capacity, insufficiently trained health workers, overcrowded facilities and poor patient-provider

communication.” (Note that a few of these such as late diagnosis are consequences of unsafe care.)

“Unsafe NCD care emerges from systemic gaps in primary care, information access, coordination, training, supply chains, equity, and governance.”

"In our setting [rural Dominican Republic], the most common form of unsafe NCD care is not a dramatic clinical error. It is a quiet failure of continuity."

"Often, when people think of critical illness, they assume these patients are in ICUs, and as there are only a few ICU beds, it appears to be a minor issue. But ACIOS [African Critical Illness Outcomes Study] found that one in eight inpatients are critically ill and less than half of them receive essential emergency and critical care."

"Rather than being the main instigators of an accident, operators tend to be the inheritors of system defects created by poor design, incorrect installation, faulty maintenance and bad management decisions. Their part is usually that of adding the final garnish to a lethal brew whose ingredients have already been long in the cooking."

"People of course play a part when things go wrong, but they are simply the final link in the chain, the final garnish to a lethal brew as Jim Reason memorably says. Clinical staff are often 'set up to fail' by the systems they work in, as the story of the missed diagnosis [epiglottitis] showed us."

"First, there was fragmentation. Different symptoms were considered separately, there was apparently no one putting them together, and when initial treatments did not help, there was not always effective follow-up or reassessment. Several symptoms were attributed to pre-existing problems or ageing rather than prompting a broader review. The eventual delay in diagnosis resulted in significant and lasting harm."

"Second, there was the “everyone is a doctor” problem. Family members and other non-medical people were understandably trying to help, but were making medical suggestions that influenced the patient's decisions."

"The risk we saw [in Eritrea] most often wasn't a single dramatic error, it was accumulation. Someone managing two or three conditions at once, on multiple medications, with limited health literacy and no one coordinating the whole picture. A missed follow-up or a misunderstood dosage rarely looked dramatic in the moment, but it compounded over months."

TO WHAT EXTENT IS ACCESS TO RELIABLE HEALTHCARE INFORMATION A DETERMINANT OF PATIENT SAFETY?

“One of the main causes of ‘unsafe care’ for people living with NCDs is ‘lack of access to reliable healthcare information’ for both patients and healthcare providers.”

“Patients may not be aware of evidence-based scientific knowledge on prevention, early detection, and appropriate, timely treatment.”

“Health providers at the primary and community level often lack access to scientific updates to guide and communicate to patients on early detection, diagnoses, and to make treatment and follow-up decisions.”

“Lack of updated evidence-based standard protocols at health facilities for treatment and for avoiding medication, diagnostic, and equipment errors is also one of the causes of ‘unsafe care’.”

“Reliable health information is a fundamental determinant of safety.”

“Reliable information sits at the center of this.”

“When that information is fragmented, safe management of a chronic disease becomes almost impossible, however skilled the individual clinician.”

“Failure to translate evidence into policy and practice is a glaring cause of poor-quality and unsafe care.”

"The [Global Patient Safety Action] plan does not acknowledge lack of availability of reliable healthcare information as a patient safety issue. This seems to be a major gap in the plan."

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (49) Q1. What is unsafe care and what is its local and global impact? (6) Patients for Patient Safety

20 September, 2026

As one of the founding members of Patients for Patient Safety, and a member of the Steering Committee of Pfps for 9 years, until 2016, I would like to tell Neil yes it was 1 patient in ten / not one person in ten, so it was dramatic when Sir Liam Donaldson fought for establishing the Patients Safety program in the WHO and fought again strongly to establish PATIENTS for PATIENT SAFETY starting in 2004. It was an uphill battle and the UK government gave several millions pounds to fund it.

Errors in health care are very common and yes it is 1 in 10 Patients.

Myself as an infant I had a combination of new combinations DTP vaccine and Oral experimental which gave me polio all four limbs at age 9 months.

And I have suffered several major health errors in my life, including bad surgeries (2), a dramatic fall by a bad carer in rehabilitation center (I lost my semi valid left arm and shoulder). As I recently gave lectures seminars in two different big retirement places in KZN South Africa, in 2024 and 2025, I had the opportunity to review Sir Donaldson post 'retirement' figures and they are dramatic. Enormous errors in diagnostics, 100s of 1000s of errors in medication in the UK alone yearly.

The fact that the remedy demands concertation and collaboration between Patients action groups and health services should not blind us to that dark reality. And this affects transmissible diseases as well as NCDs.

1. Transmissible diseases. It is very sad that in countries with HIV epidemics the fact that it is a bloodborne disease transmitted in health care, regular, communal etc is forgotten. In KZN where I lived part of the year since 2023, the rate of HIV infections among young women is extremely high, over 20% and yet people are not aware of the risk from reuse of needles in injections

When a child is sick, mother brings the young one to the nearest free clinic where the baby is systematically given an injection. (Presumably some antibiotics!!)

The Punjab in Pakistan is also a very high HIV rate, like KZN in South Africa. But there has been a campaign or expose on children having HIV from injections, notably with Dr Altaf, formerly WHO; and now Aga Khan Foundation. And his group even got the British BBC to do an exposé on dirty health care.

But here we wish to talk of NCDs

Who remembers the Geneva Patient who got double breast removal mastectomy for cancer before it was recognized that there had been an error in specimen in the lab and the advanced cancer concerned another patient! !

Geneva has the best paid health labor force in the world ! Yet errors do occur in wealthy Switzerland.

Then there is no attention to cleaners, in Geneva; Paris or New York, or most places, health establishments outsource cleaning and the cleaning staff has no training on infection control! I often had to speak with the cleaners, most of them eager to learn

I remember one event at the WHA in Geneva, when Dr Tedros was flanked with a lady from a WHO dept with an upside down MOP, A BROOM! Unfortunately WHO is always short of funds to pursue great initiatives.

I remember that as the first time that the issue of flood cleaning, rails, had been brought up in a WHA. And I participated in different capacities, in WHA between 1980s and 2022!

Then on Care and NCD:

McKinsey estimates that in the coming decade there will be 1.6 billion elderly between the age of 70 and +100.

And investments in aging have an ROI of 3 !

WITS University study on aging and exercise nationwide in South Africa, found that people who exercised regularly lived 15 years longer without major ailments !

This information is crucial

Myself I exercised and or swam daily since childhood, it allowed me like Forrest Gump to drop all braces, orthopedic shoes; high crutches etc and to walk kilometers since adolescence for several decades.

Only got a wheelchair permanently after 60.

Then a last comment on patient safety:

Dont try to bring down the figures, the real disaster is higher than u can imagine

We need more heros like Sir Liam Donaldson.

Yesterday, I was in Dubai, UAE, where i live now, all day i listened to a major event organized by

the Morocco SIM and their network: NewZealand, UAE, UK around the world. And it is available for replay on the web

It was Amazing!! How simulation exercises can help train staff in health systems and remind all that the solution to unsafe health systems is not blame, isn't to point the finger or licence staff: no, THE NO BLAME ATTITUDE is required. As Sir Liam also insisted and continues to say..

Safety needs to be improved dramatically in a common effort.

Xpertone organizes events on AMR and Pandemic Prevention.

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HIFA profile: Mrs Garance Fannie Upham, has 40+ years of involvement in health care issues in Africa and LDC countries, and some in India (Norwegian Church AID study on bloodborne HIV in India), and occasional work with the Tamil Nadu M.G.R. University in Chennai)

She is President, AMR Think-Do-Tank, Geneva international, and has been Editor-in-Chief, AMR Control 2015,16,17,18,19-20, and 2021 :

"AMR & The Environment, a Global and One Health Security Issue"

She has been a Guest Member, Asia-Pacific Working Group on AMR, and of the CSO, Global AMR R&D Hub, Berlin

She is also Member, Global Network on Emergency Medicine, GNEM, and ex-Member, Steering Com., Patients for Patient Safety, PSP, World Health Organization (2004-Jan 2014)

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Spotlight: Patient safety and NCDs (50) Patient safety from a clinical laboratory perspective (1) A missed diagnosis of epiglottitis (7)

21 September, 2026

Dear HIFA colleagues,

I am forwarding (a translation of) a message below from our HIFA-Spanish forum, and a comment from me. With thanks to Jackeline Alger (Honduras), HIFA-Spanish coordinator.

<https://www.hifa.org/forums/hifa-spanish>

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"I would like to share my perspective from the clinical laboratory regarding cryptic parasitic infections. These are characterized by the difficulty of confirming a diagnosis when the parasite load is low and available tests have limited sensitivity. An example of this is leishmaniasis,

caused by the *Leishmania* protozoan, which can present in various clinical forms depending on the species.

"This situation can be exacerbated in healthcare facilities facing high patient demand and limited resources. This creates constant concern regarding patient safety, as there is a real risk of overlooking infections; if unidentified, these infections do not receive appropriate treatment and can progress to serious complications. Faced with these diagnostic limitations, we have a professional commitment to seek strategies that increase diagnostic certainty and accuracy—such as using more sensitive methods, repeating tests, integrating clinical and epidemiological criteria, and maintaining close communication with medical staff—to ensure every patient has the best chance of timely identification and treatment.

"While all of the above can be implemented, in settings with high demand and limited resources, it becomes a challenge that can only be overcome through teamwork, both within and outside the clinical laboratory."

Jackeline

HIFA-Spanish Coordinator

HIFA-es Profile: Jackeline Alger, MD, PhD, is a physician and parasitologist. She is the Executive Director of the Antonio Vidal Institute of Infectious Diseases and Parasitology in Tegucigalpa, Honduras. She served as the HIFA Country Representative for the years 2015 and 2018. Email: jackelinealger AT gmail.com. Why did I join HIFA?

<https://www.youtube.com/watch?v=nuXED4xpLJk>

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COMMENT (NPW): I note a parallel here with my experience as a junior hospital doctor with a child with epiglottitis. In both cases, it is recognised that it is often very difficult to make a diagnosis. In my case, I learned (40 years later!) that epiglottitis is missed at first presentation in about 80% of cases (if I had known this at the time, I would have felt much less self-blame over the past four decades). Jackeline describes difficulty in diagnosis of leishmaniasis because of the sensitivity of the test.

A missed diagnosis may be an example of unsafe care and/or it may be that the condition was difficult to recognise, and clinicians (or laboratory staff) followed appropriate processes but the diagnosis only became apparent later.

Therefore, in Jackeline's lab, a missed diagnosis of leishmaniasis may simply be a consequence of low sensitivity, in which case it would not normally be classified as 'unsafe care'. However, if the wrong test was carried out, or done inappropriately, or there was a reporting or interpretation error, then this would be classified as 'unsafe care'. In the case of the child with epiglottitis, I now recognise that it was not my 'missed diagnosis' in the A&E department that was the primary issue - it was the multiple systems factors that led to the tragic events of the subsequent 2 hours.

I hope other clinicians will be able to look back on their experiences and see how factors beyond their control may have led to adverse outcomes. There is of course another group to consider: patient safety events whereby a single clinician has been largely or solely responsible. These events are uncommon but must be especially hard to bear.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (51) Q3 What can be done to better understand and improve health systems? (2) Q3 Discussion highlights

21 September, 2026

Dear HIFA colleagues,

As a reminder, our guiding questions are:

1. What is unsafe care and what is its local and global impact?
2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?
3. What can be done to better understand and improve health systems for safer care for people living with NCDs?
4. How can we better support patients and primary and facility-based health workers to deliver safe care?

www.hifa.org/patientsafety

Here are some highlights from our discussion so far in relation to Question 3. What can be done to better understand and improve health systems for safer care for people living with NCDs? I have added a comment from me below.

1. “We have learned over many years that the real causes lie in weaknesses in healthcare systems.”
2. “Understanding these gaps is the first step toward designing safer, more resilient systems.”
3. “Countries should establish stronger patient-safety surveillance and incident-reporting systems, conduct routine quality-of-care audits, map NCD care pathways, strengthen referral and counter-referral, and use patient and community feedback.”
4. “Primary healthcare should be strengthened as the foundation for prevention, early detection, treatment and long-term follow-up.”
5. “Digital health records, decision-support tools and interoperable information systems can improve continuity and reduce errors.”
6. “There are a variety of techniques that can be used to assess the system. These include process mapping, incident analysis, interviews, observation and ethnography.”

COMMENT (NPW):

With regard to 1, for me the first question that arises is: how can we categorise the 'real causes in healthcare systems'.

The WHO fact sheet notes the following:

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Factors leading to patient harm

Patient harm in health care due to safety breaks is pervasive, problematic and can occur in all settings and at all levels of health care provision. There are multiple and interrelated factors that can lead to patient harm, and more than one factor is usually involved in any single patient safety incident:

- system and organizational factors: the complexity of medical interventions, inadequate processes and procedures, disruptions in workflow and care coordination, resource constraints, inadequate staffing and competency development;
- technological factors: issues related to health information systems, such as problems with electronic health records or medication administration systems, and misuse of technology;
- human factors and behaviour: communication breakdown among health care workers, within health care teams, and with patients and their families, ineffective teamwork, fatigue, burnout, and cognitive bias;
- patient-related factors: limited health literacy, lack of engagement and non-adherence to treatment; and
- external factors: absence of policies, inconsistent regulations, economic and financial pressures, and challenges related to natural environment.
- technological factors: issues related to health information systems, such as problems with electronic health records or medication administration systems, and misuse of technology;
- human factors and behaviour: communication breakdown among health care workers, within health care teams, and with patients and their families, ineffective teamwork, fatigue, burnout, and cognitive bias;
- patient-related factors: limited health literacy, lack of engagement and non-adherence to treatment; and
- external factors: absence of policies, inconsistent regulations, economic and financial pressures, and challenges related to natural environment.

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What approaches or tools can be used in different clinical contexts, especially in low-resource environments and in primary care?

On point 4, “Primary healthcare should be strengthened as the foundation for prevention, early detection, treatment and long-term follow-up”, how does this look in practice to 'strengthen' primary care, especially in LMICs?

On point 5. “Digital health records, decision-support tools and interoperable information systems can improve continuity and reduce errors”, this makes a case for universal access to electronic health records and integration of health records with decision-support tools. Which countries are making the most progress in this direction?

On point 6. some but by no means all facilities routinely audit their services, including where care goes wrong. In other cases incidents are not analysed or are 'swept under the carpet'. What is the basic minimum that should be done to analyse incidents, and which guidance is most useful, especially for overworked, understaffed settings in LMICs?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (52) Empowering health workers

21 September, 2026

Dear HIFA colleagues,

The Global Patient Safety Action Plan notes:

'Harm to patients cannot be corrected solely by urging health workers to be more careful... An alternative emerging approach in patient safety focuses on proactively making health care safer through an emphasis on *the conditions under which people succeed rather than fail*.' [my emphasis]

<https://www.who.int/teams/integrated-health-services/patient-safety/poli...>

Global Patient Safety Action Plan, page 2

It can be argued that a majority of health workers, particularly in low- and middle-income countries, are working in systems that set them up to fail. Worse, when failure occurs, the individual health worker often unfairly takes the blame.

On HIFA we regularly describe the basic needs of health workers.

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Information is a key component of the basic needs of all healthcare providers. These needs may be summarised as:

- Skills
- Equipment

- Information
- Systems
- Medicines
- Incentives
- Communication facilities.

This spells the acronym SEISMIC - a seismic shift is needed to address the needs of front-line healthcare providers in low-income countries. For too long their needs have been ignored. We need an approach that is not only patient-centred but is also health-worker-centred. [4]

HIFA focuses on the Information needs of healthcare providers, but clearly the full range of needs must be met to empower healthcare providers to deliver high quality care, as described in HIFA's theory of change (HIFA Strategy 2025-2027, p5).

<https://www.hifa.org/about-hifa/hifa-universal-health-coverage-and-human...>

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A safe healthcare system is one that is not only patient-centred but is also (importantly) health worker-centred.

Too often the needs of health workers are ignored.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (53) How can we better support patients and health workers? Q4 Discussion highlights

21 September, 2026

Dear HIFA colleagues,

Below are highlights from our discussion on Question 4. How can we better support patients and primary and facility-based health workers to deliver safe care?

1. "Patients should be empowered through health-literacy programmes, culturally appropriate information, self-management education and meaningful participation in care decisions."
2. "Patients need understandable information about symptoms, medicines, warning signs, appointments, lifestyle changes and when to seek urgent care."
3. "Health workers need continuous training, practical guidelines, adequate staffing, essential medicines and diagnostics, supportive supervision and safe working environments."

4. "It's crucial to provide updated evidence-based protocols and patient-health provider communication skills at the primary and community level of health facilities."
5. "Patient organisations are vital to ensure lived experience is heard, to equip people with tools for advocacy, and to help navigate complex treatment choices."
6. "People living with NCDs can identify gaps that healthcare systems may overlook, including delayed diagnoses, fragmented referrals, medicine shortages, inadequate communication and unsafe transitions between hospital and home."
7. "There is also now, thankfully, a great deal more understanding of the impact of error and harm on patients, families and healthcare professionals though blame and recrimination are still far too common."
8. "Some organisations have active programmes to support all concerned after serious events."

Regarding statement 2 and 3, the Global Patient Safety Action Plan emphasises the importance of reliable information for patients but ignores reliable healthcare information for health workers.

The section in the Global Patient Safety Action Plan 'Strategic objective 5. Health worker education, skills and safety' talks exclusively of patient safety principles and excludes clinical knowledge and availability of reliable healthcare information.

Indeed the basic needs of health workers [<https://www.hifa.org/about-hifa/hifa-universal-health-coverage-and-human...>] are barely mentioned in the Plan.

I would argue that safe care is only possible when the basic needs of health workers are met.

This is perhaps implied in describing 'system factors' as being of primary concern (rather than medical error) but is not overt.

What more can we say about the role of patients in promoting safe care? What more about health workers?

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (54) Q1. What is unsafe care and what is its local and global impact? (7) Questions about estimate of deaths from unsafe care, incidence of unsafe care, and definition of unsafe care

21 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-41-q1...>]

Dear HIFA Community

Neil posed some important questions of definition asking about how harm is defined and what do we mean by unsafe care. WHO it seems do not have an accessible definition on their website.

This is quite a complex issue as one can define harm in various ways and clearly it overlaps, as Neil pointed out, with care that is simply of very poor quality.

Patient safety was founded in part on the class studies of 'adverse events' beginning with the Harvard Medical Practice study in the 1980s. This and similar studies systematically reviewed records of patients admitted to hospital looking for occasions where a patient suffered an 'adverse event'. They defined an adverse event as some harm that came to the patient as a result of problems in healthcare rather than their disease. This could be something that went wrong in treatment (wrong site surgery), a more general form of harm (such as hospital acquired infection) or failures of other kinds (like a missed diagnosis). Their criterion for labelling something a 'harm' was that it was sufficiently serious to require an extra day in hospital.

There have been many similar studies in many countries since then. Most used the same definition of adverse events and the same denominator of hospital admission. So, when a figure of 10% is quoted it means that 10% of patients going into hospital suffer some kind of harm during their stay, about half of which are generally judged to be preventable. Many of these are not serious, but a small number are very severe.

Clearly one can use different definitions of unsafe care and poor quality care but this is probably the most common one in use in studies of harm to patients in hospital.

Best wishes

Charles

HIFA profile: Charles Vincent trained as a clinical psychologist and worked in the British NHS for several years. Since 1985 he has focused on conducting research on the causes of harm to patients, the consequences for patients and staff, and methods of improving the safety of healthcare. [charles.vincent AT psy.ox.ac.uk](mailto:charles.vincent@psy.ox.ac.uk)

Spotlight: Patient safety and NCDs (55) The shared medical record and patient safety

22 September, 2026

The NHS Modernization Bill is going through its parliamentary stages. Section 52 includes the support of a national Single Patient record:

" Single patient record (1) Information The National Health Service Act 2006 is amended as follows. (2) Before section 251 (but after the italic heading "Patient information") insert— "250E Single patient record (1) (2) (3) The Secretary of State may by regulations make provision for the purpose of establishing a system for making patient information readily available to— (a) (b) patients who have received health care as part of the health service in England or have received social care in England, and people involved in the provision to patients of health care or social care in England.

This exciting national development of a Single patient record readily available to patients who have received health care as part of the health service in England, or have received social care, calls the patients into play as active participants in patient safety. Working with colleagues has helped to develop the following a possible set of guidance with 8 key areas of perspective These are designed to provide independent perspective to practitioners on how digital healthcare and health-information systems can better serve patients and the public, clinicians and healthcare professionals, healthcare organisations, researchers and academic institutions, and healthcare

policymakers and professional bodies to ensure that digital-health initiatives remain clinically meaningful, ethically responsible, patient-centred and practically useful.

Key Areas of perspective

1. Patient Access & Personal Health Records

- Provide strategic advice regarding patient access to medical records and personal health information.
- Review approaches to patient-facing electronic health records.
- Advise on how patients can better understand, contribute to and engage with information contained within their records.
- Provide perspective on transparency, patient participation and trust.
- Identify practical barriers that may prevent patients from effectively using digital health information.

2. Clinical Informatics & Digital Health

- Advise on the clinical implications of digital-health initiatives.
- Review proposed approaches to electronic health records and information systems.
- Provide clinical perspective on how technology affects healthcare delivery.
- Advise on the relationship between data, information, clinical reasoning and patient care.
- Contribute to discussions concerning the future development of patient-centred digital healthcare.

3. Medical Ethics & Patient Autonomy

Provide advice concerning ethical principles relevant to healthcare information, including:

- Beneficence
- Non-maleficence
- Patient autonomy
- Justice
- Privacy and confidentiality
- Informed participation
- Responsible information sharing
- Patient consent and transparency

Help consider the patient perspective when developing policies, technologies and information-sharing practices.

4. Patient Safety & Clinical Governance

- Review digital-health initiatives from a patient-safety perspective.
- Identify potential risks associated with inaccurate, incomplete or poorly communicated clinical information.
- Advise on the relationship between record quality and safe clinical decision-making.
- Contribute to discussions concerning clinical governance and information quality.
- Provide an independent patient-centred perspective on proposed safeguards and assurance mechanisms.

5. Healthcare Data & Research

- Provide advice on the responsible use of healthcare data for research and service improvement.

- Contribute to discussions concerning access to primary-care and clinical datasets.
- Consider the balance between research value, patient interests, privacy and appropriate governance.
- Provide perspective on responsible processing and sharing of personal health information.
- Support constructive dialogue between clinicians, patients, researchers and technology organisations.

6. Patient & Public Perspective

- Bring the patient and public perspective into strategic discussions.
- Advise on health literacy and accessibility of digital health information.
- Identify areas where healthcare technology may unintentionally create barriers for patients.
- Encourage meaningful patient participation in the development of healthcare information systems.
- Contribute to approaches designed to strengthen trust between patients, clinicians and healthcare organisations.

7. Policy & International Perspective

- Provide historical and international perspective on the development of electronic health records and patient-access initiatives.
- Contribute to discussions involving national and international healthcare-information policy.
- Participate in selected professional, academic or policy forums where appropriate.
- Provide insight into international approaches to health-data governance and digital healthcare.
- Advise on emerging developments affecting patient-centred health information.

8. Strategic Thought Partnership

- Participate in periodic advisory meetings with senior leadership.
- Review selected strategic documents, proposals and digital-health initiatives.
- Provide independent written or verbal observations when requested.
- Challenge assumptions constructively and identify potential patient or clinical implications.
- Contribute to strategic discussions concerning the long-term direction of patient-centred digital healthcare.

HIFA profile: Richard Fitton is a retired family doctor - GP. Professional interests: Health literacy, patient partnership of trust and implementation of healthcare with professionals, family and public involvement in the prevention of modern lifestyle diseases, patients using access to professional records to overcome confidentiality barriers to care, patients as part of the policing of the use of their patient data Email address: richardpeterfitton7 AT gmail.com

Spotlight: Patient safety and NCDs (56) Diagnostic errors

22 September, 2026

Below are extracts from a 2015 publication called Improving Diagnosis in Health Care. It appears to reflect US experience. The experience in other countries may be different.

<https://www.nationalacademies.org/read/21794/chapter/2>

'The delivery of health care has proceeded for decades with a blind spot: Diagnostic errors—inaccurate or delayed diagnoses—persist throughout all settings of care and continue to harm an unacceptable number of patients. For example:

- A conservative estimate found that 5 percent of U.S. adults who seek outpatient care each year experience a diagnostic error.
- Postmortem examination research spanning decades has shown that diagnostic errors contribute to approximately 10 percent of patient deaths.
- Medical record reviews suggest that diagnostic errors account for 6 to 17 percent of hospital adverse events.
- Diagnostic errors are the leading type of paid medical malpractice claims, are almost twice as likely to have resulted in the patient's death compared to other claims, and represent the highest proportion of total payments.
- National Academies of Sciences, Engineering, and Medicine. 2015. Improving Diagnosis in Health Care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/21794>.

'Getting the right diagnosis is a key aspect of health care — it provides an explanation of a patient's health problem and informs subsequent health care decisions. Diagnostic errors stem from a wide variety of causes, including: inadequate collaboration and communication among clinicians, patients, and their families; a health care work system that is not well designed to support the diagnostic process; limited feedback to clinicians about diagnostic performance; and a culture that discourages transparency and disclosure of diagnostic errors — impeding attempts to learn from these events and improve diagnosis.'

A further cause is lack of clinical knowledge and experience, together with lack of access to reliable healthcare information.

National Academies of Sciences, Engineering, and Medicine. 2015. Improving Diagnosis in Health Care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/21794>

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Spotlight: Patient safety and NCDs (57) The shared medical record and patient safety (2)

22 September, 2026

Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-55-sh...>

Many thanks for your latest message Richard.

Since you joined HIFA several years ago we have all recognised the importance of patient access to the medical record as part of the information that every person and every health worker needs to protect their own health and the health of others.

I have just re-read your 2024 blog: 'Safety and outcomes improve when patients access their own health records. This is why it matters.'

<https://joinedupcarederbyshire.co.uk/news/blog-safety-and-outcomes-impro...>

Below are extracts. These are compelling reasons why universal access to patient health records would improve care and patient safety.

==

"I became interested in sharing records with patients during the 1980s while working in an inner-city practice – an area of moderate deprivation...

I was already sharing records with patients when I was asked to give evidence at the trial of Dr Harold Shipman.

Dr Shipman had murdered over two hundred patients.

He altered the notes of the patient that I signed the cremation form of to hide his crime.

I felt that patients' relatives would have spotted the falsification of the records if access to records was standard...

So how does patient access to records help the NHS and social care?

Patients detect and report notes of other patients that have been incorrectly put in their notes.

Patients detect and report errors and omissions.

Patients report inappropriate access to their records by examining the audit trail of users.

Patients report clinical content that they do not wish to be shared further.

And how does patient access to records help patients and carers?

Patients are better able to give fully informed consent for treatments.

Patients have more complete and satisfying consultations with healthcare professionals.

Patients use the record to represent themselves when complex issues which they do not understand are discussed with other professionals.

Patients share the records with carers and families. Parents access their children's records until 16 years of age. (Children can ask this to finish after the age of 13.)

Patients look up their results, diagnoses and care pathways become better at managing their treatments and long-term conditions.

In short, access to patient records puts patient in charge of their own health."

==

It seems likely that Harold Shipman would not have been able to murder so many of his patients if they (or their representatives) had ongoing access to their medical records. Less dramatically,

the list of benefits such as identification and correction of errors would improve patient safety and quality of care generally.

I reviewed the Global Patient Safety Action Plan and it makes several references to patient access to medical records, but without explaining the rationale for this. Your list of 10 'Hows' above fills that gap.

I look forward to learning more about this topic.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (58) Joint Commission International webinar

22 September, 2026

Dear HIFA colleagues,

We recently publicised a webinar by Joint Commission International. The message below announces that a recording of the webinar is now available. I have added a comment below.

(The recording includes a verbatim text transcript - very useful for those who do not have time to watch the full recording)

World Patient Safety Day 2026

Safe Care for Noncommunicable Diseases: Watch the Grand Rounds Replay

In recognition of World Patient Safety Day 2026, we join the global healthcare community in recognizing this year's theme, "Safe Care for Every Patient with a Noncommunicable Disease."

Noncommunicable diseases (NCDs) affect billions of people worldwide and require care that is safe, coordinated, and person-centered across every stage of the healthcare journey. Advancing safer care for people living with chronic conditions requires collaboration among healthcare leaders, clinicians, patients, families, and policymakers around the world.

As part of this year's observance, Joint Commission International hosted our latest Patient Safety Pathways™ Grand Rounds, Safe Care for Noncommunicable Diseases: Safe Care for Life, featuring expert perspectives on the patient safety challenges and opportunities that exist across the continuum of care.

If you were unable to attend live, or would like to revisit the discussion, we are pleased to share the replay.

Watch the Replay

<https://player.vimeo.com/video/1225731199?h=7111f8abbe&badge=0&autopause...>

Thank you for being part of a growing global community committed to improving patient safety and advancing safer care for every patient.

Looking ahead, we hope you'll join us for the next Patient Safety Pathways Grand Rounds on 9 December at 7:00 AM CST.

Transforming Safety Events into Opportunities for Learning

Registration details will be available soon.

We look forward to continuing the conversation with you.

Sincerely,

Joint Commission International

COMMENT (NPW): I have reviewed this. One of the questions asked to the participants was: Who is the most underutilised resource for patient safety?

Overwhelmingly they said "patients and families"

One panellist says to his patients "I see you for 30 mins twice a year. The rest of the 8-9000 hours a year is *you* managing your health"

But I would add that more needs to be done to empower patients to take responsibility for their health. This can include action plans, tools, what and how to monitor... And this requires a change in approach among health workers.

Engaging patients in their own personal health record could substantially increase their sense of responsibility.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (59) Preventable versus unpreventable harm

22 September, 2026

WHO states that 'around 1 in 10 patients is harmed in health care' and that 'above 50% of harm (1 in every 20 patients) is preventable'

<https://www.who.int/news-room/fact-sheets/detail/patient-safety>

What is meant here by 'preventable' and how is this assessed?

Here are some extracts from a BMJ paper 'Preventable harm: getting the measure right' BMJ 2019;366:l4611 doi: 10.1136/bmj.l4611 (Published 17 July 2019)

<https://www.bmj.com/content/bmj/366/bmj.l4611.full.pdf>

'Separating harm into outcomes that are deemed either preventable or inevitable is a necessary step to advance efforts toward patient safety. Yet no consensus exists as to what constitutes

preventable harm, and even experienced clinicians vary in the extent to which they agree on whether an error is preventable. Panagioti and colleagues define preventable harm as the result of an identifiable modifiable cause and an event the recurrence of which can be avoided by the adaptation of a process or adherence to guidelines. This approach, although reasonable, has important limitations.'

'Patient harm, however, is usually caused by the interplay of many linked failings across the system, not just a missed process of care.'

'In addition, many complications are only partially preventable, and therefore distinguishing the preventable from the inevitable becomes difficult.'

PREVENTABLE HARM

Harm is classified as preventable when reviewers identify a modifiable factor that contributed to the event and believe that changing a process of care, following a guideline, or taking a different action would probably have avoided it.

Examples:

Wrong medication administered because of a labelling error.

Failure to provide recommended thrombosis prophylaxis.

Infection resulting from failure to follow established infection-control procedures.

In such cases, reviewers can point to a specific action or system change that might reasonably have prevented the outcome.

One definition of unpreventable harm is 'harm that occurs despite appropriate care and when no identifiable, feasible intervention is thought likely to have avoided it'

However, if care is appropriate then it cannot be classified as 'unsafe'.

I'm unclear how we define unpreventable harm due to unsafe care. Can anyone help with this?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (60) Causes of harm

22 September, 2026

Our landing page for this Spotlight lists some causes of harm as follows:

1. Medication errors. Medication-related harm affects 1 out of every 30 patients in health care, with more than a quarter of this harm regarded as severe or life threatening.
2. Surgical errors. Harm may occur before, during or after surgery. Most unsafe surgical care

arises not from dramatic errors, but from small system failures — missed checks, poor communication, and inadequate monitoring — that accumulate into avoidable harm.

3. Health care-associated infections. Hand hygiene, failure of aseptic technique, poor sterilisation of instruments, inadequate environmental cleaning...

4. Diagnostic errors. These occur in 5–20% of physician–patient encounters.

5. Incorrect treatments.

6. Patient misidentification

7. Unsafe injection practices

In our discussion we have emphasised another pervasive cause of harm, namely a lack of clinical knowledge and lack of access to reliable healthcare information. We have also noted the importance of factors such as an overburdened, exhausted workforce.

Indeed, any practice environment, setting, or facility that does not meet the basic needs of a healthcare provider to deliver effective care can be described as 'unsafe'.

One point that we have not learned in this discussion is the relative contribution of all the above to unsafe care.

The only pointer I have noted is the WHO fact sheet that states that around 50% of preventable errors are medication errors.

The list of seven above is typical of what the patient safety movement have traditionally focused on. Charles Vincent and others have since shown that unsafe care is primarily due to health systems factors rather than isolated errors.

I would like to suggest that future research on patient safety could look more closely at the contribution of a failure to meet the basic needs of healthcare providers.

On HIFA we have described these with the acronym SEISMIC

- Skills
- Equipment
- Information
- Systems
- Medicines
- Incentives
- Communication facilities.

This inevitably widens the scope from unsafe care to poor-quality care. That said, I remain sceptical about the difference. For me, if I am a patient and I receive poor quality care, this by definition is unsafe. If I receive poor care and I die as a result, this is undeniably 'unsafe' in which case around 5 million people die every year due to unsafe care and not 3 million as widely reported.

As we have stated the figure of 5 million is almost certainly a gross underestimate because it does not include care in home and community (author communication). The paper from which this 5m comes has a glaring gap which has not yet been filled. It gives estimates of deaths from poor quality care but is unable to analyse the quantitative contributions of different determinants.

Kruk M, Gage A, Joseph N et al.

Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries

The Lancet, 2018; 392, 2203-2212

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31668-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31668-4/fulltext)

For example, we do not know to what extent the seven causes listed above may have contributed, nor do we know to what extent lack of access to reliable healthcare information contributed.

Data on this is very scarce. One approach is through social autopsy. Merlin Wilcox and colleagues wrote a paper 'Care pathways during a child's final illness in rural South Africa: Findings from a social autopsy study.' 2019. They concluded: 'Modifiable factors for preventing deaths during a child's final illness occur both inside and outside the home. The most important modifiable factors occurring inside the home relate to caregivers' recognition of illness and appreciation of urgency in response to the severity of the child's symptoms and signs. Outside the home, modifiable factors relate to inadequate referral and follow-up by health professionals. Further research should focus on identifying and overcoming barriers to referral.' <https://www.repository.cam.ac.uk/items/8b6b90bf-3c64-440c-84f3-d2c64208995e>

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (61) Q1. What is unsafe care and what is its local and global impact? (8) Wearing gloves

23 September, 2026

Dear HIFA colleagues,

In response to Q1, what is unsafe care:

It's a standard practice since the 1990's (as per CDC and WHO guidelines) to wear gloves in various situations in health facilities e.g., performing venepuncture, etc..

I still remember that it took much effort in behaviour change and funding investments to implement these best practices among the health providers, health facilities, and health policies in LMICs. However, even today, it is not practiced uniformly, which makes me wonder if there is inadequate communication of scientific evidence in simple language to reach the community, thus resulting in unsafe care.

Local and global efforts should be made to empower patients with access to reliable healthcare information so that they can demand health policies for safe care.

Best wishes

Dr. Meena Nathan Cherian, MBBS, MD (Anaesthesia)
(Former WHO Lead Emergency and Essential Surgical Care Program, Geneva, Switzerland).
Director, Global Health New Challenges: Geneva Foundation for Medical Education & Research, Switzerland. www.gfmer.ch/surgery/cancer.htm (NSA-WHO)
Senior Advisor Global Action International Society of Geriatric Oncology Permanent Committees - SIOG
Senior Advisor, International College of Surgeons-Global Affairs. <https://icsglobal.org/> (NSA-WHO)
Adjunct Prof. The Chinese University of Hong Kong, Shenzhen, China.
<https://med.cuhk.edu.cn/en/teacher/371>
WHO-HIFA Essential Health Services; mHEALTH-INNOVATE. www.hifa.org (NSA-WHO).
Geneva, Switzerland. +41 763837253(m); cherianm15@gmail.com

HIFA profile: Dr Meena Nathan Cherian was a professor of anaesthesiology from Christian Medical College Hospital, Vellore, India. She trained, worked, and taught in several countries, USA (Johns Hopkins Hospital), Southeast Asia and Africa. She worked at the World Health Organization Headquarters, Geneva, Switzerland, as the Emergency and Essential Surgical Care Program Lead where she created the 'surgical care' program resulting in the first World Health Assembly Resolution on 'Emergency and Essential Surgical Care and Anaesthesia in the context of Universal Health Coverage'. Currently she works as the Director, Global Health New Challenges program, Geneva Foundation for Medical Education and Research, Geneva, Switzerland; Adjunct Prof. The Chinese University of Hong Kong, Shenzhen, China; Senior Advisor, Global Action, International Society of Geriatric Oncology, Switzerland; Member of the WHO-HIFA Working Group on Essential Health Services and COVID-19; and HIFA mHEALTH-INNOVATE Working Group. She is a member of the HIFA Steering Group.
<https://www.hifa.org/support/members/meena> cherianm15 AT gmail.com

Spotlight: Patient safety and NCDs (62) Conclusion

23 September, 2026

Dear HIFA colleagues,

Thank you to all who have contributed to this rich global conversation. The discussion now draws to an end officially, but we welcome further contributions on patient safety and NCDs over the coming weeks and months. We shall prepare a summary and a concise learning brief suitable for publication on the WHO Health Services Learning Hub (HLH).

Our thanks to our Patient Safety Spotlight working group: Diana Zandi (WHO), Charles Vincent (University of Oxford), Meena Cherian (HIFA steering group) and Ashwathy Sunil (Geneva Graduate Institute) for your help in putting this together. Thanks to WHO for sponsorship.

HIFA Spotlights are a rapid, easy and affordable way to put YOUR priority topic at the centre of the global health community. For one focused week, we mobilise the HIFA forums to generate insights, visibility, and engagement around the issue you care about most.

We welcome proposals for new Spotlights in December, January and February. Contact: neil@hifa.org

Further information about HIFA Spotlights here: www.hifa.org/spotlights

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (63) Q3 Discussion highlights (2) Patient safety in settings where staff and resources are limited

24 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-51-q3...>]

From my experience working in a hospital in Cambodia, I have found that the problem is often not the absence of guidelines or policies. The difficulty is making them part of routine clinical practice.

One approach we have used is structured weekly reporting, with departments reviewing problems, discussing what happened, agreeing on actions, and following up on those actions. We also use departmental checklists and regular feedback. These are simple measures, but they create a regular process for identifying problems and checking whether changes are actually being made.

I think this is particularly important in settings where staff and resources are limited. A system for patient safety has to be practical enough for busy clinical teams to use consistently. It cannot depend only on developing new guidelines or introducing new technology.

For me, strengthening the health system means creating a clear link between evidence and what happens at the bedside: clear responsibilities, simple tools, regular review, and feedback to the people providing care. Local involvement is also important. Staff are more likely to identify problems and act on them when they are involved in finding the solutions.

I would be interested to hear what others consider the minimum practical system for patient-safety monitoring and improvement in overstretched primary-care and hospital settings in LMICs.

HIFA profile: Suren Kanayan is the Administrative Manager at Central Hospital in Cambodia. Professional interests: Maternal and Child Health, Obstetrics & Gynecology Clinical Practice,

Healthcare System Strengthening in LMICs, Telemedicine and Digital Health Platforms. Email: skan71 AT yahoo.com

Spotlight: Patient safety and NCDs (64) Q's 1-4: Overview - Hodges' model

24 September, 2026

[Re. <https://www.hifa.org/news/hifa-spotlight-noncommunicable-diseases-stay-i...>]

Below I have tried to respond to each of the Guiding questions drawing out key (for me) terms:

1. WHAT IS UNSAFE CARE AND WHAT IS ITS LOCAL AND GLOBAL IMPACT?

Question 1 immediately draws attention to the existence of a SYSTEMS(s), and its level of maturity and hence coherence.

The responses to this question #1 already identify unsafe care, but of course we must be cognisant of what is not recognised?

Drug errors and other mistakes that are not reported?

(So, to what extent is the 'system' - systematic?)

Local and global alludes to geographies, the patient's and the health services.

What is the level of centralised to community provision and the distribution of the population from the service locations.

There must be a measure, an index to measure where things stand across local and global as translated to

urban - city, town, village, rural, remote?

The questions are understandably broad, but in question 1 how does time and distance impact upon continuity of care, health prevention and education to help foster self-care?

To what extent can the glocal be introduced through technological solutions?

2. WHAT ARE THE MAIN CAUSES OF UNSAFE CARE FOR PEOPLE LIVING WITH NCDs? TO WHAT EXTENT IS ACCESS TO RELIABLE HEALTHCARE INFORMATION A DETERMINANT OF PATIENT SAFETY?

Question #2 also concerns expectations, this applies in resource limited contexts and in highly specialised care services.

Having access to healthcare information is one thing, but what is the salience of that information in light of:

The patient, informal carers, culture in which the facts, insights, information ... is fielded?

To what extent is the patient's level of health literacy able to utilise the information provided?

- Same applies to the wider social, culture - quotidian experience?

Is the patient 'stuck' in a 'well' (pardon the irony), a minima - this may increase their vulnerability, due to disempowerment, loss of motivation, inability to envision change - a stabilised achievable quality of life?

[A chronic condition is seen in its chronic - overwhelming terms?]

Is this where even occasional follow-up can make a huge difference? What is the minimum threshold for such visits - contacts (tech-mediated too)?

Are community / social assets fully recognised, patients having a buddy?

3. WHAT CAN BE DONE TO BETTER UNDERSTAND AND IMPROVE HEALTH SYSTEMS FOR SAFER CARE FOR PEOPLE LIVING WITH NCDs?

Across questions 1-4 I continue to believe a recognised global and generic model for healthcare and education can help us individually, and collectively to better understand and improve health systems for safer care for people living with NCDs?

Situated and variously person or service-centred, Hodges' model can support individual and collective reflection and critical thinking:

<https://hodges-model.blogspot.com/>

- and can assist in curricula planning, and bridge the theory-practice gap (and other gaps!).

Inclusion of the POLITICAL care (knowledge) domain in Hodges' model extends the model beyond:

medical
bio-medical
& bio-psycho-social models

We keep 'talking' determinants and yet the economic, housing, security and other dimensions are neglected, and yet their role in causation (surely?) inevitable.

4. HOW CAN WE BETTER SUPPORT PATIENTS AND PRIMARY AND FACILITY-BASED HEALTH WORKERS TO DELIVER SAFE CARE?

Having a common shared template for assessment, planning, intervention and evaluation that encourages unconditional positive regard can help(?).

https://docs.google.com/document/d/1XdhXfS-aLZM78_cyXFQB0vkDUPE1Q4kN-XN2...

The question suggests an opportunity for deployment of Hodges' model starting within education - early teens?

Please see above - plus having an ethos - philosophy of care is vital and Hodges' model is applicable to:

equitable - equality - high quality
accountability - reporting (data infrastructure synergy)
treatment - disease - NCDs management
systems - thresholds perspectives (this applies in all questions)

Jones, P. (2025). A Conceptual Mapping Exercise of Deprivation of Liberty Safeguards in Residential & Community Care Using Hodges' Model and Threshold Concepts. *Journal of Evaluation in Clinical Practice*, 31: e70085. <https://doi.org/10.1111/jep.70085>

primary, secondary, tertiary
quaternary
public sector - private - voluntary/charitable
rehabilitation, reablement, recovery
prevention

S. Bettiol, P. Jones, H. A. Onyedikachi, and W. G. Kernohan, (2026) Bridging Gaps in Oral Health Frameworks: Mapping With Hodges' Health Career - Care Domains - Model, Journal of Public Health Dentistry. 1-14, <https://doi.org/10.1111/jphd.70034>.

health education
literacies (All of them)
community
strengths
addressing lack of parity of esteem - in health and education ...
Hope!

Work is ongoing to study Hodges' model. A bibliograophy is provided in the blog's sidebar.

Kind regards,

(Mr) Peter Jones

Wigan, UK

h2cmng@yahoo.co.uk

Part-time Community Mental Health Nurse, Tutor and Researcher

Blogging at "Welcome to the QUAD"

<http://hodges-model.blogspot.com/>

<https://bsky.app/profile/h2cm.bsky.social>

HIFA profile: Peter Jones is a Community Mental Health Nurse with the NHS in NW England and a a part-time tutor at Bolton University. Peter champions a conceptual framework - Hodges' model - that can be used to facilitate personal and group reflection and holistic / integrated care. A bibliography is provided at the blog 'Welcome to the QUAD' (<http://hodges-model.blogspot.com>). h2cmuk AT yahoo.co.uk

Spotlight: Patient safety and NCDs (65) Conclusion (2)

25 September, 2026

Thanks, Neil and HIFA colleagues.

I hope that, since a few people have their applications pending to join HIFA and are waiting to send their comments will be included in this important document.

Best wishes

Dr. Meena Nathan Cherian, MBBS, MD (Anaesthesia)

(Former WHO Lead Emergency and Essential Surgical Care Program, Geneva, Switzerland).

Director, Global Health New Challenges: Geneva Foundation for Medical Education & Research, Switzerland. www.gfmer.ch/surgery/cancer.htm (NSA-WHO)

Senior Advisor Global Action International Society of Geriatric Oncology Permanent Committees - SIOG

Senior Advisor, International College of Surgeons-Global Affairs. <https://icsglobal.org/> (NSA-WHO)

Adjunct Prof.The Chinese University of Hong Kong,Shenzhen,China.

<https://med.cuhk.edu.cn/en/teacher/371>

WHO-HIFA Essential Health Services; mHEALTH-INNOVATE. www.hifa.org (NSA-WHO).

Geneva, Switzerland. +41 763837253(m); cherianm15@gmail.com

HIFA profile: Dr Meena Nathan Cherian was a professor of anaesthesiology from Christian Medical College Hospital, Vellore, India. She trained, worked, and taught in several countries, USA (Johns Hopkins Hospital), Southeast Asia and Africa. She worked at the World Health Organization Headquarters, Geneva, Switzerland, as the Emergency and Essential Surgical Care Program Lead where she created the 'surgical care' program resulting in the first World Health Assembly Resolution on 'Emergency and Essential Surgical Care and Anaesthesia in the context of Universal Health Coverage'. Currently she works as the Director, Global Health New Challenges program, Geneva Foundation for Medical Education and Research, Geneva, Switzerland; Adjunct Prof. The Chinese University of Hong Kong, Shenzhen, China; Senior Advisor, Global Action, International Society of Geriatric Oncology, Switzerland; Member of the WHO-HIFA Working Group on Essential Health Services and COVID-19; and HIFA mHEALTH-INNOVATE Working Group. She is a member of the HIFA Steering Group.

<https://www.hifa.org/support/members/meena> and Spotlight working group on Patient Safety and NCDs. cherianm15 AT gmail.com

Spotlight: Patient safety and NCDs (66) Conclusion (3)

25 September, 2026

"I hope that, since a few people have their applications pending to join HIFA and are waiting to send their comments will be included in this important document."

Thanks Meena, yes we have six new members waiting to be registered. I shall do this now.

Further comments on the topic are welcome in the coming days. All messages received by 30 September will be included in our synthesis. Here again is the background to our Spotlight:

<https://www.hifa.org/news/hifa-spotlight-noncommunicable-diseases-stay-i...>

The four guiding questions:

1. What is unsafe care and what is its local and global impact?
2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?
3. What can be done to better understand and improve health systems for safer care for people living with NCDs?
4. How can we better support patients and primary and facility-based health workers to deliver safe care?

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (67) Communication failures and patient safety

26 September, 2026

Neil and HIFA Colleagues

Reliable communication is a key factor in access to reliable health care information, and indeed in most aspects of health care. Several of the responses to the HIFA spotlight on patient safety have mentioned communication problems as important risk factors.

Although I am well aware of the hazards of reading too much into individual experience, sometimes the occurrence of only a few instances of an observation can be of more general significance (it only takes one drop to know that seawater is salty!). With that, and Neil's request for personal examples, in mind, I offer the following observations.

In my or my family's fairly recent personal interactions with the health services (in the UK) there has been:

- Misidentification/wrong name (twice!)
- Failure to warn of a potentially fatal adverse reaction to medication
- Omission of discussion of important recommended treatment options
- Late communication of health care information
- Treatment information not being passed on between health professionals

These may be problems at the individual or at the system level – poor record keeping and transmission systems, uncoordinated teams, overworked staff etc – but either way the effect is the same – otherwise good health care - and so patient safety - being put at risk by communication failures.

There is ample evidence that this is not just my experience. The seminal 2004 study “Communication Failures: An Insidious Contributor to Medical Mishaps” by Kathleen M Sutcliffe et al. (<http://doi.org/10.1097/00001888-200402000-00019>) reported that communication was one of the top cited contributing factors to mishaps. More generally the recent literature review by Keshtkar et al. (2025), “Impacts of Communication Type and Quality on Patient Safety Incidents: A Systematic Review.” (<https://www.acpjournals.org/doi/10.7326/ANNALS-24-02904>) looked at over 67,000 patients and found that poor communication alone caused 13% and was a contributory factor in 24% of safety incidents. At an estimated one in 10 patients being subject to an adverse event while receiving hospital care in high-income countries, and more than 130 million adverse events due to unsafe care occurring in hospitals in low- and middle-income countries alone (ref: “Global Patient Safety Action Plan 2021–2030) that is a lot of harm related to communication deficiencies.

The WHO publication “Global Patient Safety Action Plan 2021–2030: Towards eliminating avoidable harm in health care” does make some reference to communication issues, in particular:

“..... research and patient safety incident reports show that patients' conditions are often misdiagnosed because of clinical misjudgements, or when the correct test is not carried out or test results are lost, or because of miscommunication between different parts of the same health care system, among other reasons. Prominent among these reasons is the failure to communicate well with the patient.”

and

“ incorrect patient identification is responsible for medication errors and wrong site, wrong patient surgery. Improving critical communication amongst health workers and with patients is crucial and would prevent millions of adverse events.”

However, the Action Plan says little about steps to mitigate such problems. Increasing attention to reducing deficiencies in communication in healthcare practice seems likely to offer significant gains to patient safety.

geoff.royston@gmail.com

HIFA profile: Geoff Royston is an Independent Health Analyst and Researcher, former Head of Strategic Analysis and Operational Research in the Department of Health for England, and Past President of the UK Operational Research Society. His work has focused on informing the design, implementation and evaluation of policies and programmes in health and social care, and on fostering the capabilities of others to work in these areas. Associated activities have included modelling for understanding the performance of complex systems, analysis and communication of risk, and horizon scanning and futures thinking. He has also worked on information and communication technology in the health sector, notably in leading the design and national launch of the telephone and online health information and advice service NHS Direct. He has served on both scientific and medical UK Research Council panels, and as an impact assessor for the UK higher education Research Excellence Framework. He is a member of the editorial board for the journal Health Care Management Science and in 2012 was Guest Editor for its special issue on Global Health. He has been a consultant for the World Health Organisation, is a long standing member of the EURO Working Group on Operational Research Applied to Health Services, and is an expert adviser to the mHIFA (mobile Healthcare Information for All) programme. <http://www.hifa.org/projects/mobile-hifa-mhifa> He is also a member of the main HIFA Steering Group and the HIFA working group on Evaluating the Impact of Healthcare Information.

<http://www.hifa.org/support/members/geoff>
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Spotlight: Patient safety and NCDs (68) Introduction: Patrick Songa, Congo-Kinshasa (2)
Personal experience - Poor communication between health workers

27 September, 2026

[<https://www.hifa.org/dgroups-rss/introduction-patrick-songa-congo-kinsha...>]

Dear HIFA colleagues,

I would like to share a personal experience from Eastern DRC related to patient safety and continuity of care.

My grandmother was diagnosed with diabetes at a health facility.

When she returned the next day, she saw another clinician who could not find the record from her previous visit. Her assessment was repeated, and the information about her diabetes was not carried forward.

This made me think about how poor documentation and communication between health workers can affect patient safety and trust in health services.

In some communities, I have also seen people turn to traditional practitioners when they do not receive proper follow-up or feel that their treatment is not helping.

I believe that better record-keeping, communication between health workers, and follow-up could help improve the safety and quality of NCD care.

Best wishes,

Patrick Songa

Disclosure: I used ChatGPT to help edit and structure this message.

HIFA profile: Patrick Songa is Project manager at Corridor4health, Congo - Kinshasa.
patricksonga AT gmail.com

Spotlight: Patient safety and NCDs (69) A closing contribution from a rural primary-care clinic

28 September, 2026

Dear Neil, and colleagues,

Thank you for convening this Spotlight, and for the invitation to add final thoughts before the synthesis. I offer these from a small, free primary-care and dental clinic serving 32 rural mountain communities in the Dominican Republic, staffed in part by rotating volunteers — a modest setting, but perhaps a useful one for the questions you posed.

Across the four guiding questions, one thread has run through our experience: in a resource-limited, dispersed setting, the greatest threat to patients living with NCDs is rarely a dramatic clinical error. It is the quiet breakdown of continuity — a follow-up that never happens, a medication that lapses, information that does not travel with the patient. And continuity, unlike in a well-resourced system, holds only if we protect it deliberately; nothing about our setting protects it automatically.

On what can be done (your third and fourth questions), the most useful “system” we have is a handful of no-cost habits:

- A predictable clinic rhythm our chronic-disease patients can count on, so follow-up is not left to chance.
- A stable local clinical anchor — a regular physician and local team who provide “the same faces” continuity while visiting volunteers come and go, so a returning patient’s history and plan are known.
- Information that travels with the patient: a simple shared record and medication list that move with them across visits and to the pharmacy.
- Communication in the patient’s own language — Spanish, and Haitian Creole through a consistent interpreter — because, as many in this discussion have said, information is only safe if the patient and family can actually use it.
- A simple way to notice and follow up when someone does not return, rather than assuming that no news is good news.

I would add one point in support of patients and frontline workers alike: the patients and families themselves are part of the safety system. Where people manage their conditions for the many weeks between visits, their understanding — and small forms of support among neighbours — extends a clinic’s reach far more cheaply than any technology.

None of this requires new funding or new tools. It requires deciding that continuity is itself a safety practice, and organising around that belief. Thank you again for a valuable discussion; I have learned a great deal from colleagues in very different settings.

With best wishes,
fb

Frank Brightwell
Founder and Executive Director
Somos Amigos Medical Missions

HIFA profile: Frank Brightwell is Executive Director at Somos Amigos Medical Missions, in the United States. Email: frank AT somosamigos.org

Spotlight: Patient safety and NCDs (70) A closing contribution from a rural primary-care clinic (2)

28 September, 2026

Dear Frank and all,

Thank you Frank for your valuable contribution from Dominican Republic. This aligns with the previous contribution of Isaias Yosief at the Massawa Zonal Referral Hospital, Eritrea. Together this suggests these points are important through multiple levels of the health system worldwide, especially in low-resource settings.

<https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-43-co...>

To what extent are these priorities communicated in existing publications and manuals? One of the outcomes of this discussion could be to help ensure that such measures are better communicated.

The WHO Global Patient Safety Action Plan notes that 'Improving critical communication amongst health workers and with patients is crucial and would prevent millions of adverse events' and indicates that WHO should 'Develop tools and guidance for improving patient safety across the continuity of care, for example in primary care settings, including preventive and promotive care, and safe communication during transitions of care'.

I was unable to find specific guidance on these points in the Plan itself. So what patient safety guidance is available for primary care and facility-based care in low-resource settings? Does it cover the measures proposed by Isaias and Frank?

I have looked without success to find practical guidance on the Patient Safety section of the WHO website. A google search identified a 2022 publication from the WHO EMRO office: Patient safety assessment manual for primary care.

<https://iris.who.int/server/api/core/bitstreams/3841b952-040f-47a3-b303-...>

I asked Copilot "can you identify a practical manual on patient safety for primary care and low-resource settings?" and its strongest recommendation was the EMRO publication noted above.

This raises a number of further questions:

1. How useful is the 'Patient safety assessment manual for primary care' - My impression was 'not very useful' but it would be good to hear from Frank and Yosief.

2. It appears there is a publication for the EMRO region and presumably other regions are unlikely to use it?

3. How does WHO HQ and regions make decisions about the publication of practical manuals for low-resource settings? It would seem that this would be best handled by HQ unless there are specific regional peculiarities? For example, WHO Geneva is responsible for the highly acclaimed Pocket Book of Hospital Care for Children: Guidelines for the Management of Common Childhood Illnesses - this is probably the best-known WHO practical clinical manual for low-resource settings.

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

Spotlight: Patient safety and NCDs (71) A closing contribution from a rural primary-care clinic (3) Practical guidance for continuity and safe care in low-resource settings

30 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-70-cl...>]

Dear Neil, and colleagues,

Thank you for the generous response, and for linking my contribution with Isaias Yosief's — it is encouraging to see the same pattern recognised at both hospital and primary-care level.

You asked directly whether the WHO EMRO Patient safety assessment manual for primary care (2022) covers the measures Isaias and I described, and how useful it is. I have now read it, and I share your impression. It is a serious and careful document, but it is not, I think, the practical guidance a frontline team in a low-resource setting is looking for — for two reasons.

First, it is an accreditation and assessment instrument rather than a how-to guide. It sets out 125 criteria across five domains against which a facility is externally surveyed and certified at one of four levels. It is written for ministries of health and trained surveyors, and it presumes strategic plans, budgets, committees and documentation in English — an administrative apparatus that many small, rural or volunteer-supported clinics simply do not have. As a way of telling a stretched primary-care team what to actually do first, it is not designed for that.

Second, and more to the point of this discussion, it does not substantively address continuity of care. The manual is strong on several things — patient and family engagement, communication in the patient's own language and health literacy, patient identification, and medication safety. But continuity, the thread Isaias and I both placed at the centre, appears only as a single line in a medical-records audit and within the section on outbreak management. There is nothing on relational continuity (the value of the same clinician or team over time), nothing on systems to protect scheduled follow-up or to notice and recall patients who do not return, and nothing on information or medication records that travel with the patient across visits and to the pharmacy, beyond facility-bound medication reconciliation. Safe transitions of care are addressed only for medicines.

So I would agree the manual is of limited use for our purpose — not because it is poor, but because it answers a different question, for a different audience, and in a different region (it is EMRO-specific and heavily shaped by COVID-19).

If anything, this seems to me to strengthen the outcome you proposed. There appears to be a real gap in short, practical, frontline guidance on continuity and safe transitions of care for primary and community settings in low-resource contexts — the very measures this discussion has surfaced. Helping to fill or better communicate that gap would be a worthwhile result of the Spotlight, and I would gladly contribute what our small clinic has learned.

With best wishes,

fb

Frank Brightwell

Founder and Executive Director

Somos Amigos Medical Missions

HIFA profile: Frank Brightwell is Executive Director at Somos Amigos Medical Missions, in the United States. Email: frank AT somosamigos.org

Spotlight: Patient safety and NCDs (72) Preventable versus unpreventable harm (2) Guard rails, accountability and external evaluation

30 September, 2026

[Re: <https://www.hifa.org/dgroups-rss/spotlight-patient-safety-and-ncds-59-pr...>]

Neil, you raise an important question that (a) identifies the “anomalies” in the traditional “individual disease based “paradigm (Safe Care for NCDs) of our Spotlight Discussion and (b) may be more effectively addressed within the transformative context of a shifting paradigm of a whole of community and society approach (Safe Care for life).

Despite our references to “patient” and “safety” as seemingly generic concepts, patients globally are neither homogeneous or monolithic.

The varied “life” factors of individuals – as recorded in the SDGs - intersect in every individual's “wellbeing” and impact the contexts of our personal and collective health/care safety as well as harm. The paradox of Unsafe yet appropriate care as well as unpreventable harm emerges from systemic disregard of values of pluralism (the notion of appropriate being considered exclusively) included in the spirit of the Ubuntu philosophy.

The typical LMIC constraints or HIC advantages – for preventable harm and safe care are often mirrored in pockets of certain communities in both settings, the only difference being in the nature of their intra or inter- sectional life experience of benefit or handicap.

Listening to a TV interview of Dario Amodei, CEO of Anthropic, I hear three important words - Guard rails, accountability and external evaluation - addressing possible solutions for unpreventable and appropriate harms of AI security. Perhaps, they may also offer some timely insights to resolving the Patient Safety paradox?

Esha Ray Chaudhuri

Calgary, Canada

HIFA profile: Esha Ray Chaudhuri is an Equity Analyst, in Canada. Professional interests: Equity Issues in Health and Health Care with particular focus on interface of Local and Global contexts. She is affiliated to Patients for Patient Safety Canada-Healthcare Excellence Canada, and is a member of the GLL4QUHC at WHO.

Spotlight: Patient safety and NCDs (73) Reflections on Questions 1-4

30 September, 2026

[In response to guiding questions:

1. What is unsafe care and what is its local and global impact?
2. What are the main causes of unsafe care for people living with NCDs? To what extent is access to reliable healthcare information a determinant of patient safety?
3. What can be done to better understand and improve health systems for safer care for people living with NCDs?
4. How can we better support patients and primary and facility-based health workers to deliver safe care?]

Hi HIFA colleagues,

I apologize if this has come later than allowed given the excellent conclusions and summaries that have already come up. As I was having some technical difficulties accessing the full site, Dr. Cherian recommended sharing thoughts when I was back in good internet range, but regardless I'm excited to be part of this community.

Regarding guiding question #1: Wearing my different hats on surgical innovation and as a cardiologist, I've increasingly come to think that the infamous Anna Karenina quote regarding happy families is applicable here - all [safe care delivery systems] are alike [in ways that matter]; each [unsafe care delivery system] is unhappy in its own way. Safe care delivery aligns a drive for continuous improve and excellence with well-trained human resources, equipped with adequate physical and systems resources, supported by appropriate infrastructure and medical materials, to delivery high-quality, low-variance, individualized care to patients who are active participants in their own health. Deviation along any of the pathways creates unsafe care. Our colleagues on this forum have shared beautifully on the local and global impact.

Regarding guiding question #2: NCDs are quite broad because chronic diseases and risk factors dominate much of the high and middle-income countries' (and, increasingly, lower incomes countries' too) dialogue; yet surgical conditions that could potentially be quite directly treatable and curable qualify too. One unifying thread is what I would call the "rusty scalpel" phenomenon. A colleague in the safe surgery space had posed the challenge: in environments where even having a rusty scalpel and someone willing/able to wield it is an expected "best case scenario", how does one get not only organizational and market but even patient buy-in to innovations to improve? I see this same phenomenon daily in cardiology too, though instead of

rusty scalpel it's patients who are used to seeing their parents and grandparents having died early of cardiovascular disease if they haven't died of accidental trauma even earlier. Or it's fellow healthcare professionals resisting patient transfer to higher level of care for lifesaving therapies because with heart failure care advancing so rapidly, their idea of what's available to save patients and therefore which patients are viable candidates for advanced therapies haven't kept pace. Reliable healthcare information is the biggest tool to replace the rusty scalpel for patients, clinicians, and health system stakeholders alike.

Regarding guiding question #3 and 4: These are immense questions that our colleagues in this forum have striven to tackle in big systems ways at the level of Joint Commissions and WHO guidance resources, all the way to individual cases highlighting roles of communications, education, setup, and patient/provider navigation of the care delivery setting itself. The numbers of patients are immense when we talk about NCDs - Freihart et al 2025 estimated 12.4 billion incident cases and 43.8 million attributable death in 2021 alone, costing a staggering 1.73 billion DALYs - and, for most of the chronic conditions within this umbrella, each case is lifelong. That means the economics of the entirety of the care journey matter intimately to patients - witness the number of patients who stop taking blood pressure medications when they lose their jobs and can't afford medications, as just one example - and to systems thinking about delivery at scale - scale of patient epidemiology, but also of timeframes. This has meant in turn that on the innovation side of things, novel technologies and treatments have increasingly needed to be evaluated under the lens of real world evidence, over lots of time and in lots of patients. Researchers and regulatory pathways in different countries are still working to figure out how to do so, especially with the explosion of digital health technologies as well as use of unevenly regulated technologies such as AI and LLMs. On the care delivery side of things, longitudinal care management at the point of need is still the keystone of the whole system. Tracking outcomes and processes in efficient, low-burden ways; and optimizing NCD management without proportionately increasing healthcare human resource burden are both potentially two sides of a single digital transformation coin.

HIFA profile: Debbie Teodorescu is a Cardiologist/Founder of MultiCare Pulse Heart Institute/SurgiBox Inc, USA. Professional interests: NCD, SSI, research and innovation. dlteodor AT gmail.com

Spotlight: Patient safety and NCDs (74) Reflections on Questions 1-4 (2)

30 September, 2026

Dear Debbie and all,

Thank you for your thought-provoking reflections. I would like to pick out two points that resonate with me and comment on them below:

1. "Appropriate infrastructure and medical materials, to delivery high-quality, low-variance, individualized care to patients who are active participants in their own health"
2. "Reliable healthcare information is the biggest tool to replace the rusty scalpel for patients, clinicians, and health system stakeholders alike"

Indeed reliable healthcare information is key to patient safety and quality of care. We need increased availability of reliable information in at least three respects:

A. clinical knowledge, ranging from the most basic - such as the importance of giving a child with diarrhoea more fluids and not less - to the more complex - such as selecting an antibiotic for a severely ill patient

B. personal health record - not only by different health professionals, to ensure continuity, but also by patients

C. knowledge of patient safety principles and applications

The point about 'high-quality, low-variance' reminds me of an excellent video by Global Health Matters (WHO/TDR): Bridging the Knowledge Divide.

<https://www.youtube.com/watch?v=7xMSku0r7lY&t=280s>

The host Garry Aslanyan interviews Joy Phumaphi, Executive Secretary of the Africa Leaders Malaria Alliance (ALMA) and former Minister of Health for Botswana.

Right at the beginning he asks her: What changes have you noted about global health knowledge over the course of your career?

Here is a summary of her response, which merits attention coming from someone with so much experience and expertise:

"World Health Organization guidelines were printed, so there was essentially one main source of information. It was relatively straightforward to know what to do because you did not have to search through multiple sources or decide which information was reliable. You could rely on the WHO as the authoritative source.

"Over the past few years, however, the situation has changed considerably. There are now so many sources of health information, which can make it very difficult to know what to trust. There are centres of excellence around the world producing and sharing information, but their recommendations and data are not always aligned. As a result, different sources can provide conflicting information. In addition, there are individuals who deliberately spread disinformation, as well as misinformation that may be shared unintentionally but can be equally harmful... Overall, I feel that the situation is in some ways worse now than when I first began working in healthcare."

The key difference now is that there is uncontrolled high-variance without the ability to tell reliable information from misinformation, and with the latter presented more persuasively and malevolently.

The Global Patient Safety Action Plan would be stronger if it included a section to address these points. HIFA is currently working with the WHO to develop a technical brief on how to accelerate progress towards universal access to reliable healthcare information and I shall liaise with my colleagues to see how these points can be included and expanded.

Best wishes, Neil

HIFA profile: Neil Pakenham-Walsh is coordinator of HIFA (Healthcare Information For All), a global health community that brings all stakeholders together around the shared goal of universal access to reliable healthcare information. HIFA has 20,000 members in 180 countries, interacting in four languages and representing all parts of the global evidence ecosystem. HIFA

is administered by Global Healthcare Information Network, a UK-based nonprofit in official relations with the World Health Organization. Email: neil@hifa.org

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