Quality (1) Models of care for patients with hypertension and diabetes in humanitarian crises: a systematic review

13 March, 2021
Dear HIFA colleagues,

As we embark on a new project on quality health services, supported by WHO, I invite you to share relevant research, experience and expertise. Here is a new paper in Health Policy and Planning.

CITATION: Models of care for patients with hypertension and diabetes in humanitarian crises: a systematic review

Michael S Jaung, Ruth Willis, Piyu Sharma, Sigiriya Aebischer Perone, Signe Frederiksen, Claudia Truppa, Bayard Roberts, Pablo Perel, Karl Blanchet, Éimhín Ansbro

Health Policy and Planning, https://doi.org/10.1093/heapol/czab007

Published: 10 March 2021

ABSTRACT

Care for non-communicable diseases, including hypertension and diabetes (HTN/DM), is recognized as a growing challenge in humanitarian crises, particularly in low- and middle-income countries (LMICs) where most crises occur. There is little evidence to support humanitarian actors and governments in designing efficient, effective, and context-adapted models of care for HTN/DM in such settings. This article aimed to systematically review the evidence on models of care targeting people with HTN/DM affected by humanitarian crises in LMICs. A search of the MEDLINE, Embase, Global Health, Global Indexus Medicus, Web of Science, and EconLit bibliographic databases and grey literature sources was performed. Studies were selected that described models of care for HTN/DM in humanitarian crises in LMICs. We descriptively analysed and compared models of care using a conceptual framework and evaluated study quality using the Mixed Methods Appraisal Tool. We report our findings according to PRISMA guidelines. The search yielded 10 645 citations, of which

45 were eligible for this review. Quantitative methods were most commonly used (n = 34), with four qualitative, three mixed methods, and four descriptive reviews of specific care models were also included. Most studies detailed primary care facility-based services for HTN/DM, focusing on health system inputs. More limited references were made to community-based services. Health care workforce and treatment protocols were commonly described framework components, whereas few studies described patient centredness, quality of care, financing and governance, broader health policy, and sociocultural contexts. There were few programme evaluations or effectiveness studies, and only one study reported costs. Most studies were of low quality. We concluded that an increasing body of literature describing models of care for patients with HTN/DM in humanitarian crises demonstrated the development of context-adapted services but showed little evidence of impact. Our conceptual framework could be used for further research and development of NCD models of care.

Best wishes, Neil

Let's build a future where people are no longer dying for lack of healthcare information - Join HIFA: www.hifa.org
HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health campaign (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (2) First do no harm: practitioners' ability to diagnose system weaknesses and improve safety

20 March, 2021
Dear HIFA and CHIFA colleagues,

The Archives of Disease in Childhood has two interesting new OA papers on quality and patient safety in low-resource settings, from Mike English (paediatrician), Charles Vincent (patient safety expert) and colleagues.

Here is the first:

CITATION: English M, Ogola M, Aluvaala J, et al. First do no harm: practitioners' ability to 'diagnose' system weaknesses and improve safety is a critical initial step in improving care quality. Archives of Disease in Childhood 2021;106:326-332.

https://adc.bmj.com/content/106/4/326.info

ABSTRACT

Healthcare systems across the world and especially those in low-resource settings (LRS) are under pressure and one of the first priorities must be to prevent any harm done while trying to deliver care. Health care workers, especially department leaders, need the diagnostic abilities to identify local safety concerns and design actions that benefit their patients. We draw on concepts from the safety sciences that are less well-known than mainstream quality improvement techniques in LRS. We use these to illustrate how to analyse the complex interactions between resources and tools, the organisation of tasks and the norms that may govern behaviours, together with the strengths and vulnerabilities of systems. All interact to influence care and outcomes. To employ these techniques leaders will need to focus on the best attainable standards of care, build trust and shift away from the blame culture that undermines improvement. Health worker education should include development of the technical and relational skills needed to perform these system diagnostic roles. Some safety challenges need leadership from professional associations to provide important resources, peer support and mentorship to sustain safety work.

WHAT IS ALREADY KNOWN ON THIS TOPIC?

Harm resulting from unsafe care is common and results in significant adverse health and economic consequences in high-income countries.

Efforts to prevent or reduce harms often focus on identifying errors so that their specific causes can be addressed.

More recently, attention has been turned to considering how harms arise as a product of complex interactions in systems.

WHAT THIS STUDY ADDS?

Patient safety is much less well studied in low-resource settings than in higher income settings.

We suggest how concepts being employed to advance patient safety thinking in higher income settings could be usefully applied by practitioners in low-resource settings.

The ability to diagnose system weaknesses should become a core skill for those leading teams, wards, departments or facilities in low-resource settings.

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Best wishes, Neil

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20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (3) How to do no harm: empowering local leaders to make care safer in low-resource settings

20 March, 2021
Dear HIFA and CHIFA colleagues,

Here is the second paper on quality and patient safety in low-resource settings.

CITATION: Vincent CA, Mboga M, Gathara D, et al. How to do no harm: empowering local leaders to make care safer in low-resource settings. Archives of Disease in Childhood 2021;106:333-337.

https://adc.bmj.com/content/106/4/333

ABSTRACT

In a companion paper, we showed how local hospital leaders could assess systems and identify key safety concerns and targets for system improvement. In the present paper, we consider how these leaders might implement practical, low-cost interventions to improve safety. Our focus is on making immediate safety improvements both to directly improve patient care and as a foundation for advancing care in the longer-term. We describe a 'portfolio' approach to safety improvement in four broad categories: prioritising critical processes, such as checking drug doses; strengthening the overall system of care, for example, by introducing multiprofessional handovers; control of known risks, such as only using continuous positive airway pressure when appropriate conditions are met; and enhancing detection and response to hazardous situations, such as introducing brief team meetings to identify and respond to immediate threats and challenges. Local clinical leaders and managers face numerous challenges in delivering safe care but, if given sufficient support, they are nevertheless in a position to bring about major improvements. Skills in improving safety and quality should be recognised as equivalent to any other form of (sub)specialty training and as an essential element of any senior clinical or management role. National professional organisations need to promote appropriate education and provide coaching, mentorship and support to local leaders.

SELECTED EXTRACT: 'In many clinical settings in LRS, it may be simply not feasible to follow all professional guidelines, so decisions must be made about what is a 'must do' and what is 'do if possible' among a huge number of potential things to do.'

COMMENT (NPW): This last observation is hugely important. One of the key characteristics of useful healthcare information is that it should be actionable. Ideally, clinical guidelines

should be implementable with the resources available in the setting where they are used. I would be interested to hear people's experience in this regard. On the one hand, there is a real problem if the guidance is written with the assumption that the health facility is well resourced. There is also the clinical challenge of what to do in fluctuating settings, for example where there is a stock-out of the antibiotic that is indicated for a case of sepsis, or where there is no oxygen available for a patient with severe COVID-19.

Should there be more emphasis on guideline development for low-resource settings? Should guidance routinely say, "If X is not available, do Y"? Clinical judgement in these settings requires a high degree of expertise - how can health workers be better supported in such decision-making?

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Join CHIFA (child health and rights): http://www.hifa.org/joinchifa

Best wishes, Neil

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (4) The Overlooked Pandemic: How to transform patient safety and save healthcare systems #PSAW2021 #zeroharm

22 March, 2021
Forwarded from the Global Patient Safety Network, with thanks to Hatice Kucuk.

The new report - The Overlooked Pandemic: How to transform patient safety and save healthcare systems - is available here:

https://www.ssdhub.org/wp-content/uploads/2021/03/1863-Sovereign-Strateg...

Dear GPSN Team,

Please find the recording of our Patient Safety Launch Event on 18th March, that Dr Tedros delivered a keynote for, under this link:

RECORDING – PATIENT SAFETY REPORTT LAUNCH:

https://us02web.zoom.us/rec/share/KGnHHU1Qe0qN5dt6LFZ12kjJqGGIOrZwl0Cw2n...

Passcode: yLw3h*LX

Thank you

Hatice Kucuk

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SELECTED EXTRACTS FROM THE REPORT (NPW)

Unsafe care results in over 3 million deaths each year worldwide (WHO). [Comment: If we accept that poor quality care is, by definition, unsafe care, then the real number is actually much higher than this: 5 to 8.6 million deaths per year. NPW]

The social cost of patient harm is US$1-2 trillion a year.

Unsafe care disproportionately impacts low- and middle-income countries, where 134 million adverse events occur in hospitals every year, contributing to 2.6 million deaths (WHO).

4 in 100 people die from unsafe care in the developing world (WHO).

Comment: A huge but unknown number of deaths are the direct or indirect result of lack of availability of reliable healthcare information. NPW.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (5) WHO/UNICEF: Understanding barriers to quality of care: An approach for situational analysis of WASH and quality in health care facilities

25 March, 2021
With thanks to Shams Syed, WHO (one of the authors). WHO and Unicef have just published: Understanding barriers to quality of care: An approach for conducting a situational analysis of water, sanitation and hygiene (WASH) and quality in health care facilities

https://apps.who.int/iris/bitstream/handle/10665/340297/9789240022577-en...

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SELECTED EXTRACTS (NPW)

This document describes an approach for conducting a national situational analysis of water, sanitation and hygiene (WASH) as a basis for improving quality of care (herein referred to as quality, as defined in Box 1). A situational analysis is the first of the eight practical steps recommended by WHO and UNICEF as a means to trigger action to improve and sustain WASH in health care facilities, a prerequisite for providing quality care (1).

The availability of water, sanitation and hygiene (WASH) services in health care facilities, especially in maternity and primary-care settings where they are often absent, supports core aspects of quality, equity and dignity for all people. Recent data from WHO and UNICEF show that globally, one in four health care facilities lack basic water services, one in ten have no sanitation services and one in three have neither hand hygiene facilities at the point of care nor systems to segregate waste1. In Least Developed Countries, the gaps are even greater, where twice as many facilities lack basic water and sanitation services.

For a full explanation of the practical steps and case studies which illustrate them, refer to WHO & UNICEF. 2019 WASH in health care facilities: Practical steps for universal access to quality care. https://www.who.int/water_sanitation_health/publications/wash-in-health-...

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Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (6) WHO Fact Sheet: Quality health services

20 April, 2021
Dear HIFA colleagues,

We are currently planning a new WHO/HIFA project on Learning for Quality Health Services, which will include three thematic discussions here on HIFA:

https://www.hifa.org/projects/learning-quality-health-services

By way of introduction to the topic, I invite you to review the WHO Fact Sheet: Quality health services.

Extracts below. Full text here: https://www.who.int/news-room/fact-sheets/detail/quality-health-services

- Between 5.7 and 8.4 million deaths are attributed to poor quality care each year in low- and middle-income countries (LMICs), which represents up to 15% of overall deaths in these countries.

- Sixty per cent of deaths in LMICs from conditions requiring health care occur due to poor quality care, whereas the remaining deaths result from non-utilization of the health system.

- Inadequate quality of care imposes costs of US$ 1.4–1.6 trillion each year in lost productivity in LMICs.

- In high-income countries, 1 in 10 patients is harmed while receiving hospital care, and 7 in every 100 hospitalized patients can expect to acquire a health care-associated infection.

- It has been estimated that high quality health systems could prevent 2.5 million deaths from cardiovascular disease, 900 000 deaths from tuberculosis, 1 million newborn deaths and half of all maternal deaths each year.

- Globally, the essential structures for achieving quality care are inadequate: one in 8 health care facilities has no water service, one in 5 has no sanitation service, and one in 6 has no hand hygiene facilities at the points of care.

- An estimated 1.8 billion people, or 24% of the world's population, live in fragile contexts that are challenged in delivering quality essential health services. A large proportion of preventable maternal, childhood and neonatal deaths occur in these settings.

What is quality?

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge. This definition of quality of care spans promotion, prevention, treatment, rehabilitation and palliation, and implies that quality of care can be measured and continuously improved through the provision of evidence-based care that takes into consideration the needs and preferences of service users – patients, families and communities...

Specifically, WHO is:

- supporting countries in the development, refinement and implementation of national quality policies and strategies for an integrated approach to quality health services;

- working with partners and a network of countries to learn how to improve the quality of care for maternal, newborn and child health at scale and in a sustainable way;

- developing the technical foundations for improving quality of care in fragile, conflict-affected and vulnerable settings;

- strengthening infection prevention and control (IPC) capacity alongside efforts on water, sanitation and hygiene (WASH), since both are pivotal to quality health services;

- promoting patient safety initiatives to reduce harm to patients in the delivery of quality essential health services;

- spearheading the development of quality of care measurement frameworks, indicators and reporting on progress;

- supporting the sharing of lessons and experiences within and between countries through the WHO Global Learning Laboratory for Quality UHC and by fostering twinning partnerships to improve quality of care; and

- providing support to countries in their work on community engagement for quality, people-centred and resilient health services.

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Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Coordinator, WHO-HIFA Collaboration: HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

Quality (7) WHO Fact Sheet: Quality health services (2)

20 April, 2021
Great stuff. Great opportunity. Very educative.

Neil thanks for sharing and thanks to your immediate team who have worked on this project.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for

Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

http://www.hifa.org/support/members/joseph-0

http://www.hifa.org/people/steering-group

Email: jneana AT yahoo.co.uk

Quality (8) WHO/UNICEF: Understanding barriers to quality of care: An approach for situational analysis of WASH and quality in health care facilities (2)

21 April, 2021
On 25 March I posted a message about a new WHO and Unicef publication: Understanding barriers to quality of care: An approach for conducting a situational analysis of water, sanitation and hygiene (WASH) and quality in health care facilities.

I also posted this on the SuSanA forum (Sustainable Sanitation Alliance) and the lead moderator Elisabeth Muench reminds us of a publication on this topic in 2019.

Water, sanitation, and hygiene in health care facilities practical steps to achieve universal access to quality care

https://apps.who.int/iris/bitstream/handle/10665/340297/9789240022577-en...

I forward the message below.

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Hi Neil,

Your post prompted me to take another look at the 2019 WHO publication in order to understand: what are the barriers to providing WASH in health care facilities? (as it seems like such a no brainer, that clean water and sanitation are paramount for health care facilities to be effective)

I found them listed on page 14 here:

Incomplete standards

Inadequate monitoring

Disease-specific budgeting

Disempowered workforce

Poor WASH infrastructure

Each of those factors are explained in more depth in the document.

Furthermore, the document talks about "Eight Practical Steps to Improve and Sustain WASH in Health Care Facilities" in Section 3:

1. Conduct situation analysis and assessment
2. Set targets and define roadmap
3. Establish national standards and accountability mechanisms
4. Improve and maintain infrastructure
5. Monitor and review data
6. Develop health workforce
7. Engage communities
8. Conduct operational research and share learning.

Point 4 in that list is probably the hardest one and requires the most funds!

Regards,

Elisabeth

P.S. I have also updated the Wikipedia article on WASH with this information, see here:

https://en.wikipedia.org/wiki/WASH#Health_facilities

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Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (9) Harmful healthcare in Tanzania

21 April, 2021
'Fifty-three percent of 1995 drugs prescribed and 43% of 891 tests ordered were unnecessary.' This is one of the findings of a new study in Health Policy and Planning. 'Clinically harmful care was more likely in for-profit than faith-based facilities and less common in urban than rural areas.'

CITATION: How much healthcare is wasted? A cross-sectional study of outpatient overprovision in private-for-profit and faith-based health facilities in Tanzania

Jessica J C King, Timothy Powell-Jackson, Christina Makungu, James Hargreaves, Catherine Goodman

Health Policy and Planning, https://doi.org/10.1093/heapol/czab039

Published: 14 April 2021 [restricted access]

ABSTRACT

Overprovision — healthcare whose harm exceeds its benefit — is of increasing concern in low- and middle-income countries, where the growth of the private-for-profit sector may amplify incentives for providing unnecessary care, and achieving universal health coverage will require efficient resource use. Measurement of overprovision has conceptual and practical challenges. We present a framework to conceptualize and measure overprovision, comparing for-profit and not-for-profit private outpatient facilities across 18 of mainland Tanzania's 22 regions. We developed a novel conceptualization of three harms of overprovision: economic (waste of resources), public health (unnecessary use of antimicrobial agents risking development of resistant organisms) and clinical (high risk of harm to individual patients). Standardized patients (SPs) visited 227 health facilities (99 for-profit and 128 not-for-profit) between May 3 and June 12, 2018, completing 909 visits and presenting 4 cases: asthma, non-malarial febrile illness, tuberculosis and upper respiratory tract infection. Tests and treatments prescribed were categorized as necessary or unnecessary, and unnecessary care was classified by type of harm(s). Fifty-three percent of 1995 drugs prescribed and 43% of 891 tests ordered were unnecessary. At the patient-visit level, 81% of SPs received unnecessary care, 67% received care harmful to public health (prescription of unnecessary antibiotics or antimalarials) and 6% received clinically harmful care. Thirteen percent of SPs were prescribed an antibiotic defined by WHO as 'Watch' (high priority for antimicrobial stewardship). Although overprovision was common in all sectors and geographical regions, clinically harmful care was more likely in for-profit than faith-based facilities and less common in urban than rural areas. Overprovision was widespread in both for-profit and not-for-profit facilities, suggesting considerable waste in the private sector, not solely driven by profit. Unnecessary antibiotic or antimalarial prescriptions are of concern for the development of antimicrobial resistance. Option for policymakers to address overprovision includes the use of strategic purchasing arrangements, provider training and patient education.

KEY MESSAGES

- Limited resources available for universal health coverage must be used efficiently in low- and middle-income countries, and overprovision is not only wasteful but can cause clinical harm to individual patients and wider public health harms.

- By sending standardized patients (SPs) to 227 private-for-profit and faith-based health facilities in Tanzania, we found 81.4% of patients received some unnecessary care, 67.2% received care that could threaten public health (prescription of an unnecessary antibiotic or antimalarial) and 6.2% received care that could be clinically harmful to the individual patient.

- Private-for-profit facilities were more likely to provide potentially clinically harmful care

than not-for-profit facilities but no more likely to provide unnecessary care or care harmful to public health.

- Policymakers need to understand factors that lead to overprovision when considering interventions such as changing provider payment mechanism, training and consumer education.

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Best wishes, Neil

Coordinator, WHO-HIFA Collaboration: HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

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HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (10) Eight Compelling reasons to attend the ISQua Virtual conference (8-11 July 2021)

21 April, 2021
Good afternoon

I hope you are well.

Dr Neil Pakenham-Walsh has asked that I forward information to you regarding ISQua's Virtual Conference to be circulated amongst your networks.

Please see a link to the blog post here - https://isqua.org/resources-blog/blog/eight-compelling-reasons-to-attend...

It would be great if you could also promote the attached article via your website, newsletter, or social media channels. [*HIFA does not carry attachments]

If you have any questions, please let me know.

Many thanks for your assistance.

Kind regards
Aoife

Aoife Dowling
Corporate Services Officer
International Society for Quality in Health Care
Dublin, Ireland
Web: www.isqua.org

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Quality (11) Harmful healthcare in Tanzania (2) Overprescription of medicines

22 April, 2021
Dear Neil and HIFA friends, yes, in Tanzania drugs are overprescribed, more is for antibiotics and for children. Not only in non-for-profit or private settings as in the study but also in public ones (Gwimile et al/Kilimanjaro).

However this phenomenon is not confined to Africa or poor countries, it is a worldwide trend. Just because I know it well, Italy 'has' thousand different molecule-drugs in the pharmacies. Silvio Garattini, scientist of world reputation in the field, declared that more than half of them are unnecessary, without proved efficacy, useless.

Being the pharmaceutical market flourishing all over (it is a highly lucrative market indeed) it is easy to understand why we doctors keep prescribing more and more. We are definitely under pharma companies' influence, they 'teach' us about drugs, they pay us if we prescribe their products. Worldwide.

As a youg pediatrician I was 'invited' by formula milk producers (names omitted but not one excluded) to prescribe it more, in order to 'help those mothers with little milk'.

And I did it.

Market/profit/money dominate our medical behaviour, you advocate "more information and training to prescribers", I think that political approach would be better.

Greetings from Kilimanjaro

Massimo

"The king felt sick in his bed. All court's doctors arrived and soon prescribed a number of bleedings through salass, leeches, scarifications and then they made him vomit, pass stools and sweat. His death was of a big concern for he had responded well to therapy".

This happened centuries ago when medicine was in darkness. The origin of diseases was unknown therefore treatment was the one for the king. Now we know much more about diseases, we know their origin and how to diagnose them. However treatment is still unscientifically left in the hands of drugs producers and doctors that have the power (magic power) to prescribe wathever they liked to whoever they liked. As it happened to the poor king.

HIFA profile: Massimo Serventi is a long-standing Pediatrician working in Africa since 1982. He has worked for several NGOs in 6 African/2 Asian countries. His interests include clinical and community pediatrics, adherence to clinical guidelines and school education as the major determinant of good health. massimoser20 AT gmail.com

Quality (12) Quality improvement and newborn care

25 April, 2021
Dear Sir

I am professor in Division of Neonatology, Department of Pediatrics in B.P. Koirala Institute of Health Science (BPKIHS), Dharan, which is a Largest Tertiary Care University Teaching Hospital in Nepal. I am involved in teaching Neonatology and providing support to policy issues and academic initiatives related to newborn health in close association with Government of Nepal and other International partners. I am passionately interested in Quality Improvement (QI) Science, QI is a part of my psyche as a healthcare professional and safety is my raison d'etre. I am also currently selected as a member of the Working Group on Learning for Quality Health Services as member For WHO Global Learning Laboratory (GLL) for quality Universal Health Care (UHC) and Healthcare Information for all (HIFA).

I am interested in interacting with HIFA group of Quality Health services especially related to Newborn health.

Sincerely

Prof (Dr) Nisha Keshary Bhatta
Professor
Division of Neonatology

Department of Pediatrics & Adolescent Medicine
B.P. Koirala Institute of Health Science (BPKIHS)
Dharan, Nepal

HIFA profile: Nisha Bhatta is professor in Division of Neonatology, Department of Pediatrics in B.P. Koirala Institute of Health Science (BPKIHS), Dharan, which is Largest Tertiary Care University Teaching Hospital in Nepal. She is involved in teaching Neonatology and providing support to policy issues and academic initiatives related to newborn health in close association with Government of Nepal and other International partners. She is passionately interested in Quality Improvement (QI) Science. She is a member of the HIFA-WHO working group on Learning for quality health services.

https://www.hifa.org/support/members/nisha-0

https://www.hifa.org/projects/learning-quality-health-services

Email: nishakesharybhatta AT yahoo.com

Quality (13) Webinar report: What is the role of compassionate leadership in driving quality care? (4)

28 April, 2021
Below are brief extracts from the webinar on Compassionate leadership, held on 11 March 2021. The full text is available here:

https://taskforce.org/wp-content/uploads/2021/04/GHCR-vol.-5_compassiona...

What is the role of compassionate leadership in global health? Critical for sure! For some interesting perspectives that will make you think, see this report out from a recent Global Health Compassion Rounds.

https://taskforce.org/global-health-compassion-rounds-volume-5-report/

The theme of our rounds today is compassionate leadership. You may ask, "Why compassionate leadership?" We now have randomized clinical trials that document the benefits of compassion training for individuals, but we struggle to develop and sustain compassionate organizations. As you'll hear today, leadership is crucial for compassionate organizations.

In my conversations with global health leaders over the last several years, they've described three challenges to compassion in their work. The first is compassion at a distance. In global health, we often work at great distances from

the people whose health we are working to improve. We see the numbers and the populations rather than the individuals and faces.

Second, there is a barrier of what I call "compulsion to save the world" and an over-identification with work. There is a preoccupation with metrics, measures, and outcomes to the neglect of relationships, process, and compassion.

And third there's a "conspiracy of silence." So many people in global health are motivated by a sense of compassion. But for some reason we don't feel comfortable sharing this with each other, so the power of this collective energy of shared motivation is hidden. One objective of these global health compassion rounds, is to break this "conspiracy of silence."...

WHO Director General Tedros Ghebreyesus highlighted back in 2018 a few words that remain poignant to this day. He told us, “Quality is not a given. It takes vision, planning, investment, compassion, meticulous execution, and rigorous monitoring, from the national level to the smallest, remotest clinic.” All of that happens through leadership...

Evan Harrel: I think all five of these takeaways are tremendous, but I would like to leave us with the final one. Leaders are everywhere. Leadership is about motivating others towards a shared goal. Global health has a clearly defined goal of relieving suffering and helping remove the causes of suffering. We can all contribute to moving towards that goal....

Laura Berland: I think what we're hearing, and it's so important, is that when you come into alignment with your deeper values with what really matters in life, with your love, with your purpose, with why you're here—that when all of that starts resonating, that becomes the spiral of win, win, win, win...

Evan Harrel: I just want to say—and Monica expressed this earlier so clearly—we all have this innate ability for compassion, and the trick is to awaken it. And when we awaken it, we are coming into that alignment. So compassion really isn't something to be learned. Compassion is something that's forgotten, so once we've forgotten, all we have to do is reawaken it and remember...

David Addiss: Here we are. We're on a journey together exploring the deeply human interior of our own compassion and our own being. And we're doing that in the context of global health, which is a massive effort to alleviate suffering.

Quality (14) Webinar report: What is the role of compassionate leadership in driving quality care? (5)

1 May, 2021
Report out from the Global Health Compassion Rounds held on Mar. 11, 2021, focused on the value of compassionate leadership in global health.

Compassionate Leadership in Global Health

Report & webinar recording available now!

View recording (https://www.youtube.com/watch?v=-j4taruXI0Y)

Download report (https://taskforce.org/global-health-compassion-rounds-volume-5-report/)

Our Panelists

Laura Berland, Founder & Executive Director, and Evan Harrel, Chief Operating Officer, together run the Center for Compassionate Leadership. They offered their framework to train and enable leaders to lead with compassion, starting from the inside out.

"We have to come back to that fundamental quiet place so we have the ability to turn our attention to what matters."

Monica Worline is an organizational psychologist whose work is dedicated to cultivating compassionate leadership and an environment that brings people's humanity alive at work. She presented a compelling case for why compassion belongs on any leaders' strategic agenda.

"I'm not teaching anyone how to be compassionate. What we're doing is awakening compassion that's already available to humanity and is there as a resource that we have."

Manvir Victor is the Chairman of Patients for Patient Safety and a renowned radio DJ in Malaysia. He shared how his personal healthcare experience motivated him to become an active patient advocate.

"Only when doctors are genuinely compassionate are patients able to trust them with their lives."

Zerihun Tadesse, Ethiopia Country Representative, The Carter Center, shared his motivations, successes, and challenges in pursuing compassionate leadership.

"It works very well if you first connect as human beings before you connect as coworkers, so that tends to be my philosophy."

Save The Date!

The next Global Health Compassion Rounds will be held on
Thurs., June 17, 2021 @ 11 am EDT (UTC -4).

GHCR is hosted by the Focus Area for Compassion and Ethics (FACE) (https://taskforce.org/face/) at the Task Force for Global Health and the Global Learning

Laboratory (GLL) (https://www.who.int/servicedeliverysafety/areas/qhc/gll/en/index6.html) at the World Health Organization.

Questions? Email us at face@taskforce.org (mailto:face@taskforce.org)
https://twitter.com/FACEofHealth
mailto:face@taskforce.org
https://taskforce.org/face/

Quality (15) Introduction: Moses Kumaoron Orfega, Nigeria - National Health Insurance Scheme and Universal Health Coverage

1 May, 2021
Hi Everyone!

My name is Moses Kumaoron Orfega, and I'm happy to be part of this Group. I am from Nigeria, and I currently work with the National Health Insurance Scheme (NHIS). I've been working with the Scheme for over nineteen years.

During this period, I've been assigned various schedule of duties relating to information technology, monitoring and evaluation, international collaboration, and (currently) service improvement.

I have had my education in Mathematical Statistics & Computer Science, Information Technology, and Social Protection. I have also acquired on-the-job experience in Social Health Insurance and Universal Health Coverage (and related matters).

My major areas of interest (in order of preference) are Social Protection, Universal Health Coverage and Information Technology. Looking forward to having fruitful discussions with you all...

--

ORFEGA, Moses Kumaoron

HIFA profile: Moses Kumaoron Orfega is a Service Improvement Desk Officer at the National Health Insurance Scheme, Nigeria. Professional interests: Social rotection and Financing; Social Health Protection and Universal Health Coverage; Service Quality Improvement; Information Technology. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. Email: ofegamoses AT gmail.com

Quality (16) Introduction: Lani Marquez, USA - Case book: Improving Health Care in Low- and Middle-Income Countries

3 May, 2021
Dear HIFA members,

I am really pleased to join the WHO/HIFA joint project on “Learning for Quality Health Services” and to join the HIFA community. I am a public health professional who has focused for the past 20 years on using knowledge management techniques to improve learning about how to improve health care quality, working for a series of USAID-funded health systems strengthening projects. I am passionate about how knowledge management approaches can add value to health care improvement efforts and am eager to contribute to the HIFA community.

One of our legacy products from the USAID Applying Systems to Strengthen and Improve Systems (ASSIST) Project, which ended in June 2020, was an open-access book of 12 case studies on specific applications of quality improvement methods in 11 low- and middle-income countries. The book, freely available at https://link.springer.com/book/10.1007%2F978-3-030-43112-9 , includes case studies written by implementers in Kenya, Mozambique, Tanzania, Uganda, India, Kyrgyz Republic, Georgia, Ukraine, Guatemala, Haiti, and Honduras. The chapters of the book describe applications of a range of quality improvement methods, including accreditation, audit and feedback, certification, collaborative improvement, electronic medical records and performance analysis, incentives/recognition, quality improvement linked to financing mechanisms, evidence-based standards, and team-based problem-solving. Each case presents the aim of the improvement intervention, describes the efforts to address that aim, and results of those efforts. Cases end with a discussion of efforts to scale-up/spread/institutionalize successes and a reflection on lessons learned from the work.

This book was the brainchild of Dr. James Heiby, who dedicated his career at USAID to promoting the use of improvement methods in low- and middle-income countries. Jim said, “It is my hope that this sample of improvement case studies will show the reader the power of improvement methods, expand their evidence base, and most importantly, encourage a better understanding of the culture and practice for improvement in order to achieve better health outcomes for all.”

I feel this book is a fitting resource to share through HIFA. Look forward to interacting with you.

Lani

LANI MARQUEZ
Knowledge Management Director
C 301-275-0755

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University Research Co., LLC
5404 Wisconsin Avenue, Suite 800
Chevy Chase, MD 20815 USA

Lani Rice Marquez works with the University Research Company and is based in USA. Interests: Quality improvement, knowledge management. Extensive experience with technical writing and editing and facilitation of webinars and peer-to-peer learning activities.

https://www.hifa.org/support/members/lani-rice

https://www.hifa.org/projects/learning-quality-health-services

Quality (17) Introduction: Moses Kumaoron Orfega, Nigeria (2) Implementation of national electronic record systems

3 May, 2021
Hi Moses, [https://www.hifa.org/dgroups-rss/quality-15-introduction-moses-kumaoron-...

We would be very happy to share our UK experiences with the development and implementation of National electronic record systems if it can help your work in Nigeria. We still have a long way to go but all patients are registered on life long digital records.

We produced a report for our House of Lords and have engaged with our medical regulators, Professional medical association, indemnity bodies and with our national health service administrators.

National electronic health record systems have basic standard and technical requirements in a number of areas that include:

Emerging Global Health care records standards
Clinical governance
Information Governance
Ethics of professionals
Health and care outcomes
Law of country and international law
Data security
“The State” and the declaration of human rights
Culture and memes of People and the many publics
Consent, understanding and individual morals of citizens (data subjects under our European General Data Protection regulation)

These are all linking up globally, now, through technology, connectivity, the internet and radiotelephony.

West Pennine Local Medical Committee provided an information toolkit for their 60 family practices and over 200,000 patients which I have pasted.

Let us know if we can help further. [...]

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

Quality (18) Introduction: Martin Dohlsten, WHO - The Network for Improving Quality of Care for Maternal, Newborn and Child Health

4 May, 2021
Dear HIFA members,

I am very pleased to join to the HIFA community. I am a public health professional with experience from several sub-Saharan Africa countries, currently based in WHO HQ, working in the Maternal, Newborn, Child and Adolescent Department, with a focus on Quality of care. I am part of the Secretariat for The Network for Improving Quality of Care for Maternal, Newborn and Child Health (Quality of Care Network). This is a broad partnership of committed governments, implementation partners and funding agencies working to ensure that every pregnant woman, newborn and the child receives good quality care with equity and dignity. The goals of the Network are to halve maternal and newborn deaths and stillbirths in health facilities by 2022 and to improve patients' experience of care in participating in health facilities in Network countries.

Ten countries are currently members of the Network: Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Kenya, Malawi, Nigeria, Sierra Leone, the United Republic of Tanzania, and Uganda. These countries are well-positioned to make rapid progress, as evidenced by a high degree of political will and commitment to support and resource maternal and newborn health services from their governments and, from funding and technical partners, strong, funded commitment and support.

For more information on this work, please check https://www.qualityofcarenetwork.org/

Please feel free to connect and I am happy to share more around the work of the QoC Network!

Kind regards,

Martin Dohlsten
Technical Officer
Maternal, Newborn and Child Health
Department of Maternal, Newborn, Child, Adolescent Health and Aging
Universal Health Coverage
World Health Organization, Geneva
Email: dohlstenm@who.int

HIFA profile: Martin Dohlsten is a Technical Officer in Maternal, Newborn and Child Health at World Health Organization, Gevena, Switzerland. He is a member of the WHO-HIFA working group on Learning for quality health services.
https://www.hifa.org/support/members/martin-0
https://www.hifa.org/projects/learning-quality-health-services
dohlstenm AT who.int

balogunkehinde1 AT gmail.com

Quality (19) Introduction: Kebede Eticha - WASH / IPC Consultant at UNICEF

4 May, 2021
Dear HIFA members,

It is my pleasure to inform you that I have joined the working group on Learning for Quality Health Services. I am a public health professional with over 20 years work experiences working for government health sector, INGO and WHO in Ethiopia. At WHO I got the opportunity to learn and document on the Clean and Safe health care facilities program and support the capacity for WASH in health care facilities improvement (WASH FIT). Recently I have been also working

for UNICEF East and Southern Africa regional office as WASH and IPC consultant which provided me the opportunity to learn and support countries with the IPC practices in the context of Covid-19.

Kindly look at the link for the documentation on the role of WASH to achieving quality universal coverage at

https://apps.who.int/iris/rest/bitstreams/1083779/retrieve

Kind regards,

Kebede Eticha Gela

HIFA profile: Kebede Eticha is a WASH / IPC Consultant at UNICEF Eastern and Southern Africa Regional Office. He is a member of the WHO-HIFA working group on Learning for quality health services.
https://www.hifa.org/support/members/kebede-0
https://www.hifa.org/projects/learning-quality-health-services
keticha.ke AT gmail.com

Quality (20) Introduction: Kehinde Balogun, Nigeria - Quality improvement, HIV control, Catholic Relief Services

6 May, 2021
Dear HIFA Forum,

I am happy to be part of the WHO/HIFA project on Learning for Quality Health Services. My name is Kehinde Balogun. I am a medical doctor, a public health and quality improvement expert with over 10 years experience directly providing and leading healthcare service teams. I am also a monitoring and evaluation professional. At the moment, I lead a monitoring and evaluation team within Catholic Relief Services, an international organization working on a large-scale project to support the provision of preventive and treatment services to achieve HIV epidemic control in Nigeria where I champion use of routine data to inform interventions and improve overall quality of care and services on the program.

Before now, I have worked as a quality improvement specialist, focusing mostly on improving outcomes for people living with HIV/AIDS, but also applying the lessons to other aspects of health services in my country including improvement of clinical and laboratory interface in hospitals, improving patient experience of maternity care, reducing waiting time in hospital, etc.

I wrote a blog published WHO Global Learning Laboratory (GLL) newsletter on eliminating mother to child transmission of
HIV http://www.integratedcare4people.org/news/806/eliminating-mother-to-chil.... I was also a reviewer/contributor to some WHO documents on quality improvement viz :

1. WHO National Quality and Policy
Handbook: http://www.who.int/servicedeliverysafety/areas/qhc/nqps_handbook/en/

2. WHO document on Quality Health
Services: https://www.who.int/publications/i/item/9789240011632

I look forward to participating more actively on the HIFA platform.

Warm regards,

BALOGUN KEHINDE AYANTUNDE MD; MBA; MPH; CSSGB; FISQua

HIFA profile: Kehinde Ayantunde Balogun is a medical doctor who works with the Catholic Caritas Foundation of Nigeria (CCFN) as a Quality Improvement Specialist. He is a certified Six Sigma Green Belt and a Fellow of the International Society for Quality in Healthcare. He is presently running his Master of Business Administration (MBA), and Master of Public Health (MPH) programmes. Currently he is working on a Centers for Disease Control and Prevention (CDC) funded care and treatment program for HIV/AIDS and TB across several states of Nigeria, and he is the Quality Improvement (QI) lead for the Benue region. His interests include public health, quality improvement in healthcare, HIV/AIDS, reproductive health, child and maternal health, and research. He is a member of the WHO-HIFA working group on Learning for quality health services.
https://www.hifa.org/support/members/kehinde-ayantunde
https://www.hifa.org/projects/learning-quality-health-services
balogunkehinde1 AT gmail.com

Quality (21) Introduction: Ann Lawless, Australia - Sociologist and patient representative

7 May, 2021
Hello!

I have joined HIFA on the recommendation of the WHO Global Learning Laboratory (WHO GLL). I have the honour of being invited to participate in a joint project between WHO GLL and HIFA. This is the Working Group on Learning for Quality Health Services. https://www.hifa.org/projects/learning-quality-health-services

I have lived experience as a person with a disability, and have a passionate concern for equity and justice. I am interested in the forms of participative democracy and its processes.

I am a health activist and health advocate with decades of experience as a health consumer representative (patient representative) in three states across Australia. I have been active in international fora as I have an interest in global and international health, and health equity. As examples, I have been involved with ISQua, the IAPO Patients Congress and the Asia-Pacific Patients Congress. I am a health activist active internationally, nationally, at state level, and locally in my neighbourhood.

I am a sociologist with a doctorate and provide leadership in this field through the Australian Sociology Association. With over sixty publications, I have experience as a researcher, author, mentor of doctoral candidates and an educator in the health and social sciences.

I am curious and like to live life to the full and enjoy many fun hobbies and interests!

Dr Ann Lawless
Twitter: @Anntics

Dr Ann Lawless,
Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the WHO-HIFA working group on Learning for quality health services.
https://www.hifa.org/support/members/ann
https://www.hifa.org/projects/learning-quality-health-services
lawlesszest AT yahoo.com

[There is no Quality (22)]

Quality (23) Introduction: Bhupendra Rana, India - Quality, Patient Safety and Accreditation

8 May, 2021
Dear HIFA Members,

I am delighted to say that I have joined HIFA after learning about it through my membership of the Working Group constituted by WHO Global Learning Laboratory (WHO GLL) and HIFA. This is the Working Group on Learning for Quality Health Services.

https://www.hifa.org/projects/learning-quality-health-services

I am an Expert of Healthcare Quality, Patient Safety and Accreditation with over 20 years of experience. Currently, I am the CEO of Quality and Accreditation Institute (QAI), an emerging Accreditation Body in India. I have led the development of eight accreditation standards at QAI in just less than three years. Prior to QAI, I was instrumental in establishing national accreditation body in 2006, held the position of Director & CEO-Incharge and led the development of over a dozen accreditation standards and international recognition.

I have the honor of supporting WHO Patient Safety Friendly Hospital Framework in EMRO by conducting surveys and training programmes. I have supported countries including national Ministries of Health in Bhutan, Bangladesh, Indonesia, Oman, Nigeria and Nepal in developing accreditation standards, setting up accreditation bodies and ISQua accreditation

through my assignments as consultant to WHO, the World Bank, Asian Development Bank, USAID as well as independent consultant.

I am a Founding Member of Scientific Advisory Board, International Alliance of Patients' Organisations, London, UK and International Academy for Quality and Safety (IAQS), Serving as a Board Member of Asian Society for Quality in Healthcare (ASQua), Empanelled Expert in WHO Roster on Healthcare Quality and Patient Safety. Served as Board Member of ISQua (October 2014- October 2016, October 2017- October 2020) and ISQua External Evaluation Association (IEEA), (October 2017- October 2020), Member, ISQua Board Accreditation Committee (2017-2020), Chairman- ISQua Accreditation Council (2014-2016) and President of Asian Society for Quality in Healthcare (ASQua)(2011-12).

I hold PhD in Biochemistry, Post Graduate Diploma in Hospital & Health Management and U.G. Diploma in German.

I look forward to working with you all!

Bhupendra Kumar Rana
Twitter: @bkrana71
bkrana@qai.org.in

With regards,
Bhupendra Kumar Rana|MSc PhD PGDHHM MAHA
Chief Executive Officer
Quality & Accreditation Institute (QAI)
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M: +91-9899548050
email: bkrana@qai.org.in Web: www.qai.org.in
LinkedIn |Twitter |Facebook

Our Vision:
Nurturing the largest global pool of organisations and people through quality improvement and accreditation framework.

HIFA profile: Bhupendra Kumar Rana is Chief Executive Officer of the Quality & Accreditation Institute (QAI), Noida, India. He is a member of the WHO-HIFA working group on Learning for quality health services.
https://www.hifa.org/support/members/bhupendra-kumar
https://www.hifa.org/projects/learning-quality-health-services
Email: bkrana AT qai.org.in

Quality (24) Introduction: Ibrahima Sall, Senegal - Engaging leaders in quality health services

10 May, 2021
Dear all

I am a physician in a teaching hospital in Senegal. It is an honor of being recommended and joining the group. I hope this will help us to improve access and learning for health quality.

Our commitment on quality of care is necessary. One topic i would like to share is about trust on quality care in LMICs. The perception of a part of our leaders is that there is no quality or lack of equipment in our hospitals. So they always go in others countries for medical care. The fact is that quality is sometimes correlated to development. Is that true?

May be in some aspects it may be true according to kind of complex diseases. But if we do not reverse the way of thinking no real political engagement or financial investment will be a priority in our country.

Does someone have already works in a kind of awareness or methodology to improve this topic ?

Ibrahima Sall MD

HIFA profile: Ibrahima Sall is a Consultant Surgeon at the Main Hospital and Army Teaching Hospital in Dakar, Senegal. Professional interests: Healthcare quality and risk management in surgery and oncology. He is a member of the HIFA-WHO working group on Learning for quality health systems.

https://www.hifa.org/support/members/ibrahima

https://www.hifa.org/projects/learning-quality-health-services

Email: sall_i17 AT yahoo.fr

Quality (25) Introduction: Nilufar Rakhmanova, Cambodia - Quality improvement

13 May, 2021
Hello,

This is Nilufar Rakhmanova, a Chief of Party of a USAID Enhancing Quality of Healthcare Activity (EQHA), currently leading a large quality improvement project in Cambodia that focuses not only in CQI but also accreditation, continuous professional development, competency based education. In my free time, dance folk dances of the Silk Road Dance Company. I am an ISQua Fellow.

Facebook: https://web.facebook.com/EQHACambodia twitter:
@NilufarRakhman1 nrakhmanova@fhi360.org

Nilufar Rakhmanova, MD, MPH
Chief of Party. USAID Enhancing Quality of Healthcare Activity (EQHA)
Phone: 855.23.211.914|Mobile: 855.77.444 395|nrakhmanova@fhi360.org|
Address: Phnom Penh Center, Building F, 6th & 7th Floor (Room# 675 & 771), Corner Sihanouk (274) & Sothearos (3) Blvd., Sangkat Tonle Bassac, Khan Chamkamon, Phnom Penh, Cambodia. P.O Box: 2586
Facebook: https://web.facebook.com/EQHACambodia
twitter: @NilufarRakhman1

Quality (26) Introduction: Mark Cantor, Australia - Systems thinking

27 May, 2021
Hello everyone and thank you for the opportunity to participate in this forum. I am a retired engineer and have spent most of my career implementing continuous improvement, mostly in improving the reliability, quality and safety performance of high risk industries. I am passionate about helping people achieve excellence through understanding systems thinking.

In the seven years since retirement I have volunteered as a health consumer representative. I have been fortunate to witness different aspects of the health care system. At a regional level I have participated in Management and Leadership Teams, Patient Safety and Quality Committees, a Mental Health Rehabilitation Stream, a Suicide Prevention Project and numerous other aspects. On a much smaller level I am also a patient representative for a local private endoscopy centre. On a global level I was an initial member of the ISQua Person Centred Care Community of Practice. As part of that community and as part of a research project I have also undertaken considerable research into the concepts of person centred care.

Currently I am assisting a friend to understand and navigate our health care system, a system in which she has worked as a disability nurse. She has just completed further qualifications. An event in December has left her with arm numbness, headaches, seizures and, after release from hospital, a stuttering speech impediment. A 30mm diameter arteriovenous malformation fairly deep in her brain is the culprit. Understanding the issues, the options, the risks, the consequences and the cost is a challenge for any individual.

As a society we have technical capabilities from the pages of science fiction and pending assessment, my friend may benefit from absolute leading edge “Gamma Knife” technology. Potentially an hour treatment and then home. Alternatively, brain surgery risks permanently disabling her language ability.

The assessment begins with a specialist imaging request, dictated to an intern, scribbled on a referral form, photocopied, faxed, scanned, misinterpreted, then delegated for special attention to an individual leaving for two weeks holiday. After six weeks of phone calls,

messages, call backs, arguments, stress, anxiety, security complaints, privacy breaches, and the outcome was that the specialist imaging request was inappropriate for this pathology. Another two week wait for an appointment for another referral.

I have very little hair left to pull out, but the health system and the above paradox drives me to tug on the remaining strands. We continuously risk lives and cost lives with a reluctance to address some of the simplest yet profound system problems.

I would love the opportunity to contribute some of my experience to addressing this paradox.

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services.

https://www.hifa.org/projects/learning-quality-health-services

Email: markacantor AT me.com

Quality (27) Global Health Compassion Rounds, June 17 - Compassion, WASH, and quality of care

3 June, 2021
Please join our discussion about compassion, WASH, and quality of care.

Compassion, WASH & Quality of Care

This Global Health Compassion Rounds will explore how WASH interventions are vectors for compassion and why recognizing this can accelerate urgent action in quality of care improvements.

Thursday, June 17, 2021

11:00 am-12:30 pm EDT (GMT -4)

Register Now! https://emory.zoom.us/webinar/register/WN_QLsM2HlJSUGguBgGO9cSKw

PANELISTS

Sheillah Simiyu
African Population & Health Research Center

Sheillah is a public health researcher focused on WASH issues in urban settings, informal settlements, and child nutrition. In addition, she has consulted for over 10 years with

organizations such as World Vision, Action Against Hunger, and SNV Netherlands Development Organization. She is interested in gendered aspects of WASH, as well as psychosocial well-being in relation to WASH.

Omar El Hattab
WASH Regional Advisor,
UNICEF Middle East & North Africa Region

Omar's regional portfolio with UNICEF includes over 10 countries, including Yemen, Syria, Iraq, and others. With over 25 years of experience, he has also served as Chief WASH with UNICEF in several duty stations, as well as Technical Advisor for UNDP and the Kuwait Fund for Arab Economic Development. He is keenly interested in human-centered and sustainable WASH interventions for vulnerable, conflict-affected populations.

Stephanie Ogden
Water Team Director, CARE

Stephanie leads CARE's water and development work, focused on systems strengthening and institutional development to ensure sustainable, equitable water and sanitation services for all. She began her career in WASH as a Peace Corps volunteer in rural El Salvador, where she focused on WASH and women's empowerment. With over 18 years experience, she has lived and worked with organizations in Latin America, Africa, and Central Asia.

Bruce Gordon
Unit Head of WASH
World Health Organization

Bruce oversees a global portfolio of water and health-related work ranging from development of norms on drinking-water and wastewater/sanitation to global monitoring of access to WASH and burden of disease. He has contributed to WHO's work on sustainable development with a focus on children's health and environment.

Maggie Montgomery
Technical Officer, World Health Organization

As the "WASH Settings" team lead, Maggie focuses on WASH in health care facilities, household water treatment technology performance, and WASH in emergencies. In addition to global efforts, she supports a number of country-focused WASH efforts in sub-Saharan African and southern Asia. She is also a licensed civil engineer in the State of California with experience developing recycled wastewater projects.

What are Global Health Compassion Rounds?

The rounds are a safe space to discuss topics on compassion within health service delivery. They will be themed and include an introduction on “why this round,” followed by invited reflections from a global health expert. The remaining time will be dedicated to open discussion to continue exploring compassion with the global community.

Hosted by the Focus Area for Compassion and Ethics (FACE) at the Task Force for Global Health and the WHO Global Learning Laboratory (GLL).

For additional questions, please email us at face@taskforce.org

Quality (28) Introduction: Dhruva Sreenivasa Chakravarthi, India

8 June, 2021
Thank you for joining me into HIFA.

About myself in brief:

Work Experience:

13+ years in Healthcare Administration & Management &12+ years in business of IT in Sales, Support and total Solution Providing

Education :
Pursuing PhD in Management (Healthcare Management) in KL University, Andhra Pradesh;
M.Phil (Hospital &Health Management Systems) from BITS, Pilani, Rajasthan.;
UGC NET qualified for Assistant Professorship

Fellowships/Assistnments :
Fellow of ISQua(International Society for Quality in Healthcare);
Performance Excellence Healthcare Assessor based on Baldrige Excellence Framework.
Assessor for WHO Patient Safety Friendly Hospital Standards;Green Healthcare Facility Accreditation;
NQAS National External Assessor : NHSRC under MoHFW, Govt. Of India, New Delhi
5S Lead Assessor;ISO 9001:2015 Lead Assessor : As provisional Auditor IRCA
In the panel of Examiners of QIMPRO' Healtcare Qualtech Prize of Team Excellence Awards for Continual Quality ImprovementLead Editor for ESN Publications; Reviewer for some National/International Journals

Certifications/Professional Developments:
PGDMLS (Post Graduate Diploma in Medico Legal Systems);LSSGB (Lean Six Sigma Green Belt);CHSP (Certified Healthcare Safety Professional)
ADQM(Advanced Diploma in Quality Management : Healthcare);PGDHA (Post Graduate Diploma in Hospital Administration)
MCSE (Microsoft Certified Solutions Expert);CSR (Mastering Corporate Social Responsibility Certificate Course)

One of the Lead Editor & Author contribution for one of the book chapter of ESN Publications which achieved the World Book of Records (for Thickest book in the world), India Book and Asia book of records(for Maximum authors contribution to a book)

Also a member of some value added bodies like :PMI (Project Management Institute), QCI (Quality Council of India), ISQua (International Society for Quality in Healthcare), IRCA (International Register for Certified Auditors), ACA (Academy of Hospital Administration), RFHHA (Research Foundation for Hospital and Healthcare Administration, TSI (Telemedicine Society of India), NHRDN (National Human Resource Development Network), CAHO (Consortium of Accredited Healthcare Organisation), HIMA (Health Information Management Association of India, IRA (Inspira Research Association), NATHEALTH(Healthcare Federation of India)

Also Member of Voice of Healthcare - National Health Council;
CAHO : Student Research Committee Member.
Member : PMI Life Sciences Group

I am most happy if my services are useful in any means in regards to my professional expertise and happy to volunteer.

thank you
D S Chakravarthi
Linkedin: www.linkedin.com/in/dschakri
twitter: @dschaks
cell: 9848145227, 7013037586

HIFA profile: Dhruva Sreenivasa Chakravarthi is CEO of Prashanth Hospital & Research Scholar, India. He is interested in: Peer Learning and Peer sharing of quality comes in quality care in healthcare settings. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. Dschakri AT rediffmail.com

Quality (29) WHO Global Learning Laboratory Webinar: Enhancing the quality of health services, 29 June

10 June, 2021
View this email in your browser https://mailchi.mp/5e38a1215502/who-global-learning-laboratory-webinar?e...

** WHO Global Learning Laboratory Webinar :
** Enhancing the quality of health services – introduction to a new planning guide for implementers

Planning for quality is required at the national, district and facility-levels to enhance quality of care, and drive efforts towards universal health coverage. WHO recently launched Quality Health Services: a planning guide to support key actions required to improve the quality of health services for the entire population, recognizing the unique pathway for each country. The planning guide focuses on actions required at the national, district and facility levels to enhance quality of health services, providing guidance on implementing key activities at each

of these three levels. It is intended to support those working at all levels of the health system translate intention into results, delivering an impact on the quality of services for people across the world.

This 60-minute session will provide an overview of the WHO Quality Health Services: a planning guide, discussing how it can be applied to improve the quality of care across the health system. The document is available here: WHO Quality Health Services: a planning guide (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...)

Learning Objectives:

The 60-minute session will enable participants to:

* Learn about how the WHO Quality Health Services: a planning guide can be applied to support activities on quality health services.

* Understand how activities required at the national level can support delivery of quality health services across all levels of health system.

* Explain what staff at the district level can do to improve quality of health services.

* Describe activities that facility health workers can undertake to improve the quality of health services.

Intended audience:

The session is open to anyone with an interest and a passion in improving the quality of health services. It will be of relevance to staff working at all levels of the health system (national, district and facility) who have a role in enhancing the quality of health services. It is also relevant to all stakeholders initiating and supporting action at facility, district and/or national levels both in the public and private sectors.

Date:

29 June 2021
Time:
Geneva, Switzerland 15:00 CEST
Washington DC, USA 09:00 EDT
Tokyo, Japan 22:00 JST
London, United Kingdom 14:00 BST
New Delhi, India 18:30 IST
Lagos, Nigeria 14:00 WAT
Cairo, Egypt 15:00 EET
(click here for other time zones) (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...)

Registration:

If you are interested in participating in the webinar, please register here (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) .

Quality (30) Enhancing the quality of health services (2)

10 June, 2021
Our thanks to our colleagues at WHO GLL - Oriane, Nana and Shams - for organising this one-hour webinar on WHO Quality Health Services: a planning guide. The event is on 29 June and I encourage everyone on HIFA to participate.

Why? Three reasons

1. Because poor quality of care causes between 5.7 and 8.4 MILLION avoidable deaths each year. We actually know little about the relative roles of different contributing factors at different levels of care (self-care, family, community, primary, secondary, tertiary). It is clear that failure to access and apply reliable healthcare information - at all levels - is a leading cause of preventable death and suffering worldwide (this is the rationale for HIFA). There are clearly many other factors that contribute to delays, indecision, incorrect diagnosis, wrong treatment decisions, communication error... that characterise poor quality care.

2. The webinar will introduce WHO Quality Health Services: a planning guide, a framework for improving the quality of health services, from a national, district and facility level perspectives. To get the most from the webinar, you may like to review the guide here: https://apps.who.int/iris/bitstream/handle/10665/336661/9789240011632-en...

3. Most importantly, HIFA members have a practical role to make a difference over the coming days, weeks and months. WHO has asked HIFA 'TO CAPTURE AND SHARE APPROACHES USED FOR DELIVERING QUALITY HEALTH SERVICES'. We are working together to implement a series of three thematic discussions on the HIFA forums (English, French, Portuguese, Spanish) to learn from one another on how to improve quality of health services. WHO Quality Health Services: a planning guide will be our reference. Our collective outputs will be synthesised by HIFA volunteers to help inform new WHO publications. The first thematic discussion starts on 28 June. Further information to follow shortly.

See: https://www.hifa.org/projects/learning-quality-health-services

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (31) Introduction: Sebastian Kevany, USA - Global health security and diplomacy

11 June, 2021
Dear HIFA, I am a former consultant with the World Health Organization (WHO), based in Ireland & the USA. My professional interests focus on global health security and diplomacy. I am currently working on pandemic response in
Hawaii https://apcss.org/college/faculty/kevany/ . All the best, Sebastian

HIFA profile: Sebastian Kevany is a former consultant with the World Health Organisation (WHO), Ireland & USA. Professional interests: Global health security and diplomacy. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services Email: sk AT diplomatichealth.com

Quality (32) Information privacy and quality of care

16 June, 2021
Dear HIFA, I would be interested in the group's opinions on information privacy and quality of care. For example during the pandemic, data privacy was often prioritized over epidemic control. A paper I wrote on the subject is here https://apcss.org/urgent-policies-required-to-grant-public-access-to-pro... . Would less data privacy and more 'information for all' have helped to both improve quality of care and control the epidemic?

Thank you, Sebastian

HIFA profile: Sebastian Kevany is a former consultant with the World Health Organisation (WHO), Ireland & USA. Professional interests: Global health security and diplomacy. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services Email: sk AT diplomatichealth.com

Quality (33) Global Health Compassion Rounds: Compassion, WASH, and quality of care, June 17

16 June, 2021
Please join our discussion about compassion, WASH, and quality of care.

https://taskforce.org/face/

https://www.who.int/initiatives/who-global-learning-laboratory-for-quali...

PLEASE JOIN US!
Thursday, June 17, 2021
11:00 am-12:30 pm EDT (GMT -4)
Register Now!
(https://emory.zoom.us/webinar/register/WN_QLsM2HlJSUGguBgGO9cSKw)

Compassion, WASH & Quality of Care

This Global Health Compassion Rounds will explore how WASH interventions are vectors for compassion and why recognizing this can accelerate urgent action in quality of care improvements.

PANELISTS

Sheillah Simiyu
Associate Research Scientist,
African Population & Health Research Center

Sheillah is a public health researcher focused on WASH in low-income urban communities and in rural areas Africa. Her work focuses on WASH and health, community participation, and the link between WASH and development. With over 15 years' experience, she has worked in academic and research institutions, and has consulted with development organizations such as World Vision, Action Against Hunger, and SNV Netherland Development Organization..

Omar El Hattab
WASH Regional Advisor,
UNICEF Middle East & North Africa Region

Omar's regional portfolio with UNICEF includes over 10 countries, including Yemen, Syria, Iraq, and others. With over 25 years of experience, he has also served as Chief WASH with UNICEF in several duty stations, as well as Technical Advisor for UNDP and the Kuwait Fund for Arab Economic Development. He is keenly interested in human-centered and sustainable WASH interventions for vulnerable, conflict-affected populations.

Stephanie Ogden
Water Team Director, CARE

Stephanie leads CARE's water and development work, focused on systems strengthening and institutional development to ensure sustainable, equitable water and sanitation services for all. She began her career in WASH as a Peace Corps volunteer in rural El Salvador, where she focused on WASH and women's empowerment. With over 18 years experience, she has lived and worked with organizations in Latin America, Africa, and Central Asia.

Bruce Gordon
Unit Head of WASH
World Health Organization

Bruce oversees a global portfolio of water and health-related work ranging from development of norms on drinking-water and wastewater/sanitation to global monitoring of access to WASH and burden of disease. He has contributed to WHO's work on sustainable development with a focus on children's health and environment.

Maggie Montgomery
Technical Officer, World Health Organization

As the "WASH Settings" team lead, Maggie focuses on WASH in health care facilities, household water treatment technology performance, and WASH in emergencies. In addition to global efforts, she supports a number of country-focused WASH efforts in sub-Saharan African and southern Asia. She is also a licensed civil engineer in the State of California with experience developing recycled wastewater projects.

Register Now!
(https://emory.zoom.us/webinar/register/WN_QLsM2HlJSUGguBgGO9cSKw)

** What are Global Health Compassion Rounds?

The rounds are a safe space to discuss topics on compassion within health service delivery. They will be themed and include an introduction on “why this round,” followed by invited reflections from a global health expert. The remaining time will be dedicated to open discussion to continue exploring compassion with the global community.

Hosted by the Focus Area for Compassion and Ethics (FACE) (https://taskforce.org/face/) at the Task Force for Global Health and the WHO (https://www.who.int/initiatives/who-global-learning-laboratory-for-quali...) Global Learning Laboratory (GLL) (https://www.who.int/servicedeliverysafety/areas/qhc/gll/en/index6.html) .

https://taskforce.org/face/

For additional questions, please email us at face@taskforce.org (mailto:face@taskforce.org)
https://twitter.com/FACEofHealth
mailto:face@taskforce.org
https://taskforce.org/face/

Quality (34) Information privacy and quality of care (2) Knowledge management and the coronavirus pandemic

17 June, 2021
Hi Sebastian,

Thanks for drawing attention to your work (https://apcss.org/urgent-policies-required-to-grant-public-access-to-pro...). In fact, I have been working on the idea of national knowledge preparedness plans for some time (see "Knowledge management and the coronavirus pandemic: an online discussion". Knowledge Management for Development Journal Vol. 15 No. 2 (2020) Community Notes https://km4djournal.org/index.php/km4dj/article/view/491 - there is an outline K preparedeness plan as an annex to that paper).

If anyone has further ideas about what a knowledge preparedness plan should contain, so that countries can be in a better position to deal with emergency or pandemic-associated infodemics in future, please get in touch.

Chris

Chris Zielinski

chris@chriszielinski.com

Blogs: http://ziggytheblue.wordpress.com and http://ziggytheblue.tumblr.com

Research publications: http://www.researchgate.net

HIFA profile: Chris Zielinski: As a Visiting Fellow in the Centre for Global Health, Chris leads the Partnerships in Health Information (Phi) programme at the University of Winchester. Formerly an NGO, Phi supports knowledge development and brokers healthcare information exchanges of all kinds. Chris has held senior positions in publishing and knowledge management with WHO in Brazzaville, Geneva, Cairo and New Delhi, with FAO in Rome, ILO in Geneva, and UNIDO in Vienna. Chris also spent three years in London as Chief Executive of the Authors Licensing and Collecting Society. He was the founder of the ExtraMED project (Third World biomedical journals on CD-ROM), and managed the Gates Foundation-supported Health Information Resource Centres project. He served on WHO's Ethical Review Committee, and was an originator of the African Health Observatory. Chris has been a director of the World Association of Medical Editors, UK Copyright Licensing Agency, Educational Recording Agency, and International Association of Audiovisual Writers and Directors. He has served on the boards of several NGOs and ethics groupings (information and computer ethics and bioethics). UK-based, he is also building houses in Zambia. chris AT chriszielinski.com

His publications are

at www.ResearchGate.net and https://winchester.academia.edu/ChrisZielinski/ and his blogs are http://ziggytheblue.wordrpress.com and https://www.tumblr.com/blog/ziggytheblue

Quality (35) Information privacy and quality of care (3) 4 priorities to reaffirm patient voice in the coming era of AI healthcare

18 June, 2021
Dear Sebastian and Chris, thanks for this conversational thread to HIFA. Here is an article that may be of interest:

4 priorities to reaffirm patient voice in the coming era of AI healthcare | Impact of Social Sciences (lse.ac.uk)

https://blogs.lse.ac.uk/impactofsocialsciences/2021/06/18/4-priorities-t...

HIFA profile: Ann Lawless is is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the WHO-HIFA working group on Learning for quality health services.

https://www.hifa.org/support/members/ann

https://www.hifa.org/projects/learning-quality-health-services

lawlesszest AT yahoo.com

Quality (36) Introduction: Bistra Zheleva, USA - Children's HeartLink

19 June, 2021
Hello,

My name is Bistra Zheleva, I work at Children's HeartLink an NGO based in Minneapolis, USA and focused on building capacity and advocating for quality pediatric cardiac services globally. Our core work is with hospitals in low- and middle-income countries to help them develop into centers of excellence in pediatric cardiac care and training. We currently have 18 hospital partners in 5 countries and 5 are CoEs. Most of what we focus on is quality improvement that results in improved patient outcomes, which in our field translate directly into patient survival. We also help develop patient care pathways to assure referral and follow

up of children with heart disease. Finally, we advocate through awareness building and research to contribute to the body of knowledge in this field.

Congenital heart disease is the most common birth defect in the world and globally it is rising as a cause of infant mortality, causing about 217,000 deaths annually, with 70% of those in infants. Rheumatic heart disease is a completely preventable disease of poverty that affects adolescents and causes about 306,000 deaths globally. Globally, 10.4 million young people (ages 1-24) live with RHD and 9.4 million (ages newborn-19) live with congenital heart disease. Together these two diseases build a significant burden of heart diseases in children that is treated largely with open heart surgery, a clinical intervention that unless performed with high quality skills and care may result in untimely death or long-term complications.

I am also a member of the International Quality Improvement Collaborative for Pediatric Cardiac Care, a collaborative of pediatric cardiac centers from LMICs participating in a global registry of more than 100,000 patient cases and implementing QI interventions to reduce mortality and morbidity.

I look forward to the discussions in this group, learning from everyone, and sharing our experience over the last 20+ years.

Bistra

Bistra Zheleva
Vice President of Global Strategy and Advocacy
Children's HeartLink
T +1 952.928.4860 ext 19
M +1 612.709.6657
Minneapolis, USA
Who Made That Twitter Bird? - The New York Times@bzheleva
www.childrensheartlink.org

HIFA profile: Bistra Zheleva is Vice President of Global Strategy and Advocacy at Children's HeartLink in the USA. Email address: bistra AT childrensheartlink.org

Quality (37) Free and virtual Business Ethics Forum in medical industries in Asia-Pacific

21 June, 2021
Dear HIFA Colleagues,

Asia-Pacific Economic Cooperation (APEC) has a free and online Business Ethics Forum starting in June and running over the next four months. It's focus is health and particularly ethics in the industries providing medical devices and biopharmaceuticals. They say they

welcome broad participation (including patient representatives): it is free to register and attend. They are developing updated ethics and principles statements in both sectors. Their invitation appears below.

Dear APEC Business Ethics for SMEs Partners,

We are honored to invite you to join the 8th APEC Business Ethics for SMEs Forum. This year's forum will take place virtually through a series of dynamic, interactive sessions from June-October 2021.

The Business Ethics for APEC SMEs Initiative is the world's largest public private partnership dedicated to reinforcing business ethics and integrity across health systems, which has taken on greater significance amidst COVID-19 response and recovery. The Forum will commence with a series of meetings dedicated to Consensus Frameworks across the APEC region, where participants will have the opportunity to learn about and engage with these unique ethical collaborations. The Forum will also include roundtables dedicated to patient organizations and healthcare professional associations, as well as expert panels on emerging ethical dilemmas in patient data and ethical business practices in the context of Environmental, Social, and Governance. These activities, and much more, will culminate in a high-level plenary session that will include the launch of modernized APEC Kuala Lumpur Principles for the Medical Device Sector and APEC Mexico City Principles for the Biopharmaceutical Sector, among many other exciting announcements.

Interested participants are invited to visit the online delegate portal for more information about the sessions and to register for the Forum. The first session will take place at 10:30 AM (EDT) / 10:30 PM (SGT), Tuesday, 22 June, featuring the Canadian Consensus Framework. Once your registration application is submitted and accepted, you will be able to access the Forum's virtual live stage for all event sessions. Please return to the portal on a regular basis for updates, including schedule, speakers, and pre-reading materials.

If you have any questions, please contact apecethics@crowell.com. For further information about the Business Ethics for APEC SMEs Initiative, please visit https://klprinciples.apec.org/ (medical device sector) and https://mcprinciples.apec.org/ (biopharmaceutical sector).

We hope you will join your colleagues from around the world to participate in the 2021 APEC Business Ethics for SMEs Forum.

Kind Regards,

Stakeholder Liaison

Business Ethics for APEC SMEs Initiative

--

Dr Ann Lawless,

Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.
https://www.hifa.org/projects/learning-quality-health-services
https://www.hifa.org/support/members/ann
Email: lawlesszest AT yahoo.com

Quality (38) Catalyst Group for Quality Health Services: Introduction + patient centered NCD care

21 June, 2021
Dear all,

Good to meet many of the members of the Catalyst Group for Quality Health Service today during the Zoom meeting. My name is Tineke de Groot. As a nurse, international public health professional, lecturer and researcher, I have a passion for Universal Health Coverage. I have worked in a variety of primary healthcare settings in South America, Sub-Saharan Africa and the Netherlands and have a Masters in Public Health from the University of South Africa. I have been a health system advisor on various health projects worldwide. I work in training healthcare professionals at the Christian University of Applied Sciences (Netherlands) to work in low-income settings. I also work for Primary Care International (UK) on developing e-learnings on NCD care for healthcare professionals in LMIC. I am currently writing a proposal for a PhD thesis on patient centered NCD care in LMIC.

Thinking on quality of care, I really would like to emphasise the patient's perspective on quality of care. Given the fact that 77% of NCD deaths occur in LMIC, I would like to share this article on the NCD patient
journey: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7553852/pdf/12325_2020_Arti...

This article states: 'Health systems in LMICs must recognize that the patient journey for NCDs starts long before the onset of symptoms and signs. Strategies designed to improve the patient journey must incorporate the patient-centered perspective at each touchpoint of their journey in the healthcare system: awareness, screening, diagnosis, treatment, and adherence. Effective communication strategies for improving health literacy, patient activation, and incorporation of narrative medicine in physician education positively impact the awareness of patients. Use of appropriate risk assessment tools to tailor therapies, integrated management of chronic illness in primary healthcare, shared decisionmaking, and decision aids ensure timely and accurate diagnosis. Improved access to NCD treatments, embodying the principles

of person-centered care and positive therapeutic alliance, requires commitment at a policy level to deliver safe, affordable, and effective care equitably. Long-term management of NCDs entails substantial self-management of their conditions by patients, which can be augmented by pharmacists and nurse-led interventions. The NCD care continuum pathway needs to move from the traditional acute incident management protocol to a public health approach of prevention and delay of disease onset through early identification and management of risk factors; early diagnosis and appropriate management; and good adherence through effective communication and follow-up. In addition, comprehensive palliative care models must be evaluated and integrated into national health policy and action plans.'

Anybody having examples of best practices of patient centered NCD care in LMIC?

Looking forward to responses.

Met vriendelijke groet/ regards,

Tineke de Groot–de Greef, MPH, RN
Senior Lecturer of Nursing,

Coordinator Postgraduate Course
International Public Health
E adgroot@che.nl
T 0318 696 300
Tw @tinekhealth4all
Christelijke Hogeschool Ede
Christian University of Applied Sciences
Postbus 80, 6710 BB Ede
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I www.che.nl
Tw @dehogeschoolede #CHEde

HIFA profile: Tineke de Groot is Senior Lecturer of Nursing at the Christian University of Applied Sciences in the Netherlands. Professional interests: International Public Health, Child health. She is a member of the HIFA-WHO catalyst group on Learning for quality health services.
https://www.hifa.org/projects/learning-quality-health-services
Email: adgroot AT che.nl

Quality (39) Information privacy and quality of care (3) Knowledge management and the coronavirus pandemic (2)

22 June, 2021

Thanks Chris! [Chris Zielinski, UK: https://www.hifa.org/dgroups-rss/quality-34-information-privacy-and-qual...

My idea is that there needs to be a protocol for sharing information in emergency epidemic environments. Under such circumstances, if it is going to prevent a much larger outbreak and public health crisis, protected health information needs to be shared (without compromising confidentiality). Might you agree?

For me, far too much emphasis was placed on data privacy in health data at the expense of public health and epidemic control during 2020. With much greater granularity on the location of outbreaks and infections, at least geographically, much could have been done, in my opinion, to prevent the spread.

Thank you! Sebastian

HIFA profile: Sebastian Kevany is a former consultant with the World Health Organisation (WHO), Ireland & USA. Professional interests: Global health security and diplomacy. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services Email: sk AT diplomatichealth.com

@hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (40) Information privacy and quality of care (4)

22 June, 2021
Forwarded on behalf of Siamola Murundo, Kenya.

Dear Sebastian,

I have read your message and interests [https://www.hifa.org/dgroups-rss/quality-32-information-privacy-and-qual... and I am interested to have a discussion on the subject matter. Very important. Privacy is essential, as it reduces other challenging and death contributing factors like stress and stigma.

To bring people together there is still a need for data privacy.

HIFA profile: Siamola Murundo is a Programs Assistant with the Organization Of African Youth in Kenya, and has a professional interest in reproductive health, epidemiology, demography, health emergencies, GBV, and social behaviour change. Email address: murundosimwa AT gmail.com

Quality (41) Introduction: Zewdie Mulissa - Improving maternal and newborn quality of care - Data quality improvement

22 June, 2021
I am a public health physician (MD, MPH), certified healthcare Improvement Advisor (IA) and Fellow of the International Society for Quality in a Health Care (FISQua) with an early stage research experience. Recently, I monitored a large collaborative quality improvement project meant to reduce maternal and newborn mortality in Ethiopia. The project also involved embedded research on maternal and newborn health (MNH) quality of care (QOC), some publications of which are already available online including Effect of data quality improvement intervention on health management information system data accuracy: An interrupted time series analysis. [*see note below] Both maternal & newborn mortality remained high despite efforts made so far in my country. The tragically high maternal &newborn mortality is mainly due to poor quality of care.

My deep analysis of the problem during the practice & research on MNH quality of care (QoC) inspired me in developing a future career which combines research and public health practice in improving maternal and newborn quality of care in low-and middle-income countries (LMICs). Pursuing a graduate degree in Global Health will help me to have better understanding of global health methods to avert the problem & also generate evidence for actionfor policy makers in LMICs. To this end, I developed a synopsis entitled “Improving maternal and newborn quality of care in Ethiopia: mixed methods approach” to pursue my higher degree research (PhD). I appreciate any support you could extend in this line.

Kind regards, Zewdie Mulissa (MD, MPH, FISQUA)

Senior Performance Monitoring and Improvement AdvisorIntraHealth International, Ethiopia project office, Addis Ababa, Ethiopia.Tele: +251911806969, Email: zmulissa@yahoo.com, skype: zewdie. mulissa

HIFA profile: Zewdie Mulissa is Senior Performance Monitoring & Improvement Advisor at IntraHealth International, Ethiopia. Professional interests: Quality of Care; Monitoring; Evaluation. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services

Email: zmulissa AT yahoo.com

[*Note from HIFA moderator (Neil PW): Thank you for sharing this Zewdie and it was good to meet you yesterday at the Catalyst Group meeting. For the benefit of others on HIFA, here is the link to the paper Zewdie mentions:

https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0237703 The paper concludes 'A Data quality improvement initiative embedded within a clinical improvement collaborative improved accuracy of data used to monitor maternal and newborn health

services in Ethiopia'. We look forward to hear more from HIFA members on how to support data quality at different levels of the health system.]

Quality (42) Patient centered NCD care (2)

22 June, 2021
Dear Tineke de Groot,

Thanks for sharing your idea on patient centered care on NCDs.
[https://www.hifa.org/dgroups-rss/quality-38-catalyst-group-quality-healt...

I think https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6890192/ would be an input to your request. [*see note 1 below]

However, I would like to know why you are interested in patient centered care only instead of holistically assessing the capacity of health system as well as the experiences of care to improve service delivery & accelerate reduction in morbidity & mortality. [*see note 2 below]

Thanks,

Zewdie

Kind regards, Zewdie Mulissa (MD, MPH, FISQUA)

Senior Performance Monitoring and Improvement AdvisorIntraHealth International, Ethiopia project office, Addis Ababa, Ethiopia.Tele: +251911806969, Email: zmulissa@yahoo.com, skype: zewdie. mulissa

HIFA profile: Zewdie Mulissa is Senior Performance Monitoring & Improvement Advisor at IntraHealth International, Ethiopia. Professional interests: Quality of Care; Monitoring; Evaluation. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services

Email: zmulissa AT yahoo.com

[*Note from HIFA moderator (Neil PW):

1. For the benefit of those who may not have immediate web access, here is the citation and conclusion of the paper: Diabetes Self-Management Education (DSME) – Effect on Knowledge, Self-Care Behavior, and Self-Efficacy Among Type 2 Diabetes Patients in Ethiopia: A Controlled Clinical Trial. Diabetes Metab Syndr Obes. 2019; 12: 2489–2499. Published online 2019 Nov 29. doi: 10.2147/DMSO.S223123. The paper concludes: Our study found significant improvements in the intervention participants' diabetes knowledge scores and in their adherence to dietary and footcare recommendations. This demonstrates that our DSME intervention may be of clinical importance in developing countries such as

Ethiopia.

2. Tineke emphasises the patient's perspective on quality of care but also refers to training of healthcare professionals and health systems issues. She makes the point that ‘Health systems in LMICs must recognize that the patient journey for NCDs starts long before the onset of symptoms and signs' is Strategies designed to improve the patient journey must incorporate the patient-centered perspective at each touchpoint of their journey in the healthcare system: awareness, screening, diagnosis, treatment, and adherence. Effective communication strategies for improving health literacy, patient activation, and incorporation of narrative medicine in physician education positively impact the awareness of patients...']

Quality (43) Improving maternal and newborn quality of care (2)

23 June, 2021
Hi Zewdie [Zewdie Mulissa, Ethiopia]

This is so unfortunate that despite so many efforts being put in this way, still we have so many miles to go. This is for your information that Maternal and Newborn Health in India is in a similar situation. Even after so many programmes, NGOs, Government schemes, Maternal Mortality rate (MMR) and Infant Mortality Rate (IMR) remained high. In India I would say, the probable reason for this is- one Quality of Care as you mentioned and second is knowledge and Health Seeking Behaviour of patients [Note 1-4].

I believe that along with focussing on the quality of care provided to pregnant women, health seeking behaviour of women and their families needs to be worked up on. I'd like to share my knowledge with you regarding this topic. If I find anything relevant to your topic, I'll share it with you.

Hope this will help you.

Good luck!

Note1- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6482804/
Note 2- https://www.researchgate.net/profile/S-Gopalakrishnan-4/publication/2834...

Note 3- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5749068/

Note 4- http://rchiips.org/NFHS/pdf/NFHS4/TN_FactSheet.pdf]

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Thanks & Regards!

Rajinder Kaur

(Masters in Public Health)

Project Assistant

Department of Community Medicine & School of Public Health

PGIMER, Chandigarh

HIFA profile: Rajinder Kaur is a Project Assistant at PGIMER Chandigarh India, India. Professional interests: Research; Health promotion; IEC material development; Health of street vendors; Rights of women and children. megrewal00 AT gmail.com

Quality (44) Patient centered NCD care (3)

23 June, 2021
It is possible to separate health care provision into four areas

1. Acute illnesses and their management
2. Continuing and multimorbidities management
3. Health promotion
4. Preventative health care

1. and 4, are by necessity mainly executed by service providers and health professionals.

2. is executed jointly by service provider and patient

3. is mainly executed by individuals, families, patients and communities through their culture, diet, exercise, relationships etc

Patient orientated/partnered/centred care is essential for 2. and 3.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

Quality (45) Please forward: Learning for quality health services: A new thematic discussion on HIFA

24 June, 2021
The WHO Global Learning Laboratory (GLL) for Quality UHC and Healthcare Information For All (HIFA.org) are delighted to announce a new thematic discussion on HIFA: Learning for quality health services. The discussion starts on 28 June and will continue through to 20 August.

Quality of health services is critical to achieving universal health coverage (UHC): Between 5.7 and 8.4 million deaths are attributed to poor quality care each year in low- and middle-income countries, accounting for up to 15% of overall deaths in these countries. Improving access to health services must go hand in hand with improving the quality of these services. There is an urgent need to place quality at the centre of national-, district- and facility-level actions in order to progress towards UHC.

The discussion will explore in depth the following questions:

- What does quality of care mean to you, in your particular context? Why is it important to make the case for quality of care?

- From your experience, what might work best to enhance national commitment to quality of care? Have you seen any practical solutions that should be shared wider?

- From your experience, what are the biggest challenges for district health managers in tackling quality of care issues? Have you seen any practical solutions that should be shared wider?

- From your experience, what are the biggest challenges for improving quality of care at the facility level? Have you seen any practical solutions that should be shared wider?

Please forward this message to your contacts and networks and invite everyone to join us!

https://www.hifa.org/news/learning-quality-health-services-new-thematic-...

www.hifa.org/joinhifa

We have more than 60 HIFA members volunteering for this project. Also, we are introducing for the first time the concept of HIFA Catalysts, whose role is to stimulate comment and debate. We look forward to a rich discussion!

HIFA profile: Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (46) Learning for quality health services: A new thematic discussion on HIFA (2) WHO Quality Planning Guide and Fact Sheet

24 June, 2021
Dear HIFA colleagues,

To get the most from the upcoming discussion I encourage you to download these two WHO publications, which we are using as a reference throughout:

1. Quality health services: a planning guide (2020)

https://www.who.int/publications/i/item/9789240011632

The WHO Quality Health Services: a planning guide focuses on actions required at the national, district and facility levels to enhance quality of health services, providing guidance on implementing key activities at each of these three levels. It highlights the need for a health systems approach to enhance quality of care, with a common understanding on the activities needed by all stakeholders. The guide articulates the key actions required to improve the quality of health services for the entire population. It recognizes that the path varies for each country, district and facility – stimulating the reader to consider multiple factors and entry points for action. This planning guide is for staff working at all levels of the health system (i.e. national, district and facility) who have a role in enhancing the quality of health services. It is also relevant to all stakeholders initiating and supporting action at facility, district and/or national levels both in the public and private sectors.

2. WHO Fact Sheet on Quality Health Services (2020)

https://www.who.int/news-room/fact-sheets/detail/quality-health-services

HIFA profile: Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (47) Patient centered NCD care (4)

24 June, 2021
Nice and interesting classification from Richard, but misses out palliative care, and is rather compartmentalised for comfort. Missing out on integration, vertically and horizontally, may lead to non holistic care and inadvertent omission and commission. Healthcare seems better as a continuum without too much differentiation and restriction, provided the provider of the care is trained and skilled and there are checks and balances. Structured, integrated and harmonised approach should yield the best results.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

http://www.hifa.org/support/members/joseph-0

http://www.hifa.org/people/steering-group

Email: jneana AT yahoo.co.uk

Quality (48) Patient centred NCD care (5) Self-management education

24 June, 2021
Thank you Dr Zewdie and Dr Richard for commenting on patient centered NCD care, (and Neil for the footnotes),

@Zewdie, thank you for bringing in a valuable article on patient centered NCD care, proving that Diabetes Self-Management Education (DSME) makes a difference. Self-management interventions seem to be under researched in LMIC as described by Haern et al 2019 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6608949/ .

That is one of the reasons that I deliberately choose for the patients' perspective, because I think there is still a lot to gain in the area of self-management and patient engagement in research, specifically in LMIC and on NCDs (as described e.g. in https://bmjopen.bmj.com/content/9/5/e026514 and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7196100/)

However, the patients' perspective will automatically bring in service delivery and the health system as a whole.

@Richard, thank you for the valuable division in NCD care.

Best wishes,

Tineke de Groot

HIFA profile: Tineke de Groot. As a nurse, international public health professional, lecturer and researcher, Tineke has a passion for Universal Health Coverage. She has worked in a variety of primary healthcare settings in South America, Sub-Saharan Africa and the Netherlands and holds a Masters in Public Health from the University of South Africa. She has been a health system advisor on various health projects worldwide. She works in training healthcare professionals at the Christian University of Applied Sciences (Netherlands) to work in low-income settings. She also works for Primary Care International (UK), developing e-learnings on NCD care for healthcare professionals in LMIC. She is a member of the HIFA-WHO catalyst group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services

Email: adgroot AT che.nl

Quality (49) WHO Webinar: The role & impact of faith actors (3) Compassion

24 June, 2021
Thanks a lot Dr. Fitton, for your attendance and report from the webinar. [https://www.hifa.org/dgroups-rss/coronavirus-1304-who-webinar-role-impac...] Looks interesting! I'll check out the references (and I encourage other HIFA members to do same).

Compassion appears to be at the centre of healthcare offered by faith based providers / facilities, and this has the potential to transform the health system.

ORFEGA, Moses Kumaoron

HIFA profile: Moses Kumaoron Orfega is a Service Improvement Desk Officer at the National Health Insurance Scheme, Nigeria. Professional interests: Social Protection and Financing; Social Health Protection and Universal Health Coverage; Service Quality Improvement; Information Technology. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. Email: ofegamoses AT gmail.com

Quality (50) Information privacy and quality of care (5)

24 June, 2021
Dear Siamola, thank you for this [*see note below]. In a theoretical crisis outbreak scenario, would you still hold this view? For example, if there was an Ebola outbreak, would you still prioritize data privacy over infection control? Thanks, Sebastian

HIFA profile: Sebastian Kevany is a former consultant with the World Health Organisation (WHO), Ireland & USA. Professional interests: Global health security and diplomacy. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services Email: sk AT diplomatichealth.com

[*Note from HIFA moderator (Neil PW): Sebastian refers to Siamola Murundo, Kenya, who wrote 'Dear Sebastian, I have read your message and interests [https://www.hifa.org/dgroups-rss/quality-32-information-privacy-and-qual... and I am interested to have a discussion on the subject matter. Very important. Privacy is essential, as it reduces other challenging and death contributing factors like stress and stigma. To bring people together there is still a need for data privacy.]

Quality (51) Enhancing the quality of health services – introduction to a new planning guide for implementers

24 June, 2021
From our colleagues at WHO. I encourage all HIFA members to join this 1 hour webinar, which coincides with the start of the HIFA thematic discussion on Learning for quality health services. We look forward to see you there!

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Enhancing the quality of health services – introduction to a new planning guide for implementers

29 June 2021 15:00 – 16:00 CET

Planning for quality is required at the national, district and facility-levels to enhance quality of care, and drive efforts towards universal health coverage. WHO recently launched Quality Health Services: a planning guide to support key actions required to improve the quality of health services for the entire population, recognizing the unique pathway for each country. The planning guide focuses on actions required at the national, district and facility levels to enhance quality of health services, providing guidance on implementing key activities at each of these three levels. It is intended to support those working at all levels of the health system translate intention into results, delivering an impact on the quality of services for people across the world.

This 60-minute session will provide an overview of the WHO Quality Health Services: a planning guide, discussing how it can be applied to improve the quality of care across the health system.

When: 29 June 2021, 15:00-16:00 CEST (click here for other time zones)

Register here https://who.zoom.us/webinar/register/WN_8kWoEO7IRImG_Qw-CtzGig

Learning Objectives:

The session will enable participants to:

Learn about how the WHO Quality Health Services: a planning guide can be applied to support activities on quality health services.

Understand how activities required at the national level can support delivery of quality health services across all levels of health system.

Explain what staff at the district level can do to improve quality of health services.

Describe activities that facility health workers can undertake to improve the quality of health services.

Intended audience:

The session is open to anyone with an interest and a passion in improving the quality of health services. It will be of relevance to staff working at all levels of the health system (national, district and facility) who have a role in enhancing the quality of health services. It is also relevant to all stakeholders initiating and supporting action at facility, district and/or national levels both in the public and private sectors.

--

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (52) Institute of Medicine report: Crossing the quality chasm

25 June, 2021
The New thematic discussion [https://www.hifa.org/news/learning-quality-health-services-new-thematic-...] might benefit from considering the IOM's report "Crossing the Quality chasm" - details below. *** The report includes changes of basic assumptions and values - the patient becomes an active - not passive - participant in the healthcare process. in information governance and in clinical governance. [*see note below]

https://www.ncbi.nlm.nih.gov/books/NBK22857/#:~:text=The%20final%20repor...

I would also recommend the WHO's patient Safety plan 2021 to 2030. https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_10Rev1-en.pdf#:~:text=...

*** Institute of Medicine report: Crossing the Quality Chasm: A new Health System for the twenty first millennium.

"The report finds that the current system is unable to provide safe, high quality care in a consistent manner. It consists of 10 rules to redesign the health system and a series of recommendations, including the allocation of $1 billion by Congress to support reform efforts. Crossing the quality Chasm can be read or ordered on line at www.nap.edu.

"Although it was thought by some that this report would not catch as much attention as the first, it has created quite a splash in the media. Headlines such as "US Health Care System said lacking" and "IT must BE used to reform US Health System" can be found in both the trade and popular press.

"New rules to redesign and improve ca

Private and public health purchasers, health care organisations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

1. "Care based on continuing healing relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the internet, by telephone, and by other means in addition to face-to-face visits.

2. Customisation based on patient needs and values. The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

3. The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over the health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision-making.

4. Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. Evidence-based decision-making. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

6. Safety as a system property. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. The need for transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based-practice, and patient satisfaction.

8. Anticipation of needs. The health system should anticipate patient needs, rather than simply responding to events.

9. Continuous decrease in waste. The health system should not waste resources or patient time.

10. Co-operation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and co-ordination of care.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

[*Note from HIFA moderator (Neil PW): Thank you Richard. The Institute of Medicine report relates specifically to USA. It would be interesting to compare with approaches for improving quality in other countries. Can any HIFA members share reports relating to other countries?]

Quality (53) Learning for quality health services: A new thematic discussion on HIFA (2) Between 5.7 and 8.4 million deaths are attributed to poor quality care

26 June, 2021
Learning for quality health services: A new thematic discussion on HIFA

https://www.hifa.org/news/learning-quality-health-services-new-thematic-...

"Between 5.7 and 8.4 million deaths are attributed to poor quality care each year in low- and middle-income countries, accounting for up to 15% of overall deaths in these countries."

Questions from the naive and new to HIFA:

- Is the data for the 5.7 - 8.4 million deaths available?

- Is the analysis that attributed those deaths to "Quality" available?

- What aspects of quality were the major contributor to those deaths? Such as; - ACCESS to facilities, resources, healthcare professionals? - ENDEMIC DISEASE, insect borne, sanitation, vaccination? - POVERTY, malnutrition? - HEALTHCARE SYSTEM FAILURE?

It is very difficult to fix something if you don't know why it is broken??

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. markacantor AT me.com

Quality (54) Between 5.7 and 8.4 million deaths are attributed to poor quality care (2)

26 June, 2021
Dear Mark, (Mark Cantor, Australia)

You ask important questions:

"- Is the data for the 5.7 - 8.4 million deaths available?

- Is the analysis that attributed those deaths to "Quality" available?

- What aspects of quality were the major contributor to those deaths? Such as; - ACCESS to facilities, resources, healthcare professionals? - ENDEMIC DISEASE, insect borne, sanitation, vaccination? - POVERTY, malnutrition? - HEALTHCARE SYSTEM FAILURE?"

The figures are based on a Lancet study in 2018 by Kruk et al which concluded that '8·6 million excess deaths [in 2016] were amenable to health care of which 5·0 million were estimated to be due to receipt of poor-quality care and 3·6 million were due to non-utilisation of health care'.

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

In 2019 I wrote to the corresponding author of the study to ask: how did you define the term non-utilisation of health care?. As a result we learned that this definition only includes care from the facility level upwards. It does not include home-based or community-based care. Of course, care is a continuum from home through the different levels of the health system. A broader definition of 'quality of care' would need to include the care given in the home (or on

the roadside), which is partly determined by the level of basic healthcare knowledge of families, bystanders and community health workers.

I raised this on HIFA and we concluded that poor quality care - including care in the community - must therefore cause considerably *more* than 5 million excess deaths per year. Poor quality care may in fact be responsible for up to 3.4 million more deaths per year than originally reported.

WHO's current website appears to accommodate this observation by saying 'Between 5.7 and 8.4 million deaths are attributed to poor quality care each year in low- and middle-income countries'.

https://www.who.int/news-room/fact-sheets/detail/quality-health-services

(I am not sure why the precise numbers have changed from [5m and 8.6m] in The Lancet to [5.7m and 8.4m] on the WHO website. This is presumably due to data obtained since 2018, or a new interpretation of the original data, but I am unaware of such data. Can anyone help?)

We still have a lot to learn about the prevalence and causes of poor quality care, and therefore a lot to learn about how to improve care and reduce avoidable deaths and suffering.

Best wishes, Neil

Coordinator, WHO-HIFA Collaboration: HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

Let's build a future where every person has access to reliable healthcare information and is protected from misinformation - Join HIFA: www.hifa.org

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (55) Institute of Medicine report: Crossing the quality chasm (2)

26 June, 2021
Richard, Neil,

I haven't seen the book you referenced to be able to compare, but it looks as though it is spawned out of ongoing work?? from the "National Academies of Science, Engineering &

Medicine" compared to "Institute of Medicine; Committee on Quality of Health Care in America".

I was recommended this book by Prof. Ed Coffee (Zero Suicide Prevention)

https://www.nap.edu/catalog/25152/crossing-the-global-quality-chasm-impr...

This certainly had a Global Committee

DONALD M. BERWICK (Co-Chair), Institute for Healthcare Improvement, Boston, Massachusetts

SANIA NISHTAR (Co-Chair), Heartfile, Islamabad, Pakistan

ANN AERTS, Novartis Foundation, Brussels, Belgium MOHAMMED K. ALI, Emory University, Atlanta, Georgia PASCALE CARAYON, University of Wisconsinâ€“Madison MARGARET AMANUA CHINBUAH, PATH, Accra, Ghana MARIO ROBERTO DAL POZ, Instituto de Medicina Social, UERJ,

Human Resources for Health, Rio de Janeiro, Brazil
ASHISH JHA, Harvard Global Health Institute, Harvard T.H. Chan School of Public Health, Harvard Medical School, Boston, Massachusetts
SHEILA LEATHERMAN, Gillings School of Global Public Health, University of North Carolina at Chapel Hill
TIANJING LI, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland
VINCENT OKUNGU, PharmAccess, Nairobi, Kenya
NEERAJ SOOD, Sol Price School of Public Policy, University of Southern California, Los Angeles, California
JEANETTE VEGA, Chilean National Health Fund, Santiago, Chile MARCEL YOTEBIENG, College of Public Health, Ohio State University, Columbus, Ohio; and University of Kinshasa, Democratic Republic of Congo

The review committee was equally global.
https://www.nap.edu/catalog/25152/crossing-the-global-quality-chasm-impr...

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services.
https://www.hifa.org/projects/learning-quality-health-services
markacantor AT me.com

Quality (56) What does quality of care mean to you?

26 June, 2021

Greetings everyone,

The first thematic discussion 'Enhancing the quality of health services across levels of the health system' is just around the corner - We hope you are as excited as we are.

Quality of health services is critical to achieving universal health coverage. Between 5.7 and 8.4 million deaths are attributed to poor quality care each year in low- and middle-income countries, accounting for up to 15% of overall deaths in these countries. Improving access to health services must go hand-in-hand with improving the quality of these services. Further, poor quality health services can decrease people's trust in the health system.

During the introductory 2-week discussion we will be exploring two fundamental questions. First, what does quality of care mean to you, in your particular context? Second, why is it important to make the case for quality of care? Our initial thoughts will take us into the next phase of the discussion to explore actions required at each level of the system.

This further exploration will be based on the WHO Quality Health Services: a planning guide

https://apps.who.int/iris/bitstream/handle/10665/336661/9789240011632-en...

that is designed to support key actions at the national, district and facility levels to enhance quality of health services. It highlights the need for a systems approach to enhancing quality of care, and for a common understanding of the essential activities at each level and among all stakeholders.

Best regards,

Oriane

HIFA profile: Oriane Bodson is a Technical Officer, Quality of Care at the World Health Organization, Geneva. She is a member of the HIFA-WHO Working group on Learning for Quality Health Services.

https://www.hifa.org/projects/learning-quality-health-services

https://www.hifa.org/support/members/oriane

Quality (57A) Quarterly Pulse newsletter June 2021

26 June, 2021
[Note from HIFA moderator (NPW): HIFA is in plain text. If you have web access, you may like to view this newsletter in your browser: https://mailchi.mp/6b5c34dd7402/quarterly-pulse-1670551?e=5c94b201ed This newsletter comes from our colleagues at WHO, with whom we are working on Learning for Quality Health Services]

June 2021

Reducing Staff Burnout Takes More than Pizza Parties

The COVID-19 pandemic is exacerbating existing issues with health professional burnout and it is escalating the stressors on the health workforce to unprecedented levels globally...

Network for Improving Quality of Care for Maternal, Newborn and Child Health: Evolution, Implementation and Progress 2017-2020

The report outlines progress made to date and provides reflections on successes and shortfalls during implementation of activities for the Network for Improving Quality of Care for Maternal, Newborn and Child Health. The report also shares how quality of care improvement has been catalyzed over the past years with country examples of implementation in the network countries - Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Kenya, Malawi, Nigeria, Sierra Leone, the United Republic of Tanzania, and Uganda...

Article Spotlight

* Community-based postnatal care services for women and newborns in Kenya: an opportunity to improve quality and access? (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) – Journal of Global Health, March 2021

* Evaluation of water, sanitation and hygiene status of COVID-19 healthcare facilities in Ghana using the WASH FIT approach (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) – Journal of Water, Sanitation and Hygiene for Development, April 2021

* Hand Hygiene during the Early Neonatal Period: A Mixed-Methods Observational Study in Healthcare Facilities and Households in Rural Cambodia (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) – International Journal of Environmental Research and Public Health, April 2021

* Caring for the carers: Ensuring the provision of quality maternity care during a global pandemic (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) – Women and Birth, May 2021

* Factors Influencing Compassion Fatigue among Hospice and Palliative Care Unit Nurses (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) – Journal of Hospice and Palliative Care, March 2021

* Patient-Centered Care and Associated Factors at Public and Private Hospitals of Addis Ababa: Patients' Perspective (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) – Patient Related Outcome Measures, May 2021

National Quality Policy and Strategy (NQPS)

Enhancing the quality of health services – introduction to a new planning guide for implementers

WHO recently released Quality Health Services: a planning guide (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) to support key actions required to improve the quality of health services for the entire population, recognizing the unique pathway for each country. The planning guide focuses on actions required at the national, district and facility levels to enhance quality of health services, providing guidance on implementing key activities at each of these three levels. It is intended to support those working at all levels of the health system translate intention into results, delivering an impact on the quality of services for people across the world. A 60-minute webinar providing an overview of the WHO Quality Health Services: a planning guide (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) and discussing how it can be applied to improve the quality of care across the health system will be held on Tuesday 29 June. More information about the webinar is

available here (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) . Post webinar, a thematic discussion (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) will be held [on HIFA] to continue to explore how to take action on quality through the use of this planning guide.

Infection prevention and control (IPC) & Water sanitation and hygiene (WASH)

The WHO Global IPC Portal (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) is a resource for health-care and other professionals working in the field of IPC that supports conducting situational analysis, tracking progress and making improvements to IPC programmes and/or activities at national and facility level in accordance with WHO standards and associated implementation materials...

Compassion

The Global Health Compassion Rounds held on June 17 explored how specific WASH tools are vectors for compassion in the health arena and examined how the “compassion-WASH-quality” triangulation can yield positive results for people. The world requires urgent action on WASH for the benefit of people across the world. Compassion is increasingly recognized as a critical consideration for health and development. The confluence of these three areas requires active exploration to help us collectively accelerate urgent action. You missed it? A recording of the webinar as well as a short report will be available soon. Watch out for the next Global Health Compassion Rounds.

Patient Safety

This year, the World Patient Safety Day 2021 theme is “Safe maternal and newborn care”. The global campaign proposes a wide range of activities to be implemented on and around 17 September 2021, including the launch of the World Patient Safety Day 2021–2022 goals.

WHO encourages all stakeholders to join the global campaign to promote collective efforts for safe maternal and newborn care, particularly during childbirth. Visit the event page here (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) for information on how to get involved.

Let us exchange on quality health services planning

Join and explore quality issues at all levels of the system. The recently released Quality Health Services: a planning guide (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) will be introduced in the webinar, enhancing the quality of health services – introduction to a new planning guide for implementers webinar (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) . The discussion hosted by HIFA allows you to share experiences on how to improve the quality of health services at different levels of the health system. Please join the HIFA discussion forums (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) from 28 June 2021 to contribute to the exchange. It promises to be a lively discussion across the world allowing us to share experiences, challenge each other and spark new thinking. Discussions will be available in

English, French, Portuguese and Spanish.

Embark on the Quality Improvement tour of South East Asia

The Nationwide Quality of Care Network invites you to join the Quality Improvement tour of South East Asia. After learning from teams from Bangladesh and Bhutan, the next online interactive session will be on “Experience of Quality Improvement from a Government Hospital in Maldives” on 26 June. Register here (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...)

Announcement

* The learning brief on quality considerations in maintaining essential health services during COVID-19 is available now! Please visit the brand-new HLH website (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) to read it.

* The WHO Academy is looking for 500 beta testers to test the digital platform and the learning programmes. Sign up here (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) . You can also access the registration to become a beta tester directly in 4 languages, Chinese (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) , French (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) , Russian (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) and Spanish (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...) . Arabic will be available soon.

* The NQPS Learning Pod has a new look! Cannot wait to find out? Do no wait any longer and visit the NQPS Learning Pod (https://who.us15.list-manage.com/track/click?u=540192c501e50b6f7f2ffe21d...(1).aspx) .

Quality (57B) What does quality of care mean to you? (2)

27 June, 2021
Oriane Bodson (WHO) asks: What does quality of care mean to you?

https://www.hifa.org/dgroups-rss/quality-56-what-does-quality-care-mean-you

There are many ways of describing quality, and they vary from person to person and from group to group. Some people (including me) see health outcomes as the prima facie indicator of quality, while others give emphasis to the patient experience.

I look forward to hear your thoughts. hifa@hifaforums.org

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (58) What does quality of care mean to you? (3)

27 June, 2021
Attributes of quality care should include:

Patient experience includes outcome, cost effectiveness/ affordability, efficacy, responsiveness of the system, being treated equitably in a timely manner.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

http://www.hifa.org/support/members/joseph-0

http://www.hifa.org/people/steering-group

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Quality (59) What does quality of care mean to you? (4)

27 June, 2021
Really looking forward to learning from perspectives that are shared through this thematic discussion on quality health services. The issue warrants careful consideration at all levels of the system - national, district and facility. Of course the community binds it all together. Lives indeed depend on whether we can place adequate attention to the quality of care that is received by our fellow human beings across the world - very real and not abstract.

The WHO Quality Health Services: a planning guide was recently issued to support actions required at the national, district and facility levels to enhance quality of health services, providing guidance on implementing key activities at each of these three levels, recognizing the unique pathway for each country. Countries are using different pathways to advance the provision of quality health services. The WHO planning guide is intended to support those working at all levels of the health system to translate intention into results on quality health services for people across the world. Hoping that many of you will join the briefing webinar this coming Tuesday that Neil has mentioned previously. See: https://www.who.int/news-room/events/detail/2021/06/29/default-calendar/...

To get us started the introductory questions that Oriane Bodson has posed warrant our attention. First, what does quality of care mean to you, in your particular context? Second, why is it important to make the case for quality of care? Our initial thoughts will take us into the next phase of the discussion to explore actions required at each level of the system.

For those that want a quick view of quality see the WHO Quality Fact Sheet:

https://www.who.int/news-room/fact-sheets/detail/quality-health-services

Looking forward to this...

HIFA profile: Shams Syed is the Quality Team Lead within the Department of Integrated Health Services in the UHC & Life Course Division at WHO Headquarters in Geneva. He is a member of the HIFA working group on Essential Health Services and COVID-19. https://www.hifa.org/support/members/shams https://www.hifa.org/projects/essential-health-services-and-covid-19 syeds AT who.int

Quality (60) Improving maternal and newborn quality of care (3)

28 June, 2021
Dear Rajinder Kaur and all,

In your message you highlighted 'knowledge and health seeking behaviour of patients' as a major contributor to high maternal and infant mortality.

https://www.hifa.org/dgroups-rss/quality-43-improving-maternal-and-newbo...

The first three papers you cited describe knowledge deficits and health seeking but do not link this explicitly to health outcomes. Would you or others like to say more on this subject?

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (61) What does quality of care mean to you? (5) Measuring quality of care

28 June, 2021
Quality - What does quality of care mean to you?

Parsing the meaning and making the case for quality of care

-- Tomislav Meštrović, May 28 2021

An improved understanding of quality of care is an indispensable step not only to improve patient-centered outcomes, but also to enhance healthcare quality research and public health initiatives. Without a clear meaning of what quality of care actually represents, basically all quality improvement schemes are destined to be fragmented, or even ineffective. Hence, we have to strive to transform a sort of abstract phenomenon into a framework that can be theoretical to start with, yet testable. Such conceptualization of quality of health services is something that this new thematic discussion aims to achieve, and I envision it will enable easier measurement of quality indicators, as well as the appraisal of its interconnectedness with other salient concepts within the healthcare environment. Each individual attribute which will get profiled in our discussions may serve as a guide to develop theory or to test existing theories in future research.

As we will probably observe as the discussion unfolds, the meaning of healthcare quality can differ, especially considering our diverse vantage points. For me, quality of care means that the care is provided to the patient when there is a need for it in an effective, safe and affordable manner (therefore, as a follow-up to Oriane's post, I am in the group that gives

emphasis to the patient experience). It also means patients are involved and engaged, so that they can take ownership of their own health. Furthermore, quality of care means that harms are minimized as much as possible during care delivery, and that communities are involved in ensuring best practices of healthy living. In any case, we should all strive to understand that quality of care is more than just a popular catch-phrase - it is something to strive for as a key ingredient of modern health care.

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. Email address: Email address: tomislav.mestrovic@gmail.com

Quality (62) What does quality of care mean to you? (6) Measuring quality of care (2)

28 June, 2021
What is quality?

I have thought about this and reflected on how many times I have been asked to prove the quality of care. I have measured the quality with the agreed quality metrics of the day. I have completed the organisational matrix recording the answers to the questions 'how many interventions?' and 'how much contact time?'. I look back on this and wonder, did we ask 'how may it be better next time?' Sadly I confess, not very often and not very loudly. We got on with recording and reporting and repeating what we had done the day before. That is not Quality.

Quality for me is asking that final question, asking it, reflecting on it, and then acting on the answers. And asking and improving it all again.

Quality is dynamic and requires discussion, decisions, and sometimes a little disruption. This is why I am here on this forum.

Quality is multi dimensional with multiple layers with multiple meanings. I have worked at these layers and notice the links, and the gaps.

I shall give two examples.

I recently worked with the MoH in Zambia working with the team to define quality and design the national approaches needed. We needed to do more than prove what was happening, we needed to improve it. This national quality improvement approach was helped by the WHO quality strategy documentation and these eight points become the foundation of the work.

From this we could measure much of what was defined as quality. This now links up with the latest WHO documents. [*see note below]

Now in 2021, with the lastest WHO documents we can build on these foundations and count each level we work at, and each clinical encounter we have.

And the gaps.

On a personal level, my clinical encounters over the weekend have had quality at their core too. The weekend's approach to quality needed not just the infrastructure to make sure our environment was safe and our evidence that was sound, we needed empathy too. The patients could only see our eyes and some were scared. For the patients before me quality was in the relationship we formed in those brief moments together as much as the care performed. The skills, or 'agency' needed to make each of these contacts count as quality for all parties involved can be seen as a competency, I see it more as human compassion. This is also part of quality. But there is no need organisationally to prove it.

In sociological theory the linking aspect between infrastructure and agency is called capital, and this for me is where a culture of quality comes in.

Somehow the intangible invisible glue linking skills and structure, is the quality element we also need. For me this includes personal habits of being conscientious in our work and kind in our words. This includes an organisational culture that values its staff as much as its statistics. A system that wants to improve quality as well as prove quality, and supports staff to do it. The gap for me is how we value this.

The latest WHO work enables us to measure what matters and improve quality as well as prove quality, thereby providing the care needed to improve health experiences and outcome.

Perhaps quality is the less visible capital, culture and compassion as well as the visible policies, plans and projects. We know all of these count to our patients, some more than others. With the help of WHO we can now make sure they can all be counted too.

--

Dr Marion Lynch

Drmarionlynch@gmail.com

HIFA profile: Marion Lynch is a global health consultant and nurse with nearly 40 years of experience in international health service design and education. She has a Doctorate in Health

Science and a Visiting Professor in with University of West London. Marion has designed and delivered Masters level quality improvement programmes within the NHS in the UK and led the 2021 THET conference stream on compassion. She is a member of the HIFA Catalyst Group on Learning for quality health services.

[*Note from HIFA moderator (Neil PW): Thank you Marion for this valuable exploration. The two documents to which Marion refers are:

1. Quality health services: a planning guide (2020)

https://www.who.int/publications/i/item/9789240011632

2. WHO Fact Sheet on Quality Health Services (2020)

https://www.who.int/news-room/fact-sheets/detail/quality-health-services]

Quality (63) What does quality of care mean to you? (7)

29 June, 2021
Greetings I'm Suad Eltahir Ali Ahmed community physician from Sudan my experience is in the area of public health with special focus on NCD, Mental health and protracted experience in injury violence and disability.

My interest in quality is because it affects directly the outcome of all effort exerted to control these diseases and health condition commencing from services at community level and extending to the level of programs, policy and decision making

I'm looking forward to gain solid background and exchange experience interactively

Regards

HIFA profile: Suad Eltahir Ali Ahmed is a Freelance community physician, Sudan. Professional interests: Health systems, specifically primary health care. Email: suatam2009 AT gmail.com

Quality (64) What does quality of care mean to you? (8) Measuring quality of care (3)

29 June, 2021
Good day

For me quality of care means a resilient health system that is able to deliver services when they are needed to the best of standards possible.

In my opinion a measure of quality involves looking at multiple parameters but ultimately considers the experience of the patient. Having a patient centred approach to healthcare can allow us to strive to provide the best care we can to the best of our ability at the right time in the best environment.

Quality improvement initiatives should look at the whole continuum of care and be able to introduce the best standards at all stages of care.

Often quality assessment tools we have developed and used just consider the perspective of the service provider from a technical perspective. Yet in my opinion, the customer (patient) experience and patient outcome provide the ultimate measures of whether quality is central in our health delivery system or not.

In low resource settings, we have made a lot of compromise in quality and patients have come to expect poor quality service at public health facilities. The excuse is we do not have enough resources. But quality is not about how much we have but how best we utilise what we have to provide the best service possible. Quality improvement, first and foremost will require a change of mindset, a paradigm shift from the frontliner providing a service in all areas that make up a health system.

Regards,

Venus Mushininga

HIFA profile: Venus Mushininga is a pharmacist with the Ministry of Health and Childcare in Zimbabwe. She is a founder and President of the Zimbabwe Society of Oncology Pharmacy and the Zimbabewan delegate to the European Society of Oncology Pharmacy. Professional interests: Oncology, Dissemination of information through to Health Professionals and the public, Research. She is co-coordinator of the HIFA working group on information for Prescribers and Users of Medicines.

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http://www.hifa.org/projects/prescribers-and-users-medicines

http://www.hifa.org/support/members/venus

Email: vmushininga AT gmail.com

Quality (65) Introduction: Paulina Pacheco Estrello, USA

29 June, 2021

[Note from HIFA moderator: Original message in Spanish below. Join HIFA-Spanish: http://www.hifa.org/join/unase-hifa-espanol]

Greetings to all the participants in this discussion forum!

My name is Paulina Pacheco. I am currently an Independent Consultant in various health topics. Although I was born and raised in Mexico City, I currently reside in California, United States. I have over fifteen years old of experience in the health sector in Mexico. My passion for the topic of quality in health emerged during my career in public administration, specifically when I worked as Area Director in the Directorate General of Quality Education in Health, of the Federal Health Secretariat of Mexico. I am convinced that providing medical care that does not comply with the required quality standards, it may be more harmful than not provide it.

Best regards,

HIFA profile: Paulina Pacheco Estrello is an Independent consultant, Mexico. Professional interests: Health Systems Quality of Healthcare; Universal Health Coverage; HR development; Philanthropic activities. She is a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email: pacheco.paulina AT gmail.com

ORIGINAL MESSAGE BELOW

Un saludo a todos los participantes de este foro de discusión!

Mi nombre es Paulina Pacheco. Actualmente soy Consultora Independiente en diversos temas de salud. Aunque nací y crecí en la Ciudad de México, actualmente radico en California, Estados Unidos. Tengo más de quince años de experiencia en el sector de la salud en México. Mi pasión por los temas de calidad en salud surgió durante mi carrera en la administración pública, específicamente cuando trabajé como Directora de Área en la Dirección General de Calidad Educación en Salud, de la Secretaría de Salud Federal de México. Estoy convencida de que brindar atención médica que no cumpla con los estándares de calidad requeridos, puede resultar más dañino que no brindarla.

Saludos cordiales,

HIFA profile: Paulina Pacheco Estrello es consultora independiente, México. Intereses profesionales: Sistemas de salud Calidad de la atención sanitaria; Cobertura de salud universal; Desarrollo de recursos humanos; Actividades filantrópicas. Correo electrónico: pacheco.paulina AT gmail.com

Quality (66) What does quality of care mean to you? (9)

29 June, 2021
For me, the quality of care consists of an approach that aims to produce and provide health care that conforms to the best possible standards based on current scientific knowledge and that takes into account the human and autonomous character of the person who receives them. Ultimately, this care must be effective, economical, continuous, integrated, equitable and safe.

Kind regards,

Frank Nduu Nawej

HIFA profile: Frank Nduu Nawej is a Health services Manager at Ligue des Droits du Malade (LDM), Democratic Republic of Congo. His interests include Quality of health services, health care's humanisation and patients rights. frankndu AT yahoo.fr

Quality (67) What does quality of care mean to you? (10) Measuring quality of care (4)

29 June, 2021
I am Nkwan Jacob, an IPC;WASH Nurse from Cameroon. I have 23 years experience as a nurse.

This topic on quality health care touches my heart. It has been observed that more people die due to poor quality of care than lack of care, and that the health industry kills more than the plane industry.

Unfortunately, in my health system is that quality is subjective and not well defined, and quality standards and indicators are not available. Therefore, it is difficult, if not impossible, to measure quality. Many patients continue to suffer even in facilities that are said to be providing quality health care, and in most cases, the staff are not honest to accept their errors, instead they always try to defend themselves at the expense of patients safety.

I strongly believe that quality can only best be defined by the patient, and until we involving them in care, we will simply be doing the opposite.

Jacob

Nkwan Jacob Gobte RN, BNS, MPH
Infection Prevention & Control/WASHNurse
Baptist Training School for HealthPersonnel (BTSHP), Banso
Cameroon Baptist Convention HealthServices
2019 APIC Hero of Infection Prevention,2018 SHEA Ambassador

Water, Sanitation & Hygiene (WASH)Working Group

Infection Control African Network,(ICAN)

HIFA profile: Nkwan Jacob Gobte is an IPC/WASH Nurse at Cameroon Baptist Convention Health Services, Cameroon. Professional Interests: Infection Prevention and Control; Water; Sanitation and Hygiene. He is a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email: nkwanjacobgobte AT yahoo.com

Quality (68) What does quality of care mean to you? (11)

29 June, 2021
Good morning Neil I am forwarding the email I had sent earlier to share my thoughts on Quality and Care, within the typical Canadian context of being a patient/family /community member in our *pluralist society, where Quality challenges take on an unique form in the intersections of governance policies at both national and district level and impact delivery of equitable Care at the facility level.*

These intersectoral and inter-level dynamics *need critical consideration to prevent (harmful) miscommunications about the aspects of Quality Care among the Stakeholders and by doing so, can*

(a) recognize the "invisible' chasms in Quality and

(b) discuss, design and deliver tangible approaches to help patients /families/ communities participate as equal partners in all discussions of Quality Care.

Thank you,

Looking forward to the Webinar tomorrow ! [*see note below]

Esha Ray Chaudhuri

Calgary, Alberta, 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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

[*Note from HIFA moderator (Neil PW): Esha refers to the WHO webinar today 29 June on Quality Health Services: a planning guide: https://www.who.int/news-room/events/detail/2021/06/29/default-calendar/...]

Quality (69) What does quality of care mean to you? (12)

30 June, 2021
Dear all on HIFA,

Thank you for your contributions so far on the question: "What does quality of health care mean for you?". Here are some snapshots of your responses, with links to the full messages:

What does quality of health care mean for you? "Health outcomes, cost effectiveness, equity" (HIFA member, Nigeria) https://www.hifa.org/dgroups-rss/quality-58-what-does-quality-care-mean-...

What does quality of health care mean for you? For me, quality of care means that the care is provided to the patient when there is a need for it in an effective, safe and affordable manner... (HIFA member, Croatia) https://www.hifa.org/dgroups-rss/quality-61-what-does-quality-care-mean-...

What does quality of health care mean for you? Quality for me is asking 'how may it be better next time?'... (HIFA member, UK) https://www.hifa.org/dgroups-rss/quality-62-what-does-quality-care-mean-...

What does quality of health care mean for you? "For me quality of care means a resilient health system that is able to deliver services when they are needed to the best of standards possible..." (HIFA member, Zimbabwe)https://www.hifa.org/dgroups-rss/quality-64-what-does-quality-care-mean-...

What does quality of health care mean for you? "Based on current scientific knowledge and that takes into account the human and autonomous character of the person who receives them..." (HIFA member, DR Congo) https://www.hifa.org/dgroups-rss/quality-66-what-does-quality-care-mean-...

In addition to receiving HIFA through your email, you can follow the discussion on our RSS feed here:

https://www.hifa.org/rss-feeds/17

Please email your contributions to: hifa@hifaforums.org

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (70) What does quality of care mean to you? (13)

30 June, 2021
Dear colleagues,

I have appreciated all of the posts in this Quality discussion but wanted to comment on Venus Mushininga's post about what quality means, because it especially resonated with me. She wrote, "Often quality assessment tools we have developed and used just consider the perspective of the service provider from a technical perspective. Yet in my opinion, the customer (patient) experience and patient outcome provide the ultimate measures of whether quality is central in our health delivery system or not."

Examining patient experience of care (as well as provider experience of care!) are as important as compliance with technical standards and may have even more impact on patient adherence to treatment and outcomes.

Our quality strategies must go beyond promoting and measuring compliance with standards to address the human dynamic between providers and patients — communication, empathy, behavioral incentives — as well as the engagement of broader community stakeholders in improving care. As Venus noted, this "will require a change of mindset, a paradigm shift … in all areas that make up a health system" and changing patient and community expectations about the care they receive, especially in public facilities, to create a stronger demand for quality and accountability mechanisms to hold providers and managers to account if these expectations are not met.

Lani

LANI MARQUEZ

Knowledge Management Director
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HIFA profile: Lani Rice Marquez works with the University Research Company and is based in USA. Interests: Quality improvement, knowledge management. Extensive experience with technical writing and editing and facilitation of webinars and peer-to-peer learning activities. She is a member of the WHO-HIFA Catalyst Group on Learning for quality health services.

https://www.hifa.org/support/members/lani-rice

https://www.hifa.org/projects/learning-quality-health-services

lmarquez AT urc-chs.com

Quality (71) What does quality of care mean to you? (14)

1 July, 2021
Dear HIFA members,

Quality of care is inclusive of both physical, mental and emotional aspects while providing healthcare services. Physical includes infrastructure, human resources, consumables, etc. are available in a particular healthcare facility/ system. But, the behaviour, attitude, communication skills and other soft skills of healthcare professionals towards the patients/ clients is an important consideration in recovery of the patient/ client. Quality of care is a more holistic approach for pathways to recovery.

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Best regards,

Dr. Sanchika Gupta

(Pronoun: She/Her/Hers)
HIFA Global CR Coordinator
Healthcare Information For All
Email: sanchika12@gmail.com

HIFA works with the World Health Organization and others to improve the availability and use of reliable healthcare information and protect people from misinformation.

20,000 members, 400 supporting organisations, 180 countries, 12 projects, 6 forums, 4 languages

W: www.hifa.org Twitter: @HIFA_org Facebook: HIFAdotORG

HIFA profile: Dr Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international NGOs namely INCLEN, MAMTA, Jhpiego and Pathfinder International. She acquired technical expertise in advocacy, program management, research, monitoring and evaluation throughout her fieldwork in eight Indian states (Assam, Bihar, Haryana, Jharkhand, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh). She is the nominee of ‘120 under 40: the new generation of family planning leaders’ in 2019. In the recent years, she has been associated with HIFA through its Social Media Working Group and EHS-COVID19 project. In 2021, HIFA nominated her as Global Country Representative Coordinator. Currently, she is based

in New Delhi, India and is available on email id sanchika12@gmail.com or Twitter @sanchika_gupta. https://www.hifa.org/support/members/sanchika

Quality (72) What does quality of care mean to you? (15)

1 July, 2021
Dear Colleagues

You might like to consider the perspective of how patients and health professionals can work together in solidarity, and the layers of representation issues it raises.

The Allies and Trojan Horses of Patient Advocacy (savvy.coop)

https://www.savvy.coop/blog/the-allies-and-trojan-horses-of-patient-advo...

Dr Ann Lawless,

Perth, Western Australia, Australia

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.

https://www.hifa.org/projects/learning-quality-health-services

https://www.hifa.org/support/members/ann

Email: lawlesszest AT yahoo.com

Quality (73) What does quality of care mean to you? (16)

1 July, 2021
Quality - What does quality of care mean to you?

-- Tomislav Meštrović, Jul 1 2021

I had an interesting discussion with another HIFA member, pediatrician Massimo Serventi who works in Tanzania. He commented on the quality of care from the patient's perspective, and emphasized how physicians and healthcare personnel should clearly communicate all the details and always provide appropriate contact information. He also mentioned that patients

should receive a health booklet with diagnosis and treatment information in plain language, together with a telephone number for contact purposes. I believe this is especially pertinent for countries with lower rates of health literacy.

I am confident that these are important points that would contribute to patients' individual perceptions of quality of received care. Actually, they may mirror patients' perceptions of standards in hospital wards and also shed light on how patients define quality. I would also like to remind everyone about one salient theoretical model of quality of care from the patients' perspective (QPP) that was developed in 1993 by Wilde and his colleagues, and that is used as a theoretical foundation for a plethora of studies in the field of health quality.

In my opinion, Wilde's approach is one of the best frameworks that views care quality through the patient's eyes, and entails four dimensions: 1) the medical-technical competence of the caregivers; 2) the physical-technical conditions of the care organization; 3) the degree of identity-orientation in the attitudes, and 4) actions of the caregivers and the socio-cultural atmosphere of the care organization. Anyone who is interested can find out more on the following link: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1471-6712.1993.tb00180...

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. He is also a member of the HIFA-WHO working group on Learning for quality health services.

https://www.hifa.org/projects/learning-quality-health-services

https://www.hifa.org/support/members/tomislav

Email address: Email address: tomislav.mestrovic@gmail.com

Quality (74) Webinar: Ensuring Quality Products during Emergencies, July 13, 2021

1 July, 2021
Ensuring Quality Products during Emergencies: A webinar series on quality assurance for humanitarian settings

This two-part webinar series focuses on quality assurance (QA) of health commodities used in humanitarian and emergency response settings. Health supply chain managers and program staff who manage health supplies during emergencies will learn the principles of QA and the actions they can take to ensure that quality is in focus throughout the supply chain.

The webinar series is conducted by JSI supply chain experts Barbara Lamphere and Gregory Roche. It is funded by USAID's Bureau for Humanitarian Assistance (BHA) and conducted in cooperation with the International Association of Public Health Logisticians (IAPHL).

Part 1: Principles of Quality Assurance

Tuesday, July 13, 2021, 9 am EST/14:00 GMT

In Part 1 of this webinar series, participants will learn to define QA and identify products that are typically associated with emergency response.

They will relate general QA principles to QA principles in the context of emergency response and discuss how QA is applied to pharmaceutical and non-pharmaceutical products. Participants will be able to practice their learning through a post-webinar online game and access additional QA resources.

Register at:
https://jsi.zoom.us/webinar/register/8916240276880/WN_OABCspLKSpaMhcXf6d...

For information about Part 2 of the webinar, please visit:
https://www.jsi.com/ensuring-quality-products-during-emergencies-a-webin...

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<http://www.facebook.com/jsihealth>
<http://www.twitter.com/jsihealth>

HIFA profile: Anne Marie Hvid is a KM Advisor at JSI, United States. Professional Interests: Health supply chain, MCH, family planning, humanitarian logistics. anne_marie_hvid AT jsi.com

[*Note from HIFA moderator (Neil PW): Are you planning to register for this webinar? Would you be willing to represent HIFA and share your observations with HIFA in a brief message after the event? Contact: neil@hifa.org]

Quality (75) What does quality of care mean to you? (17)

1 July, 2021
Quality of care must have this items to exist or to have meaning:

1) Space to patient on time it means avoiding overcrowding.

2) Primary Health Care with best well trained Clinicians, able to diagnose accurately the basic initially diseases like HTA, Diabetes, Allergy in skin, alimentary and respiratory. Cases to pass for Public Health investigation with Laboratory help.

3) Learn to educate people about good health.

4) Referential services well directed by the best GPs to avoid overcrowded Hospitals and bad use of diagnose tools.

5) Drugs to really treat the diseases bcs we are growing up a new condition where patients use many different treatments all life it means medicines are not working.

6) Chemistry specialists for a perfect hygiene of builds, food and clothes.

7) Perfect dashboard system for monitoring and evaluating all the mentioned activities.

Health personnel must be efficient, efficacy of diagnose tools and medicines on place and privacy to attend patients.

IIK

HIFA profile: Isabel I Keshavji is a GP at the Health Ministry in Mozambique. Professional interests: Non Communicable Diseases. isabelkeshavji AT yahoo.com

Quality (76) What does quality of care mean to you? (18) WHO Fact Sheet

1 July, 2021
The WHO Fact Sheet on Quality health services defines quality as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge'.

https://www.who.int/news-room/fact-sheets/detail/quality-health-services

'This definition of quality of care spans promotion, prevention, treatment, rehabilitation and palliation, and implies that quality of care can be measured and continuously improved through the provision of evidence-based care that takes into consideration the needs and preferences of service users – patients, families and communities.

'Multiple quality elements have been described over the past decades. There is now clear consensus that quality health services should be:

- effective by providing evidence-based health care services to those who need them;

- safe by avoiding harm to the people for whom the care is intended;

- people-centred by providing care that responds to individual preferences, needs and values, within health services that are organized around the needs of people;

- timely by reducing waiting times and sometimes harmful delays for both those who receive and those who give care;

- equitable by providing the same quality of care regardless of age, sex, gender, race, ethnicity, geographic location, religion, socio-economic status, linguistic or political affiliation;

- integrated by providing care that is coordinated across levels and providers and makes available the full range of health services throughout the life course; and

- efficient by maximizing the benefit of available resources and avoiding waste.'

Our discussion on HIFA has suggested further elelments such as affordability (Tomislav Mestrovic, Croatia), cost-effectiveness (Joseph Ana, Nigeria), dynamic improvement (Marion Lynch, UK), resilience (Venus Mushininga, Zimbabwe).

The WHO definition above implies the 'bottom line' to the definition of quality is health outcomes. The primary measure of quality would be improvement in health outcomes, including morbidity and mortality. Many of the contributors to our discussion have emphasised the perspective of patients and the patient experience. Would anyone like to comment on the links between improvement in health outcomes and patient experience?

Best wishes, Neil

Coordinator, WHO-HIFA Collaboration: HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

Let's build a future where every person has access to reliable healthcare information and is protected from misinformation - Join HIFA: www.hifa.org

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (77) Patient led shift handover in hospitals

2 July, 2021
Dear Colleagues

I have been speaking with patient reps across Australia and had a discussion about how patients can become active - and add to quality of care - during the handover from one shift in the hospital to another. Here is a short video about such a pilot program in a hospital.

'The Patient's Voice' - 2017 NSW Health Awards 'Patients as Partners' winner - YouTube https://www.youtube.com/watch?v=77APxD3PIeM [*see note below]

Dr Ann Lawless,

Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.

https://www.hifa.org/projects/learning-quality-health-services

https://www.hifa.org/support/members/ann

Email: lawlesszest AT yahoo.com

[*Note from HIFA moderator (Neil PW): Thank you Ann. For the benefit of those who may not have immediate web access, here are extracts from the video:

'Patient's Voice has taken the handover back to the bedside in all cases and it's also now the patients handing over to the nurses rather than a nurse talking to a nurse, it is actually involving the patients and the patients deliver

their handover to the nursing staff...

So they [patients] tell us what they understand of their journey each day. They tell us what the plan of care is for them and that way we can check that they understand what's going on. They understand why we're doing what we're doing

and it's putting them back at the center of their care... We've gone from 6% to 86% of our patients saying they feel valued within their health care journey.']

Quality (78) Quality of care for patients with myocardial infarction

2 July, 2021

[Note from HIFA moderator (Neil): The original message is in Spanish and is shown below.]

[Google translation]

Dear members of the HIFA community,

I share with you an article [*see note below] in which I had the opportunity to collaborate, on the Gaps between the supply and demand of acute myocardial infarction treatment in Mexico. The results obtained undoubtedly show the areas of opportunity that exist in terms of the quality of services to attend to this condition, understanding this concept as something multifactorial.

Best regards,

HIFA profile: Paulina Pacheco Estrello is an Independent consultant, Mexico. Professional interests: Health Systems Quality of Healthcare; Universal Health Coverage; HR development; Philanthropic activities. She is a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email: pacheco.paulina AT gmail.com

[*Note from HIFA moderator (Neil PW): The original message had an attacht but HIFA does not carry attachments. The paper is freely available here: https://www.saludpublica.mx/index.php/spm/article/view/11032

CITATION: Pérez-Cuevas R et al. Gaps between supply and demand of acute myocardial infarction treatment in Mexico. Salud Publica Mex. 2020. https://doi.org/10.21149/11032

ABSTRACT

Objective. To analyze acute myocardial infarction (AMI) admissions and in-hospital mortality rates and evaluate the competence of the Ministry of Health (MOH) hospitals to provide AMI treatment.

Materials and methods. We used a mixed-methods approach: 1) Joinpoint analysis of hospitalizations and in-hospital mortality trends between 2005 and 2017; 2) a nation-wide cross-sectional MOH hospital survey.

Results. AMI hospitalizations are increasing among men and patients aged >60 years; women have higher mortality rates. The survey included 527 hospitals (2nd level =471; 3rd level =56). We identified insufficient competence to diagnose AMI (2nd level 37%, 3rd level 51%), perform pharmacological perfusion (2nd level 8.7%, 3rd level 26.8%), and mechanical reperfusion (2nd level 2.8%, 3rd level 17.9%).

Conclusions. There are wide disparities in demand, supply, and health outcomes of AMI in Mexico. It is advisable to build up the competence with gender and age perspectives in order to diagnose and manage AMI and reduce AMI mortality effectively.

[Original message in Spanish below]

Estimados integrantes de la comunidad HIFA,

Les comparto un artículo en el que tuve la oportunidad de colaborar, sobre las Brechas entre la oferta y la demanda del tratamiento de infarto agudo al miocardio en México. Los resultados obtenidos sin duda muestran las áreas de oportunidad que se tienen en cuanto a la calidad de los servicios para atender dicho padecimiento, entendiendo dicho concepto como algo multifactorial.

Saludos cordiales,

HIFA profile: Paulina Pacheco Estrello es consultora independiente, MÃ©xico. Intereses profesionales: Sistemas de salud Calidad de la atenciÃ³n sanitaria; Cobertura de salud universal; Desarrollo de recursos humanos; Actividades filantrÃ³picas. Correo electrÃ³nico: pacheco.paulina AT gmail.com

Quality (79) What does quality of care mean to you? (19)

2 July, 2021
Good morning

My name is Karen Zamboni, I am a Health Adviser at the UK Foreign, Commonwealth and Development Office where I work on policy development to support quality health systems, and also a researcher at the London School of Hygiene and Tropical Medicine - my research focusing on evaluation of quality improvement interventions in the area of maternal and newborn care in low and middle income settings.

What is quality for me?

In my experience that definition depends on how close to patients our perspective is. Fundamentally, it is about providing the most appropriate and evidence-based care in a respectful way to meet patients' needs, and respecting their preferences, their autonomy and their dignity.

While health workers at the frontline have a primary responsibility for delivering quality services, decisions at health systems level (facility, district, regional, national) have a huge bearing on enabling or hindering such quality provision. Therefore, quality of care is also fundamentally about leadership and a decision-making mindset, that challenges the status quo in a constructive way, continuously strives to improve and to better respond to the needs of patients and health workers, so their interaction can be of quality.

Karen

HIFA profile: Karen Zamboni is a Health Adviser at the UK Foreign, Commonwealth and Development Office. She is a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services karen.zamboni AT lshtm.ac.uk

Quality (80) What does quality of care mean to you? (20) Patient experience and health outcomes

2 July, 2021
Neil, thank you for opening the door to discuss links between improvement in health outcomes and patient experience in more depth, which is an important facet of the quality of care. As the utilization of patient experience measures is becoming evermore pervasive, it is pivotal for patients, providers and funders to have a full understanding whether good patient experience actually correlates with improved outcomes. This will also help us to better grasp the drivers of overall health-care utilization.

And this is indeed a field of research that needs more data, as the literature so far is inconsistent. Some studies demonstrate that better patient experiences can be linked to lower rates of mortality, disease complications and hospital readmissions; on the other hand, other reports did not find these types of associations. Such discrepancy is often explained in regards to what domains of patient experience have been analysed. For example, communication with doctors and nurses have shown much more robust association with clinical outcomes than, for example, hospital environment or overall hospital rating.

Consequently, the latter can then be translated to the process of shared decision-making when patients are involved in decisions regarding their care. In a way, healthcare professionals and patients decide together as partners for the benefit of the patient. A recent study by Hughes et al. (10.1016/j.amjsurg.2018.01.011) actually showed that nonexistent or poor shared decision-making can be linked to worse patient-reported health outcomes and higher utilization of healthcare services. Hence, the role of shared decision-making between patients and providers has an intrinsic value to patient experience and quality outcomes, and should be always taken into account when discussing quality of care.

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. He is also a member of the HIFA-WHO working group on Learning for quality health services.

https://www.hifa.org/projects/learning-quality-health-services

https://www.hifa.org/support/members/tomislav

Email address: tomislav.mestrovic AT gmail.com

Quality (81) What does quality of care mean to you? (21) Patient experience and health outcomes (2)

2 July, 2021
Health care as "the degree of adherence to agreed standards to help determine a good level of practice and knowledge of the expected results from a service, therapeutic or diagnostic procedure", meaning that quality in health care means ensuring that health outcomes are achieved.

HIFA profile: Hewa Mhammad is a Medical Assistant at Klara org.for Healthy & Society at Ebril, Iraq/Kurdistan. Professional interests: Working in the field of human medicine. Email: chiaerbil70 AT gmail.com

Quality (82) What does quality of care mean to you? (22) Patient experience and health outcomes (2) Compassion

2 July, 2021
I share the same view with Neil.

When the question "What does quality of care mean to you?" was posed, my first impulse was to take a second look at the WHO definition of "quality of care". The most important thing (in my humble opinion) to consider, as noted in that definition, is "...INCREASE THE LIKELIHOOD OF DESIRED HEALTH OUTCOMES ... consistent with evidence-based professional knowledge."

The definition appears to be quite comprehensive in scope and elements (though, it may not necessarily be exhaustive). And I think one of the key elements of quality of care is PEOPLE-CENTREDNESS. But I've been wondering if this would also imply COMPASSION.

Though it may not be a sufficient condition, compassion/compassionate care is important in patients' healing process. To some (I do not want to presume 'many'), compassion determines their choice of care providers/givers.

--

ORFEGA, Moses Kumaoron

HIFA profile: Moses Kumaoron Orfega is a Service Improvement Desk Officer at the National Health Insurance Scheme, Nigeria. Professional interests: Social Protection and Financing; Social Health Protection and Universal Health Coverage; Service Quality Improvement; Information Technology. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. Email: ofegamoses AT gmail.com

Quality (83) What does quality of care mean to you? (23) Patient experience and health outcomes (3)

2 July, 2021
Dear HIFA members

For the first time since I joined this group I have read with a lot of passion all the contribution on this subject matter. From the contributions, it is clear that quality health care means different things to different people, but the definition proposed by the WHO has most of the essential elements one will expect to see, that is safety, effectiveness, efficiency, patient centered, and delivered in a timely and respectful manner.

I have adopted a working definition which defines quality as "care that meets clients expectations, based on scientific evidence, safe, effective, efficient, technically acceptable, and must be delivered in a timely and respectful manner".

Client's expectation can be influenced by several factors including the level of education, social status, culture and religious background, among other factors.

It is important to note that clients expectation may not be fright [right] all the times, meaning we still have to evaluate if the client's expectation are realistic or not. Client's expectation can change from time to time.

Jacob

Nkwan Jacob Gobte RN, BNS, MPH
Infection Prevention & Control/WASH Nurse
Baptist Training School for Health Personnel (BTSHP), Banso
Cameroon Baptist Convention Health Services
2019 APIC Hero of Infection Prevention, 2018 SHEA Ambassador
Water, Sanitation & Hygiene (WASH) Working Group
Infection Control African Network, (ICAN)

HIFA profile: Nkwan Jacob Gobte is an IPC/WASH Nurse at Cameroon Baptist Convention Health Services, Cameroon. Professional Interests: Infection Prevention and Control; Water; Sanitation and Hygiene. He is a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email: nkwanjacobgobte AT yahoo.com

Quality (84) What does quality of care mean to you? (24) Patient experience and health outcomes (4)

2 July, 2021
Dear Neil and Colleagues,

Very happy to contribute to the thematic discussion on quality health services and look forward to meeting the rest of the group.

I am Dr. Adanna Chukwuma, Senior Health Specialist at the World Bank Group. I lead and contribute to teams in Europe and Central Asia that support countries in designing health financing and service delivery reforms to improve access to high quality health care. My academic background is in medicine, global health, and health systems.

My interest in quality stems from my professional experience working as a physician in Northern Nigeria and seeing firsthand the gaps in infrastructure and the supply of human resource for health, due to underinvestment and rising conflict in the region. Since then, I have led and contributed to peer-reviewed research exploring the determinants of variation in quality of care in selected countries in Africa, including conflict. In Armenia, I have facilitated a twinning partnership with the Korean HIRA to work with the MoH to develop an operational roadmap for monitoring, reporting, and paying for improvements in quality of care. In other countries, I have worked with our clients to design investments that improve infrastructure, human resource for health supply and training, develop clinical guidelines and pathways, or modify purchasing arrangements to support quality improvements.

In a recent publication with my co-authors on the impact of conflict on quality, I defined health care to be of “good quality” to the extent that it increases the probability of better health outcomes. Versions of this definition have been used in reports by WHO, the Institute of Medicine, and the World Bank. In practice, this translates to care that has the right inputs (structural quality – e.g. infrastructure, equipment, health workers), the right processes (evidence-driven, person-centered, safe, timely, integrated), and the right outcomes (avoiding preventable complications, etc.).

I look forward to learning from other members of the group.

Best Wishes,

Adanna

Adanna Chukwuma MD MSc ScD

Senior Health Specialist,

Health, Nutrition, and Population Global Practice,

Europe and Central Asia Region

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HIFA profile: Adanna Chukwuma is a Senior Health Specialist at the World Bank Group, United States. She is a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services achukwuma AT worldbank.org

Quality (85) Current research (1) Quality of HIV services

2 July, 2021
Dear HIFA and HIFA-Zambia colleagues,

As we explore issues around how to increase quality of healthcare [https://www.hifa.org/news/learning-quality-health-services-new-thematic-... I invite you to share current research on this topic.

Here is a paper from the journal Health care management science, looking at quality of HIV services in several African countries. Unfortunately the full text is restricted access. I have requested the full text from the authors.

CITATION: Sosa-Rubi S.G. et al. Efficiency, quality, and management practices in health facilities providing outpatient HIV services in Kenya, Nigeria, Rwanda, South Africa and Zambia.

Health care management science. 24 (1) (pp 41-54), 2021. Date of Publication: 01 Mar 2021. https://pubmed.ncbi.nlm.nih.gov/33544323/

ABSTRACT

Few studies have assessed the efficiency and quality of HIV services in low-resource settings or considered the factors that determine both performance dimensions. To provide insights on the performance of outpatient HIV prevention units, we used benchmarking methods to

identify best-practices in terms of technical efficiency and process quality and uncover management practices with the potential to improve efficiency and quality. We used data collected in 338 facilities in Kenya, Nigeria, Rwanda, South Africa, and Zambia. Data envelopment analysis (DEA) was used to estimate technical efficiency. Process quality was estimated using data from medical vignettes. We mapped the relationship between efficiency and quality scores and studied the managerial determinants of best performance in terms of both efficiency and quality. We also explored the relationship between management factors and efficiency and quality independently. We found levels of both technical efficiency and process quality to be low, though there was substantial variation across countries. One third of facilities were mapped in the best-performing group with above-median efficiency and above-median quality. Several management practices were associated with best performance in terms of both efficiency and quality. When considering efficiency and quality independently, the patterns of associations between management practices and the two performance dimensions were not necessarily the same. One management characteristic was associated with best performance in terms of efficiency and quality and also positively associated with efficiency and quality independently: number of supervision visits to HIV units.

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Join HIFA-Zambia: http://www.hifa.org/join/join-hifa-zambia

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (86) Current research (2) Quality of care and respectful care: Intrapartum experiences in Zambia and Tanzania

2 July, 2021
Dear HIFA and HIFA-Zambia colleagues,

CITATION: Lavender T et al. Respectful care an added extra: a grounded theory study exploring intrapartum experiences in Zambia and Tanzania. BMJ Global Health. 6(4), 2021 04. https://gh.bmj.com/content/6/4/e004725

ABSTRACT

BACKGROUND: Quality of maternal and newborn care is integral to positive clinical, social and psychological outcomes. Respectful care is an important component of this but is suboptimum in many low-income settings. A renewed energy among health professionals and academics is driving an international agenda to eradicate disrespectful health facility care around the globe. However, few studies have explored respectful care from different vantage points.

METHODS: We used Strauss and Corbin's grounded theory methodology to explore intrapartum experiences in Tanzania and Zambia... The process involved application of memos, reflexivity and positionality.

RESULTS: Findings demonstrated that direct and indirect social discrimination led to inequity of care. Health-providers were believed to display manipulative behaviours to orchestrate situations for their own or the woman's benefit, and were often caring against the odds, in challenging environments. Emergent categories were related to the core category: respectful care, an added extra, which reflects the notion that women did not always expect or receive respectful care, and tolerated poor experiences to obtain services believed to benefit them or their babies. Respectful care was not seen as a component of good quality care, but a luxury that only some receive.

CONCLUSION: Both quality of care and respectful care were valued but were not viewed as mutually inclusive. Good quality treatment (transactional care) was often juxtaposed with disrespectful care; with relational care having a lower status among women and healthcare providers. To readdress the balance, respectful care should be a predominant theme in training programmes, policies and audits. Women's and health-provider voices are pivotal to the development of such interventions.

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Join HIFA-Zambia: http://www.hifa.org/join/join-hifa-zambia

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (87) What does quality of care mean to you? (25)

3 July, 2021
Neil, thank you for adding this question to this thematic discussion: ‘What does Quality health care mean to you?’.

To me quality of care as described by the WHO definition, ‘quality of care is “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge” is the most appropriate, but it needs to be adjusted to the context of where in the world it is to be used / applied, because the availability and functionality of the basic fundamentals on which quality care relies are mostly lacking in LMICs, which comprise the majority of the world population, e.g. the lack of ‘basic WASH services in health care, human rights, upholding patient dignity, retaining health care workers for ensuring that universal health coverage (UHC) and primary health care commitments. Most countries lack basic Health Law/ Act, mandatory Health Insurance, basic equipment and 24/7 power. It is also not possible to provide quality care when the following failings are rife: bad attitude and behaviour of staff; non functional infrastructure and poor access; inadequate supply of drugs; laboratory commodities / consumables (inadequate Logistics & Supply Chain with constant Out-of-

Stock); inadequate supply of basic & advanced equipment including unpredictatble Oxygen supply; over-dependence on donor assistance and funding and low domestic funding for health; inadequate personnel knowledge, skills, capability and capacity; inadequate contact by Health Workers with patients and family; inadequate monitoring & mentorship for upcoming practitioners (Inadequate Training and retraining); no statutory national Quality Standards for practitioners to work to meet; Lack of Health Information / Library (record keeping still mostly paper based); inequalities in access to Health care: rich versus poor; rural versus urban; able versus disabled; and lack of or inadequate Monitoring and Evaluation and health ombudsman.

The above was our mostly our finding in 2004, after a comprehensive situational analysis of the health system of a State in Nigeria which led us to introduce Clinical Governance to Nigeria, but only after modifying the version described by Liam Donaldson, et al in the UK in 1998. We produced the Home-grown context informed 12-Pillar Clinical Governance Programme version to address the unique challenges that confront attempts at achieving quality health care in LMICs. The twelve pillars which are inter-related and have shown positive and quality of care results where the 12-Pillar Clinical Governance Programme is implemented are : *Policy / Law, *Funding Mix, *Infrastructure, *Equipment, *Utilities and Ambience, Clinical Effectiveness, Audit, Risk Management, Education and Training. Patient and Public involvement (PPI), Information and IT (ICT)(Health Information Resource Centres), Staff and staff management. (* essential additional pillars for clinical governance often lacking in LMICs). www.hriwestafrica.org

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

http://www.hifa.org/support/members/joseph-0

http://www.hifa.org/people/steering-group

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Quality (88) What does quality of care mean to you? (26)

3 July, 2021
Dear HIFA colleagues,

We are having a parallel discussion on Quality health services our sister forum CHIFA (child health and rights). Below I am forwarding a message from Ruth Davidge, South Africa. Her comments relate to newborn care, but I am sure they are relevant across the whole spectrum of care. Comment from me below.

--

As a neonatal nurse responsible for improving standards of neonatal care in my province these questions are very pertinent. I totally agree with the WHO definitions described in previous mails.

However focussing specifically on nursing care, the challenges I am finding is that nurses are very dependent on the historical practices in their unit and on Dr orders. Very few have access to current scientific literature (journals), ongoing education, textbooks, conferences etc in order to update their knowledge, nor are they empowered or confident enough to question the care rendered in their units. They lack neonatal specific training and leadership and mentoring. They are therefore driven by routine nursing care with which they are comfortable.

In order to improve the quality of their care they need to know the required standard of care (evidence based) and then measure their care against this. They then need to measure this care against the health outcomes achieved.

The skills necessary for this reflective process are not widely taught and therefore auditing tends to be more of a compliance process (ticking boxes) rather than a motivating process to bring about change. Many of our facilities really struggle to analyse their morbidity and mortality data with insight, and action plans are fairly generic, frequently focussing on the need for training and not actually measuring whether any training received actually has impact and leads to improved care rendered.

Therefore I would like to add to our discussions on the components of quality of care, the need for a process of reflection on services rendered, critical thinking skills and confident, empowered staff able to propose and implement changes.

Without visible, strong, competent (knowledgeable and experienced), visionary, supportive (empathetic) leadership, improving quality is a very difficult and slow process.

God bless

Ruth Davidge RN RM RPN, Cert. Neon Intensive Care, fANSA

KZN Neonatal Coordinator

info@nnasa.org.za

CHIFA profile: Ruth Davidge is Neonatal Coordinator at PMB Metro, Hospitals Complex Western, Kwa-Zulu Natal, South Africa. She is President of the Neonatal Nurses Association of Southern Africa, NNASA. She is a Registered Nurse and on the board of the Council of International Neonatal Nurses, COINN. ruth.davidge AT kznhealth.gov.za www.nnasa.org.za www.nnasa.org.za She is a CHIFA Country Representative for South Africa http://www.hifa.org/support/members/ruth

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Comment (NPW): The WHO Quality Health Services: a planning guide emphasises support for health workers as one of the five founding principles for improving the quality of health services. 'Health workers often work in conditions that are difficult, under-resourced and that hinder excellence. Systemic conditions – such as poor organization of care, unclear goals, wasteful rules, inadequate information flows – prevent health workers from carrying out their tasks successfully. Thus, a clear focus is required to support health workers.'

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (89) What does quality of care mean to you? (27) Compassion (2)

3 July, 2021
Thank you Moses Orfega (Nigeria) and Marion Lynch (UK) for introducing the concept of compassion into our discussion on quality health services.

The WHO fact sheet on Quality health services emphasises the importance of compassion: 'A fundamental shift in service delivery is needed such that quality services are delivered with compassion, focused on the needs of people and communities, as providing services with compassion has been shown to improve outcomes in several settings.'

https://www.who.int/news-room/fact-sheets/detail/quality-health-services

The Quality Planning Guide which serves as a reference for our discussion also highlights compassion:

'The Director General of WHO has emphasized that quality is not a given (5). As he highlights: “It takes vision, planning, investment, compassion, meticulous execution, and rigorous monitoring, from the national level to the smallest, remotest clinic.”'

'Effective and compassionate care for patients and the community should be central to all activities.'

The latter is one of the 'five guiding principles for system-wide efforts to improve quality'.

https://www.who.int/publications/i/item/9789240011632

We typically think of compassion in the context of the relationship between the frontline health worker and the patient. The terms *all activities* and *system-wide efforts* carry a profound message that I would have missed had I not attended the recent (and ongoing) series of webinars organised by our colleagues at the WHO Global Learning Laboratory for Quality UHC https://www.who.int/initiatives/who-global-learning-laboratory-for-quali... and the Focus Area for Compassion and Ethics https://taskforce.org/face/ In essence, we need to promote compassion at all levels of the health system, from national planning through to clinical care.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (90) What does quality of care mean to you? (28) Empowered health workers

3 July, 2021
Dear HIFA colleagues,

Ruth Davidge (South Africa) eloquently says: 'Very few [nurses] have access to current scientific literature (journals), ongoing education, textbooks, conferences etc in order to update their knowledge, nor are they empowered or confident enough to question the care rendered in their units. They lack neonatal specific training and leadership and mentoring. They are therefore driven by routine nursing care with which they are comfortable.'

Quality health care requires that all players are adequately informed with reliable information. Too often, health workers (and patients) are not adequately informed. Or they may have access to reliable information that is relevant and implementable, but choose not to apply it. Ruth's observation that nurses may not be 'confident enough to question the care rendered in their units' raises further important issues about dysfunctional hierarchy and power relationships. I remember talking with a pharmacist in Tamil Nadu, India. Discussing his work, I asked, What would you do if there was a serious error in a doctor's prescription?

He said that when he was younger, he would point out the error, but the doctors usually shouted at him, so now he keeps quiet and dispenses whatever is written.

As Ruth says: 'In order to improve the quality of their care they need to know the required standard of care (evidence based) and then measure their care against this... I would like to add to our discussions on the components of quality of care, the need for a process of reflection on services rendered, critical thinking skills and confident, empowered staff able to propose and implement changes.'

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (91) What does quality of care mean to you? (29) Empowered health workers (2)

4 July, 2021
Neil, thank you.

Two things in your post made me want to post this comment. The two things are (i) 'dysfunctional hierarchy' and ii) 'Ruth's observation that nurses may not be 'confident enough to question the care rendered in their units' raises further important issues about dysfunctional hierarchy and power relationships. I remember talking with a pharmacist in Tamil Nadu, India. Discussing his work, I asked, What would you do if there was a serious error in a doctor's prescription? He said that when he was younger, he would point out the error, but the doctors usually shouted at him, so now ':

On (i) 'Dysfunctional hierarchy' , we have been concerned for a while about this phenomenon, which includes the unhelpful culture of inter-professional disharmony which for instance, makes nurses boycott/refuse to attend ward rounds with doctors. The ignorance that ward rounds traditionally are conducted for many good clinical reasons, including continuity of care, exchange of learning/knowledge, and peer support and motivation. That ward rounds are not meant to be about 'master versus servant' or a platform for competition for superiority, but in recent years we hear that's what it has been interpreted to mean. With such parallel ward rounds, the patient loses but also the clinicians lose even more, because of such misunderstanding and unnecessary power-play. As a resident in the 1980s, I experienced such behaviour by the nurses on starting a new posting, and thank goodness with my consultant's support, I nipped it in the bud there and then on my first ward round, by educating the nurses and other team members on the vital role that team ward round plays to give patients quality multidisciplinary care and outcome. Parallel ward rounds should never be allowed!.

On (ii) I dare to think how many patients may have received poor and probably dangerous care because 'the nurse feels scared to speak to a doctor who may have prescribed wrong treatment'. Scary really!. I am reminded of the seminal publication released by the Institute of Medicine (IOM, USA) in 1999, titled 'To Err is Human' which in many ways addresses this

dangerous habit. Because we are mortals, we shall make mistakes, no matter our expertise, and in the best centres, so that is not news. The news is what we do/system does, when we discover (or somebody points out) our error!. What does the individual do about the error and what does the system put in place to help the practitioner reduce his / her error in practice, so that it does not occur again?.

In both cases, the solution seems to me to lie in education, learning and re-learning, and in harmonious multidisciplinary team working that encourages each member of the health team to feel appreciated and is enabled and confident to ask questions when in doubt. The patient, the practitioner, and the whole health system lose otherwise.

In implementing the 12-Pillar Clinical Governance programme we teach this principle.

Joseph Ana.

AFRICA CENTRE FOR CLINICAL GOVERNANCE RESEARCH & PATIENT SAFETY

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National Implementing Organisation: 12-Pillar Clinical Governance

National Healthcare Standards and Quality Monitor and Assessor

National Implementing Organisation: PACK Nigeria Programme for PHC

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HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
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Quality (92) What does quality of care mean to you? (30) Empowered health workers (3)

4 July, 2021
Hi Neil

I would like to add my two-cents worth on this issue of empowered staff and the ability to ask questions. As you and Ruth have noted, the unequal power relationship continues even today. As a nurse educator in Singapore, we often teach our nursing students that we are not handmaidens of physicians but rather partners in care but the reality on the ground speaks otherwise. Like the example you gave of the pharmacist in Tamil Nadu who often got shouted at, many nurses continue to experience this type of verbal abuse or put downs both in the hands of the physicians and even within our own nursing profession. Evidence-informed care and changes can only come about when there is a change in the environment of practice that allows for diverse views and questions (especially questions that raise important points and make people uncomfortable) but could have greater implications for change. Only then we can provide the type of care that we call quality.

Subadhra Rai, RN., PhD

HIFA Representative (Singapore)

HIFA profile: Subhadra Rai is a Research Fellow at the Centre for Biomedical Ethics at the National University of Singapore. She is a HIFA country representative for Singapore.

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[Note: There was no Quality (93) post]

Quality (94) Patient experience and health outcomes (5) Compassion (3)

4 July, 2021
Orfega Moses K. raises an important point about the significance of the "Likelihood of Desired Health Outcomes" in Quality of Care as defined by the WHO and goes on to connect this variable of the DHO (Desired Health Outcome) among others - with People centredness and Compassion. [https://www.hifa.org/dgroups-rss/quality-82-what-does-quality-care-mean-...]

Both as a "patient" with decades of lived experience as a family caregiver and a Professional with research and field work experience on Equity Issues in Health and Education in South Asia, East Africa and North America, I believe there are critical variations in perception as well as reality of the DHO variables in addition to the fact that the variations per se emerge from diverse norms about both People centredness and Compassion.

The GLL (WHO) - HIFA Catalysts platform provides a rich platform for this compelling conversation about Stakeholders' need for authentic information on the diversity of norms !

Esha Ray Chaudhuri

Calgary, Alberta, 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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services.

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Quality (95) What does quality of care mean to you? (31) Patient experience and health outcomes (6)

4 July, 2021
I am glad to share my thoughts on the thematic discussion – what quality of care is? As the colleagues have indicated, it entails considerable and complex elements with a view to ensure the six dimensions of QoC (safety, effectiveness, efficiency, timeliness, patient centeredness and equity). The Donabedian quality framework with three elements (structure, process and outcome) could be the overarching one.

Patient and clients satisfaction surveys (outcome) often used to measure quality and to identify areas of improvement in the general facility and different departments. Also, auditing and monitoring of key performance indicators (KPI) in different domains including availability and functionality of quality team, infrastructures including WASH, infection prevention and control core components, staffing and training, diagnostic capacity, access to

the service, stakeholders' feedback mechanisms etc against the set standards helps to ensure continuous improvement.

Regards,

Kebede

HIFA profile: Kebede Eticha is a PhD candidate and has over 10 years experience working for UN agencies and INGOs as consultant in the fields of WASH and IPC in development and humanitarian program contexts. He is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (96) What does quality of care mean to you? (32) WHO Quality Planning Guide

4 July, 2021
Dear HIFA colleagues,

Thank you for your comments on the question What does quality of care mean to you? We're having a rich exploration of different aspects of quality and I invite you to continue sending any thoughts you may have to hifa@hifaforums.org

The comments are broadly consistent with the WHO Quality Health Services: a planning guide, which says (on page 1):

'What do we mean by quality?

There is growing acknowledgment that quality health services across the world should be:
- effective: providing evidence-based health care services to those who need them;
- safe: avoiding harm to people for whom the care is intended; and
- people-centred: providing care that responds to individual preferences, needs and values.

'In addition, to realize the benefits of quality health care, health services must be:
- timely...
- equitable...
- integrated...
- efficient...'

WHO Quality Health Services: a planning guide

https://www.who.int/publications/i/item/9789240011632

Please do have a look at the guide, which is freely available at the above URL. We'll be referring to it often during this discussion.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (97) Making the case for quality of care

4 July, 2021
As we move into our second week of our discussion on Learning for quality health services, I invite you to reflect on the question: Why is it important to make the case for quality of care?

Perhaps the most powerful single piece of data is provided by the WHO Fact sheet on quality health services https://www.who.int/news-room/fact-sheets/detail/quality-health-services

'Between 5.7 and 8.4 million deaths are attributed to poor quality care each year in low- and middle-income countries (LMICs), which represents up to 15% of overall deaths in these countries.'

You may like to comment on the importance of quality of care globally, or in a particular area of care, or in your country. What do you feel are the main contributors to poor quality care in your setting?

When we talk about "making the case" for quality care, what do we mean and to whom are we 'making the case'? Are we saying that all stakeholders need to work together to better understand and address quality issues, and/or are we suggesting that specific groups (governments?) need to be taking this more seriously and investing more in proven approaches to improve quality? What is already being done well, and what is not being done well?

A related question: Which aspects of poor quality health care are the most important in terms of avoidable death and suffering? What measures can be taken to improve quality in these settings?

Best wishes, Neil

Coordinator, WHO-HIFA Collaboration: HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

Let's build a future where every person has access to reliable healthcare information and is protected from misinformation - Join HIFA: www.hifa.org

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (98) Making the case for quality of care (2) WASH

4 July, 2021
WHO estimates: Globally, the essential structures for achieving quality care are inadequate: one in 8 health care facilities has no water service, one in 5 has no sanitation service, and one in 6 has no hand hygiene facilities at the points of care.

Therefore, in order to making the case for quality of care if all LMICs in their national health plans should invest at the first referral level health facilities to improve the quality of care in the following:

i) Monitoring and Evaluation system in place and learning from the data, evidence based policies and plans at local level.

ii) Infrastructure availability/maintenance/functioning water and sanitation system, electricity, equipment, medicines, oxygen, beds, and supplies of linen, gloves, soaps.

iii) Referral systems in place at PHC for continuum of care.

iv) Updating training skills, including compassion

v) Correct information for patients.

Best wishes

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EHS-COVID (427) Quality (99A) Enablers and barriers to implementing primary health care in the COVID-19 context

4 July, 2021

This new paper in Health Policy and Planning looks at enablers and barriers to implementing primary health care in the COVID-19 context. The authors describe PHC as 'people centred comprehensive primary health care that incorporates public health and equity principles'. This mirrors how we have defined 'quality' in the current discussion. I am reminded of Dr Tedros's 2018 paper: How could health care be anything other than high quality? https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30394-2/fulltext and I invite reflections on the links between 'Learning for quality health systems' and 'Maintaining essential health services during COVID-19'.

CITATION: Modified scoping review of the enablers and barriers to implementing primary health care in the COVID-19 context

Alexandra Edelman et al.

Health Policy and Planning, https://doi.org/10.1093/heapol/czab075

Published: 29 June 2021

ABSTRACT

Since the Alma Ata Declaration of 1978, countries have varied in their progress towards establishing and sustaining comprehensive primary health care (PHC) and realizing its associated vision of ‘Health for All’. International health emergencies such as the coronavirus-19 (COVID-19) pandemic underscore the importance of PHC in underpinning health equity, including via access to routine essential services and emergency responsiveness. This review synthesizes the current state of knowledge about PHC impacts, implementation enablers and barriers, and knowledge gaps across the three main PHC components as conceptualized in the 2018 Astana Framework. A scoping review design was adopted to summarize evidence from a diverse body of literature with a modification to accommodate four discrete phases of searching, screening and eligibility assessment: a database search in PubMed for PHC-related literature reviews and multi-country analyses (Phase 1); a website search for key global PHC synthesis reports (Phase 2); targeted searches

for peer-reviewed literature relating to specific components of PHC (Phase 3) and searches for emerging insights relating to PHC in the COVID-19 context (Phase 4). Evidence from 96 included papers were analysed across deductive themes corresponding to the three main components of PHC. Findings affirm that investments in PHC improve equity and access, healthcare performance, accountability of health systems and health outcomes. Key enablers of PHC implementation include equity-informed financing models, health system and governance frameworks that differentiate multi-sectoral PHC from more discrete service-focussed primary care, and governance mechanisms that strengthen linkages between policymakers, civil society, non-governmental organizations, community-based organizations and private sector entities. Although knowledge about, and experience in, PHC implementation continues to grow, critical knowledge gaps are evident, particularly relating to country-level, context-specific governance, financing, workforce, accountability and service coordination mechanisms. An agenda to guide future country-specific PHC research is outlined.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

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Coordinator, WHO-HIFA Collaboration: HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

Quality (99B) Empowered health workers (4)

5 July, 2021
[Re: https://www.hifa.org/dgroups-rss/quality-90-what-does-quality-care-mean-...]

I have always appreciated hearing from the pharmacists and encourage mutual respect. My advice stand your ground. Do not compromise. You are equally Professional. If anything goes wrong you too can be culpable.

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for Trinidad & Tobago. She innovated a Programme “Dial-a-Doctor” giving advice on health and wellness to the general public in T&T. She is one of the founders of a Wellness Company in T&T- Better Health Ltd www.phac.com ; www.wellnesscaribbean.com She is committed to sharing messages of health, wellness, prevention, and medical professionalism. svrccfp AT yahoo.com She is a HIFA Country Representative http://www.hifa.org/support/members/sonia

Quality (100) WASH (2) COVID-19 communication and community engagement

5 July, 2021
Dear Colleagues

This is a very important topic more especially now with the COVID pandemic. Its not only crucial to LMRC but globally. I totally agree with the colleagues who have brought it very important areas to consider. I would to echo SNF give a few examples as well.

Previously I.e. few years back lack of quality was linked to poverty which was mostly due to lack of hygiene. In simple terms only those who had low or no education (low social economic status and LMRC because these have limited resources in their health institutions, households). However, I feel its no longer the case, much as its true but we also need to check on the following areas:

1. Quality of awareness messages and how they are given (language, who delivers the messages, type of jiggles, age targets, place etc) quality can be compromised if the message is not clear and biased which is the case these days even with COVID. Look at the COVID preventive messages simple easy to follow but who is starting to break the rules (those who are supposed to be role models - leaders, both politicians, church and community leaders). Check the political campaign rallies, funeral gathering, meetings are these places following the preventive measures of COVID (proper masking, hand washing/sanitizing and more especially social distancing)

2. Consistency and continuity in giving the messages instead of giving such messages for a period and stop because you never will reach all at the same time. But mostly messages are given for a period very intensively and suddenly they are gone. So there is no reminder and therefore many think once the messages are no longer available the issue is closed

3. Understanding and Ownership: when communities understands the importance of anything and how it can affects their lives both negatively/positively they react to it in a similar way accepts or not accepting the messages. Sometimes people don't conform to issues because they feel its not a priority to them at that time. Therefore its important to study and know their basic needs at that time, address them if need be or find a temporary alternative before bringing what is needed. That way the community will understand and later with their involvement will be able to own thus bringing change. A good example is borehole for safe

water if these are just given to communities they easily get damaged and no one is responsible

So my suggestion being that awareness messages be relevant, consistent, continuous, available to right people all times, and role models should be aware that they are being observed/watched by all

HIFA profile: Rebecca C Ngalande is a Maternal and Neonatal Health Specialist Mentor & Consultant. Currently working in Malawi, and previously at Deanna Kay Isaacson Midwifery Training School In Liberia as Mentor to midwifery faculty as well as faculty member for midwifery students. najeremanna AT gmail.com

Quality (101) What does quality of care mean to you (33) Quality and quantity

5 July, 2021
Viewed conceptually 'quality' has for millennia been dichotomised and debated with its philosophical counterpoint of 'quantity'.

In 21st century healthcare theory, practice and management 'quality' must be defined:

- scientifically;
- psychologically;
- socially;
- politically
- and spiritually.

That is, what metrics can we use, what is the emotional and social impact, what are the implications politically? For example, what will we pay for? Covid is a critical context and ongoing lesson; COP26 and each northern and southern year another.

The choreography of quality and quantity comes to the fore in: sustainable development goals; universal health coverage; universal basic income; quality of life (human, flora-fauna, biosphere); individual - collective - planetary health.

A situated and contextual perspective is vital and can be identified and represented using the generic conceptual framework Hodges' model:

Previous posts on 'quality':

https://hodges-model.blogspot.com/search?q=quality

'quantity'

https://hodges-model.blogspot.com/search?q=quantity

This model can assist in reflection and critical thinking about research (mixed-) methods, methodologies, ethics, standards (local - global) and governance.

Kind regards,

Peter Jones
Community Mental Health Nurse, Tutor & Researcher
Early Intervention Team, Salford, Manchester, UKBlogging at "Welcome to the QUAD"
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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

Quality (102) What does quality of care mean to you? (34) Improving the quality and safety of health services

6 July, 2021
Dear HIFA Participants,

Please accept this email in the manner in which it is written, with a genuine desire to help. It is intended to spark debate, challenge the status quo, and hopefully contribute to the improvement of global healthcare. I expect it will offend some but I hope it makes others stop and think.

I would like to make an observation about the healthcare system based on what I have witnessed in the last decade relative to my 40 years experience as an engineer and manager.

My observation is that while many aspects of healthcare are at the leading edge of science, truly amazing and well beyond my comprehension, there are many more mundane aspects of the healthcare industry that are three to four decades behind other industries, and that gap costs both lives and money. I have numerous examples and anecdotes but one in particular I would like to share to support my observation. It represents loss and sadness combined with a deluge of frustration.

A thirteen year old boy suffered from several food allergies, but he and his mother controlled them without issue. He was admitted to hospital overnight for asthma. His mother, with considerable prescience, was extremely concerned about someone else being responsible for feeding him and emphasised the point to nursing staff.

He woke after a good night on oxygen, he was given breakfast and was dead within 30 minutes!

Two of the key findings from the coroner:

- The death of Louis Tate reinforces the need for continued improvement of the quality and safety of our health services.

- All hospital services, activities and staff - not only the obviously ‘clinical’ ones — need to be an active part of the patient safety agenda.

FYI

https://www.hospitalhealth.com.au/content/facility-admin/article/it-shou... 3 minute read

https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/amended... 90 minute read

I spent my engineering career working in many large, high risk, complex organisations ranging from State owned Railway Systems, the Royal Australian Navy, and Orica, the largest mining explosives company in the world. I also spent ten years consulting to many other organisations. The majority of that time was focused on improvement from diagnosing locomotive problems and improving fleet reliability, to managing large projects and plant shut downs, to redesigning organisations and global enterprise computer systems.

I have spent eight years volunteering as a health consumer representative, on various Health Facility Leadership Teams, Patient Clinical Quality Teams, and other opportunities. For several years I have also been a reviewer for Continuous Improvement papers for ISQua Conferences. In the last ten years I have also spent a lot of time in hospitals with my ageing parents and in-laws. The list of issues is broad and complicated.

I believe the difference between these two worlds offers a fantastic opportunity for improving quality in healthcare. Specifically in the considerable proportion of healthcare that is not clinical but costs lives.

Very Sincerely,

Mark Cantor

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services.

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Quality (103) Making the case for quality of care (3) PACK (Practical Approach to Care Kit)

6 July, 2021
'----- should invest at the first referral level health facilities to improve the quality of care---' suggested by Dr Meena Nathan Cherian [https://www.hifa.org/dgroups-rss/quality-98-making-case-quality-care-2-w... sounds to me like what the PACK (Practical Approach to Care Kit) programme, piloted in Nigeria in 2017 and currently on-going in Bauchi State Nigeria, is advocating by example.

The Pillars of the PACK Nigeria progamme for PHC are: i) The PACK Guide, ii) The Facility Readiness, iii) Onsite scheduled Training iv) Supportive Supervision, Mentoring, Monitoring & Evaluation; v) a Community Communications plan. The benefits are very low hanging and has shown potential to pay for itself as a quality improvement programme.'

Citation:

Using a mentorship model to localise the Practical Approach to Care Kit (PACK): from South Africa to Nigeria

BMJ Global Health Oct 2018, 3 (Suppl

DOI: 10.1136/bmjgh-2018-001079

https://gh.bmj.com/content/3/Suppl_5/e001079

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

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Quality (104) Making the case for quality of care (4)

6 July, 2021
Neil thank you for getting the second week going in this interesting Thematic discussions. I decided to comment on the various questions in Q&A sequence:

1: You may like to comment on the importance of quality of care globally, or in a particular area of care, or in your country

Comment: Quality of care is important to all nations, whether high or middle or low or very low income. Simply because every human being on this planet, irrespective of social, economic, ethnic, race, gender, political or religious classification and persuasion knows the value and importance of good health.

2: What do you feel are the main contributors to poor quality care in your setting?

Comment: The main contributors to poor quality care are many in every circumstance but probably a longer list and more complex in the countries with bad political governance, with less resources, poor / lack of the 12-Pillar clinical governance, and countries with larger burden of neglected social determinants of health exacerbated by ignorance, poverty and disease. It is a complex, toxic mixture in most parts of the world, sadly even in this decade of the SDGs.

3: When we talk about "making the case" for quality care, what do we mean and to whom are we 'making the case'?

Comment: In every country, the case for quality of care should be made to the Leaders and Policy makers who may need reminding as they contend with prioritization of where to allocate and spend scarce and limited State resources, even though as I said above every human being understands the importance of quality care. Reminders also keep in the public front burner.

4: Are we saying that all stakeholders need to work together to better understand and address quality issues, and/or are we suggesting that specific groups (governments?) need to be taking this more seriously and investing more in proven approaches to improve quality? What is already being done well, and what is not being done well?

Comment: There is no alternative to ‘all stakeholders working together’, if the delivery of quality care is the objective!!. Some requirements for successful team working include: the recognition by each member of the team of the other members contribution, avoiding

practising beyond ones training and competence, a team spirit of 'live and lets live', and mutual respect and appreciation within the team. There should be a transformational change at the leadership and policy makers level, to the evidence-informed views that investment in health pays in the bigger picture of the whole country economy and GDP growth ('Health is and means Wealth'). The African Union (AU) surprisingly, appreciated as much far back in 2000: it mandated African Countries to allocate at least 15% of annual budgets to health.

Sadly, we are still asking which African country has achieved that target and sustained it year on year since 2000? But thankgoodness, it is not all bad news, as there are instances of some measure of progress in the efforts to deliver quality care and outcomes: e.g. i) the Global Annual Child death in 2012, dropped to 6.9 million, i.e. Less than 7 million for the first time, and in 2014 it dropped further to 6.6 MILLION, and in 2015 was LESS THAN 5 MILLION mainly due to progress in some LICs – like Tanzania, Rwanda, Uganda (*UNICEF ANNUAL REPORTS 2013). ii) Reports from Nigeria on the MDG years showed that for* *Goal 4**: ''in 2008 under-five mortality rate dropped to 94 deaths/1000 in 2012; infant mortality rate to 61/ 1,000 live births in 2012; and Nigeria achieved Polio interruption in 2015 and finally eradicated the disease in 2020.And then for Goal 5 : ''Maternal Mortality rate dropped to average of 545/100,000 in 2012, and 350 per 100,000 in 2015; also there was increased deliveries conducted by skilled attendants from 38.9% to 53.6% in 2012. (source: OSSAP-MDG office, Nigerian Presidency 2016.).

At present time, the World seems to be on a welcome trajectory of controlling the dreadful COVID-19 pandemic with the development of active and potent vaccines within the shortest time-ever in human history, attributable to the huge, unprecedented investment in research and development and unimaginable advances in science!.

5: A related question: Which aspects of poor quality health care are the most important in terms of avoidable death and suffering? What measures can be taken to improve quality in these settings?

Comment: The practice of clinical governance (which we adjusted to 12-Pillars to make it suitable for LMICs) in all facilities in all tiers of the health system and in the private sector can proven to lead to strengthening health systems and the delivery of quality care in a sustainable and affordable way. That will lead to reduction in morbidity and mortality, from all causes.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for

Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

http://www.hifa.org/support/members/joseph-0

http://www.hifa.org/people/steering-group

Email: jneana AT yahoo.co.uk

Quality (105) Patient experience and health outcomes (7)

6 July, 2021
If Health Outcomes are the indicator of Quality, how do you define and measure a Health Outcome?

Alive?
Lifespan?
Quality of Life?
Not Sick?

There is considerable discussion regarding the fact that doctors only treat the sick rather than keeping people well.

Mark Cantor

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services.

https://www.hifa.org/projects/learning-quality-health-services

markacantor AT me.com

Quality (106) COVID-19 communication and community engagement (2)

6 July, 2021
While I agree with the 4 points of attention listed by Rebecca Ngalande [https://www.hifa.org/dgroups-rss/quality-100-wash-2-covid-19-communicati..., I want to emphasize that the most important point if one wants to win adherence to any public health message is the content of this message, not its wording or length, neither who is disseminating it. This is especially true when vaccination is at stake, since vaccination is

more likely to raise doubts, distrust and hostility than most other public health initiatives. A work we have been conducting in Africa, in ECOWAS countries, and works by other teams show that a large majority of people think that the threat of COVID-19 is exaggerated, a significant part believes that the pandemic is not present in their country, and a large portion distrusts products coming from the North. In this condition, why would people get vaccinated? What could they think about the promotion of COVID-19 vaccines?

Therefore, communication efforts to win adherence to the COVID-19 vaccination must focus on showing that COVID-19 is real in the African countries. This is crucial at the current stage of COVID-19 management.

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HIFA profile: Bernard Seytre is a Consultant at BNSCommunication in France. Professional interests: Health communication and education. Email address: seytre AT bnscom.fr

Quality (107) Improving the quality and safety of health services (2)

6 July, 2021
Dear Mark

It's an interesting point [https://www.hifa.org/dgroups-rss/quality-102-what-does-quality-care-mean.... I guess that it all depends on your perspective.

We should learn from 'never events', the idea of 'Black box thinking' where we should not need a plane to crash in order to prevent it happening again, perhaps should apply to healthcare too. Predictive event planning surely can't always perhaps prevent human behaviour failure.

Although, in a well-resourced healthcare systems we do have access to healthcare on demand, and as tragic as this event may be, in under resourced countries, access to basic care or even oxygen and a breakfast is a something that also needs to be tackled.

David

HIFA profile: David Chandler has diverse experience, being involved in the UK voluntary sector since 1993. He has held the posts of coordinator of the Skin Care Campaign at the National Eczema Society, general manager at Teaching Aids at Low Cost, an international

healthcare training and education NGO, Chief Executive of the Psoriasis Support Trust and also co-founded and jointly managed the Psoriatic Arthropathy Alliance with his wife Julie. During this time David has been a patient advocate, and given presentations on the patient perspective in Europe and the US, written and published articles, developed awareness campaigns and been involved in the development of both quantitative and qualitative research. David is currently Chief Executive of PAPAA - The Psoriasis and Psoriatic Arthritis Alliance a UK patient charity. Prior to moving into healthcare advocacy he worked in commercial business. David is also involved in other committees as expert patient and lay public representative, including the National Institute for Health and Care Excellence (NICE) Commission for Human Medicine (CHM)and INVOLVE at the National Institute for Health Research (NIHR). David also has a keen interest in social inclusion and equality issues. davidchandler AT btconnect.com

Quality (108) Improving the quality and safety of health services (3)

7 July, 2021
David, [David Chandler, UK]

Thanks for your reply. You are correct in that a majority of the world does not have access to even a reasonable degree of healthcare. Many not even basic human rights.

Some simple questions:

1. Where is the data and the analysis that identifies those places & people?

2. Where is the analysis that identifies the specific problems for each group of people?

I believe there is a major cultural problem that puts all these issues into one overwhelming issue that remains unsolved.

Does someone in India dying from a lack of oxygen provide a suitable excuse for an appalling managerial neglect in Melbourne?

If high income countries can't do quality right, why would we expect LMIC to achieve any better?

Regards,

Mark

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services.

https://www.hifa.org/projects/learning-quality-health-services

markacantor AT me.com

Quality (109) Improving the quality and safety of health services (4) Patient advocacy

7 July, 2021
Dear David,

Another tough question for you. Apologies in advance!

With regard to "access to basic care or even oxygen and breakfast"

Do you personally have any direct access to those people?

Do you personally have any capability to change or address that problem?

To me quality is about what we do, or what we walk past??

In the role that you perform in your Psoriasis charity, how do you improve the quality of care for patients?

I am interested, because in the last 8 years I have found being a patient advocate, the most soul destroying role I have ever done.

Mark

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services.

https://www.hifa.org/projects/learning-quality-health-services

markacantor AT me.com

Quality (110) What does quality of care mean to you? (35)

7 July, 2021
What is health

(These are notes made during patient education sessions years ago)

"Health is a full expression and combination of mental, physical, social and spiritual activity, states, attributes and experience that enhances or do not diminish other's health. Health for all species of life is driven by evolved biological behaviour. Each individual and family's day to day life – eating, sleeping, ssocialising etc - and exercising incorporates healthy and unhealthy behaviours.

"Fitness is an abundance of health. Fitness results from practice and the exercise of physical, mental social and spiritual activities. Many diseases and illnesses derive from physical, mental, social and environmental inactivity and adverse environments. Fitness prevents the early onset of some of these diseases.

"Wellness is a positive subjective experience of life. Illness is a subjective or objective negative feeling or experience caused by internal or external factors.

"Life is the joint expression of DNA within its environment - conception, birth, growth, adolescence, adulthood, mating, living and dying determines our actions. Eating, shelter, warmth, drinking, communication and acceptance by human society are daily objectives in life."

Quality of healthcare is the most safe and effective utilization of knowledge, equipment, and other interventions by professionals, community and individuals to prevent disease, palliate or cure immediate disease and continyuing diseases and to promote and improve individual, community and planetary health. It is best planned and delivered in conjunction and partnership with patients and publics.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

Quality (111) Improving the quality and safety of health services (5) Continuing professional development

7 July, 2021
Dear HIFA colleagues,

Last week I forwarded a message from our sister forum CHIFA (child health) from Ruth Davidge, South Africa. She described how 'nurses are very dependent on the historical practices in their unit and on Dr orders. Very few have access to current scientific literature

(journals), ongoing education, textbooks, conferences etc in order to update their knowledge, nor are they empowered or confident enough to question the care rendered in their units'.

https://www.hifa.org/dgroups-rss/quality-88-what-does-quality-care-mean-...

Below is a message from Dave Woods, also in South Africa, about facility-based 'learning communities of nurses (and doctors) who can take responsibility and manage their own professional growth and continuing education'.

It would be interesting to hear more examples of such groups in practice. How can effective groups be supported? How can those in positions of authority be encouraged to introduce them?

From: "Dave Woods, South Africa" <pepcourse@mweb.co.za>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Quality Health Care for Children [6]

Dear All

So many of the challenges in learning, understanding and leadership that Ruth Davidge emphasises in hospitals that are not supported by formal training and audit can be remedied by establishing learning communities of nurses (and doctors) who can take responsibility and manage their own professional growth and continuing education. This widely used and evaluated method of self-help tuition can be accessed through local study clubs using the freely available course books on the open-access Bettercare website (https://bettercare.co.za/learn). There is no reason why most maternal and newborn services should not have the benefit of good training.

Best wishes, Prof Dave Woods

CHIFA Profile: Dave Woods is Emeritus Professor in Neonatal Medicine at the School of Child and Adolescent Health, University of Cape Town, South Africa. He is Chairman of the Perinatal Education Trust and Eduhealthcare, both not-for-profit non-government organisations that develop appropriate self-help distance learning material for doctors and nurses who care for pregnant women and their children in under-resourced communities. He has 30 years experience as a clinical neonatologist, with particular interests in perinatal care and training of health professionals. He is currently developing paper-based continuing learning material in maternal care, newborn care, child health, and care of adults and children with HIV/AIDS. He is also participating in the design and development of wind-up appropriate health technology for poor countries. www.pepcourse.co.za pepcourse AT mweb.co.za

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Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (112) Learning for primary healthcare workers: a multi-directional approach (2)

8 July, 2021
Dear Jane

Many thanks for this excellent blog:

https://pci-360.com/rethinking-global-primary-healthcare-worker-educatio...

whose core message is: 'A multi-directional approach to learning is essential to bring real value and innovation'

I agree. As the authors say: 'Learning from each other, learning from within, and learning to lead requires creating and facilitating global communities of practice, enabling access to peer support at scale and facilitating learning beyond a specific context or cohort. It’s essential to reflect on what other avenues exist for us to connect with globally and really develop a co-produced sense of what good quality primary care is.'

As a global health community of practice, HIFA is always eager to improve and to make connections with other communities of practice. We look forward to collaborating with PCI and others to 'really develop a co-produced sense of what good quality primary care is'. This issue is especially relevant to our current WHO-HIFA project on Learning for quality health services. https://www.hifa.org/news/learning-quality-health-services-new-thematic-... Indeed this project is very much about encouraging a multi-directional approach with an emphasis on learning from those on the front lines of care.

I invite HIFA members to reflect and share thoughts on *how* HIFA (and PCI and others) can further increase our impact on shared learning and experience.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (113) Webinar recording: Enhancing the quality of health services – introduction to a new planning guide for implementers

8 July, 2021
Dear webinar registrant,

Thank you for registering for the recent launch webinar on the WHO Quality Health Services: a planning guide https://www.who.int/publications/i/item/9789240011632

We hope the event provided you with a useful overview of the key actions required at the national, district and facility-levels to enhance quality of care.

* To access a recording of the webinar, please visit the website https://www.who.int/news-room/events/detail/2021/06/29/default-calendar/...

* To view the planning guide document, please visit the website https://apps.who.int/iris/handle/10665/336661

* To learn more about WHO's work on quality of care, please visit the website https://www.who.int/teams/integrated-health-services/quality-health-serv...

Kind regards,

WHO Global Learning Laboratory for Quality Universal Health Coverage

Sharing knowledge and experiences, challenging ideas and sparking innovation

To learn more, visit: https://www.who.int/initiatives/who-global-learning-laboratory-for-quali...

To register or sign up for our mailing list, contact: gll4QUHC@who.int

Quality (114) Improving the quality and safety of health services (7) Digital identity

8 July, 2021
Mark,

You rightly ask "Where is the data"? [Mark Cantor, Australia: https://www.hifa.org/dgroups-rss/quality-108-improving-quality-and-safet...]

You may be interested in the United Nations ID2020 which aims to give every citizen a digital identity - ref below. Although privacy lobbis have concerns about being known, being unknown and unresourced is probably worse!

Interestingly censuses and registrations of populations are not new as identified by this piece about the Roman emperor Augusus written in "ComeReasonMinistries" -:

More than One Census

Although on its face we seem to have a difficulty here, there are several pieces that we must consider before jumping to the conclusion that Luke and Josephus were speaking about the same event. Indeed, it seems that Caesar Augustus was the type of leader who ordered many censuses in his day. Records exist to show that Roman-controlled Egypt had begun a census as early as 10 B.C. and it was repeated every 14 years. And Augustus himself notes in his Res Gestae (The Deeds of Augustus) that he ordered three wide-spread censuses of Roman citizens, one in 28B.C., one in 8 B.C. and one in 14 A.D. In between there are several other censuses that happened locally across Rome. Luke's account corroborates the idea of multiple censuses for Judea when he writes "This was the first census taken while Quirinius was governor of Syria." Certainly, the word "first" implies that more than one census happened.

https://en.wikipedia.org/wiki/ID2020

ID2020 is a nongovernmental organization (501(c)(3)) which advocates for digital ID for the billion undocumented people worldwide and under-served groups like refugees. Dakota Gruener is the executive director of ID2020. The NGO was relatively unknown before being publicized because of misinformation related to the COVID-19 pandemic by conspiracy theorists.

History

In May 2016, at the United Nations Headquarters in New York, the inaugural ID2020 summit brought together over 400 people to discuss how to provide digital identity to all, a defined Sustainable Development Goal including to 1.5bn people living without any form of recognized identification.[1] Experts in blockchain and other cryptographic technology joined with representatives of technical standards bodies to identify how technology and other private sector expertise could achieve the goal.[2][3]

In 2019, ID2020 started a new digital identity program in collaboration with the government of Bangladesh and Global Alliance for Vaccines and Immunization.[4]

Mission

ID2020 is a public-private consortium in service of the United Nations 2030 Sustainable Development Goal of providing legal identity for all people, including the world's most vulnerable populations.[5]

ID2020 has published a ten-point mission statement, which includes: "We believe that individuals must have control over their own digital identities, including how personal data is collected, used, and shared."[6]

Participants

Accenture,[7] Microsoft, Avanade Inc, PricewaterhouseCoopers, and Cisco Systems Inc have contributed their expertise to ID2020.[5]

I am for each individual globally having an identity.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

Quality (115) Introduction: Ivan Teri, USA - Elizabeth Glaser Pediatric AIDS Foundation

8 July, 2021
Dear HIFA members,

I am delighted to be a part of this group and a member of the WHO/HIFA project on Learning for Quality Health Services. I am the Associate Director for Program Optimization/global Quality Lead at Elizabeth Glaser Pediatric AIDS Foundation (Washington D.C) overseeing the implementation of quality assurance and improvement for health programs and services. For the past 7 years, my role has been to guide the quality of work of the Foundation's staff and ensure the Foundation maintains a culture of continuous improvement across its 17-country global footprint. I am a certified Manager of Quality/Organizational Excellence and certified Quality Improvement (QI) Associate with over 14 years international experience in the health and social development sector. I am also a member of the World Health Organization's (WHO) Quality of HIV Care Global Technical Working Group. I am passionate about working to transform Africa's healthcare systems to better serve current and future populations with quality, safe and client-centered services.

To learn more about EGPAF's program optimization approach, please visit: https://www.pedaids.org/resource/improving-effectiveness-program-optimiz...

To learn more about EGPAF's quality improvement work, please visit: https://www.pedaids.org/resource/haba-na-haba-maximizing-the-impact-of-p...

I look forward to participating actively on the HIFA platform, learning and sharing with you all.

Kindly,

Ivan E. Teri MIH, CQIA, CQM/OE

IVAN E. TERI | Associate Director, Program Optimization | TL&PO

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Washington, DC 20036 U.S.A | m: 202.203.8698 | e: iteri@pedaids.org

Until no child has AIDS | Ancora Imparo

HIFA profile: Ivan Teri is Associate Director of Program Optimization EGPAF, United States. He is a certified Quality Management/Improvement leader with 15 years international experience in the health and social development sector, particularly in sub-Saharan Africa. Ivan is passionate about working to transform Africa's healthcare systems to better serve current and future populations with quality, safe and client-centered services. Professional interest: Organizational Excellence, Quality Improvement, Data Analytics & Digital Health. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services iteri AT pedaids.org

Quality (116) PACK (Practical Approach to Care Kit) (2)

8 July, 2021
Many thanks, Joseph Ana. [https://www.hifa.org/dgroups-rss/quality-103-making-case-quality-care-3-...]

The information you shared provides very useful links to resources that are relevant to me (and perhaps, to other members of the Forum also). As a Nigerian myself, I'd like to learn about the current state of the programme. What I've been able to find so far about the programme is contained
here: https://gh.bmj.com/content/bmjgh/3/Suppl_5/e001079.full.pdf (which you co-authored). Can you (or someone else in the Forum) avail us with information on - or links to - the current state of the programme (PACK) as it's being piloted in (Bauchi State) Nigeria?

Specifically, are there any efforts to scale up the programme nationally? If so, are there any plans to integrate these efforts with any existing national quality policy and strategy in the country? What role is PACK playing in the

National Strategic Health Development Plan II (2018-2022)? (I couldn't find any section in the strategic plan that deals with quality issues generally, except that which pertains to medicines and other health products)

--

ORFEGA, Moses Kumaoron

HIFA profile: Moses Kumaoron Orfega is a Service Improvement Desk Officer at the National Health Insurance Scheme, Nigeria. Professional interests: Social Protection and Financing; Social Health Protection and Universal Health Coverage; Service Quality Improvement; Information Technology. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. Email: ofegamoses AT gmail.com

Quality (117) PACK (Practical Approach to Care Kit) (3)

9 July, 2021
The PACK Nigeria team is glad that Moses Orfega found our post on the quality improvement tool 'very useful'. On the specific questions that he asked, I can respond as follows: The introduction phase of the implementation of PACK Nigeria in Bauchi state started in November 2020 and is about to conclude this month. Already discussions on scale up has started with the relevant stakeholders in the state. PACK Nigeria is going National, already discussions are advanced in four other states. The programme is aligned to at least 14 existing guidelines in use in Nigeria health system including the PHC, including the 2014 National Policy on Task Shifting. This is the unique attribute of PACK NIgeria as it provides a practical solution to the access and quality care challenges exacerbated by the acute Human for Health shortage. This why the Federal Ministry of Health (FMOH) and the National Primary Health Care Development Agency (NPHCDA), the Community Health Practitioners Regulatory Board (CHPRB), the Nursing and Midwifery Council (NMC), the Medical and Dental Council of Nigeria (MDCN), etc acclaimed the pilot report.

When the Hon Minister of Health, Prof Isaac Adewale, launched the National Strategic Health Plan II on 5th September 2018 (one year after the PACK Nigeria pilot report was released), he said, and I quote, that ' ------- the Plan was approved at the National Council of Health’s meeting that took place in Kano on June 21. He explained that the plan had five strategic pillars and 15 priority areas, saying the five pillars included enabling environment for attainment of health sector goals and increased utilisation of essential package of health services. Others are strengthening the health system and protection from health emergencies as well as health financing'. That is precisely the advantages that PACK Nigeria demonstrated in States PHC during pilot and now in Bauchi State PHC as contained in the Interim Report.

“In total, this new plan has 15 thematic areas, 48 strategic objectives and 282 interventions that will help us to really improve the healthcare delivery that will offer our people.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF

(Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

http://www.hifa.org/support/members/joseph-0

http://www.hifa.org/people/steering-group

Email: jneana AT yahoo.co.uk

Quality (118) COVID-19 communication and community engagement (3)

9 July, 2021
Dear Bernard: [https://www.hifa.org/dgroups-rss/quality-106-covid-19-communication-and-...]

The points you've raised about the state of - and perception about - CoViD-19 in Africa (and perhaps more precisely in West Africa) are sadly true.

I agree with you that "communication efforts to win adherence to the COVID-19 vaccination must focus on showing that COVID-19 is real in the African countries". But I also wish to state that communication efforts must focus MORE on how to SHOW that some of the pieces of information we hear and see in the media about the virus are unfounded. At the moment, majority of the people have come to accept that CoViD-19 is real. And I think the real challenge now is how to convince the people, and create trust in the SAFETY and efficacy of the vaccines. As noted in some of the previous mail threads in this Forum, the world is currently suffering not just from CoViD-19 pandemic, but also from 'infodemic'. Thus, it is becoming increasingly difficult for an average person to ascertain which information is true about the virus and which is false.

So, how can we disproof and dispel 'false rumours' and 'misinformation' about the pandemic? How can we create confidence in the people about the SAFETY of the vaccines?

--

ORFEGA, Moses Kumaoron

HIFA profile: Moses Kumaoron Orfega is a Service Improvement Desk Officer at the National Health Insurance Scheme, Nigeria. Professional interests: Social Protection and Financing; Social Health Protection and Universal Health Coverage; Service Quality

Improvement; Information Technology. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. Email: ofegamoses AT gmail.com

Quality (119) COVID-19 communication and community engagement (4)

9 July, 2021
Thank you Moses Orfega (Nigeria) and Bernard Seytre (France) for your comments on trust and people's attitude to COVID-19 and the vaccine.

As we have discussed previously on HIFA, the people's trust - in their government, health system, public health messaging - is crucial not only for COVID-19 communication but for all areas of health care, self-care and health decision making.

The WHO Publication Quality health services: a planning guide (2020) recognises the importance of trust in at least two aspects:

'Poor quality health services – particularly unsafe care – can decrease people’s trust in the health system.'

'Stakeholder and community engagement are pivotal to building trust within the health system and ensuring that service delivery is centred on people.'

https://www.who.int/publications/i/item/9789240011632

This implies that COVID-19 and vaccine hesitancy cannot be addressed by specific means alone. A holistic approach is needed to build quality of care, engaging communities meaningfully and visibly in the process.

And it provides part of the answer to our current question 'Why is it important to make the case for quality of care?'. It's important not only for direct health outcomes, but also for building the people's trust (which in turn promotes public health).

Best wishes, Neil

Coordinator, WHO-HIFA Collaboration: HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

Let's build a future where every person has access to reliable healthcare information and is protected from misinformation - Join HIFA: www.hifa.org

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (120) Accreditation

9 July, 2021
Having worked in the accreditation system, I consider accreditation as one of the pathways to improve Quality of care in any health system. It has been accepted globally as a regulatory intervention to set standards, and monitor quality of care. The idea behind an accreditation programme is to evaluate a health care organization via self and external assessment, against predetermined optimal standards, to improve and set standards of care. In addition, as countries like India use the insurance route towards achieving universal coverage, and accreditation offers an opportunity to use it as a tool to set standards and monitor quality of care at the National level. The standards framed for accreditation cover critical aspects both for organization and patient.

Accreditation offers both tangible and non-tangible benefits. The concept of accreditation, and ensuing recognition of having achieved a level, can motivate a facility to do better, validate a facility's quality of care and therefore attract more patients. Standards can enhance the training and capacity building of staff, thereby increasing the motivation of staff. Patient satisfaction increases due to the improved services like reduction in waiting time for the services received, improved infrastructure, standardization of care. In addition, improving quality of care to match set standards can also be incentivized. For example, the CGHS (Central Government Health Scheme) and ex-servicemen contributory health scheme (ECHS) have made provision to offer more remuneration to hospitals accredited by the NABH. So, at a time when health systems are struggling to provide even basic levels of care, and in low-resource settings like India, accreditation, particularly in phases can provide the framework, the know-how and the motivation for healthcare facilities to improve their quality of care.

HIFA profile: Manu Gupta is an Independent consultant in India. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services. https://www.hifa.org/projects/learning-quality-health-services manugupta08 AT gmail.com

Quality (121) Improving the quality and safety of health services (7) The role of professional associations

9 July, 2021
I was glad to read Kingsley George's comments from Nigeria and the various points he made [https://www.hifa.org/dgroups-rss/quality-113-improving-quality-and-safet...]. Very useful because these are some of the points that have dominated public and professional discussion

for years. I can say that in its response to these points, guideline production, evidence and context informed, improving diagnosis accuracy and concordance between specialists, decision about when to do CS for delivery, and advocacy for more domestic funding for health, the Nigerian Medical Association (NMA) established a Standing Committee on Clinical Governance which as at this has a Clinical Governance Coordinator in all 36 states and the Federal Capital territory (FCT) to advocate the necessary changes working with the relevant State Ministry of Health.

So, changing is coming in the near term in all these areas.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

http://www.hifa.org/support/members/joseph-0

http://www.hifa.org/people/steering-group

Email: jneana AT yahoo.co.uk

Quality (122) WHO Bulletin: Emergency care with lay responders in underserved populations: a systematic review - How do we define 'poor quality care'?

9 July, 2021
'First aid education and task shifting to laypeople for emergency care may reduce patient morbidity and mortality and build community capacity to manage health emergencies for a variety of emergency conditions in underserved and low-resource settings.' Thisis the conclusion of a systematic review in the current July issue of the WHO Bulletin. Citation, abstract and a comment from me below, including a question relevant to our current discusssion on quality: How do we define 'poor quality care'?

CITATION: Emergency care with lay responders in underserved populations: a systematic review

Aaron M Orkin et al.

Bull World Health Organ. 2021 Jul 1; 99(7): 514–528H.

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ABSTRACT

Objective: To assess the individual and community health effects of task shifting for emergency care in low-resource settings and underserved populations worldwide.

Methods: We systematically searched 13 databases and additional grey literature for studies published between 1984 and 2019. Eligible studies involved emergency care training for laypeople in underserved or low-resource populations, and any quantitative assessment of effects on the health of individuals or communities. We conducted duplicate assessments of study eligibility, data abstraction and quality. We synthesized findings in narrative and tabular format.

Findings: Of 19 308 papers retrieved, 34 studies met the inclusion criteria from low- and middle-income countries (21 studies) and underserved populations in high-income countries (13 studies). Targeted emergency conditions included trauma, burns, cardiac arrest, opioid poisoning, malaria, paediatric communicable diseases and malnutrition. Trainees included the general public, non-health-care professionals, volunteers and close contacts of at-risk populations, all trained through in-class, peer and multimodal education and public awareness campaigns. Important clinical and policy outcomes included improvements in community capacity to manage emergencies (14 studies), patient outcomes (13 studies) and community health (seven studies). While substantial effects were observed for programmes to address paediatric malaria, trauma and opioid poisoning, most studies reported modest effect sizes and two reported null results. Most studies were of weak (24 studies) or moderate quality (nine studies).

Conclusion: First aid education and task shifting to laypeople for emergency care may reduce patient morbidity and mortality and build community capacity to manage health emergencies for a variety of emergency conditions in underserved and low-resource settings.

COMMENT (NPW)

It would be interesting to assess whether and how individual healthcare information resources can reduce morbidity and mortality. One such resource is Where there is no doctor, whose target audience includes lay health workers, covering the full spectrum of health care including emergencies. Another is the First Aid app from the Red Cross, available free in multiple versions for different countries and languages. Would anyone like to volunteer to look into these questions?

I also note the introduction: 'Conditions that could be treated with prehospital and emergency care account for an estimated 24 million lives lost each year in low- and middle-income countries'. This refers to a 2015 study in the World Journal of Surgery which is restricted access so I cannot read it and it's impossible to say how the authors define this. I would be grateful if someone can explain the data of the latter study and the 2018 Lancet study which found that '15·6 million excess deaths from 61 conditions occurred in LMICs in 2016. After excluding deaths that could be prevented through public health measures, 8·6 million excess deaths were amenable to health care of which 5·0 million were estimated to be due to receipt of poor-quality care and 3·6 million were due to non-utilisation of health care'.

These two studies are measuring different things, but it seems to me likely that there was 'poor quality care' (whether pre-hospital or in-hospital) in many if not most of the 24 million lives lost each year from conditions that could be treated with prehospital care. If this is the case, then the 5 million attributed to poor care in The Lancet article is probably a gross underestimate.

Of course, this all depends on how we define 'poor quality care'. In the Lancet study, a misdiagnosis by a community health worker resulting in the death of a child would not be considered 'poor quality care' because the latter was defined by the authors (personal communication) as care received after arrival at a health facility.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (123) Improving the quality and safety of health services (8) Digital identity (2)

10 July, 2021
Hello Richard,

Very interesting, I'll check it out. [https://www.hifa.org/dgroups-rss/quality-114-improving-quality-and-safet...]

I agree wholeheartedly with that concept. Some time ago I participated in a research study looking at facet joint damage in people with historical whiplash injuries. At the start of the research they go out and beg for volunteers, but imagine if every MRI ever taken was available and you were able to search them all by characteristic. You could cut research times significantly. Let alone the ability to use 'big data' analysis on issues like chronic fatigue or long covid.

I've spent some time and a few coffees with this gentleman,

https://www.newcastle.edu.au/profile/pablo-moscato

Sadly the breast cancer research he was doing here https://hmri.org.au/researchers/pablo-moscato never every really got off the ground because of the lack of data

A few years ago I had a brief holiday in India. Our tour guide was very enthusiastic about Modi's plan to get every Indian a mobile phone with an ID as a foundation for medical and social services etc. Not sure how it is going.

One of my longer term desires is to get people in healthcare to see the power & possibilities of data and IT.

Regards,

Mark

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services.

https://www.hifa.org/projects/learning-quality-health-services

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Quality (124) Digital identity (3) Confidentiality or secrecy?

11 July, 2021
Mark,

My wife and I live in the Pennine Hills in the North West of England where there is poor mobile reception. People from the campsite nearby frequently walk down to the road by our house to find mobile reception. A lady was doing this earlier this week and we began to talk about global mobile and digital connection.

I told her about the UN ID2020 initiative which she thought was "Big Brother--ish. (*** Aldous Huxley had published in 1932 his futuristic novel *Brave New World*, in which every facet of humanity came under central control of the ultimate, despotic government. The author described some pretty amazing technological tools for the times for use in enslaving all peoples.)

There seems to be a balance between privacy and inclusion for universal health care. If, as a society, we don't know someone exists (consider refugees) we cannot offer them vaccinations, cancer screening, comorbidity management, drug surveillance etc

Confidentiality or secrecy?

Confidentiality that allowed no sharing of data without asking the patient at each episode of sharing (with laboratories, ambulance services, appointment booking, pharmacy requests, communications with other professional bodies), each time would reduce efficiency in many areas of clinical and administrative care management. Delays, omissions and unavailability in the recording and communicating of patient data adversely affect the processes and outcomes of care.

The medico-legal literature holds examples of poor outcomes for patients and doctors caused by poor communication between professionals and patients. Not communicating or not making available full patient data and referenced care pathways automatically to patients prevents some options being considered by patients and other parties to achieve the best patient outcome and the best patient education and motivation.

“Confidentiality”, practised as secrecy without appropriate sharing, prevents sharing of information and delays decisions about the care of disabled, dependent and failing elderly patients in the community. Terminal care and social care are also handicapped by traditional models of confidentiality as secrecy. Confidentiality is not secrecy. Confidentiality is the best use of information in the balanced best interest of the safety and privacy of patients in a trusted, contractual, negotiated, professional and transparent relationship.

We were involved in the preliminary European discussions on the drafting of the European General Data Protection Regulation https://gdpr-info.eu/

One two day meeting in London was attended by over 100 people including five European regulators but no data subjects at all. After the first day I sat down to write a data subject's wish list which I have pasted below.

Data processors and data controllers and data subjects need proof of provenance, veracity and processing of data. I hope to continue to persuade the WHO and UN to support these ethical processes of processing personal health data.

Here is the data subject paper that I sent to he Minister of Justice in Europe:

Data controllers (GPs in our particular case) should no longer be able to refuse online access to data subjects to all of their real time digital data if the technology can allow this access. (there is no section in our current DPA that deals with immediate access to digital data)

Data subjects should have the option of being part of a dynamic and ongoing process of deciding which pats of their data are sensitive.

Sensitive data (as defined by citizens as they view their data as it is being created with real time access to data that current technology allows– or later as they view it through their access rights) should be digitally coded as "sensitive" and recorded at source as processing takes place.

Data subjects should have an opportunity to be involved in the decisions that are made about the retention and destruction of their data. One option would be a statutory requirement for data controllers to approach data subjects say 6 months before they destroy personal data to see if the data subjects would like to have the data retained or to have it processed at their own expense

Finally(!)

· Data controllers should be statutorily required to publish the details of data and parties involved in the information flows of sensitive data.

· Data controllers should be obliged to publish the details of bulk transfers of personal data that they make from one data controller to another and to automatically log which data controllers have accessed a data subject's data. (An audit trail again.)

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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Quality (125A) What does quality of care mean to you? (36) Improving the quality and safety of health services (9)

11 July, 2021
Dear Marion,

In my humble opinion this is the best vision of "What is Quality?" so far. Apologies for not commenting earlier. I recommend everyone consider Marion's thoughts.
[https://www.hifa.org/dgroups-rss/quality-62-what-does-quality-care-mean-...]

I have added my comments into you words in CAPITALS.

AND NOW THAT I HAVE FINISHED, PLEASE EXCUSE MY SOMEWHAT OVERWHELMING TREATMENT OF YOUR COMMENT.

Regards,

Mark Cantor

Marion Lynch, UK
on June 28

Reply

What is quality?

I have thought about this and reflected on how many times I have been asked to prove the quality of care.

THINKING IS ONE OF THE BIGGEST CONTRIBUTORS TO QUALITY. TURNING INWARDS AND THINKING ABOUT WHAT WE DO WHAT OUR ORGANISATION DOES AND PONDERING CAN IT BE BETTER?

I have measured the quality with the agreed quality metrics of the day. I have completed the organisational matrix recording the answers to the questions 'how many interventions?' and 'how much contact time?'. I look back on this and wonder, did we ask 'how may it be better next time?' Sadly I confess, not very often and not very loudly. We got on with recording and reporting and repeating what we had done the day before. That is not Quality.

SO SO SO TRUE! THE AGREED METRICS ARE TYPICALLY HIGH LEVEL, EXECUTIVE AND MINISTERIAL. I'VE EVEN HEARD EXECUTIVES SAY "WE WANT TO BE IN THE MIDDLE, NOT TOO LOW, BUT ALSO NOT TOO HIGH AS TO DRAW ATTENTION". VERY FEW OF THESE METRICS PROVIDE ANY INFORMATION AS TO WHAT NEEDS TARGETING FOR INVESTIGATION AND IMPROVEMENT.

"REPEATING WHAT WE HAD DONE THE DAY BEFORE" THIS IS THE DAILY CYCLIC TRAP. NO ONE CAN IMPROVE QUALITY WITHOUT CHANGE. YOU CAN'T JUST DO BETTER! PEOPLE, INDIVIDUALS, TEAMS, EQUIPMENT AND PROCESSES ALL OPERATE AT A STATISTICAL RELIABILITY. YOU CAN CHANGE SOME OF THOSE RELIABILITIES WITH TRAINING, BUT MOST QUALITY IMPROVEMENT COMES FROM CHANGING THE PROCESS.

Quality for me is asking that final question, asking it, reflecting on it, and then acting on the answers. And asking and improving it all again.

A MINDSET OF ANALYSIS, INTROSPECTION, UNDERSTANDING, CONTINUOUS IMPROVEMENT AND A FORMALISED PROCESS. CONTINUOUS IMPROVEMENT MUST BE A FORMALISED, DOCUMENTED AND APPROPRIATELY RESOURCED FUNCTION OF ANY SUCCESSFUL ORGANISATION. I NEVER EVER SEE HEALTHCARE STAFF THAT ARE DEDICATED TO THIS. IN INDUSTY THERE ARE USUALLY DEDICATED PERSONNEL TO ACT AS A CATALYST AND TO DRIVE CHANGE. IN MOST LARGE ORGANISATIONS, THAT IS WHAT ENGINEERS DO. THEY USUALLY SIT TO THE SIDE OR IN A MATRIX ORGANISATION AND SUPPORT PRODUCTION. SIMILARLY IN THE NAVY, THE LINE OF COMMAND NEVER INCLUDES THE ENGINEERS.

Quality is dynamic and requires discussion, decisions, and sometimes a little disruption. This is why I am here on this forum.

AGREE WHOLE HEARTEDLY, BUT IT MUST ALSO BE CONTROLLED. MANY MAN MADE DISASTERS HAVE OCCURRED WHEN SOMEONE HAS CHANGED SOMETHING, THINKING THEY WERE MAKING IT BETTER. WHEN THEY DIDN'T REALLY UNDERSTAND WHAT THEY WERE IMPACTING. ALL HIGH RISK INDUSTRIES HAVE CHANGE MANAGEMENT PROGRAMS THAT PROVIDE A REVIEW AND APPROVAL PROCESS FOR ANY CHANGE. THE EQUIVALENT OF A DOUBLE BLIND TRIAL, I SUPPOSE, DEPENDING ON THE RISK LEVEL.

Quality is multi dimensional with multiple layers with multiple meanings. I have worked at these layers and notice the links, and the gaps.

QUALITY IS EVERYTHING THAT SUPPORTS THE FINAL INTERACTION WITH THE PATIENT. MY UNDERSTANDING OF THIS COMMENT IS WHAT I KNOW AS "SYSTEMS THINKING". EVERY SINGLE OUTCOME IS A RESULT OF PREVIOUS ACTIONS. UNDERSTANDING THE RELATIONSHIP BETWEEN ALL VARIOUS FACTORS THAT INFLUENCE AN OUTCOME.

THE "ROOT CAUSE ANALYSIS" I'VE SEEN IN HEALTHCARE IN DRIVEN BY LAWYERS, NOT A DESIRE FOR IMPROVEMENT. THE STATEMENT: "NO ROOT CAUSE FOUND" IS AN INSULT TO EVERYONE AND ABSOLUTELY DISGUSTING WHEN RELATING TO A FATALITY.

I shall give two examples. [... *see note below] Perhaps quality is the less visible capital, culture and compassion as well as the visible policies, plans and projects. We know all of these count to our patients, some more than others. With the help of WHO we can now make sure they can all be counted too.

CULTURE IS THE TOUGHEST THING TO CONTROL AND EVERYTHING HERE IS CULTURE. I HAVE NEVER WITNESSED A TRUE CHANGE IN CULTURE AND I BELIEVE IT HAS TO COME FROM THE VERY TOP. I HAVE DONE A LOT OF STUDY ON HIGH RELIABILITY ORGANISATION THEORY (HRO) AND THIS WAS HOW I BECAME INVOLVED AS A HEALTH CONSUMER REP.

YOU MENTIONED SOCIOLOGY. CAN I RECOMMEND THE WRITINGS OF A GENTLEMAN, PROFESSOR ANDREW HOPKINS.

https://www.processsafety.com.au/what-led-professor-andrew-hopkins-to-wr...

https://www.safeworkaustralia.gov.au/media-centre/use-and-abuse-culture

I HAVE HEARD THE HRO TERM USED SO MANY TIMES IN HEALTHCARE BUT THAT IT WHERE IT ENDS.

https://www.processsafety.com.au/books/learning-from-high-reliability-or...

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HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. markacantor AT me.com

[*Note from HIFA moderator (NPW): I have taken out some paragraphs from Marion's original message. The full text is available here https://www.hifa.org/dgroups-rss/quality-62-what-does-quality-care-mean-...]

Quality (125B) National commitment (1) Our experience of kick starting a quality revolution in MNH settings across India and South East Asia

11 July, 2021
Dear Colleagues,

I write to you as the current President of the Nationwide Quality of Care Network (NQOCN) of India. This is a registered organization that partners with the Ministry of Health and Family Welfare, Government of India to facilitate the delivery of perinatal care to pregnant mothers and their newborn infants.

In these initiatives, we are currently supported by the World Health Organization and are assisting in the development of point-of-care quality improvement and training initiatives that are being used in 15 states of India and in 10 other countries in this region, including Bangladesh, Myanmar, Sri Lanka, Nepal, Bhutan, Indonesia, Thailand, Democratic People's Republic of Korea, Maldives, and Timor-Leste (East Timor). To date, we have touched more than a million lives and 0.6 million deliveries.

In addition to working as Technical Partners to the Government of India, we also lead the National Mentoring Group and the technical resource group (TRG) for LaQshya (Labor Room Quality Improvement) National Flagship Program. We work closely across primary, secondary and tertiary health care settings in both public and private sectors across maternal and neonatal health domains. Our initiatives to scale up QI across India have lead to the launch of the vibrant NQOCN Point of Care Quality Improvement Community of Practice (www.nqocncop.org) which has partnerships with Oxford, BMJ, 3M, URC, Aastarika (an Infosys Initiative), CAHO, Mahatma Gandhi Institute of Medical Sciences and WHO Regional Office for South-East Asia. Our membership base consists of a large nurse mentor pool, neonatologists, paediatricians, obstetricians, quality managers and young professionals.

Our experience in driving quality improvement across India and SE Asia has been mainly through the effective use of identification and networking of champions at all levels of health

care delivery systems and utilising technology and human factors to our advantage in sustaining the momentum of the initiative.

Effective support from national and state governments thorough national health missions has been recognised by us as a major catalyst for the implementation of QI in health systems across the country .We have also supported and introduced QI in pre service medical and nursing education on voluntary basis and feel that this is an essential step to in building of a QI culture in the future health systems of the nation.

I hope to hear from colleagues about their experiences of factors which helped them scale up QI at national levels.

With best wishes

Vikram

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President NQOCN, India
ISQua Expert (2018-2023)
Guest Editor (2020-2021)
BMJ Open Quality (South Asia Edition)
Member, Editorial Board, IJQHC Communications

Vice President Elect 2022
National Neonatology Forum of India
Secretary (2013-2014)
National Neonatology Forum, India

Member National Editorial Board (2015-2017)
Indian Journal of Pediatrics

Editor in Chief (2013-2014)
Journal of Neonatology, India

Technical Resource Group Lead , Sustainable Model for LaQshya
(as notified by MOHFW, India)

Member QED Working Group, Ministry of Health & Family Welfare, India (2018-2019)
Member, National Mentoring Group for LaQshya (Labor Room Quality Improvement)

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HIFA profile: Vikram Datta is Director, Professor and President at the Nationwide Quality of Care Network, Lady Hardinge Medical College, India. Professional interests: Trained as a Neonatologist; Currently works for quality improvement across the maternal and neonatal health domains in India; Drives the South Asia QI Community of Practice which can be accessed at www.nqocncop.org. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. Email: drvikramdatta AT gmail.com

Quality (126) National commitment (2) Health information system and data quality

11 July, 2021

Health information system is one of the building blocks for patient centred care. Significance of health information system is emphasised in The WHO Quality Health Services: a planning guide [https://www.who.int/publications/i/item/9789240011632] Examples of information system includes routine facility surveys, sampled national standardized survey, routine supervision or monitoring surveys, external evaluation, inspection and accreditation household surveys Insurance programmes Patient and public questionnaires and online reviews or surveys Medical registries etc.

Health systems are complex adaptive systems, and strengthening systems is critical for universal health care. At the level of the facility as well, there are various subsystems/departments, changes in one impact another and in turn affect patient care. Hence, health information system, in the form of electronic medical record may provide a roadmap to run the various subsystems more effectively.

The health information system helps in decision-making and has main four key functions: data generation, compilation, analysis and synthesis, and communication and use. Data quality, relevance and timeliness, is important in evidence based decision at policy level, therefore a standardised approach is important for data collection.

HIFA profile: Manu Gupta is an Independent consultant in India. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services. https://www.hifa.org/projects/learning-quality-health-services manugupta08 AT gmail.com

Quality (127) National commitment (3) Quality health services in Nigeria

11 July, 2021
Dear all HIFA members:

This week, as we turn our attention to the questions "From your experience, what might work best to enhance national commitment to quality of care? Have you seen any practical solutions that should be shared wider?□", I wish to make my initial submission - the case of Nigeria - as follows.

Nigeria is a signatory to several global initiatives and agenda on health and development, including the Sustainable Development Goals (SDGs).

Nigeria's Federal Ministry of Health (FMoH) has departments, agencies, policies and other structures to ensure the provision and delivery of health services to the country's population. In 2014, the health system received a boost with the enactment of the National Health Act.

However, there is no 'National Quality Policy and Strategy (NQPS)' to promote and plan for improved quality of care outlined in a document, providing an official, explicit statement of the approach and actions required to enhance the quality of health care across (the) health system, 'linked closely with the wider national health policy and planning'□, as recommended by the WHO (https://www.who.int/news-room/q-a-detail/q-a-who-handbook-for-national-q...).

The Nigeria National Quality Policy (NNQP) which was approved early this year (2021) does not related specifically to health or quality of care.

Nevertheless, there are some national instruments that have provisions for quality of care. The first is the National Health Act 2014
(http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/104157/126947/F-693610255/...).

The second is the National Quality Assurance Policy for MEDICINES & OTHER HEALTH PRODUCTS (NQAP)
(https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&u...).

The Act does not explicitly provide for quality of care or formulation of any policy thereof, but has several provisions that allow for the provision of quality health services.

Primarily, the National Health System defines and provides a framework for standards and regulation of health services, without prejudice to extant professional regulatory laws (section 1, subsection (1) of the National Health Act 2014).

Section 13, subsection (1) (c) states that 'Without being in possession of a Certificate of Standards, a person, entity, government or organization shall not provide prescribed health services'.

Section 19, subsections (1) and (2) state further that 'All health establishments shall comply with the quality requirements and standards prescribed by the National Council on Health. The quality requirements and standards may relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety and the manner in which users are accommodated and treated.' Thus, the Act recognizes the fact that several factors and actors need to considered to ensure the delivery of quality health services.

The Act also mandates every health care provider to enable every user have full knowledge/ information pertaining to her/his state of health and necessary treatment relating to- (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user; (b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user's right to refuse health services and the implications, risks or obligations of such refusal.

Some have argued that the absence of a National Quality Policy on quality of care may be responsible for the poor health outcomes in the country. But the fundamental requirements are already in place.

Thus, in my view, a legal framework (for the regulation, development and management of a national health system that set standards for rendering health services), a national health policy and a national quality policy and strategy (NQPS) to promote and plan for improved quality of care are KEY approaches that can enhance national commitment to quality of care.

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ORFEGA, *Moses Kumaoron*

HIFA profile: Moses Kumaoron Orfega is a Service Improvement Desk Officer at the National Health Insurance Scheme, Nigeria. Professional interests: Social Protection and Financing; Social Health Protection and Universal Health Coverage; Service Quality Improvement; Information Technology. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. Email: ofegamoses AT gmail.com

Quality (128) National commitment (4) Quality health services in Croatia

12 July, 2021
National level issues in relation to quality health services

During the last two decades, quality of care became an indispensable element for most developed countries and their health strategies. As a result, well-developed quality improvement policies have actually guided the healthcare organisations in their process of tackling shortcomings and striving towards nationally posited quality of care aims. Such rich experience in improving quality of care in many countries offers a plethora of valuable lessons for other countries that are just embarking on this process - and platforms such as HIFA offer us a possibility to learn from each other.

For example, when transition countries are concerned, it is not wise to just implement the same policies that were effective elsewhere, as they may not be suitable for their (often very specific) environment. Hence, there is a need to first perform an in-depth analysis of the problems related to the quality of care (with the use of appropriate indicators which we have discussed in the previous two weeks), and only then respond with strategies that are suitable to their respective environments. In other words, reliable health service data are indeed pivotal to understanding quality problems.

One example is Croatia, which during almost three decades of independence had to pass through a challenging political and economic transition process. The positive aspect is that Croatia always had a strong primary care base, which was how many quality improvement schemes actually started. In addition, primary care offices in Croatia represent an excellent milieu for data collection due to early and pervasive computerisation in comparison to other neighbouring countries. Such data have been used to identify key indicators of quality of care, which are then included in the program of quality of care monitoring in all primary care offices, closing in turn the circle of quality improvement.

In the next two weeks, as our thematic discussion on quality of care focuses on national level issues in relation to quality health services, I will share some experiences from Croatia and neighbouring countries regarding their commitment and practical approach to the quality of care. Also, we will discuss how these examples fit within suggested national-level activities for improving quality of health services in WHO's planning guide for quality health services.

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. He is also a member of the HIFA-WHO working group on Learning for quality health services.
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Quality (129) National commitment (5) Enhancing national commitment to quality of care

12 July, 2021
Greetings everyone -

Really happy to take part of this discussion on quality of care. With my colleague Nana Mensah Abrampah, we work for the WHO Global Learning Laboratory (GLL) for Quality UHC.

The first 2-week discussion has been intense and very rich thanks to all your excellent contributions, and we cannot wait to follow the next weeks of discussion.

The following paragraphs introduce the next 2-week discussion on national commitment to quality of care.

To improve health outcomes, national-level leadership, ownership and action are required to guide, support and sustain such improvements. The precise role of those involved at the national-level varies in accordance with country context. In general, those involved include the ministry of health team responsible for coordinating national quality improvement and patient safety efforts, senior health system and political leaders, relevant steering committees or technical working groups, and other key quality-related bodies active at the country level.

The WHO Quality Health Services: a planning guide [https://apps.who.int/iris/bitstream/handle/10665/336661/9789240011632-en...] provides a range of activities that can be considered by national stakeholders including establishing commitment to improve quality, developing or renewing a national strategic direction on quality, and selecting and prioritizing interventions for quality of care. The next 2-weeks of discussion focuses on exploring ways to enhance national commitment to quality of care, providing practical examples of where this has worked.

This further exploration will be based on the WHO Quality Health Services: a planning guide that is designed to support key actions at the national, district and facility levels to enhance quality of health services. It highlights the need for a systems approach to enhancing quality of care, and for a common understanding of the essential activities at each level and among all stakeholders. The WHO National Quality Policy and Strategy Handbook [https://apps.who.int/iris/bitstream/handle/10665/272357/9789241565561-en...]is a useful resource to view for this discussion.

Looking forward to reading your exchanges,

Oriane

HIFA profile: Oriane Bodson is a Technical Officer, Quality of Care at the World Health Organization, Geneva. She is a member of the WHO-HIFA Working Group on Learning for Quality Health Services.

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Quality (130) What does quality of care mean to you? (36)

13 July, 2021
I am Balogun Stephen, a Public Health Physician, Quality Improvement Expert, the Recipient of the Lucian Leape Patient Safety Fellowship award for the year 2021, and a member of the WHO-HIFA Catalyst group on Quality Health Services. I have been a member of HIFA for more than 6 years, receiving the Country Representative of the year award in 2016. I am privileged to have contributed to two of WHO Global Learning Laboratory Handbooks (the handbook of National Quality Policy and Strategies, and the Quality health services: a planning guide). Currently, I work with Caritas Nigeria as the team lead for the Epidemiology and Surveillance unit. I also coordinate a platform of quality improvement and safety enthusiasts in Nigeria with close to 50 members.

I got interested in quality early in my life. Infact, growing up, I felt healthcare was always of high quality and safe because I could just not imagine how health could be otherwise. So, when I got the chance to be a medical doctor, I gave it my best, hoping to be the best surgeon the world has ever had. However, a chain of life-changing events happened towards the end of my medical school days that made me realize that healthcare wasn't as safe as I thought it was. Maybe it is usually not safe for many (if not most). I realized that being the best surgeon will probably not make healthcare safer for the majority of people. Of course, I understood that being excellent in your field is important and possibly the first step in the direction towards quality universal healthcare. However, my thoughts were around the systemic factors. How we can make the system better for both the care providers and users. So started my quality and quality improvement journey. To me, quality is ensuring that everyone (irrespective of social class, connection, level of education, place of residence etc.) receives the healthcare that they need, at the time that it is needed, and to meet the purpose for which it is needed, always.

Balogun Stephen Taiye MBBS, MPH, CSSGB, SMC, PMP, FISQua

ISQua Expert, ISQua Ambassador, Lucian Leape Patient Safety Scholar,

WHO Global Patient Safety Network (GSPN) Member

HIFA profile: Balogun Stephen Taiye is a Medical Officer/Quality Improvement Team Leader at the Olanrewaju Hospital in Nigeria. He is also currently a post-graduate student of

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Quality (131) National commitment (6) Making the case for quality of care (5)

13 July, 2021
Hi all,

Very pleased to see this discussion. One area I think really needs attention is how to ignite and harness the power of communities and health workers to drive national level commitment. I've seen some good examples of where this has happened in response to a scandal - for instance communities demanding better infection prevention and control after an outbreak of HIV linked to re-using of needles - but would be very interested in other examples.

We know that people want quality health services, so what does it take to translate that appetite into a case that makes sense to policy-makers? I guess this is a good example of the fact that we can't separate public health and politics; they are interdependent. And if we want to really make progress on quality we have to embrace the need to engage on a political level.

One way we can do this is to better empower and support health workers themselves to speak up. Health workers can often wield a lot of influence on the national level, but may not feel empowered to do so. How do we empower them? Share learning from other settings, connect them with peers, integrate quality within training curricula, demonstrate the value of efforts to improve quality, and engage with professional societies to advocate for change.

Communities are perhaps a harder nut to crack but I think there are some good examples of where civil society or patient groups have really pushed the quality agenda.

I'd be really interested to hear any other examples of where communities have successfully helped secure national commitment so please do share any thoughts on this.

Thank you,

Matthew

HIFA profile: Matthew Neilson is a Consultant at WHO, based in the United Kingdom. Professional interests: Public health, quality of care, quality in FCV settings, health systems preparedness and resilience. Email address: neilsonm AT who.int

Quality (132) National commitment (7) Our experience of kick starting a quality revolution in MNH settings across India and South East Asia (2)

13 July, 2021
Dear Vikram Datta,

I am very interested to hear about your work as President of the Nationwide Quality of Care Network (NQOCN) of India, which partners with the Government of India to improve quality of care for mothers and their newborn infants.

https://www.hifa.org/dgroups-rss/quality-125-national-commitment-1-our-e...

It is impressive that you are also assisting in the development of point-of-care quality improvement and training initiatives that are being used in 10 other countries in this region.

Are there other Quality of Care Network networks in India that deal with other aspects of health care?

I am also interested to hear about the NQOCN Point of Care Quality Improvement Community of Practice (www.nqocncop.org) and have subscribed to this to learn from your members.

You mention how you drive quality improvement by supporting quality champions at all levels of health care delivery systems and I would be keen to learn more about this.

As you say, I also hope to hear from other HIFA members worldwide about their experiences of factors which have helped them scale up Quality Improvement at national level.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (133) Lessons from the 37th International Society for Quality in Health Care Conference, 8-11 July

14 July, 2021
The ISQua 37th International Conference 2021, initially scheduled to hold in Florence last year but converted to a virtual conference, held between the 8th and 11th of July 2021 with about 2000 persons in attendance. The theme of the conference was “emotions, inspiration and creativity: pathways to global health quality”. It featured plenary sessions from great speakers including Melanie Calvert, Walter Ricciardi, Pascale Carayon, Glyn Elwyn, Valerie James, Sylvie Mantis, Boel Andersson Gare, Trish Greenhalgh, Rene Amelberti, Charles Vincent, Sumaia Al-Ariki, Frances Mortimer, Ron Wyatt and Yvonne Coghil. We also had sessions from WHO (GPSN & GLL for QUHC), NAHQ, Good Governance Institute. Speakers from more than 50 countries also had the opportunity to present their works. As always with the ISQua conference, there were so many lessons to learn. I am glad that this year’s conference sessions are recorded and made available, there’s still so much to learn from some of the sessions I wasn’t able to join during the conference. ISQua has also decided to make the videos available to anyone who might be interested for a token. Meanwhile, I will be sharing some of the lessons for each day here over the next few days. My key lessons of the first conference day are:

Melanie Calvert, the recipient of this year’s HAL career prize for an individual on patient-reported outcome, discussing the need for understanding of the various terminologies used in measuring patients’ care: patient experience, patient satisfaction, patient-reported outcomes, and co-production. Patient-reported outcome measures are extremely useful to understand both the ill-health and the care services as received by the patients. It helps to prioritize the things that are most important to the patient, and build the care process around these things. She also discussed the current fragmentation of these tools across different units, institutions and program areas, and the need for harmonization, both generic measurements and disease-specific measurements.

Several other speakers also talked about patient-centered care, and how COVID-19 has driven this home more than ever before. In the words of one of the presenters, “it is not [always] about being polite or gentle, it is about listening to learn, to understand the recovery priorities and goals of the patient”. Patients are active partners in their care, they spend most of the time (over 97% of time) taking care of their health. The asset that they bring on board needs to be recognized and explored.

Isabelle Castro talked about “power” as it relates to healthcare and how it has transitioned over the generations. First, we started with powers belonging to the public managers (keeping power) who decides how the healthcare system runs; then moved to understanding the need for power to be shared with the receivers of healthcare through patient participation, engagement, feedback, and quality improvement. However, the world is rapidly moving towards the third power wave - ceding powerr to the patients, understanding that the patient is first and foremost responsible for his/her care and co-producing this with the patient.

Having experienced and benefited a lot of MOOCs over the past few years, I have always considered how best to evaluate the impact of MMOC, especially in healthcare quality improvement. Tricia Woodhead gave a great presentation on this, how to explore both the Kirkpatrick and RE-AIM models that I found very useful. I found the link to the full work, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7008416/, I think it's worth checking out.

The final lesson that I'd like to share is the presentation on "the role of leadership to tackle formidable health systems challenges". The speaker described the changing health systems landscape as preparing for the "perfect storm". A "perfect storm" is an expression that describes an event where a rare combination of circumstances will aggravate a situation drastically. He believes that because:

People live longer and have fewer children
People migrate within and between countries, and cities grow bigger.
Non-communicable diseases dominate the disease burden.
Depression, heart disease and cancer are leading causes to healthy life years lost.
Infectious diseases, such as SARS-COV, HIV, tuberculosis remains a challenge to control.
Antibiotic-resistant organisms are emerging.
Health systems face rising costs.
Primary health care systems are weak and lack preventive services.
Public health capacities are outdated.

Yet, he believes that despite the challenges, building healthcare leaders guided by all of Jim Collins 5 levels of leadership can help prevent/survive the "perfect storm" that is coming. These levels are:

- Developing highly capable individuals who make productive contributions through talent, knowledge, skills and good work habits

- Grooming contributing team members who contribute their individual capabilities to the achievement of the group objectives and work effectively with others in a group setting

- Organizing people and resources toward the effective and efficient pursuit of predetermined objectives

- Catalyzing commitment to and vigorous pursuit of a clear and compelling vision, stimulating higher performance standards, and

- Building enduring greatness through a paradoxical blend of personal humility and personal will.

Two things have occupied my thoughts from the lessons from the day that I'd like to share with the group:

In countries where out-of-pocket expenditure is responsible for the bulk of healthcare financing, how useful is Patient-Reported Outcome Measures in monitoring response to

healthcare services? Does anyone in the group have experiences/outcome of research they'd love to share?

Regarding the power curve in the health sector, how well would you say your local, district/state, regional or national level has transited to ceding power to the patients? What has been the experience in your setting?

Balogun Stephen Taiye MBBS, MPH, CSSGB, SMC, PMP, FISQua

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HIFA profile: Balogun Stephen Taiye is a Medical Officer/Quality Improvement Team Leader at the Olanrewaju Hospital in Nigeria. He is also currently a post-graduate student of Public Health and Business Administration. Professional interests: patient safety, healthcare quality improvement, reproducible research, data collection and analysis. He is a HIFA Country Representative for Nigeria and was awarded HIFA Country Representative of the Year 2016.

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Quality (134) National commitment (8) Corruption and quality of care

14 July, 2021
Is the embezzlement or misdirection or misuse of health funds the greatest obstacle to quality health care? in my work with the Global Fund to Fight AIDS, Tuberculosis and Malaria a key element of our field missions was the review of funding flows to make sure (1) supplies reached health clinics and (2) reporting was accurate in terms of number of patients seen and use of resources. In those situations in which corruption or misuse of funds was a threat, quality of care was always lower. Does this resonate with anyone else?

HIFA profile: Sebastian Kevany is a former consultant with the World Health Organisation (WHO), Ireland & USA. Professional interests: Global health security and diplomacy. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services Email: sk AT diplomatichealth.com

Quality (135) National commitment (9) Australian case study - Consumer activism

14 July, 2021
Australia's national health system is two-tiered with first, (apparent) universal access to a public system called Medicare (funded by taxes) and second a private system (funded by individuals and their private health insurer). As a health consumer and citizen in a high income country I have benefited from the public system and will continue to do so as citizenship status privileges me over non-citizens for whom accessing health care can be highly problematic.

The Australian health care system includes community-controlled Indigenous health services which are used by many Indigenous Australians. These services deliver locally and coordinate through a national coalition, and also advocate about key issues in Indigenous health. For example, Indigenous Australians experience health issues not often seen in high-income countries, from leprosy, to trachoma, rheumatic fever and otitis media. There is also a major gap between the health of Indigenous Australians and the mainstream population.

Australia's universal access to health care while benefiting me greatly as a citizen has problematic areas and is not perfect in guaranteeing access. For example, rural, remote and regional communities experience problems accessing the public health system. There are health consumer groups that represent and advocate rural health issues - I was an active member while living in rural Australia but resigned when I moved to a metropolitan area. Other major gaps in accessing health care includes people with disabilities (there is currently a robust Royal Commission investigating and exposing appalling inequities in care for people with disabilities) and the aged (likewise, both national and regional Royal Commissions have helped Australians articulate gross inequities in our health system). There are other groups which are marginalised or alienated from our universal health system, and also under-addressed health issues. For example, dental health is privatised (with a very very small public dental system which is difficult to access), and many allied health services (such as physiotherapy) are privatised and difficult to access for people on low incomes or living in remote areas.

Australia's health system is highly regulated and monitored, rich with data some of which is available in open and public access through (for example) the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, as well as national government websites. The Australian health care system appears to make quality an explicit issue which is under constant scrutiny and development and which offers opportunities for consumer engagement. As a health activist I have frequently engaged with ongoing reviews of national quality standards – for example, I am a panel member of Australian Health Panel and later this week I will contribute to a structured questionnaire coordinated through the Consumers Health Forum which will allow me to comment on one of eight quality standards - standard 2, Partnering with Consumers. In the past year or so I have contributed (as a citizen and health activist) to the review of and development of other standards - there are eight national service standards. I can do this as a concerned individual directly participating online with structured design features eg a questionnaire: but I have also done this work in concert with my regional health consumers group (The Health Consumers Council of Western Australia, and when

living in New South Wales and South Australia, with similar health consumer groups). Participating in regional health consumer groups allows me to enter into rich dialogue and learning with other health consumers and to encourage each other to speak boldly back to powerful interests, to empower our individual effort as well as to act collectively. Likewise, I have been able to contribute to the national reviews through special interest groups such as those found in rural health.

Australia has rich and long history of larrakins and trouble makers, and health consumers can access a wide range of advocacy groups, either geographically based or issue based or profession based, if we wish to become active and engaged health citizens. Some but not all are funded through a variety of mechanisms such as donations and government grants). This consumer activism is an important feature of the Australian health system, and of our national, regional and local culture(s). I have entered this advocacy culture to participate in national, state (regional) and local institutions. I have also participated in special issue groups and professional associations about health issues. For example, in rural health, climate health and women's health (Australia has a horrendous shadow pandemic - the tragedy of domestic violence), and in professional associations in sociology, public health and health promotion. I offer this personal experience as a reveal of how health advocacy plays a part in the Australian universal health care system - in summary it happens through national, regionnal (state and territories, but also local government) and local institutions (such as my local women's health centre) but also through special interest groups such as rural health or health justice centres and professional associations such as the Australian Public Health Association and Australian Health Promotions Association as well as unions which have a special program serving international health called APHEDA-Union Aid Abroad. Health consumers - health advocates and the fewer of us who call ourselves health activists - are a vital force in Australian health research (where we often collaborate with health researchers) and in Australian health service review and service delivery. We experience many frustrations and setbacks but I have been inspired by fellow citizens who continue to stand up to vested interests, bureaucracies and technocrats, and advocate doggedly and with courage and with love for our mutual humanity both nationally and globally.

Dr Ann Lawless,

Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.
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Quality (136) National commitment (10) Corruption and quality of care (2)

15 July, 2021
Without doubt corruption both monetary and other forms such as favouritism in recruitment, postings, promotion, contracting and procurement, etc is a big obstacle to quality health care in every environment, especially as seen in the LMICs. That does not mean that it does not occur in HICs but it is rampant in some LMICs.

It must be fought with all the focus and commitment that a country can muster.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
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Quality (137) National commitment (11) Australian case study (2)

15 July, 2021
Well written Ann,

I support Ann's description of the Australian system.

[https://www.hifa.org/dgroups-rss/quality-135-national-commitment-9-austr...]

Our system is a hybrid of private and tax payer funded systems. Which gives us the best and worst of both philosophies.

The trick for any national governance system is to implement systems that push the balance towards the best.

I might suggest that Australia's system while very good is subject more to political and vested interests than it is to evidence based philosophies. Our current Covid-19 vaccination program is an excellent example. Many vested interests are at play and some suggest that our system is two tiered. We have both the very best and some very very average healthcare, dependent on your class!

The national aspects of healthcare should focus on these cultural and constitutional aspects of healthcare.

Mark

HIFA profile: Mark Cantor is a Health Consumer Representative and is based in Australia. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services.
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Quality (138) National commitment (12) Summary of discussion so far!

15 July, 2021
Dear all,

Thank you for your contributions so far around the theme of How to increase **national** commitment to quality, which is our focus for this week and next. You can review past messages here: https://www.hifa.org/rss-feeds/17

We have had several contributions from Australia, Croatia, India, Switzerland, UK, USA. Our thanks to Vikram Datta (India), Manu Gupta (India), Moses Orfega (nigeria), Tomislav Mestrovic (Croatia), Sebastian Kevany (USA), Matthew Neilson (UK), Ann Lawless (Australia), Oriane Bodson (Switzerland) for sharing your experience and expertise on these topics.

1. We have learned from Vikram Datta about the Nationwide Quality of Care Network in india and look forward to hearing more.

Neil comment: Do other countries have similar networks?

2. Manu Gupta emphasised the importance of quality data and health information system.

Neil comment: Would anyone like to comment further about the quality of data that is collected in different countries. How reliable is the data, and to what extent is it applied to drive quality improvement?

3. Moses Orfega noted the need for a 'National Quality Policy and Strategy (NQPS)' in Nigeria.

Neil comment: How is quality driven currently in Nigeria? Where are the gaps? Do other countries have an NQPS?

4. Tomislav Mestrovic noted that any quality improvement should start with an in-depth analysis of the problems related to the quality of care.

Neil comment: Are such analyses being undertaken in practice? Do they draw on the range of stakeholders?

5. Sebastian Kevany states that 'money and funding is the greatest catalyst for quality of health care services', and that an economic case can be made for quality health services. He also asks highlights corruption as a key challenge.

6. In Oriane's introduction message from WHO GLL, we are reminded about who are the national-level actors whose commitment to quality is needed? 'In general, those involved include the ministry of health team responsible for coordinating national quality improvement and patient safety efforts, senior health system and political leaders, relevant steering committees or technical working groups, and other key quality-related bodies active at the country level.'

The WHO Quality Health Services: a planning guide
[https://apps.who.int/iris/bitstream/handle/10665/336661/9789240011632-en...] provides a range of activities that can be considered by national stakeholders... It highlights the need for a systems approach to enhancing quality of care, and for a common understanding of the essential activities at each level and among all stakeholders. The WHO National Quality Policy and Strategy Handbook
[https://apps.who.int/iris/bitstream/handle/10665/272357/9789241565561-en...]is a useful resource to view for this discussion.

7. Matthew Neilson asks: 'How to ignite and harness the power of communities and health workers to drive national level commitment?' For health workers, suggestions include 'Share learning from other settings, connect them with peers, integrate quality within training curricula, demonstrate the value of efforts to improve quality, and engage with professional societies to advocate for change.'

Neil comment: I would add that community health workers are especially important here as the interface between the health systemand the community. And yet their voice is among the weakest of all (especially at national level).

8. Ann Lawless, Australia makes a number of interesting points about the two-tier health system in Australia, health service delivery for indigenous population, and privatisation (esepcially of dental care). She shares her long experience as a health activist, which has included engaging with 'ongoing reviews of national quality standards'

Neil comment: Health activism by consumers/patients is strong and healthy in Australia and many other high income countries. But I suspect that it is less developed in LMICs? Would anyone like to comment on the situation for health consumers/patient voice in their country?

We look forward to continue this wonderful conversation. The key points will be synthesised and made available through the WHO website for the benefit of others.

Best wishes, Neil

Coordinator, WHO-HIFA Collaboration: HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

Let's build a future where every person has access to reliable healthcare information and is protected from misinformation - Join HIFA: www.hifa.org

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (139) National commitment (13) Quality health services in Croatia (2)

15 July, 2021
Thank you Neil for opening the door for our further discussion regarding national commitment of increasing quality of care. In Croatia, the in-depth analyses (like I have noted previously) have been continuously prompted by the European Commission and European Observatory on Health Systems and Policies, and they actually do draw on a range of stakeholders. In short, they have shown that the geographical distribution of health care infrastructure and human resources is uneven in the country, with the largest number of hospitals and health workers located in central Croatia (mainly in Zagreb). This is also accompanied with a shortage of physicians and nurses (due to 'brain drain' and other reasons), most notably in rural areas and the country's islands, as well as an oversupply of some other types of health professionals (i.e., there is an evident lack of balance).

This is why in recent years Croatia has started to address these issues head on by increasing motivation and enrolment quotas to health-related disciplines (primarily medicine and nursing), as well as providing salary increases. The government has also adopted the Strategic Plan for Human Resources in Healthcare with the aim to establish a human resources management system. There was also an implementation of case-based provider payment reforms in hospitals, initially starting with broad-based categories according to treatment procedures.

And indeed, one of the principal points for health reforms in Croatia has been the hospital sector, with several efforts to improve the strategic planning of hospital infrastructure and the overall efficiency of the hospital sector. Nonetheless, the results have thus far been mixed, with progress made on a new provider (DRG) payment system, but inadequate implementation of hospital reorganisation plans and continued accumulation of debts. Now, the problem is further compounded with the ongoing COVID-19 pandemic and some reforms have stopped, but there is definitely a need for further in-depth analyses that will inform subsequent steps in quality of care improvement efforts on the country level.

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. He is also a member of the HIFA-WHO working group on Learning for quality health services.
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Quality (140) Digital identity (4) Confidentiality or secrecy? (2)

15 July, 2021
Just saw Richard Fitton's post of 11 July. [https://www.hifa.org/dgroups-rss/quality-124-digital-identity-3-confiden...]

I think the discussion of confidentiality, secrecy, privacy and anonymity operates on distinct levels in respect of medical records, on one hand, and medical research, on the other.

With medical records, the purposes of keeping patient information confidential or secret include 1) the Hippocratic Oath ("...whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets."), and 2) to preserve the patient's data from the interests of potentially unwelcome eyes, such as those of insurance companies, banks and the State.

In medical research, there is often the added concern about letting friends, family and the neighbouring community know about individuals' medical conditions, and the impact of any de-anonymisation on the research project itself. In research projects, anonymisation must usually be done in such a way that it is impossible to reverse - so that noone, not even the computer or data staff, can track back to an individual. This kind of anonymisation is usually not practised with medical records.

BTW, this post originally caught my eye because of the comment that "she thought [the UN ID2020 initiative] was "Big Brother--ish. (*** Aldous Huxley had published in 1932 his futuristic novel *Brave New World*"...). Wrong dystopian novel - "Big Brother" is from Orwell's 1984, not Huxley's Brave New World....

Best,

Chris

Chris Zielinski
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HIFA profile: Chris Zielinski: As a Visiting Fellow in the Centre for Global Health, Chris leads the Partnerships in Health Information (Phi) programme at the University of Winchester. Formerly an NGO, Phi supports knowledge development and brokers healthcare information exchanges of all kinds. Chris has held senior positions in publishing and knowledge management with WHO in Brazzaville, Geneva, Cairo and New Delhi, with FAO in Rome, ILO in Geneva, and UNIDO in Vienna. Chris also spent three years in London as Chief Executive of the Authors Licensing and Collecting Society. He was the founder of the ExtraMED project (Third World biomedical journals on CD-ROM), and managed the Gates Foundation-supported Health Information Resource Centres project. He served on WHO's Ethical Review Committee, and was an originator of the African Health Observatory. Chris has been a director of the World Association of Medical Editors, UK Copyright Licensing Agency, Educational Recording Agency, and International Association of Audiovisual Writers and Directors. He has served on the boards of several NGOs and ethics groupings (information and computer ethics and bioethics). UK-based, he is also building houses in Zambia. chris AT chriszielinski.com

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Quality (141) National commitment (14) Quality health services in Nigeria (2)

15 July, 2021
The earliest account for the call for a national action towards quality healthcare in Nigeria that we have located was in 1952 before Nigeria gained independence from Great Britain in 1960. The quality struggle has been chequered.

In 1952, the British Medical Association established a branch on Lagos Nigeria which became the Nigerian Medical Association in 1960 at independence. Its pioneer President Dr Majekodunmi became the first Minister of Health, and continued to champion the Quality Agenda that the Association had already committed itself to fight for. Fast forward to 1966-

1970 the civil war interrupted any progress and during the subsequent years after 1970, several efforts were made by the various ministers of health under a prolonged period of Military Rule till 1999 when it handed over to democratically elected government that has governed till today. During the military rule sevekay health policies were released but none became Law. The most significant effort towards systematized quality Agenda was that put forward by the Late Professor Olikoye Ransome-Kuti, immediately when WHO released the Alma Ata declaration. He underlined the fact that the primary health tier held the key to unraveling poor health care outcomes in the country, leading to the establishment of the National Primary Health Care Development Agency. He served the country twice as Minister of Health but whenever he left that office the road map was reversed in real terms. Nigeria continued to travel on this chequered route until eventually on 2014, the National Health Act (NHA 2014) became Law, attempting to bring together all the good points and objectives of previous policies.

To answer Neil's question, we can say that today, the status of quality health care in Nigeria should be looked at from the status of the implementation of the provisions of the NHA 2014. The Act provides that within 24 months of its becoming effective (which was 31st October 2016) every health facility in the country should have a certificate of standard and it should display it in the premises for public information. After long delays and outcry from the professions especially the NMA, the minister of Health in March 2017 inaugurated a key committee provided for in the NHA, the National Tertiary Health Institutions Standards Committee (NTHISC). Observers have queried why only the tertiary health institutions should have standards.

The committee has not been fully active even though in 2019, the Federal Ministry of Health launched a '˜Quality Checklist' which was authored by a consultant! Not much has been heard about the document since, and not much has been heard from the NTHISC since, too.

The lacuna has meant that independent organizations like the HRI West Africa (www.hriwestafrica.org) founder of the 12-Pillar Clinical Governance Programme and others have been very busy trying to advocate and promote such home-grown quality care tools to cover all three tiers of the health system. In addition, a few private hospitals that are committed to quality care, like the Lily Hospital, Warri and others have gone outside Nigeria to countries like South Aftica, to gain quality health facility accreditation.

So, Nigeria since 2014 has had a Health Law that mandates the country to ensure that all health facilities provide quality care which is benchmarkable to best standards comparable to what exists in the countries that millions of Nigerians troop to every year on medical tourism, spending according to several reports over $1 Billion per year. But achieving that goal is still a long way away, despite the best efforts of the independent actors.

Very Interestingly, the NMA seems to have come full cycle from 1952, because in 2012, it created the NMA Standing Committee on Clinical Governance, making its advocacy for quality health care in Nigeria, permanent, year on year.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.
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Quality (142) National commitment (15) Making the case for financial investment (2)

16 July, 2021
Experience shows us that the absence of adequate resourcing, in any service, leads to a shift in focus from quality to elements such as basic access, cost-cutting, task-shifting and other measures to 'make do' with the limited resources. According to the WHO Quality Health Services: a planning guide [https://www.who.int/publications/i/item/9789240011632] "operational planning (for quality) needs to consider resourcing requirements. While quality improvement efforts across a health system can be expected to result in more cost-effective care and less waste of resources, there will clearly be initial resource implications as activities are commenced". In the last 13 years of supporting more than 14 countries in sub-Saharan institute national QI programs, resourcing at the national level has been one of the biggest gaps. If the steps outlined in the planning guide are undertaken, there will be positive changes in the right direction. We must use the momentum and spotlight that COVID-19 has unfortunately placed on health care to lobby the highest levels of government to take quality health care more seriously by committing the necessary resources. The pandemic has shown us this is no longer a nice-to-have but rather a matter of saving lives and ensuring the best health outcomes.

HIFA profile: Ivan Teri is Associate Director of Program Optimization EGPAF, United States. He is a certified Quality Management/Improvement leader with 15 years international experience in the health and social development sector, particularly in sub-Saharan Africa. Ivan is passionate about working to transform Africa's healthcare systems to better serve current and future populations with quality, safe and client-centered services. Professional interest: Organizational Excellence, Quality Improvement, Data Analytics & Digital Health. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services Email: iteri AT pedaids.org

Quality (143) Lessons from the 37th International Society for Quality in Health Care Conference, 8-11 July (2)

16 July, 2021
The second day of the conference appeared to be centered around safety. [*see note below]

Pascale Carayon talked about “How to support the work of care teams? A human factors and systems engineering perspective to address the global quality chasm”. We discussed how members of the care team, including patients, care partners, clinicians, and other health care professionals, often experience challenges in doing their work and how those challenges can result in patient safety issues, frustration, stress, and other negative outcomes, therefore contributing to the global quality chasm. She mentioned that “Systemic conditions – such as fragmentation, mal-aligned payments, poor training, unreliable supply chains, burdensome rules, inadequate information flows, lack of useful data, corruption, and fear – prevent the most willing workforce from carrying out its daily tasks successfully and contributing to the success of the whole system. As a result, patients suffer needlessly; communities squander scarce resources, and the workforce itself becomes frustrated and exhausted as a part of the ill-functioning system”.

SEIPS (Systems Engineering Initiative for Patient Safety) model can be used to analyze and improve work systems and care processes along the patient journey. SEIPS proposes that technology and tools, tasks, persons, organizations, the physical environment, and external environments form the work systems. These systems in turn create the structures which determine patient, employee and organizational outcomes.

The WHO Global Patient Safety Network team presented “Towards Eliminating Avoidable Harm in Health Care”. It featured representatives of the government from Oman and Kenya and representatives of the patients' population. The “Global action on patient safety” started in 2019 following the adoption of the World Health Assembly (WHA) 72.6 resolution on the urgent need to reduce patient harm in health care systems around the world.

A handbook, “Global Patient Safety Action Plan 2021-2030”, has just been endorsed at the last WHA in May 2021 and will guide implementation till 2031.

The action plan is predicated on a framework that includes seven strategic objectives which can be achieved through 35 specific strategies. The strategies are:

1. Making zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of healthcare everywhere

2. Build high-reliability health systems and health organizations that protect patients daily from harm

3. Assure the safety of every clinical process

4. Engage and empower patients and families to help and support the journey to safer healthcare

5. Inspire, educate, skill, and protect health workers to contribute to the design and delivery of safe care systems

6. Ensure a constant flow of information and knowledge to drive the mitigation of risk, a reduction in levels of avoidable harm, and improvements in the safety of care

7. Develop and sustain multisectoral and multinational synergy, partnership, and solidarity to improve patient safety and quality of care

Over the past few months, I have had to engage some experts in talking about implementation science and improvement science. We agreed that why there seems to be significant overlap, they are quite different. I was happy to see the discussion coming up at the conference when we discussed “are the fields of improvement and Implementation Science converging?” Key similarities and differences between the two fields were highlighted.

Possibly the biggest takehome from the session was the realization that there has been a lack of collaboration between Improvement Science and Implementation Science over time which has hampered the flow of knowledge from research into practice. The team also demonstrated how both sciences have been applied to implement and improve large-scale projects.

The final key lesson I will be sharing for day 2 is on “co-production”. I have been involved in a co-production of care group since April 2020, yet it was another beautiful session with Boel Andersson-Gare, Glyn Elwyn, Valerie James & Sylvie Mantis. They defined co-production as “an approach where clinicians and patients make decisions together, using the best available evidence about the likely benefits and harms of each option, and where people are supported to arrive at informed preferences”. It comprises an intertwining of the patient, the system, science-informed practice, and the professionals. The willingness for both parties to be “vulnerable” was emphasized. Three key questions “patients” and care providers should consider asking themselves after an appointment are:

1. How much effort was made to help you understand your health issues?

2. How much effort was made to listen to the things that matter most to you about your health issues?

3. How much effort was made to include what matters most to you in choosing what to do next?

I did enjoy every bit of it and will be going back to revisit some sessions and watch the videos of those that I missed. I hope you find these summaries useful too.

Balogun Stephen Taiye MBBS, MPH, CSSGB, SMC, PMP, FISQua

ISQua Expert, ISQua Ambassador, Lucian Leape Patient Safety Scholar, WHO Global Patient Safety Network (GSPN) Member

HIFA profile: Balogun Stephen Taiye is a Medical Officer/Quality Improvement Team Leader at the Olanrewaju Hospital in Nigeria. He is also currently a post-graduate student of Public Health and Business Administration. Professional interests: patient safety, healthcare quality improvement, reproducible research, data collection and analysis. He is a HIFA Country Representative for Nigeria and was awarded HIFA Country Representative of the Year 2016.

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[*Note from HIFA moderator (Neil PW): Thank you Stephen for volunteering to represent HIFA for this important event, and for your comprehensive and valuable observations.]

Quality (144A) Digital identity (5) Confidentiality or secrecy? (3)

16 July, 2021
Thanks, Chris. [https://www.hifa.org/dgroups-rss/quality-140-digital-identity-4-confiden...]

There is a good public facing website about these issues at

https://understandingpatientdata.org.uk/

And the February 2021 meeting notes can be found here:

https://understandingpatientdata.org.uk/sites/default/files/2021-03/UPD%...

"Understanding Patient Data aims to make uses of patient data more visible, understandable and trustworthy, for patients, the public and health professionals.

We work with patient groups, charities, NHS organisations and policymakers to bring transparency, accountability and public involvement to the way patient data is used. Get in touch to partner with us.

We focus on data routinely collected as part of a person's interactions with the health service, that might be used for purposes beyond individual care without explicit consent. This data is highly useful for research and planning purposes, by NHS bodies, academics

and commercial organisations, but its use can be controversial.

We provide objective information about how patient data is used and bring the views of patients and the public to policymakers and data holders, to ensure data is being managed and used in ways that are worthy of public trust.

You can find out about our history, governance, funding and supporters on this page, or contact us for more information.

Understanding Patient Data (UPD) is led by a small core team, based at the Wellcome Trust offices in London, UK."

PS I need to reread and check my dystopian novels soon!

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

Quality (144B) Patient experience and health outcomes (9) Accessibility, Affability and Ability

16 July, 2021
At a recent 1969 alumni meeting in London two doctors who had successfully practised private medicine quoted the adage for successful practice as the three "A"s - Accessibility, Affability and Ability - and in that order!

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

Quality (145) National commitment (16) Four questions on national commitment to quality of care

19 July, 2021
Greetings everyone,

I hope everyone is doing good.

I have to say that it is a real pleasure to follow the discussion going on and to learn from each of you.

As you all know, we started discussing national commitment to quality of care last week. I invite you from today to explore more in depth the thematic using the following 4 questions:

1. What are the biggest challenges to enhance national commitment to quality of care in your setting? How can these challenges be overcome?

'A critical early step is for national level leadership to commit to improve quality of health services, for example through high-level official political or policy statements' (p13)

WHO: Quality health services: a planning guide
(2020) https://www.who.int/publications/i/item/9789240011632

We have touched on issues of national commitment in the past week
[https://www.hifa.org/rss-feeds/17]. We now invite you to reflect on barriers to commitment and share your thoughts on what are the biggest challenges to enhance national commitment to quality of care in your setting? How can these challenges be overcome?

2. How can leadership and national commitment to quality of care be sustained?

'Further activities will require ongoing attention to promote the sustainability of efforts' (Quality health services: a planning guide, p19)

Leaders should sustain ongoing advocacy and coordination of national programmes, and address health systems constraints on delivery of quality health services that are not easy to resolve at a facility or district level. We invite you to reflect on ways to keep the momentum to ensure the continuity of the commitment to quality. In other words, How can leadership and national commitment to quality of care be sustained?

3. How can we continuously engage with health systems leaders on quality of care?

'Development and implementation of national strategic direction on quality relies upon active engagement of stakeholders from across all levels of the health system.?' (Quality health services: a planning guide, p14)

Stakeholder and community engagement is required at all levels. An enabling environment is crucial so that every actor is empowered play a role to ensure quality is prioritized, with leadership support. We invite you to reflect on How can we continuously engage with health systems leaders on quality of care?

4. In your context, what is needed from health systems leaders to maintain quality essential health services during public health emergencies (for example the current COVID-19 pandemic)?

Public health emergencies put health systems under pressure and bring their own needs and challenges. Quality health services when delivered can lessen direct mortality from an outbreak and indirect mortality from vaccine-preventable and treatable conditions. Additionally, delivering quality of care before and during an outbreak can enhance trust in the health care system, leading to continued uptake of health services by the community. In your context, what is needed from health systems leaders to maintain quality essential health services during public health emergencies (for example the current COVID-19 pandemic)?

Really looking forward to reading your posts,

Best regards,

Oriane

HIFA profile: Oriane Bodson is a Technical Officer, Quality of Care at the World Health Organization, Geneva. She is a member of the WHO-HIFA Working Group on Learning for Quality Health Services.

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Quality (146) Four questions on national commitment to quality of care (2) Quality and quantity

21 July, 2021
"4. In your context, what is needed from health systems leaders to maintain quality essential health services during public health emergencies (for example the current COVID-19 pandemic)?"

Dear All, if I may ask, does improved quality of care necessarily entail decreased quantity of care? If resources are to be directed towards quality, doesn't that restrict quantity? In the COVID environment, there may be a need to prioritize quantity (eg. quantity of vaccinations delivered) which also prioritizing quality of care at the same time. My experience in resource-limited settings suggests that high levels of quality and quantity are both possible to achieve, but it takes a great effort.

Thanks, Sebastian

HIFA profile: Sebastian Kevany is a former consultant with the World Health Organisation (WHO), Ireland & USA. Professional interests: Global health security and diplomacy. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services Email: sk AT diplomatichealth.com

Quality (147) National commitment (17) More questions!

22 July, 2021
Dear HIFA colleagues,

Thank you for your contributions on issues of national commitment to quality. Please keep them coming. Responses will be collated and synthesised into a Learning Brief on the WHO website, for the benefit of others.

Here are some questions we might consider:

To what extent do you feel that YOUR country is committed to improve quality health services? How does your country demonstrate (or fail to demonstrate) that commitment?

Who is actually responsible for national commitment to quality? What are the relative roles of the government, professional associations, civil society organisations? What other stakeholders are responsible?

If you are a policymaker a public health professional, what are the ingredients that would support you in your efforts to increase the quality of health services? Is 'quality of health services' something that drives you as an overarching concept, or do you apply the concept of quality to individual componenets of the health system as needed?

One of the five principles of quality heal;th services, as described in the WHO Quality Planning Guide, is to support health workers. This is critical, especially at a time when health workers are exhausted and in some cases dying in service as a resul of COVID-19. In the UK, the current government's handling of pay awards is being seen as insulting by the Royal College of Nursing, among others. The NHS risks losing large numbers of experienced staff. At the same time we learn that medical student applications have increased substantially.

I look forward to your comments, whatever your perspective. Quality is a comples and multifaceted issue that benefits from everyone's experience and views.

For background, see: WHO - Quality health services: a planning guide

https://www.who.int/publications/i/item/9789240011632

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (148) National commitment (18)

22 July, 2021
Dear HIFA members,

It is encouraging to read messages from a diverse population on the quality of care in the health sector. Quality of care is a quintessential step towards Universal Health Coverage.

The challenges at the national level for commitment to quality of care are manifold. It includes Finances availability with the stakeholders. No Fund, No Work. Funding from the indigenous sources or local governance are usually sustainable in nature. But, generating a new funding source within local governance is highly dependent on the economy of the geography. Eg. Family Planning is very important for women's health. But, it is observed that there is no funding available as the budget line item in the annual budget cycle. Resultant no service provision for Family Planning.

The second challenge towards commitment is 'INFLUENCERS'. They may belong to a variety of groups and have their own vested interest. They usually sit in the driving seat during the policy making decision process. For eg. Junk food/ trans fat food items are like poison for your health. Look at the number of countries who have actually taken some concrete action against the junk food industry.

Best regards

Sanchika

HIFA profile: Dr. Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international non-government organizations. In 2021, HIFA nominated her as Global Country Representative Coordinator and Social Media Coordinator. She is also a member of the WHO-HIFA working group on Learning for quality health services. She is based in New Delhi, India and can be reached on sanchika12 AT gmail.com https://www.hifa.org/support/members/sanchika

Quality (149) Raising the Quality of Healthcare - Uncharted Ground

22 July, 2021
Our new podcast(s) about raising the quality of healthcare in the developing world are now available, and I'm eager for the HIFA community's feedback! The podcast, called "Uncharted Ground," is hosted by the Stanford Social Innovation Review. The latest episode, called "The

Healing Force of Family," is about Noora Health's work in India, where it trains families of ill patients to aid their recovery--with some remarkable results. The first episode, called "The Videos Saving Lives in the Developing World," was noted on HIFA a few months ago. It profiles Global Health Media (a HIFA member) and the impact of its instructional videos for health workers on the quality of maternal-child care. Please find these episodes at ssir.org/unchartedground -- or go to any of the major podcast platforms you prefer (Apple, Spotify, Google, Stitcher), and search on "Uncharted Ground." Again, we'd be grateful for any feedback you have. [*note from HIFA]

HIFA profile: Jonathan Levine is Zimbabwe Program Director at Wild4Life Health in the USA. Professional interests: Program strategy development, quality of healthcare service delivery in Africa, HIV/AIDS (pediatric), community health workers, program impact evaluation. jblevine100 AT gmail.com

[*Note from HIFA moderator (Neil PW): Apologies to Jonathan, this message got held up a few days before distribution. I had a look at the website and 'Uncharted Ground' looks fascinating. It 'tells the stories of nonprofit and social entrepreneurs at the forefront of global development. Host Jonathan Levine takes you on their journeys to solve some of the most daunting social issues on the planet'. I look forward to read some of the stories!]

Quality (150) Patient Experience and Health Outcomes Patient experience and health outcomes (10) Accessibility, Affability and Ability (2)

22 July, 2021
Reply to Richard Fitton (July 16) on Patient Experience and Health Outcomes
[https://www.hifa.org/dgroups-rss/quality-144-patient-experience-and-heal...]

Within the Patient lens, Fitton makes an excellent point about the three "A' s where the ongoing relevance of the adage could be highlighted by its focus on "affability" as a strategic metric of Quality Care even at the National level and beyond the boundary of *private practice* of medicine.

Yet in 2021, both the conceptualization of "affability" - largely as an individual trait of health care professionals/providers - and most significantly the ranking "order" of the three "A" s which puts "Ability" last on the scale, *need a transformative edit.*

I believe the eight interdependent elements of the national quality and policy strategy approach - as identified in the WHO Guide - present the first set of criteria for this transformation while the overall context for all Key Activities at the national level, namely, the promotion of "*system-wide action on quality"*. in the explanation of Fig.3 (p.12 of the Guide) [*see note below] could be the context of the edit.

Esha Ray Chaudhuri

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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services.

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[*Note from HIFA moderator (Neil PW): Thank you Esha. We encourage all HIFA members to review and comment on 'WHO's Quality health services - a planning guide'. This guide serves as a basis for our current discussion. Download here: https://www.who.int/publications/i/item/9789240011632]

Quality (151) What are the biggest challenges to enhance national commitment to quality of care in your setting?

22 July, 2021
Quality of care is particularly relevant in the context of LMICs such as India, where the health system is highly privatized, and characterised by high out of pocket expenditure, with enormous challenges of regulation and quality of care. It is a system which continues to face challenges of health financing, infrastructure, and human resources among others. India is a country with a wide disparity in socio economic status, so delivering high quality care, for around a population of around 1.3 billion, is itself a dauting task. But as per my view various regulations/guidelines like capping of prices by Insurance Regulatory and Development Authority, Indian public health standards, Accreditation play a vital role in delivering quality of care.

HIFA profile: Manu Gupta is an Independent consultant in India. He is a HIFA catalyst for the WHO-HIFA project on Learning for Quality Health Services. https://www.hifa.org/projects/learning-quality-health-services manugupta08 AT gmail.com

Quality (152) National commitment (19) More questions! (2)

23 July, 2021

Thanks Neil for prompting further discussion on quality and national commitment.
[https://www.hifa.org/dgroups-rss/quality-147-national-commitment-17-more...]

Australia has a very strong commitment to quality health care. As a heath consumer I have observed many instances of doctors, nurses, pharmacists, podiatrists, physiotherapists, radiologists and phlebotomists, paramedics in the ambulance service and health receptionists, ward clerks and orderlies delivering clinically competent, compassionate and technically competent care. I and other health consumers have frequently commented on how much we appreciate and value the care we receive in numerous Australian health settings, not just from clinicians and students receiving training in clinical settings, but from staff such as ward clerks in hospitals, orderlies, cleaners, food servers, chaplains and other support staff.

We have also seen mistakes, some immediately resolved with mutual understanding, and a few that were unsafe and life-endangering and needed complaints procedures to be put in place. Whistle-blowers have identified fraud, deception and other important gaps in quality. Gaps, and structural inequality, influence the delivery of health care. But overall, my experience as a patient is of a huge team of people to whom I am grateful for their service to humanity and their compassion and competence. Recently while walking with my niece behind another pedestrian we read out loud her t-shirt: it indicated she was a doctor working from a truck that roamed my local area caring for homeless people. My niece said she was her hero, and I agreed. So as citizens and health consumers we see quality at the interface between patient and health care provider. We are also aware of how many professionals and auxiliary workers contribute to quality of care - and our debt to working class staff such as cleaners, food servers, couriers, repairmen, IT staff and a cast of thousands whose sometimes invisible work contributes to quality of care. Many health services such as Australia hospitals have roles for volunteers to visit the sick and help in other ways. In a rural community I was invited as a volunteer to make a presentation to nurses at the local area hospital and received support from the medical librarian at the hospital who helped me access references and gave me short-term access to resources to prepare my presentation. Quality is a complex community!

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (153) Patient Experience and Health Outcomes (11) Accessibility, Affability and Ability (3)

23 July, 2021
Esha, I too was surprised by the separate comment by two well respected compassionate alumni with 50 years of medical experience and perhaps 30 years of private practice. Both, I know, were nice and competent guys and I think the affabikity requires a little more scrutiny.

I would suggest that Affability is a guise for compassion, approachability, coproduction of health and caring, not always easy to provide over a lifetime and easily stifled by indemnity and blame cultures.

I have cc'd Dr Neelam Dhingra Kumar of the WHO Patient Safety Plan 2021 to 2030 who may confirm a drive towards patient and community coproduction of health and no blame cultures.

Richard

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

Quality (154) BMJ: Aiming beyond equality to reach equity: the promise and challenge of quality improvement

23 July, 2021
Congratulations to Lisa Hirschhorn (HIFA Catalyst, WHO-HIFA project on Learning for quality health services) and colleagues for this new Analysis paper in The BMJ. I urge everyone to read it and share your observations and comments here on HIFA. What are the implications for our current discussion on Quality? To contribute, please send email to: hifa@hifaforums.org

CITATION: Aiming beyond equality to reach equity: the promise and challenge of quality improvement

BMJ 2021; 374 doi: https://doi.org/10.1136/bmj.n939 (Published 20 July 2021)

Cite this as: BMJ 2021;374:n939

'Quality improvement must move beyond only measuring average quality and change and focus on equity to support achieving the quality needed for effective universal health coverage...'

Key messages

- Poor quality care accounts for more deaths globally than lack of access to care

- Work to achieve universal health coverage therefore needs to consider effectiveness and equity

- Without prioritisation of equity, population level improvements in healthcare may mask those left behind because of economics, gender, ethnicity, or location

- We suggest five key areas where strategies for quality improvement need to tackle inequity: stakeholder engagement, measurement, design, improvement work, and learning

Read in full: https://www.bmj.com/content/374/bmj.n939

Best wishes, Neil

Coordinator, WHO-HIFA project on Learning for Quality Health Services

https://www.hifa.org/projects/learning-quality-health-services

Let's build a future where every person has access to reliable healthcare information and is protected from misinformation - Join HIFA: www.hifa.org

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (155) Sustainable Quality Improvement

23 July, 2021
When sustainability is considered a domain of quality in healthcare, it extends the responsibility of health services to patients not just of today but of the future. This longer-term perspective highlights the impacts of our healthcare system on our environment and communities and in turn back onto population health. A sustainable approach therefore

expands the WHO definition of value to measure health outcomes against environmental and social impacts alongside financial costs.

This would encompass the further elements of quality such as equity, affordability, cost-effectiveness, resilience and dynamic improvement as suggested by other HIFA members.

In this definition the objective of improving quality is to deliver the best possible health outcomes with minimum financial and environmental costs, whilst adding positive social value at every opportunity. This can be visually depicted in the SusQI equation from Mortimer F, Isherwood J, Wilkinson A, Vaux E. Sustainability in quality improvement: redefining value. Future Healthcare Journal, 2018 Vol.5(2):88-93.

Value = [Outcomes for patients and populations]_____

[Environmental + social + financial costs (the 'triple bottom line')]

Some of the team at the Centre for Sustainable Healthcare (www.sustainablehealthcare.org.uk) have been working on Sustainable Quality Improvement for the past 4 years and have now developed a website with lots of free resources.
See www.susqi.org

Rachel Stancliffe, Director

Join our ONLINE Sustainable Healthcare Courses. Click here<https://sustainablehealthcare.org.uk/csh-sustainability-school> to learn more!

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Quality (156) Raising the Quality of Healthcare - Uncharted Ground (2)

23 July, 2021
Thanks Neil! Just a note: These are audio podcasts, not print stories (though transcripts are available). So I hope you and others will LISTEN! [ssir.org/unchartedground]

HIFA profile: Jonathan Levine is Zimbabwe Program Director at Wild4Life Health in the USA. Professional interests: Program strategy development, quality of healthcare service delivery in Africa, HIV/AIDS (pediatric), community health workers, program impact evaluation. jblevine100 AT gmail.com

Quality (157) Patient Experience and Health Outcomes (12)

23 July, 2021
Having been silent for a while because of the wrap up of the academic year...

I still would like to get back to Neil's question of July 1st. 'Many of the contributors to our discussion have emphasised the perspective of patients and the patient experience. Would anyone like to comment on the links between improvement in health outcomes and patient experience?' I would like to comment the following:

1. Patient experience is yet to be incorporated in UHC monitoring efforts. The UHC collaborators have produced an impressive report based on an index of effective coverage of health services in 204 countries and territories (2019; doi: 10.1016/ S0140-6736(20)30750-9). UHC service coverage is merely measured by quantitative indicators, such as crude coverage or healthsystem resource inputs, or a combination of both. The same article indicates: 'WHO and member states have signalled increasing interest in understanding the impact of UHC beyond service coverage alone'. The crude coverage of diabetes treatment does tell us nothing on the quality of care and if the person living with diabetes is able to self-manage his/her disease.

2. Patient reported measures are critical to improve quality of care. Tzelepsis et al have written an interesting article on 'Measuring the quality of patient-centered care: why patient-reported measures are critical to reliable assessment' (2015; doi: 10.2147/PPA.S81975 [https://dx.doi.org/10.2147%2FPPA.S81975]. They make use of the six dimensions of patient-centered care of IOM which states that care must be: 1) respectful to patients' values, preferences, and expressed needs; 2) coordinated and integrated; 3) provide information, communication, and education; 4) ensure physical comfort; 5) provide emotional support - relieving fear and anxiety; and 6) involve family and friends. Their conclusion brings it right to the point: 'Accurate measurement of the quality of patient-centered care is essential to

informing quality improvement efforts. Using patient-reported measures to measure patient-centered care from patients' perspectives is critical to identifying and prioritizing areas of health care where improvements are needed. Patients are well positioned to provide reliable and valid information about the delivery of patient-centered care. For instance, only patients are able to accurately determine whether care was respectful to patients' values, preferences, and needs. Regularly using patient-reported measures to accurately assess the quality of patient-centered care could assist with promptly identifying areas of care where improvements are required and consequently may facilitate advancements to the delivery of patient-centered care.'

3. Qualitative description of primary health care. Weel & Kidd (2018; doi: 10.1503/cmaj.170784) advocate that strengthening of primary health care should be supported by research to improve understanding of how, and to what extent, strengthening can be done under the prevailing socioeconomic and cultural conditions of the country. Thereby specifically mentioning that research should capture characteristics such as continuity of care, person- and population-centredness, prevention, health promotion and support for patient autonomy. This qualitative description should advice policy-makers to appreciate the contributions made by primary health care toward the attainment of universal health coverage.

4. Meaningful involve patients to take action and drive change. The NCD Alliance have come up with an interesting initiative: Our views, our voices (https://www.ourviewsourvoices.org/) By listening to the voice of people living with NCDs, National NCD advocacy agendas have been developed in Kenya, Ghana, Mexico, India, Malaysia and Vietnam https://www.ourviewsourvoices.org/advocate/national-advocacy-agendas

Kind regards, Tineke de Groot

HIFA profile: Tineke de Groot. As a nurse, international public health professional, lecturer and researcher, Tineke has a passion for Universal Health Coverage. She has worked in a variety of primary healthcare settings in South America, Sub-Saharan Africa and the Netherlands and holds a Masters in Public Health from the University of South Africa. She has been a health system advisor on various health projects worldwide. She works in training healthcare professionals at the Christian University of Applied Sciences (Netherlands) to work in low-income settings. She also works for Primary Care International (UK), developing e-learnings on NCD care for healthcare professionals in LMIC. She is a member of the HIFA-WHO catalyst group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email: adgroot AT che.nl

Quality (158) What are the biggest challenges to enhance national commitment to quality of care in your setting? (2)

23 July, 2021
I agree with Manu but I'd like to add that quality of care should be seen to be more than a set of regulations, guidelines, policies or instruments. It should represent a form of “social contract” between the government and its citizens, and should be grounded in legislation that guarantees enforceable claims and holds the government and other relevant stakeholders accountable for delivery.

The role of Civil Society Organisations and communities in achieving and sustaining the above would be indispensable. And even when appropriate legislations are in place, it still takes more effort to move to the level of implementation. Formulating a national policy on quality of care that has legal backing is the next most important step. A strategy to implement the policy on quality of care then follows.

Continuous engagement "with health systems leaders on quality of care" would be achieved if the mainstream health system actors (government & regulatory authorities, professional bodies, care givers/ receivers, CSOs, communities, etc.) across all levels keep to their (statutory) responsibilities and obligations.

Above all, the role of CSOs would be key!

On "what is needed from health systems leaders to maintain quality essential health services during public health emergencies", this would depend not just on the capacity of the health system itself, but also on how well the country is grounded in SOCIAL PROTECTION. There's a limit to what health system leaders can do if the country's social protection is poorly structured and administered. A comprehensive social protection would include at least three major components - social insurance, social assistance and public works. The social insurance component would naturally have implications for universal health coverage. For whatever plan that is done without consideration for universal health coverage (population, service and cost) may be difficult to achieve the desired goals especially during epidemics. In Nigeria, we've seen how low coverage of social protection made adherence to lockdowns measures almost impossible.

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ORFEGA, Moses Kumaoron

HIFA profile: Moses Kumaoron Orfega is a Service Improvement Desk Officer at the National Health Insurance Scheme, Nigeria. Professional interests: Social Protection and Financing; Social Health Protection and Universal Health Coverage; Service Quality Improvement; Information Technology. He is a HIFA catalyst for the WHO/HIFA project on Learning for Quality Health Services. Email: ofegamoses AT gmail.com

Quality (159) Raising the Quality of Healthcare - Uncharted Ground (3)

24 July, 2021

I listened to the Noora episode. The observation about crowded hospitals is very accurate. [https://ssir.org/podcasts/entry/the_healing_force_of_family#] [*see note below]

As someone who has served as a doctor and the medical officer in that setting, I know how overwhelming it can get for the patients, their families and the health care providers. Given the enormous scale of the issue all around the LMICs; every positive initiative to improve quality of care is much needed.

Sincerely,

Shabina

HIFA profile: Shabina Hussain is an independent global health consultant and is based in the USA. Professional interests: Maternal & Child Health, Family Planning, Reproductive & Sexual Health, women's rights, survival of girl child, poverty eradication, Prevention of Infectious diseases. hussain.shabina AT gmail.com

[*Note from HIFA moderator (Neil PW): Thank you Shaabina, it's great to share feedback on resources posted by HIFA members. This paragraph from the website introduces the podcast: 'Even before the onslaught of COVID-19, public health services in many developing countries were chronically strained by a combination of burgeoning populations, severe shortages of trained clinicians, and growing burdens of disease. Noora Health harnesses an untapped resource—the family members of hospital patients in India—by training them in simple medical skills to help their loved ones recover with fewer complications and readmissions once they return home. Noora's standard of caregiving is already helping to restore trust in India's beleaguered public system and may prove to be a critical element in the country's pursuit of universal health coverage.']

Quality (160) BMJ: Aiming beyond equality to reach equity: the promise and challenge of quality improvement (2)

24 July, 2021
It seems surprising and counterintuitive that " - Poor quality care accounts for more deaths globally than lack of access to care." This would suggest that we should stop providing health care? [https://www.hifa.org/dgroups-rss/quality-154-bmj-aiming-beyond-equality-...]

If "work to achieve universal health coverage therefore needs to consider effectiveness and equity" we would suggest continued investment - culturally (Basic assumptions, values, norms and artifacts) in the co-production of health through increasing engagement with citizens and communities at all stages of the planning and intervention of healthcare and health promotion.

Of course, as patient access to records enthusiasts, we see patient access to and contribution to their records as important artifacts of this culture change.

https://www.research.manchester.ac.uk/portal/en/publications/culture-and...(10008a87-a14a-4b0a-8ee2-071f2653aaab)/export.html

Patients and doctors are presenting their hopes for and experiences of patients' access to their records on August 10th 2021 09.00 am PSTime.

Health is not provided by healthcare providers of course, Health is provided by trade, cultures and practices, society, the media, the Arts, nature, the planet and families and citizens.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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Quality (161) What are the biggest challenges to enhance national commitment? (3)

24 July, 2021
Further to Manu's post. [https://www.hifa.org/dgroups-rss/quality-151-what-are-biggest-challenges...]

There is a new citation for Hodges' model in relation to quality of life, maternal health and fragile, low income countries:

Hamilton, E. A. A., Dornan, L., Sinclair, M., McCoy, J., Hanna-Trainor, L., & Kernohan, W. G. (2021). A scoping review protocol: Mapping the range of policy-related evidence influencing maternal health outcomes in a fragile, low-income country. Journal of Advanced Nursing, 00, 1 8. https://doi.org/10.1111/jan.14956

Peter Jones

Community Mental Health Nurse, Tutor & Researcher
Blogging at "Welcome to the QUAD"
http://hodges-model.blogspot.com/
http://twitter.com/h2cm

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

Quality (162) WHO Africa: Home-based care boosts Nigeria's COVID-19 fight

24 July, 2021
Extracts from a news release and a comment from me below. Full text: https://www.afro.who.int/news/home-based-care-boosts-nigerias-covid-19-f...

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WHO Africa Home-based care boosts Nigeria's COVID-19 fight

Home-based care boosts Nigeria's COVID-19 fight

15 July 2021

Lagos – When Zainab Olowoyo got COVID-19, she was one of thousands of people residing in the populous Lagos State whose case was not severe enough for her to be sent to the nearest isolation unit. Instead, Olowoyo received hospital-level care in her own home through a Home-Based Care programme implemented by the state government in collaboration with the World Health Organization (WHO). She had a smooth recovery and was cleared of the virus within 10 days...

During the initial surge implementation phase of Home-Based Care between February and April this year, 1060 people were managed under the programme in six high burden districts of Lagos state without a single death being recorded. This accounted for 81.4% of the total number of cases. The programme was subsequently extended to all 37 Nigerian states and the country's Federal Capital Territory.

"The benefit of the Home-Based Care arrangement in Nigeria is two-pronged; firstly, it is a patient-centred approach to care, and secondly, it frees up limited bed spaces in the treatment centres for the more severe cases of COVID-19," says Dr Comfort Kusimo, World Health Organization (WHO) Incident Management System Coordinator in Lagos state...

Patients like Olowoyo who was asymptomatic or experienced only mild symptoms and had no underlying co-morbidities were managed and monitored entirely in their own homes. In addition to an initial face-to-face evaluation and subsequent monitoring through text messages and phone calls, they were also provided with psychosocial support. If they developed severe symptoms, they were transferred to the nearest isolation centre for further treatment. After recovery, they received follow-up calls for between 14 and 28 days...

"I felt proud to be part of the Home-Based Care programme," says Dr Koseda Omogbemi, one of the medical officers involved. "It helped me to reach and support patients safely and efficiently."

“Home-Based Care has not only helped to reduce the strain on local government resources, but also to alleviate fear and stigma around the virus within the community,” says Dr Rosemary Onyibe, WHO Zonal Coordinator for the Southwest Zone, which comprises Lagos state. “Many people’s understanding of COVID-19 has been significantly improved, and they will now be better equipped to play their part in the ongoing response.”

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Comment (NPW): The provision of 'hospital-level care' at home for patients who are 'asymptomatic or experienced only mild symptoms' is something that no country would be able to provide? We would be interested to hear from our colleagues in Nigeria (especially if you are working with the Home-Based Care programme) and other countries about your experience of home-based care for patients with COVID-19.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (163) Access to essential medicines and quality

24 July, 2021
I have just forwarded this on our sister forum CHIFA (child health and rights) where we are having a parallel discussion on quality. I am sharing also on HIFA, to emphasise the point that 'Failure to provide life-saving treatment [for whatever reason] is clearly grossly incompatible with 'quality health services'.'

Dear CHIFA members,

We are currently in the middle of an eight-week discussion on the HIFA forums on the subject of Learning for quality health services.

This new report from WHO and partners indicates that: 'Almost half (46%) of the world’s 1.7 million children living with HIV were not on treatment in 2020 and 150 000 children were newly infected with HIV, four times more than the 2020 target of 40,000'. Read online: https://www.who.int/news/item/21-07-2021-new-report-reveals-stark-inequa...

Comment from me below.

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New report reveals stark inequalities in access to HIV prevention and treatment services for children—partners call for urgent action

UNAIDS, PEPFAR, UNICEF, WHO, Elizabeth Glaser Pediatric AIDS Foundation

21 July 2021 Joint News Release

Almost half (46%) of the world’s 1.7 million children living with HIV were not on treatment in 2020 and 150 000 children were newly infected with HIV, four times more than the 2020 target of 40 000

In the final report from the Start Free, Stay Free, AIDS Free initiative, UNAIDS and partners* warn that progress towards ending AIDS among children, adolescents and young women has stalled and none of the targets for 2020 were met.

The report shows that the total number of children on treatment declined for the first time, despite the fact that nearly 800 000 children living with HIV are not currently on treatment. It also shows that opportunities to identify infants and young children living with HIV early are being missed—more than one third of children born to mothers living with HIV were not tested. If untreated, around 50% of children living with HIV die before they reach their second birthday.

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Comment (NPW): Failure to provide life-saving treatment is clearly grossly incompatible with 'quality health services'. Availability of life-saving treatment is a key determinant of quality.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Join CHIFA: https://www.hifa.org/join/join-chifa-child-health-and-rights

Quality (164) District-level activities for improving quality health services

25 July, 2021
Greetings Everyone,

I hope you are all doing well.

My name is Treasa Kelleher and I am new to HIFA. I work with the WHO Global Learning Laboratory for Quality UHC. I'm delighted to join HIFA and look forward to participating in the discussions on this forum.

Further to previous posts by colleagues on the thematic discussion 'Enhancing the Quality of Health Services Across Levels of the Health System', please find the below discussion points for your consideration. It is a real pleasure to follow the discussions going on and to learn from each of you.

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The health district is an essential element of a national health system, although its

interpretation depends on country and local contexts. The WHO Quality Health Services: a planning guide refers to ‘district’ as a clearly defined administrative area, where there are local government and administrative structures that take over many of the responsibilities from the national government and where there is a general hospital for referral.

Activities at the district level influence implementation of quality health services at the facility and community levels. The district level is the key interface between health facilities and higher levels, and is responsible for operationalizing national strategic direction on quality. It is at this level that planning, implementation, monitoring and supervision of activities to improve quality of health services in facilities and communities are carried out (WHO Quality Health Services: a planning guide, page 23).

During this 2-week discussion we will expand and build upon the discussion points from weeks 1-4, when we addressed fundamental questions concerning the meaning and importance of quality of care concepts and initiatives, and methods of enhancing national commitment to quality of care.

This next phase of the discussion explores actions required at the district level of the system to improve quality of health services. We now invite you to reflect on the below questions:

From your experience, what are the biggest challenges for district health managers in tackling quality of care issues? Have you seen any practical solutions that should be shared wider?

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I'm really looking forward to reading your posts.

Best wishes,

Treasa.

HIFA profile: Treasa Kelleher is a Specialist Registrar in Public Health Medicine at the Health Service Executive, Ireland. Professional interests: Global Health and Quality of Care. She is a member of the HIFA working group on Learning for Quality Health Services.
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Quality (165) National commitment (20) Accreditation (2)

25 July, 2021
Thank you Manu for your reflections. [https://www.hifa.org/dgroups-rss/quality-151-what-are-biggest-challenges...] In my own country accreditation is a significant and prominent feature of quality in Australian health care and your comments made me stop and think more

deeply as part of this conversation about quality and national commitment. Accreditation bodies are major stakeholders worthy of note in our global conversation about quality and national commitment. I spent some time today trying to clarify my understanding of how various agencies do this in my country (there is a cast of many!), and the role of health consumers in the processes.

The Australian Commission on Safety and Quality in Health Care coordinates the Australian Health Service Safety and Quality Accreditation Scheme (AHSSQAS) which uses national standards.

Accreditation is an independent process which applies these standards. The Australian Council on Healthcare Standards is an independent not-for-profit organisation which engages in continuous review of performance, assessment and accreditation. In Australia patients are called health consumers and information is available to health consumers on the websites of all these players, and makes claim that health services will (among many other things) be evaluated from the consumer/patient perspective. Problems for health consumers in these processes are several, not least of which is navigating the maze of agencies, the complexity of the bureaucracy which manages accreditation and deciphering the bureaucratic-babble. On a positive note, the websites are data rich and if one perseveres with a search it can reveal many gems and insights into quality.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (166) National commitment (21) The role of unions

25 July, 2021

A key stakeholder in Australian quality and national commitment is the vital role played by Australian unions. They make a significant national contribution in several ways: first, they represent health workers working conditions and have actively lobbied for safe levels of staffing of health services that benefits staff and improves safety and quality for patients e.g. the work of Australian nurses union(s). Second: they advocate and promote health issues e.g. recent efforts by unions to protect our universal health care system (Medicare) from erosion by conservative politicians e.g. the work of australianunions.org.au and many unions. Third, they advocate for safe working places, including physical and mental health, promoting workplace opportunities for health and safety representatives in workplaces, and promote occupational health and safety. Australian national unions have promoted

knowledge of workers rights to pandemic leave, access to PPE, vaccination literacy, rights of injured workers and their rights to both protection from injury and risk, and compensation for injury and misconduct by employers.

In both rural and urban Australian settings I have seen the role that Australian unions play in national health commitment.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (167) Free and virtual Business Ethics Forum in medical industries in Asia-Pacific (2)

25 July, 2021
The APEC Business Ethics forum continues in July, with free webinars (a virtual roundtable) on the emerging ethical decisions frameworks for patient data In Chile and in Australia. APEC is the Asia-Pacific Economic Forum, and it is conducting a public forum, online, at various intervals over the next few months. The fora focus on business ethics for the biopharmaceutical industries and medical devices industries at SME level.

For me this is a learning space, and I will attend as much of this as possible to enable my own learning, and prepare a posting to this forum. I have valued Neil's guidance on issues to focus on such as business integrity and ethics as they play a critical role in quality of health care, and if anyone in our learning community can help contribute to my education, your comments and guidance would be appreciated. [*see note below]

Dr Ann Lawless,

Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.

https://www.hifa.org/projects/learning-quality-health-services

https://www.hifa.org/support/members/ann

Quality (168) Free and virtual Business Ethics Forum in medical industries in Asia-Pacific (3)

25 July, 2021
Dear Ann,

Thank you for your comments Ann especially for your willingness to take part in the APEC Business Ethics forum with a view to sharing your observations with HIFA.

I too would be interested to hear from HIFA members about the role of business integrity and ethics in promoting quality of health services. At the negative end of the spectrum is business criminality, including for example manufacture and sale of counterfeit drugs (which are causing untold death and suffering especially in Africa) as well as numerous examples of misinformation by pharmaceutical companies.

An example at the positive end of the spectrum is the collective (albeit highly competitive) effort of biotech companies in developing vaccines for COVID-19. There are many other effects of the private sector on quality of health services. When I consider 'quality health services' I think mainly of services in the public sector - those services that are available to the majority of the population. What is the impact of corporate private healthcare companies for the few on the availability and quality of public health care for the many?

With respect to pharma, I am reminded of HIFA member Massimo Serventi's warning:

'I warn you dear African colleagues: with this trend your Countries will spend more and more for (unnecessary) drugs, your people will be more and more impoverished and resistance to antibiotics will cause deaths, many.

Remember that pharmaceutical companies are mainly in rich countries, they have All Interest to attract your attention, to exploit you once again.

Be concerned, do not leave drugs in the hands of private system without strict-regular-accurate control. There is no ethic in business, and drugs mean money$$.'

Countries with relatively weak health systems are vulnerable to unethical business behaviour. Here is Massimo again:

'What worries me is the poor attention to this phenomenon exerted by local authorities. Pharmacies are all over, they are free to sell whatever is requested by customers. No control, no concern for the poor. Yes, the poor pay much for it: they are induced to pay useless/unnecessary drugs and therefore eroding the little money they have for food.'

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

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Quality (169) District-level activities for improving quality health services (2)

[Note: this entry was numbered as 168 but I have relabeled it 169 since the next entry posted as labeled as 170]
26 July, 2021
On behalf of WHO, Treasa asks "From your experience, what are the biggest challenges for district health managers in tackling quality of care issues? Have you seen any practical solutions that should be shared wider?"

As background, the WHO Quality Health Services: a planning guide refers to 'district' as a clearly defined administrative area, where there are local government and administrative structures that take over many of the responsibilities from the national government and where there is a general hospital for referral.

'Activities at the district level influence implementation of quality health services at the facility and community levels. The district level is the key interface between health facilities and higher levels, and is responsible for operationalizing national strategic direction on quality. It is at this level that planning, implementation, monitoring and supervision of activities to improve quality of health services in facilities and communities are carried out' (WHO Quality Health Services: a planning guide, page 23).

Quality health services: a planning guide
(2020) https://www.who.int/publications/i/item/9789240011632

We would be particularly interested to hear from HIFA members who have experience as district health managers, from any country and especially from low- and middle-income countries. If you do not have such experience yourself, perhaps you may like to forward this to a contact who does have such experience? We need to hear from them in order to learn and help inform future WHO guidance.

Questions that occur to me, and which we might ask to District health managers (and to ourselves) include:

1. What does quality mean to you in your context?

2. How do you measure quality?

3. How important is the concept of 'quality' in your day-to-day work, as compared with other challenges?

4. To what extent is there a culture of quality in your district? How might this be better supported?

5. To what extent does your district operationalise national strategic direction?

6. What support does your district provide to facilities within the district to increase quality? What mechanisms are in place to respond to their needs?

Throughout this discussion, our colleagues at WHO have emphasised the importance of coordination and communication across the three main levels of the health system: national, district, and facility. Being 'in the middle', the district level is critical for this. But how it might work in practice is unclear to me (and I suspect to many of us). For example, to what extent is national strategy directive versus supportive? Are there any examples of countries where strategic direction, operationalisation, support, and deliver of services are clearly in harmony and even synergistic? I might guess that in some settings, levels of quality may be variable and dependent on the aptitudes of specific district health managers (and facility managers)? And what about political and financial factors, whether personal or organisational - how do they affect the quality of health services?

Lots of questions!

Your comments on any of these are welcome, whether or not you have experiences as a district health manager.

Thank you.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (170) Climate change, environment and SDGs

27 July, 2021
Babul raises an important point particularly in the emerging issues context.

[https://www.hifa.org/dgroups-rss/climate-change-environment-and-sdgs]

Here is an appropriate reference for further consideration of the subject within our ongoing reflections on Planning Quality Health Services:

"How Climate Scenarios Lost Touch With Reality"

By Roger Pielke jr., Justin Ritchie

Issues in science and technology

Vol xxxvii no,4 summer 2021 (National Academies of Sciences , Engineering and Medicine)

[https://issues.org/climate-change-scenarios-lost-touch-reality-pielke-ri... *see note below]

Esha Ray Chaudhuri.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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services.

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[*Note from HIFA moderator (Neil PW): Thank you Esha. For the benefit of those who may not have immediate web access, here is the opening paragraph:

'The integrity of science depends on its capacity to provide an ever more reliable picture of how the world works. Over the past decade or so, serious threats to this integrity have come to light. The expectation that science is inherently self-correcting, and that it moves cumulatively and progressively away from false beliefs and toward truth, has been challenged in numerous fields—including cancer research, neuroscience, hydrology, cosmology, and economics—as observers discover that many published findings are of poor quality, subject to systemic biases, or irreproducible.']

Quality (171) Sustainable Quality Improvement (2)

27 July, 2021
Thank you Rachel for making this crucial point: 'When sustainability is considered a domain of quality in healthcare, it extends the responsibility of health services to patients not just of today but of the future. This longer- term perspective highlights the impacts of our healthcare system on our environment and communities and in turn back onto population health. A sustainable approach therefore expands the WHO definition of value to measure health outcomes against environmental and social impacts alongside financial costs.' https://www.hifa.org/dgroups-rss/quality-155-sustainable-quality-improve...

For me, this is true at so many levels and links closely with quality health services:

1. The healthcare industry in general, from the macro level through to specific intereventions, has environmental and other costs that need to be considered in addition to health outcomes

2. A better understanding of these environmental costs - among all those who work in and use the health system - will help drive action to reduce those costs

3. Unnecessary health care (overutilization, overuse, or overtreatment) is a massive contributor to both environmental costs and poor quality health care

4. A national (and district, and facility level) commitment to quality health services is strengthened by a parallel commitment to reduce environmental costs

5. Commitment to quality health services and reduction in environmental costs are fundamentally driven by the same motivation: reduction in human suffering (compassion)

A greater understanding of these links will strengthen our individual and collective capacity to reduce human suffering both now and in the future.

I look forward to learn more from you and others on HIFA.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (172) District-level activities for improving quality health services (3) Harmonisation of quality improvement

27 July, 2021
Good day

"From your experience, what are the biggest challenges for district health managers in tackling quality of care issues? Have you seen any practical solutions that should be shared wider?"

The District level of care forms the link between primary healthcare facilities and national level facilities. It is critical for the implementation of interventions including Quality Interventions. It is expected to be the level at which most of the activities to improve quality of care are planned, implemented and monitored. As such, there is need for capacity at this level to ensure Quality Improvement goals are met in the healthcare delivery system.

One of the challenges cadres at district level face in trying to put in place Quality Improvement is the lack of harmonisation of programming. In the Zimbabwe setting, we have areas such as Maternal Health and Child Health or Pharmacy Services getting resources and support to improve quality relative to other areas. I have also observed that program Quality Improvement Initiatives are run in parallel and operate in silos. There need to move towards ensuring an integrated approach to services and Quality Improvement.

District Health Executives responsible for overseeing the Quality Improvement issues often lack the capacity to fully coordinate these and are also not fully aware of this critical role. There is need for capacity building in quality issues and it may be beneficial to have cadres that are dedicated to quality issues as part of the District Health Executives.

It is critical to recognise that quality improvement requires a multisectorial approach at district level and involvement of the community as some critical amenities such as WASH facilities may be overseen by municipalities or rural district councils but play a pivotal role in ensuring quality of health services. Cadres responsible for quality need capacitation with skills to effectively coordinate stakeholders.

Another challenge with some quality improvement initiatives is that they are linked to partner sponsored programs. When programs are terminated gains in quality are lost. There is a need to remodel how partners support implementation of programs and ensure that there is sustainability and holistic health system improvements. This requires a strengthening of partner coordination and monitoring in conjunction with the national level.

Regards,

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HIFA profile: Venus Mushininga is a pharmacist with the Ministry of Health and Childcare in Zimbabwe. She is a founder and President of the Zimbabwe Society of Oncology Pharmacy and the Zimbabewan delegate to the European Society of Oncology Pharmacy. Professional interests: Oncology, Dissemination of information through to Health Professionals and the public, Research. She is co-coordinator of the HIFA working group on information for Prescribers and Users of Medicines.

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Quality (173A) District-level activities for improving quality health services (4)

27 July, 2021
District-level activities for improving quality health services - Croatia

In accordance with the 'WHO Quality Health Services: a planning guide' [https://www.who.int/publications/i/item/9789240011632], one of the key functions for leadership at the district level is the support to health facilities in achieving stated aims. Furthermore, the guide states how district-level leadership should ensure that the foundational requirements to support quality health services are functional, and at the same time maintain engagement with national level. These are some ideas that were actually considered when Croatia aimed to implement the decentralisation reform during the last couple of decades, which is actually something that all transition countries go through - with an end-goal to suit district-level needs and ensure a health care system that is better, more fair and more efficient.

Accordingly, one of the strives was the change in the ownership of hospitals and primary health care centres, which was transferred to local authorities in order to plan and manage health care on a district level. However, the problem was that the reforms were not based on the problem analyses and resource assessment, but rather on maintaining the framework within which they were implemented. The WHO planning guide highlights adequate resource management as one of the key district-level considerations. Also, there is a need to pose the following question (also formulated in the planning guide): What is required to support management for quality health services?

Consequently, this was partly a haphazard approach that has resulted in a complete change of the essence of the district health system, whereas the given framework imposed limitations on the development and changes instead of fostering them. The situation in Croatia confirmed a huge shortage of relevant policy research and analyses in health care. Such a situation was mostly caused by lack of systematic education about methodology and possible tools for health planning and quality management, which means quality of care goals were still not reached completely. In addition, Croatia is a country with extreme differences between its regions and districts, which also has to be taken into account when the aim is to develop and sustain foundational requirements for quality of care.

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. He is also a member of the HIFA-WHO working group on Learning for quality health services.
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Quality (173B) District-level activities for improving quality health services (4)

29 July, 2021
Dear colleagues,

I wanted to respond to Treasa's questions, From your experience, what are the biggest challenges for district health managers in tackling quality of care issues? Have you seen any practical solutions that should be shared wider?

While I am not a district health worker, I have had the privilege of working with many colleagues in East Africa and Latin America from whom I learned important lessons about how to enable and empower district health managers to tackle quality of care issues. Three insights stand out:

- District health teams need to define specific roles and responsibilities for quality and provide tools and training to those tasked with supporting quality activities at the point of care.

- Quality is not just about compliance with technical standards in public facilities, but must address people's experience of care and community wants and needs. This requires that quality initiatives engage community and civil society stakeholders, as well as the private sector.

- Practical solutions to do this are creating district level mechanisms for regular review of performance and results across the whole sector, with community, civil society, and private sector engagement in these reviews. The meetings should also identify key gaps and develop action plans to address them. The district health management teams which exist in many countries need to lead these reviews and take responsibility for the engagement of broader stakeholders.

Lani

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HIFA profile: Lani Rice Marquez works with the University Research Company and is based in USA. Interests: Quality improvement, knowledge management. Extensive experience with technical writing and editing and facilitation of webinars and peer-to-peer learning activities. She is a member of the WHO-HIFA Catalyst Group on Learning for quality health services.

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Quality (174) District-level activities for improving quality health services (5)

30 July, 2021
Hello HIFA Colleagues,

This is in reference to the conversation Treasa and Lani are having over District-level activities for improving quality health services. I could not agree more what Lani has expressed. In addition to wonderful three points mentioned by Lani, for a sustainable system of quality improvement, I would like to add that it is essential to have an oversight mechanism to ensure continuous compliance to all policies, procedures and practices. Such oversight mechanism would also ensure effective monitoring of review process as mentioned by Lani at point 3.

Over last several years of observing this area of healthcare quality and safety taught us that we start doing a lot but end up with very little as it is short lived for several reasons including what Lani has highlighted. Therefore, consideration of a third party external evaluation process is worth exploring for fulfilling the gap of 'oversight mechanism' as it reviews structures-processes-outcomes on a regular basis. Further, a possibility of setting up an internal mechanism at District level with adequate resources, knowledge and authority can not be ruled out.

The key is how we can make any system 'sustainable' to achieve desired goals.

With regards,

Bhupendra Kumar Rana | MSc PhD PGDHHM MAHA
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Our Vision:

Nurturing the largest global pool of organisations and people through quality improvement and accreditation framework.

HIFA profile: Bhupendra Kumar Rana is Chief Executive Officer of the Quality & Accreditation Institute (QAI), Noida, India. He is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (175) District-level activities for improving quality health services (6)

30 July, 2021
Good day

I agree with Lani Marquez when they say that:

"Quality is not just about compliance with technical standards in public facilities, but must address people's experience of care and community wants and needs. This requires that quality initiatives engage community and civil society stakeholders, as well as the private sector."

Lani draws our attention to critical areas we need to address to ensure quality improvement:

- the experience and perspective of the patient

- involvement of multiple stakeholders including the private sector

- a need for a holistic approach to quality improvement

District managers often face a challenge in engaging the private sector. This is not only in quality improvements but in health initiatives that ultimately lead to delivery of better quality health services.

In Zimbabwe, there is a concept of Private Public Partnerships that is meant to create an environment that allows for collaboration between the public and private sectors. Despite the implementation having had its challenges, it is a critical area district managers may explore to improve quality of healthcare services. Various Public Private Partnerships (PPPs) have led to improved quality care, such as provision of dialysis services for renal patients. Leveraging on PPPs may reduce the strain of resourcing health facilities for certain services. However, monitoring for quality needs to remain a joint effort.

It will be interesting for members to share experiences that have led to improved quality through Public Private Partnerships at District level.

Regards,

Venus Mushininga

HIFA profile: Venus Mushininga is a pharmacist with the Ministry of Health and Childcare in Zimbabwe. She is a founder and President of the Zimbabwe Society of Oncology

Pharmacy and the Zimbabewan delegate to the European Society of Oncology Pharmacy. Professional interests: Oncology, Dissemination of information through to Health Professionals and the public, Research. She is co-coordinator of the HIFA working group on information for Prescribers and Users of Medicines.

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Quality (176) District-level activities for improving quality health services (7)

30 July, 2021
Lani's observations on addressing communities wants and needs were well supported and demonstrated by the use of a community Facebook page by a district matron and district manager during the recent covid vaccination campaign. 3000 citizens joined in a vaccination information and implementation campaign backed up by tannoy messages in a local supermarket, personal texting and messaging through a GP EHR and a national Spine led vaccination personal data base.

https://www.facebook.com/groups/840850043122458/?ref=share

Richard

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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.

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Quality (177) Introduction: Nicole Spieker - Pharmaccess and SafeCare

30 July, 2021
Dear HIFA team

My name is Nicole Spieker and I am part of the catalyst group [HIFA catalyst group on Learning for quality health services]. Here is my introduction for the website:

Nicole Spieker is the Director Quality of PharmAccess [www.pharmaccess.org]. PharmAccess is an international not-for-profit organization dedicated to the strengthening of

health systems in sub-Saharan Africa. Working with local public and private partners, PharmAccess' mission is to create access to affordable, quality healthcare for low income groups. This is achieved through the introduction of standards, the creation of health insurance systems, and provision of affordable loans to private clinics and research and learning. PharmAccess leverages mobile and digital technology to leapfrog health systems strengthening.

Her passion for quality of healthcare in low and middle income countries, has inspired her to launch and lead the SafeCare approach. SafeCare was founded in 2010 by the PharmAccess (Netherlands), the Joint Commission International (JCI, U.S.A) and COHSASA (South Africa). The SafeCare approach is based on internationally acknowledged (ISQua) quality standards and dissects the improvement process of healthcare providers in survey-able, measurable steps. It is based on the firm belief that there should be now compromises when it comes to quality of care in low and middle income countries, and facilities and stakeholders can be inspired to improve despite the challenges they may face. The program is operational in ten countries in over 2500 facilities with public and private sector partners amongst which Lagos State of Nigeria and the MoH&SW in Tanzania.

Prior to this, Dr Spieker was Director of clinical support services at the Aga Khan Health Services, Dar es Salaam, Tanzania and assistant professor at Aga Khan University. She holds a PhD in Molecular Genetics of the University of Amsterdam, The Netherlands.

As part of the HIFA catalyst group, Nicole aspires to share learnings, successes and challenges, as well as learn from other initiatives.

Please feel free to add my contacts listed below

Kind regards

Nicole

Nicole Spieker | Director East Africa – Director Quality | Pharmaccess

n.spieker@pharmaccess.org | phone number +31 647454234 or +254 722932624

BEAT CORONA! ACCESS SAFECARE RESOURCES BY CLICKING ON THIS LINK

https://www.safe-care.org/resources

HIFA profile: Nicole Spieker is East Africa Director for PharmAccess, Kenya. Professional interests: Quality of care; Health systems change; Digital transformation. She is a member of the HIFA catalyst group on Learning for quality health services. n.spieker AT pharmaccess.org

Quality (178) ACP-I Digital exchange [Advance care Planning - Information, 23-25 August 2021]

31 July, 2021
Hello Neil,

Just received this information from a physician friend of mine engaged with Alberta Health Services here in Alberta, Canada.

As a lifelong Stakeholder and Community member engaged in this lifelong Sharing and Learning process about complexities and more importantly *equity challenges of improving the quality of Serious Illness Care* , I wanted to share it with everyone at HIFA as an important aspect of our Quality of Care discourse.Thank you.

Esha Ray C

Canada

PS. ACP as you know stands for Advance care Planning while the " i " denotes information.

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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services.

https://www.hifa.org/projects/learning-quality-health-services

Email address: ed.consult3 AT gmail.com

---------- Forwarded message ---------

Date: Tue, Jul 27, 2021 at 11:34 PM

Subject: ACP-I Digital exchange

To: ed.consult

https://www.acp-i2021.org/

ACP-i 2021

Advance Care Planning International is proud to present the first international Advance Care Planning International digital exchange. Join us for two half days of a rich programme that will spotlight global efforts to push ACP upstream by activating communities and having

ACP conversations before crises arise.

www.acp-i2021.org

Quality (179) District-level activities for improving quality health services (8)

31 July, 2021
"From your experience, what are the biggest challenges for district health managers in tackling quality of care issues? Have you seen any practical solutions that should be shared wider?"

Challenges are many:

Regional managers suffer from underfunding and lower resources than the central level. As a results, must needed investments are insufficient. With the risk of having to close perhaps the only hospital available for the regions, it becomes a daunting task to stimulate quality of care and keep standards compliance.

A devolved health system, can help address this. Regional budgets and local decision making can help empower and invest in what is really needed, and reduce waste. Also, digital innovations are here to stay, and telemedicine and other solutions can help bring additional capacity and quality to leverage the healthcare operational capacity in the region.

Nicole Spieker

HIFA profile: Nicole Spieker is East Africa Director for PharmAccess, Kenya. Professional interests: Quality of care; Health systems change; Digital transformation. She is a member of the HIFA catalyst group on Learning for quality health services. n.spieker AT pharmaccess.org

Quality (180) Introduction: Nicole Spieker (2) GNU Solidario and WHO guideline on digital interventions for health system strengthening

31 July, 2021
Nicole, [https://www.hifa.org/dgroups-rss/quality-176-introduction-nicole-spieker...]

Re Free health software and GNU Solidario, healthcare in low and middle income countries and the ten evidence-based recommendations on the digital health interventions that were prioritized during the scoping process of the WHO guidelines on digital health

// GNU Solidario - Advancing Social Medicine //

I have had the privilege of meeting and corresponding with the GNU Solidario group for half a dozen years. GNU Solidario is a non-profit organization founded by Luis Falcón on 23 November 2009 to promote the use of Free Software in the areas of Public Health and education. GNU Solidario origins are in Argentina, with Free Software projects in the area of education in rural schools. The first mission was on 6 October 2006, in schools from Santiago del Estero.[1] The project at that time was called Linux Solidario.

That event led Luis Falcón to focus on Social Medicine and Public Health, and work with health professionals and governments to improve the lives of the underprivileged. In October 2009, the organization was officially registered in Las Palmas de Gran Canaria, Spain, where currently holds its headquarters.

In 2010, GNU Solidario celebrated the first edition of the International Workshop on eHealth in Emerging Economies - IWEEE -. Since then, IWEEE has been a meeting point for multilateral and humanitarian organizations such as Red Cross, World Health Organization, Médecins Sans Frontières, War Child, United Nations University or Caritas Internationalis, as well as for universities around the world. GNU Solidario has engaged on digital health projects in Cameroon, Gabon, Gambia, Laos, Jamaica, India, Pakistan, Mexico, Argentina, Tanzania and Brazil.

To Quality assure the ten evidence-based recommendations on the digital health interventions that were prioritized during the scoping process of the WHO guidelines on digital health 2019 (1) in LMICs, GNU Solidario are in the process of evaluating the effectiveness, feasibility for health worker for clients/individuals, acceptability for health workers for clients/individuals, resource use and gender, equity and human rights issues of the GNU free Software digital offerings in the GNU digital services implemented in oCameroon, Gabon, Gambia, Laos, Jamaica, India, Pakistan, Mexico, Argentina, Tanzania and Brazil to see how they fit the the ten recommended domains of the WHO.

These ten areas are:

- Birth notification

- Death notification

- Availability of commodities: stock notification and commodity

- Client-to-provider telemedicine (including personal health records)

- Provider-to-provider telemedicine

- Targeted client communication

- Health worker decision support

- digital tracking of clients' health status and services

- digital tracking combined with decision support and targeted client communication

- Digital provision of training and educational content for health workers Recommended

The findings, if completed, will be published.

1. WHO guideline recommendations on digital interventions for health system strengthening WHO guideline: recommendations on digital interventions for health system strengthening

https://www.who.int/publications/i/item/9789241550505

2. 13 Ensuring that published guidelines are current and accurate | Developing NICE guidelines: t he manual | Guidance | NICE

https://www.nice.org.uk/process/pmg20/chapter/ensuring-that-published-gu...

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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Quality (181) Introduction: Judith Arachie, Nigeria

31 July, 2021
Dear sir/ma,

I am a practicing Medical Laboratory Scientist with the Institute of Human Virology Nigeria.

Was introduced to this platform by a colleague, and my interest is in Quality Improvement.

Warm regards,

Judith Arachie.

HIFA profile: Judith Arachie is a Program Officer at the Institute of Human Virology Nigeria, Nigeria. Professional interest: Quality Improvement. judra15 AT gmail.com

Quality (182) Comments on identifying "chasms" in Quality Planning in my email (June 29)

31 July, 2021
Thank you Neil and also colleagues on the Forum for a consideration of the conceptual points I made in my Comments (June 29) about possibilities for the disconnect in Planning process particularly when we consider the “levels” and the “sectors” as individual themes in our ongoing discussion. [https://www.hifa.org/dgroups-rss/quality-68-what-does-quality-care-mean-...]

I look forward to submitting a more informed and cohesive analysis of the inter-sectoral and inter-level gaps in equity - as you suggest - particularly within the lens of minority Stakeholders (citizens and community members of the so-called diverse groups in present day Pluralist societies). I deliberately do not include the adjective, “comprehensive” as an identifier of my intended submission based on the belief that Learning and Sharing, like time itself, does not have a dated shelf life!

The key points in my June 29 Forum Submission related to two themes :

(1) Continuing invisibility of gaps between the local and the global contexts of Quality Concerns and

(2) largely symbolic participation of (lay ?) citizens in most readymade projects of Patient engagement or Patient Partnership.

Thus the invisible “chasms” as potential sources of harm continue to remain invisible except for the normatively excluded, but do present challenges and opportunities for everyone else, ie, how do we collectively, policy makers, planners, professionals, participants (citizen, community member, patients, family caregivers to name a few):

(a) revisit our prevailing equity norms and more importantly critically examine the assumptions that are at their base and

(b) focus on transformative initiatives to eliminate these continuing sources of harms to patient safety everywhere and more broadly to address our collective Quality of Care concerns.

A cursory check of the messages in the HIFA Summary (July 30) indicate promising approaches of “holistic oversight“ (Rana, India, July 30) and benefits of the P3 projects (Mushininga, Zimbabwe, July 30), both adding support to original points made by Lani (July 29) in the Forum. I am especially hopeful to find mention of “Ethical Considerations” engaging references to renowned IDS and NIHR resources on CEI or Community engagement / Involvement in Global Health research (Tom Barker, IDS, UK, July 30) !

We certainly are leading from the Future in our Global Learning-HIFA quest !

Esha Ray Chaudhuri

Calgary, Alberta, 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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

Quality (183) District-level activities for improving quality health services (9) Management skills of district health leaders

1 August, 2021
Good day

Are District Health Executive Teams aware of and capacitated for their role in ensuring Quality Health Service Delivery? Are there any resources available to help capacitate them? Is there any evidence, published research that document challenges faced by District Health Executives in implementing Quality Improvement initiatives?

It will be good if members could share their experiences and/or observations, publications that address the above questions.

An example of a study which sought to answer the question of the capacity of District Health Executives to execute their role was done in Zimbabwe by Muchekeza, et al; titled "District health executives in Midlands province, Zimbabwe: are they performing as expected?"

and is available on the link below:

http://www.biomedcentral.com/1472-6963/12/335

One of the findings of the study was that:

"Almost all (29/30) district health managers interviewed reported having inadequate management skills to effectively undertake their management responsibilities."

The researchers identified that:

"The poor performance could be attributed to a number of factors namely lack of management training among district health services managers, poor team work, inadequate resources, lack of induction onto the job and lack of knowledge on DHE functions among managers."

The study concluded that

"Lack of management training was the major contributing factor to the poor performance by District Health Executives in Midlands Province."

Are these findings similar to those in other countries? Have they been any successful interventions to cover this gap?

Have any countries successfully used resources available on the WHO website below to capacitate District Health Executives.

https://www.afro.who.int/publications/district-health-management-team-tr...

Thank you.

Regards,

Venus Mushininga

HIFA profile: Venus Mushininga is a pharmacist with the Ministry of Health and Childcare in Zimbabwe. She is a founder and President of the Zimbabwe Society of Oncology Pharmacy and the Zimbabewan delegate to the European Society of Oncology Pharmacy. Professional interests: Oncology, Dissemination of information through to Health Professionals and the public, Research. She is co-coordinator of the HIFA working group on information for Prescribers and Users of Medicines.

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Quality (184) District-level activities for improving quality health services (10) Policy development at State/Province level

1 August, 2021
Joining the discussion about District level Activities for QI

In India different States such as Tail Nadu and Uttar Pradesh have started developing their State Level Quality Policy. The policies have been framed with a wide consultative process at State headquarters, district headquarters and with technical support of World Bank and WHO.

The purpose of such policy is to reflect quality definition, quality Mission, Vision and Strategies with a clear reflection of local issues, and resources available. and Finally the activities of these policies is expected to be linked with State's annual budget so that the measures planned in the Quality Policy is implemented

I was wondering if :

1. such practices are common in other countries at State/Province level?

2. what mechanism is available to ensure implementation of such policies?

For May I request to give your reflection on the following monitoring of the Quality initiatives

With regards,

Santosh

Service Excellence
Perfect Care Requires Perfect Service

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HIFA profile: Santosh Kumar is an Associate Professor at the Institute of Health Management Research in India. He is involved in many projects on strengthening HMIS in India. Professional interests: working for strengthening the quality of healthcare through effective health information management systems. Santosh is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (185) QAI Journal for Healthcare Quality and Patient Safety

1 August, 2021
Dear All,

QAI Journal for Healthcare Quality and Patient Safety is pleased to invite you to submit articles. The journal covers technical and clinical studies related to health, ethical and social issues in field of Governance and Leadership, Quality Improvement, Accreditation/ Certification, Performance monitoring, People centric care, Quality culture, Patient safety (Infection prevention & control, medication safety, patient safety solutions, diagnostic safety, WHO initiatives etc.),Universal Health Coverage,. Articles with clinical interest and implications will be given preference.

QAI Journal for Healthcare Quality and Patient Safety, a publication of Quality and Accreditation Institute Pvt. Ltd, is a peer-reviewed print + online Semiannual International journal. The journal's full text is available online at http://www.QAIJ.org. The journal allows free access (Open Access) to its contents and permits authors to self-archive final accepted version of the articles on any OAI-compliant institutional / subject-based repository. Journal is published by Wolters Kluwer-Medknow.

Abstracting and Indexing Information

The journal is registered with the following abstracting partners:

Baidu Scholar, CNKI (China National Knowledge Infrastructure), EBSCO Publishing's Electronic Databases, Ex Libris – Primo Central, Google Scholar, Hinari, Infotrieve, Netherlands ISSN centre, ProQuest, TDNet, Wanfang Data

With regards,

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Our Vision:

Nurturing the largest global pool of organisations and people through quality improvement and accreditation framework.

HIFA profile: Bhupendra Kumar Rana is Chief Executive Officer of the Quality & Accreditation Institute (QAI), Noida, India. He is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (186) Business Ethics Forum in medical industries in Asia-Pacific (3) The role of private sector and ethics issues in health care

1 August, 2021
APEC is the Asia-Pacific Economic Community, a coalition of 21 nations which work cooperatively on relevant common issues across the region. In 2021 the Business Ethics Forum of APEC is conducting a series of virtual and open access meetings over four months rather than a face-to-face conference in a short period of time, and focusing on SME's (small and medium sized enterprises). More specifically they are discussing the emerging business ethics frameworks for two private sector players, the biopharmaceutical industry and the medical devices industry. The Forum has given me a unique opportunity to learn about the private sector in this region (the Pacific bordering nations), and to contemplate how it might be relevant to our global conversation about quality and health services; and to reflect on how it is relevant to patients or health consumers.

The approach to, and tone of, the conversations at the APEC Business Ethics Forum has been a positive one, with emphasis on ethical and proper conduct of small to medium sized enterprises in the private sector. The two threads so far are that they are reviewing some ethics work done a decade ago in the two sectors (so two revised and refreshed statements) - and secondly, developing and releasing to the international public the newly developed (and emerging) various national consensus frameworks for ethical decision making.

In what I refer to as their first thread, the previous work which they are now updating is the APEC Mexico City Principles (2012) for the Biopharmaceutical Sector and the APEC Kuala Lumpur Principles (2011) for the Medical Device Sector. I understand these will be released later this year, in the plenary of the Forum (likely to be October 2021).

In what I refer to as their second thread, nine of the APEC nations are releasing their Consensus Frameworks, launched in webinars which are part of the Forum. So far (August

1st 2021) Canada, Chile and Australia have released their consensus frameworks on ethics for the private sector. For example, the APEC Chilean Consensus Framework is based on five principles - transparency, independence, equity, respect and austerity. They argued that good policy accompanies good relationships, fosters trust between citizens, governments and the private sector (and other stakeholders), making citizens more aware of both public and private sectors, citizens who lobby for transparent and accountable private sector players. They argued that ethics means a better health care system; and that collaboration among stakeholders is an ethical imperative. In another example, the APEC Australian Consensus Framework was launched in a webinar on July 28th 2021, and in an hour there was some interesting brisk conversation between health consumer representatives and the presenters, and acknowledgement that such conversations among stakeholders can be difficult sometimes, that trust is not easily gained and that risk of a voluntary ethics code is tokenism. However there was also a sense that the discussion is vitally important, it moves us forward on difficult ethical conversations and that all stakeholders can be welcomed into the conversation. The Australian presenters also acknowledged that their effort is a work in progress which has only just started and with a long journey ahead. I was left with the feeling that this is indeed an important process and an important document is emerging.

The process of releasing the national consensus frameworks continues over the next few months, with further webinars and conversations in September and October 2021. So far the process has been positive and there has not been attention to unethical and bad behaviour or case studies.

From what I have seen so far each framework draws on the unique profile and experiences of the nation and private sector agents that developed them, so each has a unique national character. I also have been impressed with the genuine welcome offered to participants at the webinar, including patients, and the positive and genuine engagement with ethical behaviour and conduct by those who have developed the frameworks. The ethical engagement with patients appears to be genuine and is clearly stated in the Consensus Frameworks released so far.

The positive tone is persistent, and also noteworthy is that the ethics consensus is a consensus - there is no obligation, nor legally binding matters, in the frameworks and therefore limited regulation of the activities of the private sector. Agreeing to the framework is voluntary and is based on a seeking compliance between the private sector and other stakeholders through mutual agreement and conversation.

Dr Ann Lawless,

Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.

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Quality (187) District-level activities for improving quality health services (11) Why we need to focus on the district level

1 August, 2021
Hi

Joining a bit late but welcoming a community so committed to improving quality. Often QI works to change an individual or facility, but as we focus on strengthening primary care, where the 5 Cs (first contact access, people centeredness, continuity, comprehensiveness and coordination), the need to expand the work to look at the inter-related system which is needed to provide that care. Take as an example neonatal health - the primary care system is needed to prevent complications as much as possible - access to quality family planning, effective ANC and respectful maternity care in a staff and stocked facility, many of which rely on the management capacity of district leaders, and the needed supportive supervision. But what happens if the baby is born premature and requires higher level of care? The infant requires a district level approach to not just the care, but the referral system, coordination and continuity. This is why the guidance in the chapter on District level ongoing activities in the WHO Quality health services: a planning guide is so important - the role to focus on improving quality in the facilities but also across the system. While not often a focus of health system strengthening, the call our for management as critical to achieve the goal of quality is important-

What does the management system for quality health services look like at the district level?

What is required to support management for quality health services?

What additional resources are needed to support district-level aims and goals for quality health services?

What do mechanisms to review performance of QI interventions look like?

What stakeholders are involved in these mechanisms?

What has been others experience in measuring and improving management to drive the needed QI at the facility and district levels?

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Quality (188) District-level activities for improving quality health services (12)

1 August, 2021
Dear HIFA colleagues,

Thank you everyone for your contributions to the discussion so far. We are now entering week 6 and we have already exchanged 185 messages from 60 members in 25 countries (Australia, Cambodia, Cameroon, Canada, Croatia, DR Congo, France, India, Iraq, Ireland, Kenya, Malawi, Mexico, Mozambique, Nepal, Netherlands, Nigeria, Singapore, Sudan, Switzerland, Tanzania, Trinidad and Tobago, UK, USA, Zimbabwe).

Our guiding question from the WHO Global Learning Laboratory is: WHAT ARE THE BIGGEST CHALLENGES FOR DISTRICT HEALTH MANAGERS IN TACKLING QUALITY OF CARE ISSUES? HAVE YOU SEEN ANY PRACTICAL SOLUTIONS THAT SHOULD BE SHARED MORE WIDELY?

Below are some examples of points made in recent messages. I invite HIFA members to pick up on any of these and share your thoughts to: hifa@hifaforums.org

#68. Esha Chaudhuri, Canada: "These intersectoral and inter-level dynamics need critical consideration to prevent (harmful) miscommunications about the aspects of Quality Care among the Stakeholders"

Would anyone like to comment on coordination and communication across the three levels of the health system? (National - District - Facility)

What about engagement with stakeholders?

#133. Stephen Balogun, Nigeria. "Regarding the power curve in the health sector, how well would you say your local, district/state, regional or national level has transited to ceding

power to the patients? What has been the experience in your setting?"

What do we mean by 'ceding power to patients'?

#169: Neil Pakenham-Walsh, moderator

1. How important is the concept of 'quality' in your day-to-day work, as compared with other challenges?

2. To what extent is there a culture of quality in your district? How might this be better supported?

3. To what extent does your district align with national strategic direction?

4. What support does your district provide to facilities within the district to increase quality?

#171. Rachel Stancliffe, UK. 'When sustainability is considered a domain of quality in healthcare, it extends the responsibility of health services to patients not just of today but of the future." Neil: Rachel is a pioneer working to reduce the environmental impact of the UK National Health Service. To what extent does the health system consider the environmental costs of it work?

#172. Venus Mushininga, Zimbabwe. "One of the challenges cadres at district level face in trying to put in place Quality Improvement is the lack of harmonisation of programming. In the Zimbabwe setting, we have areas such as Maternal Health and Child Health or Pharmacy Services getting resources and support to improve quality relative to other areas. I have also observed that program Quality Improvement Initiatives are run in parallel and operate in silos. There need to move towards ensuring an integrated approach to services and Quality Improvement." Neil: Venus raises an important point: To what extent is quality a continuous thread versus fragments of activity that exist only within some areas of the health system?

#173 Lani Marquez, USA. "District health teams need to define specific roles and responsibilities for quality and provide tools and training to those tasked with supporting quality activities at the point of care." Indeed, how are roles defined and supported?

#183 Venus Mushininga, Zimbabwe: "Almost all (29/30) district health managers interviewed reported having inadequate management skills to effectively undertake their management responsibilities."

#174. BK Rana, India. "I would like to add (to Lani) that it is essential to have an oversight mechanism to ensure continuous compliance to all policies, procedures and practices."

Review messages in full: https://www.hifa.org/rss-feeds/17

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (189) Continuous quality improvement to reach 95:95:95 HIV targets

1 August, 2021
Citation, abstract and comments from me below.

CITATION: Memiah P et al.Continuous quality improvement (CQI) Institutionalization to reach 95:95:95 HIV targets: a multicountry experience from the Global South. BMC Health Services Research. 21(1):711, 2021 Jul 20.

Abstract

BACKGROUND: Scaling up continuous quality improvement (CQI) processes could be key in achieving the 95:95:95 cascade and global HIV targets. This paper describes the experiences and outcomes related to implementing CQI processes to help reach these targets, with particular focus on clinical and programmatic settings in 6 countries from the global south.

METHODS: The HIV program at the University of Maryland, Baltimore (UMB) implemented an adapted CQI model in Kenya, Tanzania, Botswana, Zambia, Nigeria and Rwanda that included the following steps: (1) analysing the problem to identify goals and objectives for improvement; (2) developing individual changes or 'change packages', (3) developing a monitoring system to measure improvements; and (4) implementing and measuring changes through continuous 'plan-do-study-act' (PDSA) cycles. We describe country-level experiences related to implementing this adaptive design, a collaborative learning and scale-up/sustainability model that addresses the 95:95:95 global HIV targets via a CQI learning network, and mechanisms for fostering communication and the sharing of ideas and results; we describe trends both before and after model implementation.

RESULTS: Our selected country-level experiences based on implementing our CQI approach resulted in an increased partner testing acceptance rate from 21.7 to 48.2 % in Rwanda, which resulted in an increase in the HIV testing yield from 2.1 to 6.3 %. In Botswana, the overall linkage to treatment improved from 63 to 94 %, while in Kenya, the viral load testing uptake among paediatric and adolescent patients improved from 65 to 96 %, and the viral load suppression improved from 53 to 88 %.

CONCLUSIONS: Adopting CQI processes is a useful approach for accelerating progress towards the attainment of the global 95:95:95 HIV targets. This paper also highlights the value of institutionalizing CQI processes and building the capacity of Ministry of Health (MoH) personnel in sub-Saharan Africa for the effective quality improvement of HIV programs and subsequent sustainability efforts.

COMMENTS (Neil PW):

1. I would be interested to understand more what 'quality improvement processes' are. The description above seems to be standard project implementation practice?

2. The above, by definition, focuses on one narrow set of outcomes (HIV targets). This reminds me of Venus Mushininga's point about quality improvement being siloed into separate health areas, and largely dependent on fragmented funding. She refers to the need for harmonization, which could perhaps risk being undermined by specific projects such as this?

3. The word 'district' is not mentioned in the paper. How is the district level supported and aligned in such projects?

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (190) District-level activities for improving quality health services (13) The health system in Nigeria

2 August, 2021
"What does the management system for quality health services look like at the district level?"

In Nigeria, the most populated country in Africa, about 206 Million people (it is said that 1:4 Africa is a Nigerian) the health statistics have not been favourable for a very long time, and actually that affects the continental picture: the health and wellbeing of Nigeria's population is significant in shaping the health indices of the continent, but partly because of the confusion or non functioning of the stated organization of the health system into tier-levels, the stats have remained very poor (even with some slight improvements in the last 5 years).

In the country, it is reported that there is a three tier system - 'primary heealth care (PHC)' under the local governments, the 'secondary care tier (General and Cottage Hospitals) under the States (36 States) / Federal Capital City, and the 'tertiary tier' level (Teaching Hospitals, Federal Medical Centres, Specialist Hospitals) mostly owned by the Federal Government. But there too much blurring of those lines because the 'District' can in reality be said to include both 'secondary' and 'primary health care' tiers, and therein lies the confusions because the two tiers are under different levels of government. So, how is care coordinated, who is in-charge of true ownership, administration, supply and replenishment, staffing, pay and conditions, and most importantly, who assures quality and safe care!.

In addition, the 'secondary care' (General hospitals) are essentially curative in design and operation, whilst the 'primary health care' (at least the one designed by the Late Professor Ransome Kuti, Minister of Health at the time, immediately following the Alma Ata Declaration in 1978) are supposed to be mainly promotive and preventive, only involved in curative and rehabilitation to lesser degrees. But at present, the 'division of roles' is theory, mainly because of poor delineation of roles between governments, poor overall financing of health across board and even then, about 60-70% of the allocation to health goes to the

tertiary level hospitals which are in the minority, more expensive to manage, elitist for a poor country people, remote and inaccessible from the rural areas where about 80% of the population reside and work.

"What is required to support management for quality health services?"

There are many things required for quality health services in the districts (General Hospitals and primary health centres) in Nigeria, beginning with better definition of roles, enacting those roles in Laws with clarity, implementing the Laws, improved funding for health at least to the level recommended in the Africa Union (AU Declaration) 2000: African countries should allocate at least 15% of their annual budgets to health. Reports have it that only Rwanda has achieved that level of fundimg consistently. But, Nigeria is not only the most populated country in the continent it also has the largest GDP. It needs to do a lot more beyond announcing that it ‘wants to strengthen and improve health care for All Nigerians’. That requires actual Political Will, not mere broadcasting of the idea.

"What additional resources are needed to support district-level aims and goals for quality health services?"

In addition to the above, the country also needs to look at the training curricular of its pre service and undergraduate health training institutions and bring them up to the 21st century, make them focus on ‘empathy, problem solving and clinical governance knowledge and skills’. Students in these institutions should graduate already thinking and talking and practicing quality and safety. The current curricular are not doing that, whether you look at Medical Schools, or Colleges of Health Technology, or Schools of Nursing and Midwifery, because they were not designed for Today’s health systems and practitioners, talk less of the Future.

There are mechanisms (Tools) which have been localized / domesticated for the Nigerian Health System and are currently being applied in both private and public owned facilities: the ‘12-Pillar Clinical Governance Programme’ for a whole health system strengthening approach and the PACK (Practical Approach to care Kit) for primary Health Care.

"What do mechanisms to review performance of QI interventions look like? What stakeholders are involved in these mechanisms?"

Both a robust ‘communications strategy (CS)’ in which there is community and user buy-in and partnership, and the ‘supportive supervision, mentoring and continuous monitoring and evaluation (SSMM&E)’, ensure consistency and continuity, learning and applying lessons learnt as the programmes are implemented.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association

(NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
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Quality (191) Empowering patients to self-manage their disease, patient support groups, health worker training

2 August, 2021
Dear all,

1. Regarding:

#133. Stephen Balogun, Nigeria. "Regarding the power curve in the health sector, how well would you say your local, district/state, regional or national level has transited to ceding power to the patients? What has been the experience in your setting?"

What do we mean by 'ceding power to patients'?’

In Kenya I was involved in NCD patient support groups, that served to:

Patients sharing their (disease) experiences and thereby creating peer education

Patients understanding their disease better, leading to higher levels of self-management

Peer support for lifestyle changes (diet and exercises)

Better treatment compliance

So, overall empowering patients to self-manage their disease and leading to better health outcomes.

COVID-19 has disrupted patient support groups; patients not being able or afraid to gather and PHCs settng other priorities. Thereby I would like to confirm the need for digital innovations and telemedicine (as mentioned by Nicole Spieker), e.g. apps that are compatible to low bandwidth and low connectivity and that would serve the benefits of patient support groups as mentioned above.

2. Regarding:

#173 Lani Marquez, USA. "District health teams need to define specific roles and responsibilities for quality and provide tools and training to those tasked with supporting quality activities at the point of care." Indeed, how are roles defined and supported?

I agree that training health care workers in Primary Health Care is key towards improvement of quality health services, which is the core business of Primary Care International (https://pci-360.com/). Defining and supporting roles could be part of a participatory training.

However, what I have seen in practice and is described in literature:

Participants often return from trainings motivated, but behaviour is not applied back at the workplace, because…

Training does not meet job requirements

Length of time between learning and application

Lack of support from management and/or working environment (https://wecanproject.eu/index.php/en/intellectual-outputs/methodological...)

As stated in the WHO document on Evaluating Training (2010). For a learning organization, learning is an ongoing process.

‘A training workshop may be an intense learning experience, but it should never be the only learning that is happening. People continue to learn throughout their working lives, but they will learn far more readily and more relevantly if they are trained, coached, given feedback, advised, encouraged, and if it is acknowledged that they are improving their work performance, that their team is improving its output, and that they are contributing to the achievement of a valued goal.’
(https://apps.who.int/iris/bitstream/handle/10665/70552/WHO_HSE_GIP_ITP_2...)

Specifically at district level I would like to advocate for teams that are able to learn interdisciplinary under the support of the management and the working environment.

Kind regards,

Tineke de Groot

HIFA profile: Tineke de Groot is Senior Lecturer of Nursing at the Christian University of Applied Sciences in the Netherlands. Professional interests: International Public Health, Child health. She is a member of the HIFA-WHO catalyst group on Learning for quality health services.

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Quality (192) Empowering patients to self-manage their disease (2)

2 August, 2021
Extracts below from the CEO of the International Alliance of Patient Organisations. Full text: https://www.iapo.org.uk/news/2021/jul/22/patient-empowerment-can-unlock-...

'Self-care activities are an essential component of patient-centered health care systems. The World Health Organization defines self-care as “the ability of individuals, families, and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider.”...

Promoting empowerment as a process, governments and health systems can drastically facilitate the adoption of self-care practices. A few critical steps include: 1) making national commitments to improving health literacy; 2) allowing patients to access their own health records easily — ideally, in digital form — to increase their knowledge of their own health conditions and readily pull up details on diagnosis and treatment plans; and 3) including modules on health, hygiene, and first aid in public school curricula.'

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org Self-care activities are an essential component

Quality (193) District-level activities for improving quality health services (13)

2 August, 2021
Dear HIFA,

I would like to share you below note for the discussion on the district level quality health service for your review and posting.

The role of district level structure for improving quality of health service depends on their respective responsibility in the tier of health service delivery: primary, secondary and tertiary levels. Often districts have role for the primary level service delivery which is at the base of the pyramid and involves community level services. The activities in this regard involve

capacity building, supportive supervision, monitoring and auditing in relation to service deliver standards, recognition of best performing facilities and support in structure and infrastructures including provision of WASH facilities.

The sub-national and province structures could have wide-ranging roles in relation to the service delivery tier depending on the country contexts. The WHO quality of care planning guide [https://www.who.int/publications/i/item/9789240011632] highlights five foundational requirements for quality health services: onsite support, measurement, sharing and learning, stakeholder and community engagement and management, which are applicable to all levels of the structure.

Regards,

Kebede Eticha

HIFA profile: Kebede Eticha is a PhD candidate and has over 10 years experience working for UN agencies and INGOs as consultant in the fields of WASH and IPC in development and humanitarian program contexts. He is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (194) District-level activities for improving quality health services (14) WHO Discussion points

3 August, 2021
Greetings Everyone,

I hope you are all having a good week.

Further to my post last week on the thematic discussion 'Enhancing the Quality of Health Services Across Levels of the Health System', please find the below discussion points for your consideration.

1. District management leadership and teams facilitate and ensure that quality of care activities are prioritized, supported and delivered at the point of care. Activities at the district level should be coordinated with national and facility-level authorities to ensure coherence and strengthening in the delivery of quality health services designed to meet the needs of the people (WHO Quality Health Services: a planning guide, page 23).

Now that we have touched on the challenges encountered by district health managers in tackling quality of care issues, we invite you to share your experience with respect to an example of district teams leading change for quality health services across health facilities in their district? What actions were taken?

2. District-level structures and operational plans play an important role in setting out implementation of quality health service activities (WHO Quality Health Services: a planning guide, page 25). This role is even clearer and visible during public health emergencies when the system faces significant challenges. We have already explored what is needed from health system leaders to maintain quality during public health emergencies at the national level.

We now invite you to explore the issues at the district level and to consider the following question: In your context, what is needed from the district-level to maintain quality essential health services during public health emergencies (for example the current COVID-19 pandemic)?

3. Stakeholder engagement at the district level - including heallth providers, civil society and communities, academic and professional associations, cooperating partners and other decentralized services such as WASH and housing authorities - is critical for quality health services. This engagement should be ongoing and continuous. Moreover, stakeholders involved in the national health sector planning process should be attentive to activities, challenges and competences at the district level (WHO Quality Health Services: a planning guide, page 23).

In your opinion, how can we encourage and support district leaders to engage with the full range of stakeholders? What should be done at the district level to ensure multi-level coordination with the national level and the facility level to enhance quality of care?

As always, I look forward to reading your posts and following the discussion.

Best wishes,

Treasa.

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Quality (195) District-level activities for improving quality health services (15) Quality and management skills

3 August, 2021
Dear Nisha Bhatta

Thank you for your message on CHIFA (our sister forum on child health) where you say 'the biggest challenges for district health managers in talking quality of care are due to lack of trained personal and equipment... trained personal, equipment and motivated workers are key for improving quality care at district level in my country [Nepal].'

I would like to ask you and others on HIFA/CHIFA:

Improving the quality of health services in low-resource settings is arguably more about meeting the basic needs of health workers and thereby empower them to carry out their work effectively and safely, than it is about setting quality goals and incremental quality improvement?

To what extent can district managers in such settings work in terms of quality improvement versus the daily challenges of meeting basic needs?

Put another way, quality cannot be separated from good management practices.

The aim would be to improve quality improvement *and* improve the effectiveness of broader leadership and management skills. How can quality improvement approaches be better integrated into the broader context of good management practices? A quality improvement approach will not be effective if other aspects of management are inadequate.

We heard from Venus Mushininga about a recent Zimbabwe study that found: "Almost all (29/30) district health managers interviewed reported having inadequate management skills to effectively undertake their management responsibilities." (of course, self-reporting of skills is highly unreliable - there is no reason to think the one person who reported having adequate skills was any more competent than the others!)

How can a quality approach be embedded within general support for management skills?

Best wishes, Neil

Join CHIFA (child health and rights): http://www.hifa.org/joinchifa

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Quality (196) District-level activities for improving quality health services (16) Quality and management skills (2)

3 August, 2021
We (Cross River State Ministry of health management team in 2004) defined the 12-Pillar Clinical Governance Programme, briefly as 'Protecting patients, supporting practitioners in tandem' for the reason that quality improvement to ensure better care outcomes must go hand-in hand with supporting the provider / care giver. Leave out one and you cannot achieve quality care. The support of the care givers includes capacity building in people and materials leadership and management for optimum deliverables.

At least that had been our experience including during scale up across more states in the country.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

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Quality (197) District-level activities for improving quality health services (17) Australian case study of role of district health issues

3 August, 2021
Quality - Districts - Australian case study of role of district health issues

Part A

As mentioned in my previous case-study style contribution to the quality conversation, Australia has a universal health care system which is two-tiered - a public tier and a private one. Australia's universal health care system is made more complex by our Federal constitution. Australia has three levels of government - a commonwealth or federal government; state and territory governments; and local government bodies (sometimes called councils, municipalities or shires). Each of these three levels of government are players in our universal health care system where they act as governors of health service delivery and health research. However they are not just three layers but intersect (and cooperate and squabble). In terms of the WHO definition of districts, both state/territorial government and local government appear to fit the definition [*see note below]. The Federal Parliament has some exclusive powers (where only it can make law) and concurrent powers (those shared with 6 state and 2 mainland territories), and of course this is an influence on Australian district descriptions of quality and health care. Health is a mix of exclusive and concurrent power (and it gets complex and cumbersome) - the universal health care is an exclusive power of the Federal government but states and territories manage hospitals and ambulance services. The Australian Constitution rules that conflicts in law - e.g. health law - is resolved by Federal law over-riding the states. This defines and limits "districts" power and influence.

Australia has a constitution but does not have a Bill of Rights or Charter of Rights, a serious gap in our attention to rights-based policy and human rights-based models of health and health citizenship. For health consumers it means we have the imagination but in reality very limited legally-enforceable capacity to argue for human rights based approaches to health, either federally or in the states and territories (that is, at district level), because the formal instrument we need to strengthen our lobbying efforts - a Bill of Rights at national and state level - is not available. A few states have introduced a Bill of Rights but they have limited scope and power. This also defines and limits what health consumers can achieve when working within districts.

States and territories (Districts) in Australia are important players that contribute unique features to the quality of our universal health care system. Each level of governance also uses policy as drivers of service delivery and of health consumer options within the universal health care system, making policy development and critique a useful skill set for health activists in all three governing levels. Likewise funding and policy are entwined and provide steerage of both the health system but also of health consumers hopes, expectations and options. My own experience of this is that it can turn a health advocate into always reacting

to an agenda and process driven by others (such as health bureaucrats and health professionals) and by steerage systems such as policy and service models. It is easy to neglect being pro-active and envisioning alternatives that grow out of citizenship and alternative modes of governance such as those used by citizen juries, citizen panels, participative and dispersed democratic forms and neighbourhoods.

Dr Ann Lawless,

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HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.

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[*Note from HIFA moderator (Neil PW): Thanks you Ann, yes the Quality planning guide notes: 'District varies according to context. For the purposes of this guide, a district is used to refer to a clearly defined administrative area, where there are local government and administrative structures that take over many of the responsibilities from the national government and where there is a general hospital for referral.']

Quality (198) District-level activities for improving quality health services (18)

3 August, 2021
Dear HIFA members,

At the district level, Quality of healthcare services corresponds to numerous factors. District is an administrative unit of an area and the entire population in the catchment area reaches a centrally situated hospital or tertiary care centre. Districts usually have different sectors/sub-divisions based on locally defined policies.

It ranges from availability of healthcare providers at different levels of facilities, skill sets of healthcare providers, availability of infrastructure, availability of consumables, non-biased services, grievance redressal mechanism both for client and healthcare providers. It even comprises healthcare services that are affordable and available at round the clock/ nominated or scheduled time.

For e.g. Functional ambulance, skilled driver and paramedical staff is important for referral cases. Availability of blood bank and Anaesthetist in case of surgical interventions. For radiological investigations, functional equipment/ machines, technicians to operate and specialists to read the report is a must.

Quality also revolves around emphasis on prevention and promotion of healthy behaviours amongst the general public.

HIFA profile: Dr. Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international non-government organizations. In 2021, HIFA nominated her as Global Country Representative Coordinator and Social Media Coordinator. She is based in New Delhi, India and can be reached on sanchika12 AT gmail.com https://www.hifa.org/support/members/sanchika

Quality (199) What does quality of care mean to you? (37)

3 August, 2021
Dear HIFA members,

Quality is not just the number of successful cases/ patients treated ensures quality services in any particular healthcare facility.

Quality is multi-dimensional with expanded arms towards clinical skills, knowledge update and sharing among healthcare service providers, infrastructure availability in the facility, usage of best practises, soft skills of providers (provider – patient interaction), confidentiality and privacy, informed choice of the client/ patient, grievance redressal mechanism, etc.

Best regards,

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HIFA works with the World Health Organization and others to improve the availability and use of reliable healthcare information and protect people from misinformation.

20,000 members, 400 supporting organizations, 180 countries, 15 projects, 6 forums, 4 languages

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YouTube <https://www.youtube.com/c/HIFAGlobalHealth/featured>

HIFA profile: Dr. Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international non-government organizations. In 2021, HIFA nominated her as Global Country Representative Coordinator and Social Media Coordinator. She is based in New Delhi, India and can be reached on sanchika12 AT gmail.com https://www.hifa.org/support/members/sanchika

Quality (200) National commitment (22) Four questions on national commitment to quality of care (3)

3 August, 2021
Dear colleagues

Four questions from our colleague Oriane Bodson serve as a summary to guide the discussion about the national (political) commitment to quality of care.

Sharing ideas in the forum is a pleasure and a real learning process in order to improve our knowledge and to be able to concretely implement the improvement of the quality of care.

1. What are the biggest challenges to enhance national commitment to quality of care in your setting? How can these challenges be overcome?

In my opinion, one of the great challenges is the realization of the need for a change of orientation towards quality as a central element of care. This awareness is often real among health practitioners. But at the national level, policy makers are often not health professionals but politicians. The objectives of the ones and the others can be totally divergent. Rightly or wrongly, political and economic considerations hamper certainly crucial and profitable investments in sustainable quality of care for the benefit of populations. If we take the example of the oxygen needs raised by the COVID pandemic, in Senegal all the regional hospitals are now equipped with central oxygen production, by necessity we will say because the management of the pandemic has become an eminently question. Politics. While securing the oxygen resource at all times is necessary for surgery or resuscitation. Does it take a crisis to be able to convince leaders at the national level?

2. How can leadership and national commitment to quality of care be sustained?

Perhaps we should create a "quality passport", a permanent and transparent dashboard which, according to criteria, would provide the status of the quality of care. Will this allow Leaders to be able to align their objectives? Is there a similar system in the world?

Above all, we believe that WHO should strongly influence this at the national level.

3. How can we continuously engage with health systems leaders on quality of care?

Developing a national strategic plan for the quality of care is undoubtedly necessary. In countries with limited resources, the question of funding arises. I believe that quality is first and foremost and perhaps the investments should be proportioned according to a "quality passport".

4. In your context, what is needed from health systems leaders to maintain quality essential health services during public health emergencies (for example thecurrent COVID-19 pandemic)?

It seems to me that the management of the pandemic must be dissociated from the traditional healthcare network. Modular and therefore removable epidemic treatment centers (ETCs) must be able to take over for public health emergencies in order to avoid congestion in traditional care structures. Not dissociating them would undermine any quality in the management of covid or the usual pathologies, especially in a country with limited resources.

I think Ashish K. Jha's quote is quite credible: “Doing more is not better, doing better is better”. And that's where the national commitment to quality care must go.

Ibrahima Sall MD
Department of surgery
Military teaching hospital
1 Nelson Mandela Avenue
BP 3006 Dakar Sénégal

HIFA profile: Ibrahima Sall is a Consultant Surgeon at the Main Hospital and Army Teaching Hospital in Dakar, Senegal. Professional interests: Healthcare quality and risk management in surgery and oncology. He is a member of the WHO-HIFA working group on Learning for quality health systems.
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Quality (201) National commitment (23) "I'd be interested to hear examples of

where communities have secured national commitment"

3 August, 2021
In a previous message, WHO consultant Matthew Neilson said:

"I'd be really interested to hear any other examples of where communities have successfully helped secure national commitment so please do share any thoughts on this."

https://www.hifa.org/dgroups-rss/quality-131-national-commitment-6-makin...

I agree it would be really interesting to hear of such examples. Either in your own experience. Or documented in a report or peer-reviewed journal article.

We have touched on 'ceding power to patients'. One aspect of this is that patients, people, communities have a voice to improve the quality of health services and to hold leaders to account (whether at national, district, or quality level).

Ann Lawless has described the role of citizen/patient advocacy in helping to shape health services in Australia. What is the situation in other countries, especially in low- and middle-income countries?

A different but related issue is the power dynamics between different levels of the health system. To what extent do facilities feel they are adequately supported and represented by districts? And to what extent do districts (provinces, states) feel supported and represented at national level? The WHO Quality Planning Guide is structured around national, district and facility activities to improve quality. Can anyone comment on how this works (or might work) in practice in your country?

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (202) The health system in Nigeria (2) National-District-Facility harmonisation

4 August, 2021
Dear Joseph,

Thank you for your message describing the Nigerian health system in relation to quality:

"In the country, it is reported that there is a three tier system - 'primary health care (PHC)' under the local governments, the 'secondary care tier (General and Cottage Hospitals) under

the States (36 States) / Federal Capital City, and the 'tertiary tier' level (Teaching Hospitals, Federal Medical Centres, Specialist Hospitals) mostly owned by the Federal Government. But there too much blurring of those lines because the 'District' can in reality be said to include both 'secondary' and 'primary health care' tiers, and therein lies the confusions because the two tiers are under different levels of government. So, how is care coordinated, who is in-charge of true ownership, administration, supply and replenishment, staffing, pay and conditions, and most importantly, who assures quality and safe care!."

Who indeed? Can you or others on HIFA say more about how the quality of health services is discussed at national, district, and facility levels? To what extent are quality improvement prioritised and objectives aligned across the levels?

We would be really interested to hear experience from a national, district and/or facility management perspective - whether in Nigeria or any other country. Are the different levels mutually supportive and aligned? Or are they in tension or even conflict?

Can anyone provide an example of a country where there is harmonisation for quality health services? Can we learn from countries such as Rwanda that have made substantial progress in health outcomes over the past 10-20 years?

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (203) District-level activities for improving quality health services (19) Management skills of district health leaders (2)

4 August, 2021
Dear Venus and all,

You ask very important questions: "Are District Health Executive Teams aware of and capacitated for their role in ensuring Quality Health Service Delivery? Are there any resources available to help capacitate them? Is there any evidence, published research that document challenges faced by District Health Executives in implementing Quality Improvement initiatives?"

Would anyone on HIFA like to step up to help answer these questions?

I am reminded of Andrew Pearson's book 'Medical Administration for Front-Line Doctors: A Practical Guide to the Management of District-level Hospitals in the Public Service or in the

Public Sector' (1995). What guides/manuals do district health managers find most useful to support your/their current work?

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (204) EHS-COVID (437) COVID-19 Preparedness and Response Plans from 106 countries

4 August, 2021
Dear HIFA colleagues,

This paper in Health Policy and Planning looks at countries' COVID-19 Preparedness and Response Plans, and finds that 'less than half considered maintaining essential health services' and only '29% considered quality of care'. Citation, abstract and comments from me below.

CITATION: COVID-19 Preparedness and Response Plans from 106 countries: a review from a health systems resilience perspective

Saqif Mustafa, Yu Zhang, Zandile Zibwowa, Redda Seifeldin, Louis Ako-Egbe, Geraldine McDarby, Edward Kelley, Sohel Saikat

Health Policy and Planning, https://doi.org/10.1093/heapol/czab089

ABSTRACT

Coronavirus disease (COVID-19) has exposed long-standing fragmentation in health systems strengthening efforts for health security and universal health coverage while these objectives are largely interdependent and complementary. In this prevailing background, we reviewed countries' COVID-19 Preparedness and Response Plans (CPRPs) to assess the extent of integration of non-COVID-19 essential health service continuity considerations alongside emergency response activities. We searched for COVID-19 planning documents from governments and ministries of health, World Health Organization (WHO) country offices and United Nations (UN) country teams. We developed document review protocols using global guidance from the WHO and UN and the health systems resilience literature. After screening, we analysed 154 CPRPs from 106 countries. The majority of plans had a high degree of alignment with pillars of emergency response such as surveillance (99%), laboratory systems (96%) and COVID-19-specific case management (97%). Less than half considered maintaining essential health services (47%); 41% designated a mechanism for health system–wide participation in emergency planning; 34% considered subnational service delivery; 95% contained infection prevention and control (IPC) activities and 29% considered quality of care; and 24% were budgeted for and 7% contained monitoring and evaluation of essential health services. To improve, ongoing and future emergency planning should proactively

include proportionate activities, resources and monitoring for essential health services to reduce excess mortality and morbidity. Specifically, this entails strengthening subnational health services with local stakeholder engagement in planning; ensuring a dedicated focus in emergency operations structures to maintain health systems resilience for non-emergency health services; considering all domains of quality in health services along with IPC; and building resilient monitoring capacity for timely and reliable tracking of health systems functionality including service utilization and health outcomes. An integrated approach to planning should be pursued as health systems recover from COVID-19 disruptions and take actions to build back better.

COMMENTS (Neil PW): This would seem to be an indictment of the (lack of) priority given nationally to (1) Maintaining essential health services, and (2) Quality health services. These are the two areas where HIFA is proud to be currently working with WHO to support in-depth discussions on HIFA (EHS-COVID; Quality).

What are the reasons behind this apparent exclusion? The discussion section notes that 'declines in outpatient visits, malaria treatment, vaccination and primary medical consultation that were observed during the 2014–15 Ebola Virus Disease (EVD) outbreaks in West Africa led to the early positioning of essential health service continuity in COVID-19 emergency management planning (e.g. in Liberia and Sierra Leone)'. This begs the question: why can't countries learn from the experience of other countries without having to wait until 'it happens to them'?

There is also the question of the extent to which a policy is realistic and feasible for a given country, and the gap between what is set down as policy and what action actually happens in practice.

We are currently discussing on HIFA the role of the District (province, state) level in quality. This paper notes: 'The limited reference of CPRPs in ensuring subnational health services, including primary health care, may be indicative of a limited bottom-up and integrated approach to planning. This limits the visibility of gaps in capacities that are present in health systems and public health functions between capital cities’, subnational and district health administration and services.'

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (205) National commitment (24) How can leadership and national commitment to quality of care be sustained?

5 August, 2021

Dear HIFA team

Here my response to: ‘How can leadership and national commitment to quality of care be sustained’:

The challenge with quality of care is that it is often placed second when it comes to the international debate around UHC. And yet, research papers from for example Margaret Kruk have demonstrated that poor quality kills more people annually than lack of access to care. Shocking statistics. Leadership can only be sustained, if it becomes an integrated part of the UHC approach, with cross organizational teams where leaders in healthcare quality join forces with leaders in healthcare financing, healthcare contracting and healthcare insurance.

HIFA profile: Nicole Spieker is East Africa Director for PharmAccess, Kenya. Professional interests: Quality of care; Health systems change; Digital transformation. She is a member of the HIFA catalyst group on Learning for quality health services. n.spieker AT pharmaccess.org

Quality (206) Patient experience and health outcomes (12) My Hospital, India

5 August, 2021
Dear HIFA members,

मेरा अस्पताल (Mera Aspatal, My Hospital) is Ministry of Health, Government of India initiative to capture patient feedback for the services received at the hospital through user-friendly multiple channels such as Short Message Service (SMS), Outbound Dialling (OBD) mobile application and web portal. The patient can submit the feedback in seven different languages on a mobile app and web portal; for the hospitals visited in the last 7 days.

The patient can also check the already submitted feedback. The collected feedback will be compiled, analysed and visualized in the form of a dashboard accessible to the different stakeholders at facility, district, state and national level.

'My Hospital' will help the government to take appropriate decisions for enhancing the quality of healthcare delivery across public facilities which will improve the patient’s experience. The patient will be able to receive effective and appropriate care. My Hospital will ultimately help establish a patient driven, responsive and accountable healthcare system.

Weblink of the portal: https://meraaspataal.nhp.gov.in/

Thank you

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Best regards,

Dr. Sanchika Gupta
(Pronoun: She/Her/Hers)
HIFA Global CR Coordinator & SoMe Coordinator
Healthcare Information For All
Email: sanchika12@gmail.com

HIFA profile: Dr. Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international non-government organizations. In 2021, HIFA nominated her as Global Country Representative Coordinator and Social Media Coordinator. She is based in New Delhi, India and can be reached on sanchika12 AT gmail.com https://www.hifa.org/support/members/sanchika

Quality (207) District-level activities for improving quality health services (20) District-level activities and primary healthcare facilities

5 August, 2021
This WHO publication identifies six challenges that are highly relevant to our discussion:

WHO: Quality in primary health care (2018)

https://www.who.int/docs/default-source/primary-health-care-conference/q...

'Challenges to enhancing the quality of primary health care are considerable. Six stand out.

1. Misunderstanding often exists on what quality means and how quality methods can be applied to primary health care to improve health system performance and health outcomes.

2. National strategic approaches to quality are often disconnected from local primary health care efforts – front-line realities faced by primary health care teams are often ignored when setting national directions.

3. Measurement efforts to assess primary health care are disconnected from improvement efforts; primary health care teams provide the information but effective feedback mechanisms are not in place.

4. Efforts to enhance quality at the primary health care level are not sufficiently integrated with overall health service delivery including district health teams and hospital care.

5. Initiatives are often seen as projects that are time-bound and not embedded within a

sustainable and longer-term approach to develop primary health care quality.

6. The evidence-based interventions that are adopted are not contextually relevant; too often, globally developed primary health care solutions cause local challenges within primary health care'

It's interesting that although 'efforts to enhance quality at the primary health care level are not sufficiently integrated with overall health service delivery including district health teams and hospital care', the publication does not address the role of district health teams. (By contrast, the new WHO Planning Guide looks in depth at the role of districts, although it seems to me that *practical* guidance is lacking even here.)

Would anyone be able to comment on the role of district health teams in supporting quality in primary care? What are drivers and barriers to a successful partnership between district health teams and primary care centres?

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (208) District-level activities for improving quality health services (21) Examples of district teams leading change

5 August, 2021
Dear Treasa and all,

Thank you for your questions: "We invite you to share your experience with respect to an example of district teams leading change for quality health services across health facilities in their district? What actions were taken?"

I have yet to find an example, but this recent paper (below) reviews 74 studies from South Africa, and makes the sobering conclusion 'The findings revealed that there were many quality improvement programmes that had been initiated, adapted, modified and then tested but did not produce the required level of quality service delivery as desired'.

In your experience, whether in South Africa or any country, are you aware of an example of district teams successfully (or unsuccessfully) leading change for quality health services? In what respects has change been implemented? Through governance or structural changes, through leadership capacity-building, through specific quality improvement initiatives?

CITATION: Curationis. 2019; 42(1): 1901.

Published online 2019 May 29. doi: 10.4102/curationis.v42i1.1901

Challenges of quality improvement in the healthcare of South Africa post-apartheid: A

critical review

Winnie T. Maphumu et al.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6556866/

ABSTRACT

Background

There is overwhelming evidence that the quality of health care in South Africa has been compromised by various challenges that impact negatively on healthcare quality. Improvement in quality care means fewer errors, reduced delays in care delivery, improvement in efficiency, increased market share and lower cost. Decline in quality health care has caused the public to lose trust in the healthcare system in South Africa.

Objectives

The purpose of this study was to identify challenges that are being incurred in practice that compromise quality in the healthcare sector, including strategies employed by government to improve the quality of health delivery.

Method

Literature search included the following computer-assisted databases and bibliographies: Medline (Medical Literature Online), EBSCOhost, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Google, Google Scholar and ScienceDirect. Furthermore, websites were used to source policy documents of organisations such as the National Department of Health in South Africa and the World Health Organization.

Results

Seventy-four articles were selected from 1366 retrieved. These articles quantify problems facing quality care delivery and strategies used to improve the healthcare system in South Africa.

Conclusion

The findings revealed that there were many quality improvement programmes that had been initiated, adapted, modified and then tested but did not produce the required level of quality service delivery as desired. As a result, the Government of South Africa has a challenge to ensure that implementation of National Core Standards will deliver the desired health outcomes, because achieving a lasting quality improvement system in health care seems to be an arduous challenge.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (209) District-level activities for improving quality health services (22)

5 August, 2021
Treasa and our WHO colleagues ask: "In your context, what is needed from the district-level to maintain quality essential health services during public health emergencies (for example the current COVID-19 pandemic)?"

If district teams are to lead change, they need to be empowered to do so. This applies to district team leaders as well as individual members of the team. Training is needed both in anticipation of public health emergencies and in direct response to emergencies. Below is an example of the latter from WHO Botswana. We would be interested to hear your experience of empowering district level teams. What else is needed other than training to build resilience and respond to emergencies?

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Greater Lobatse District Health Management Team Undergoes Rapid Response Training

09 April 2021

Lobatse, Botswana – 17 March 2021

The World Health Organization (WHO) in Botswana in partnership with the Ministry of Health and Wellness (MoHW) facilitated a Rapid Response Team (RRT) training for Greater Lobatse District Health Management Team (DHMT) on outbreak investigation, data management, community engagement, sample management and contact tracing at all levels of the national health system. The training was supported through the European Union Civil Protection and Humanitarian Aid (ECHO) funding.

When delivering opening remarks, the head of the Greater Lobatse DHMT, Dr. Motlalepula Pone appreciated the support of the MoHW and WHO. In addition, she urged the participants to take advantage of the training to improve rapid response to emergencies in Good Hope and Lobatse. The training lasted three days and had 37 participants from various cadres including clinicians, laboratory professionals, data clerks, environmental technicians as well as nurses.

The main objective of the training was to strengthen capacities at the district level for effective and rapid response and establishing a district pool (roster) of multidisciplinary experts to enable the DHMT to respond to acute public health events (disease outbreaks and other emergencies with public health implications). The RRT training was interactive and included plenary sessions, presentations, group work to review case studies as well as practical demonstrations and simulations on handwashing; use of Personal Protective Equipment’s (PPEs); safe burial practices; sample collection, processing, packaging, and shipment.

Through the continued support from WHO, Botswana continues to strengthen national capacity for outbreak investigation and response including the availability of functional Rapid Response Teams (RRTs) that enhance outbreak investigation, data management, community engagement, sample management, and contact tracing at all levels of the national health system. RRTs play a critical role in fulfilling the International Health Regulations (IHR) obligations as well as the Integrated Disease Surveillance and Response (IDSR) core functions.

As an outcome of this training, participants have adequate competencies in RRT composition, functions, alignment of RRT with current structures such as emergency operation centers and Incident Management System (IMS).

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Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (210) District-level activities for improving quality health services (23) Australian case study of role of district health issues (2)

5 August, 2021
Part B [Part A was circulated on HIFA on 3 August and is available here: https://www.hifa.org/dgroups-rss/quality-197-district-level-activities-i...]

The Western Australian Health Department is a key player in health governance in this state, providing some publicly accessible health data and making quality an explicit issue in hospitals and ambulance services, and state government health jurisdictions. It has embedded health consumer representation in a number of ways, one of which is through Care Opinion, an online portal for consumers to comment on health care. Other opportunities for active citizenship is through representation of health consumers at various levels such as major hospitals and other health service deliverers. Health consumer representation is therefore embedded in the system and is a significant feature of the quality of our universal health care system at a state and territory level. It enables commentary, complaints, and critical comment but rarely participatory dialogue.

Dialogue - authentic dialogue between equals - and in which power is shared - is more difficult in Western Australia, due to the centralised authority of state government actors and the control of vested interests in the state health system. For example, in Western Australia, the gambling industry funds health through Lottery West, a gambling group which “invests” in health care in this state. Other powerful players that benefit from a centralised and regulated approach to engaging consumers and communities include the alcohol industry, sugar industry, medical devices industry and biopharmaceutical industries. The tobacco industry also has a presence but in Australia has had its power to advertise limited but not

eradicated e.g. sponsorship of sport events remains available to the tobacco industry to promote brands and smoking.

To a limited degree our universal health care system also provides health consumers access to decision-making at an institutional (e.g., hospital) and also at state level, through competitive processes which appoint health consumer reps to boards and councils within the state system. The decision as to who will be allowed to represent health consumers in this formalised and competitive process is made by bureaucrats who are likely to use selection criteria available to the public. It is a noteworthy feature of this process of representation that it is competitive, highly formalised, highly structured to serve state purposes, and based on the centralised authority of the state health system. I know of no processes in Western Australia that enable health consumers to elect or appoint their democratically chosen representatives for formal representation at this high level within the state system. Likewise when I raised citizen juries and distributed participation models, I puzzled Western Australians and had to explain how they are used in other states such as South Australia. Citizen juries and other participative systems exist in Australia but they are limited and offer potential for future development. The reason they are not used more often maybe because of the influence of powerful players and vested interests in centralising authority over health consumers, keeping us reactive rather than proactive, protecting those who benefit from centralised systems. Forcing health consumers into reactive positions protects those who benefit from a disease-based emphasis of healthcare rather than community health and public health, and marginalizes approaches such as the political economy of health or other models of health that challenge the health system to redress social inequality and shake up the power and vested interests of the powerful and the entrepreneurs and profiteers who occupy the health space. When we turn to a rights-based approach to health care, we can be more easily enabled to stop blaming individuals for their lifestyle choices and ill-health, and rather speak of housing, employment, education, class, race and gender issues, exposing "bad players" undermining quality in universal health care in an affluent and privileged nation. For example, I live in hope that carers will be our medical heroes, and their role as players in quality provision of universal health care applauded and recognised not just in words or sentiment and that they have the freedom and capacity to exercise powerful and effective change-inducing collective lobbying for the well-being of all.

In addition to formal representation opportunities for health consumers, informal representation is possible and we are able to create influence in informal ways e.g., by joining conversations, spreading ideas, speaking directly to our state politicians, working within our union to prevent occupational injury and support injured workers, and speaking boldly in public. From time to time we can contribute to surveys, inquiries and investigations as citizens or collectively. It is noteworthy that in order to do this it is of great value to be articulate in English, highly literate in written and oral English and bureaucratic-babble, to know how rule-based health systems operate, to have online access that works well, and to be assertive and confident – and well enough to manage the stressors of writing, speaking and listening boldly in public. Excluded from some of this, are for example, non-English speakers, the homeless and so on. As a person with a disability and chronic condition, I have sometimes neglected opportunities because I did not feel well, needed to rest and prioritise self and mutual care, or did it grumpily but did not do it as well as I would have liked: that is, ill-health and stress (with its many ups-and-downs and variations) is an issue in our capacity to advocate for quality and seek change to our universal health system in the district level.

Dr Ann Lawless, Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.
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Quality (211) District-level activities for improving quality health services (24)

5 August, 2021
Dear HIFA members,

Quality is an integral part of healthcare services that are imparted in facilities. Primarily, it enhances provider – patient/client interaction and patient/client satisfaction. This in turn leads to ‘word of mouth’ publicity from them and they are the brand ambassadors.

Second, quality services have a positive psychological effect on providers and boost their confidence to excel in their services protocol. They are encouraged to learn, contribute and share their best-practises to the wider audience.

Thank you

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Best regards,

*Dr. Sanchika Gupta *

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HIFA works with the World Health Organization and others to improve the availability and use of reliable healthcare information and protect people from misinformation.

20,000 members, 400 supporting organizations, 180 countries, 15 projects, 6 forums, 4 languages

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YouTube https://www.youtube.com/c/HIFAGlobalHealth/featured

HIFA profile: Dr. Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international non-government organizations. In 2021, HIFA nominated her as Global Country Representative Coordinator and Social Media Coordinator. She is based in New Delhi, India and can be reached on sanchika12 AT gmail.com https://www.hifa.org/support/members/sanchika

Quality (212) District-level activities for improving quality health services (25)

5 August, 2021
Dear HIFA members,

Quality is an ongoing process. Public sector has healthcare staff which may be transferred to different districts. So, rotation is usually a norm in the entire service cycle. Quality services depend on the individual as well. There have been instances in the past regarding poor service provision, failed treatment and loss of lives by 'X' providers.

As per initiatives by the health authorities there is a Quality Assurance Committee with diverse members at district level. They have a mandate to oversee compliance issues in the quality protocol guidelines.

Thank you

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HIFA profile: Dr. Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international non-government organizations. In 2021, HIFA nominated her as Global Country Representative Coordinator and Social Media Coordinator. She is based in New Delhi, India and can be reached on sanchika12 AT gmail.com https://www.hifa.org/support/members/sanchika

Quality (213) National-District-Facility harmonisation (2) Kenya national policy for quality healthcare

5 August, 2021

In Reply to Neil's comment asking for examples for a national, harmonized approach towards quality:

In Kenya last year in February the National policy for quality healthcare facilitation has been launched, which to my knowledge is one of the best examples in sub Saharan Africa. I have attached it as convenience [*see note below], people can request a copy by sending me an email. This has been the work of many years of team efforts and working group, under strong leadership of the Ministry of Health. By having all partners and initiatives in an inclusive approach, public private partnerships are stimulated, a desirable approach in a country where the financial means for quality improvement and quality evaluation are limited.

Nicole Spieker

Nicole Spieker | Director East Africa - Director Quality | Pharmaccess

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HIFA profile: Nicole Spieker is East Africa Director for PharmAccess, Kenya. Professional interests: Quality of care; Health systems change; Digital transformation. She is a member of the HIFA catalyst group on Learning for quality health services. n.spieker AT pharmaccess.org

[*Note from HIFA moderator (Neil PW): Many thanks, Nicole. HIFA does not carry attachments. I have searched in vain for a URL for this publication. In the meantime, please contact Nicole if you would like to see it. Also, I invite people to comment on the challenges of implementation. To have a good plan is only the first step? To what extent are national quality plans implemented in practice? And what are the drivers and barriers to implementation?]

Quality (214) District-level activities for improving quality health services (25) Management skills of district health leaders

5 August, 2021
Dear Venus, Dear Neil and all,

I agree that the question whether District Health Executive Teams are aware of and capacitated for their role in ensuring Quality Health Service Delivery is a very salient one. I believe that a decentralized model of district health planning and management to increase quality of care and service delivery will not occur just by amending legislative issues. Districts actually need educational support (primarily learning-by-doing type of training) to enhance management skills and, in turn, health practices at the district level. And this was something that was actually pursued in Croatia.

Ten years ago, Croatia had a county/district health capacity building programme known as "*Health - Plan for It*", developed with an end-goal to assist districts to overcome recognized weaknesses and introduce much more efficient local health practices towards increasing quality of care. The experience has shown that a decentralized model of health planning and management in Croatia could not be realized without educational support given to the lower (district) level of administration. Only through the training process, district teams had managed to develop policy functions and create County Health Profiles and Strategic Framework of the County Health Plan.

In the end, the programme had cumulative effects beyond and above the district level. Such an approach to strengthen the decentralisation of the health system and giving more managing power to district health executive teams can be viewed as a mechanism to improve health outcomes and increase quality - primarily by stimulating efficiency or providing a more focused set of health care services based on need. Regarding earmarked resources for this goal, the literature shows that most central governments in Europe now see it as their role to make sure health services are delivered efficiently and equitably, (due to a range of economic, social and financial reasons), and thus are willing to invest resources into training and strengthening district-level activities.

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. He is also a member of the HIFA-WHO working group on Learning for quality health services.

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Quality (215) National commitment (25) What are the biggest challenges to enhance national commitment to quality of care?

6 August, 2021
Dear Ibrahima and all,

In response to the question 'What are the biggest challenges to enhance national commitment to quality of care in your setting? How can these challenges be overcome?' Ibrahima Sall (Senegal) said:

"In my opinion, one of the great challenges is the realization of the need for a change of orientation towards quality as a central element of care. This awareness is often real among health practitioners. But at the national level, policy makers are often not health professionals but politicians. The objectives of the ones and the others can be totally divergent. Rightly or wrongly, political and economic considerations hamper certainly crucial and profitable investments in sustainable quality of care for the benefit of populations. If we take the example of the oxygen needs raised by the COVID pandemic, in Senegal all the regional hospitals are now equipped with central oxygen production, by necessity we will say because the management of the pandemic has become an eminently question. Politics. While securing the oxygen resource at all times is necessary for surgery or resuscitation. Does it take a crisis to be able to convince leaders at the national level?"

In previous discussions on HIFA we have discussed Evidence-Informed Policy and Practice https://www.hifa.org/projects/evidence-informed-policy-and-practice and the vision of this area of HIFA's work is: 'A world where every policymaker and every health professional has access to the evidence they need to accelerate progress towards universal access to quality health care and services'.

Every policymaker needs access to information that is both reliable and relevant to support policy and practice in health service delivery and to increase quality of health services.

This is a prerequisite but, unfortunately, as Ibrahima describes, the motivations of policymakers are not always driven by public health proiorities. Over the past 18 months we have even seen heads of state actively ighnoring public health evidence and promoting dangerous misinformation.

Policymaking and the motivations that underlie it are messy. The question becomes: How to align the goals of improving quality of health services with the political motivations of policymakers?

It would be good to hear from individual policymakers who are committed to public health on this subject - they may be few and far between but they are there. We need to understand how their efforts can be better supported. HIFA member Joseph Ana has been Commissioner for Health for Cross River State and pioneered the 12-Pillar approach to clinical governance. Joseph, would you like to comment?

The UK National Health Service serves as a case study. The NHS is seen by most people in the UK with pride as a 'national treasure'. All three major political parties declare their full support to continue improving the NHS (even though their actions, particularly regarding creeping privatisation, are seen by many to be doing the opposite). They do this because they know that to do otherwise would be political suicide.

By contrast, public health systems in many other countries are seen negatively by the populations of those countries. Here perhaps the challenge is for civil society, professional associations and others to advocate for improvements in quality and increased investment in services. A 2019 WHO publication notes, for example, that 'allocating or reallocating at least an additional 1% of GDP of public spending for PHC is within reach in all countries'.

One of the reasons that policymakers do not pursue evidence-informed policymaking is because the evidence they need to do so is not readily available to them in a practical format that they can apply. Better ways are needed to provide such evidence, for example through policy briefs. Without reliable, relevant, easy-to-understand, practical evidence and tools to improve quality, policyamkers will continue to find it easier to ignore the evidence and continue to pursue non-evidence-informed policymaking, with disastrous consequences.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (216) Compassion, WASH and quality

6 August, 2021
'The absence of water, sanitation and hygiene is the source of incredible suffering around the world'

The recording of the webinar hosted by Shams Syed (WHO) and David Adiss (Focus Area for Compassion and Ethics) is now available here:

https://www.youtube.com/watch?v=E8887NMLhWc

In it, several presenters share their expertise and experience on the interdependence of compassion, WASH and quality of care.

Compassionate leadership and a compassionate approach by all those who work in the health system is an important foundation for quality. (WHO and FACE hosted a previous webinar on compassionate leadership in March 2021 [https://www.hifa.org/dgroups-rss/quality-13-webinar-report-what-role-com...]

In my view, our greatest motivation and responsibility as global health professionals is to reduce the 'incredible suffering around the world'. In doing this we need not only to identify and address the causes of suffering, but also celebrate, promote and nurture compassion among others, particularly those in positions of influence.

Best wishes, Neil

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Quality (217) National commitment (26) Webinar: Decision-maker-led

implementation research for strengthening health systems in LMICs

6 August, 2021
A webinar from the Alliance for Health Policy and Systems Research. Publicity text and a note from me below.

Would anyone be willing to attend on behalf of HIFA and share your observations with us afterwards? I note this webinar is about 'strengthening health systems'. What is the difference between 'strengthening health systems' and 'quality'? What is the role of implementation research in improving quality?

Register here: https://ahpsr.who.int/newsroom/events/item/2021/08/11/default-calendar/w...

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11 August 2021, 14:00-15:15 CEST (Geneva time)

Implementation research is targeted at interventions to overcome barriers preventing policies from working on the ground. Bringing researchers together with decision-makers at different levels to identify priorities, understand the specific challenges and test solutions is an increasingly important approach to strengthening different aspects of health systems. Beginning in 2015, the Alliance at WHO and the United Nations Children's Fund (UNICEF) in partnership with Gavi, the Vaccine Alliance, began supporting a programme of decision-maker-led research focused on immunization (DELIR). This webinar coincides with a launch of a new special issue of the journal Health Research Policy and Systems (HARPS) that presents findings from eight of these studies conducted in six countries (Chad, Ethiopia, India, Nigeria, Pakistan and Uganda). The webinar will cover key elements of the embedded implementation research approach, and some of the researchers and decision-makers involved in these projects will provide insights into the process in practice.

Moderator:
Zubin Shroff, Alliance for Health Policy and Systems Research, WHO
Speakers:
Aboubacar Kampo, UNICEF
Ngozi Akwataghibe, Royal Tropical Institute, Netherlands
Yasir Shafiq, Vital Trust, Pakistan
Hope Johnson, Gavi, the Vaccine Alliance
Abdul Ghaffar, Alliance for Health Policy and Systems Research, WHO
Arielle Mancuso, Implere, LLC
Marta Feletto, Alliance for Health Policy and Systems Research, WHO
--

Comment (NPW)

A few years ago HIFA worked with the Special Programme on Research for Tropical D8iseases (TDR) to explore the topic of Implementation Research.

https://www.hifa.org/sites/default/files/publications_pdf/HIFA_Case_Stud...

The three learning points were:

1. There is confusion about IR, particularly in relation to similar approaches like quality improvement, operational research, knowledge translation and health-services research.

2. IR provides an opportunity to better understand the health system and policy perspective

3. Difficulty in locating implementation research articles for policy making, program planning and research is a challenge.

Best wishes, Neil

Coordinator, HIFA Project on Evidence-Informed Policy and Practice

http://www.hifa.org/projects/evidence-informed-policy-and-practice

Let's build a future where every person has access to reliable healthcare information and is protected from misinformation - Join HIFA: www.hifa.org

HIFA profile: Neil Pakenham-Walsh is coordinator of the HIFA global health movement (Healthcare Information For All - www.hifa.org), a global community with more than 20,000 members in 180 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org FB: facebook.com/HIFAdotORG neil@hifa.org

Quality (218) Improving quality of care at the facility level - Challenges and solutions?

6 August, 2021
Greetings Everyone,

I hope you are all having a good week.

Thank you for your participation in the discussion so far. We have already exchanged more than 200 messages and your inputs are being synthesized to create Learning Briefs for the WHO website, to share our experience more widely with others.

We now enter the final two weeks of our discussion where we shall explore quality improvement issues at the facility level. The previous six weeks have addressed fundamental questions concerning quality of care concepts and initiatives, ways of enhancing national

commitment to quality of care, and the challenges faced by district health managers in tackling quality of care issues. You can review all messages here: https://www.hifa.org/rss-feeds/17

Background: The ultimate aim of quality improvement (QI) efforts is to deliver quality at the point of care in health facilities. A wide range of facilities provide health care to the population, including large to small hospitals and clinics, and primary care centres, including public, faith-based, private for-profit and not-for-profit facilities in both rural and urban areas.

'Not all quality-related challenges can be addressed at the facility level. In some cases, facility-level activity and progress are influenced by what happens nationally and in districts… On the other hand, a facility may be more motivated to work on problems that are identified locally, by both health providers and the local community' (WHO Quality Health Services: a planning guide, page 37).

This next discussion phase explores quality improvement issues at the *facility* level and we invite you to reflect on the question below:

From your experience, what are the biggest challenges for improving quality of care at the facility level? Have you seen any practical solutions that should be shared wider?

We welcome your inputs from any perspective: health facility manager, frontline health professional, patient advocate…

I look forward to reading your posts.

Best wishes,

Treasa.

HIFA profile: Treasa Kelleher is a Specialist Registrar in Public Health Medicine at the Health Service Executive, Ireland. She is currently working with the Quality Team in the WHO Department of Integrated Health Services. Professional interests: Global Health and Quality of Care. She is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (219) District-level activities for improving quality health services (26) Australian case study (3)

7 August, 2021
Part C

Other players contribute to a health consumers voice for quality within the state or district component of our universal health care system such as universities and professional associations. For example, staff at our state universities have consulted with homeless people and articulated the concerns of homeless people in research as well as in submissions and to inquiries. I was able to attend a virtual event organised by a nearby university that advocated for food security for remote, regional and rural Indigenous communities where food costs can be prohibitive and availability of fresh vegetables and fruit is very limited and expensive. I have also been able to attend state branches of professional associations such as Public Health Association Australia and the Australian Health Promotion Association, not only in Western Australia but also in other states, and learn, listen and join collective advocacy opportunities in both rural and urban settings. It lifts and energises the spirit to know that universities and professional associations advocate, lobby and seek to improve the quality of universal health care in this district.

Health care in Western Australia and other states and territories of Australia is resonate with health inequity, social inequality and political struggle, just as it is at a national level. Western Australian universities, professional associations and other stakeholders such as health consumer groups have addressed these issues.

Like many Australians and Western Australians, I am deeply grateful for the health care available to me, appreciate it and am aware of my privilege and blessings. For example, I deeply value my General Practitioner, podiatrist, radiology clinic and my local pharmacy as contributors to good health care! The greengrocer, parks, open spaces and public transport system also go on the list of valued players in the social determinants of my health. I am also aware that "good citizenship" asks some of us to step forward and critique the same system that we value and hold in high regard. Sometimes we have to face down people we like and respect - and speak boldly and firmly at district level. We do this individually and through collective action. We hope that quality and compassion in the districts of our universal health care system may be more than just a modern ideology, capitalist propaganda or myth, but a reality for all.

As a patient I also value the health receptionists, paramedics, orderlies, ward clerks, union representatives and other working class heroes who work in the health system in my district: each contributes to quality.

Dr Ann Lawless, Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.

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[*Note from HIFA moderator (Neil PW): Many thanks Ann. For the benefit of those who may have missed Parts A and B:

Part A: https://www.hifa.org/dgroups-rss/quality-197-district-level-activities-i...

Part B: https://www.hifa.org/dgroups-rss/quality-210-district-level-activities-i...

Patient advocacy is clearly strong in Australia, with associated commitment to quality at national, district and facility levels. What is the situation in other countries, especially LMICs?]

Quality (220) National commitment (27) How can leadership and national commitment to quality of care be sustained? (2)

7 August, 2021
Dear colleagues,

I fully agree with Nicole Spieker [https://www.hifa.org/dgroups-rss/quality-205-national-commitment-24-how-...

], that the key to sustaining leadership and national commitment to improving quality of health care is for "leaders in healthcare quality to join forces with leaders in healthcare financing, healthcare contracting and healthcare insurance" to ensure UHC. Moreover, community and civil society leaders must be part of the dialogue as well, to demand both quality of care and access.

Lani

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Quality (221) Improving quality of care at the facility level (2) Use of digital technology - Zoom and WhatsApp

7 August, 2021
[Note from HIFA moderator: The message below is forwarded from our sister forum CHIFA (child health) Join CHIFA: http://www.hifa.org/joinchifa]

I totally agree with Prof Nisha Keshary Bhatta [https://www.hifa.org/dgroups-rss/quality-care-district-hospitals]; but I feel that equally important is the *realization of the importance of quality of care* and *motivation to implement* whatever activities are feasible even in the presence of these challenges. Once the habit is inculcated, the processes can be, hopefully, adapted based on the availability of resources; getting better as the situation improves.

We have been using digital technology (Zoom and Whats App) to facilitate QI activities in some facilities in Ghana (primarily district hospitals) working within the available resources with no extra funding. While, of course, there a number of challenges, some changes have taken place. An example was getting babies discharged very early, as it conventionally happens in many facilities in low and middle- income countries, to come back in a timely manner when jaundice was detected. This was achieved primarily through interactive health education, *both in the antenatal clinics and in the postnatal wards*. In the *interactive* health education, while showing a video on the topic, the midwife is physically present and encourages the mothers to simultaneously look for the signs highlighted in the video so that she gets to practice; and even has a few 'return'□ demonstrations.

We feel commencing counseling in the antenatal clinics is important as jaundice is mainly a problem in the early newborn period and since some mothers are discharged by 6-7 hours of the delivery, hearing all these messages for the first time following the exhausting process of

birthing may not be the best option. Babies are being brought in earlier with lower levels of bilirubin and needless exchange transfusions have decreased.

While attempts were also made through community health workers to contact discharged mothers through phone calls due to the COVID pandemic, the interactive health education was more useful as not all the health workers followed the instructions appropriately due to delays in reimbursement of money for phone calls. Another expected challenge is the continuation of these activities when external facilitation activities need to be discontinued; but that is a story for another day!

Indira

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Quality (222) Australian case study (4) Citizen voice and communicative learning

7 August, 2021
Dear colleagues,

I just wanted to applaud Ann Lawless for her impassioned treatise in Quality post 210 on health consumer representation and the constraints on it in Western Australia due to vested bureaucratic and industry interests. I loved her statement, Dialogue - authentic dialogue between equals - and in which power is shared, which so eloquently captures what citizen voice in health governance should be and the critical importance of true dialogue, where all parties truly listen, not to undercut or criticize but to understand the other's point of view.
[https://www.hifa.org/dgroups-rss/quality-210-district-level-activities-i...]

It reminded me of a paper my friend and knowledge management mentor Nancy Dixon wrote for the Center for Creative Leadership, "Perspectives on Dialogue." She writes there about

the value of communicative learning: "learning to understand what others mean and to make oneself understood. The goal of communicative learning is to gain insight and to reach common understanding rather than to control."

We need to work to ensure that spaces and processes for citizen participation in health care quality governance are truly focused on communicative learning.

Lani

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Quality (223) District-level activities for improving quality health services (27) Invitation to address

7 August, 2021
Dear HIFA colleagues,

Thank you for all your contributions in the past 2 weeks on the theme of 'District-level activities for improving quality health services'. Many interesting points have been raised and WHO-HIFA working group member Tomislav Mestrovic and his team are currently collating these together with the ongoing 200+ messages in the discussion.

Personally, I was impressed by the number of questions that have been asked in the past 2 weeks. The guiding question (and subquestions) for our discussion were:

From your experience, what are the biggest challenges for district health managers in tackling quality of care issues? Have you seen any practical solutions that should be shared wider?

- do you have an example of district teams leading change for quality health services across health facilities in their district? What actions were taken?

- what is needed from the district-level to maintain quality essential health services during public health emergencies (for example the current COVID-19 pandemic)?

- how can we encourage and support district leaders to engage with the full range of stakeholders? What should be done at the district level to ensure multi-level coordination with the national level and the facility level to enhance quality of care?

In addition, we have had *lots* of related questions (below). Many if not most of these questions remain unanswered. How can we take these forward?

Would you as a HIFA member may like to respond to any of these questions by email to hifa@hifaforums.org ?

Would you (or perhaps one of your students, if you are a lecturer/educator) like to volunteer a couple of hours basic literature search to explore one or more questions? If you know someone with relevant experience/expertise, please do invite them to join us: www.hifa.org Your/their inputs will be considered in the synthesis with a view to publication on WHO website for the benefit of others.

1. District team capacity and competency

- Are District Health Executive Teams aware of and capacitated for their role in ensuring Quality Health Service Delivery? Are there any resources available to help capacitate them? Is there any evidence, published research that document challenges faced by District Health Executives in implementing Quality Improvement initiatives?

- What guides/manuals do district health managers find most useful to support your/their current work?

- We would be interested to hear your experience of empowering district level teams. What else is needed other than training to build resilience and respond to emergencies?

- How can a quality approach be embedded within general support for management skills?

- What is required to support management for quality health services?

- What additional resources are needed to support district-level aims and goals for quality health services?

- The study [Zimbabwe] concluded that "Lack of management training was the major contributing factor to the poor performance by District Health Executives in Midlands Province." Are these findings similar to those in other contries? Have they been any successful interventions to cover this gap?

2. District teams and health facilities

- Would anyone be able to comment on the role of district health teams in supporting quality in primary care? What are drivers and barriers to a successful partnership between district health teams and primary care centres?

- Improving the quality of health services in low-resource settings is arguably more about meeting the basic needs of health workers and thereby empower them to carry out their work effectively and safely, than it is about setting quality goals and incremental quality improvement?

- To what extent can district managers in such settings work in terms of quality improvement versus the daily challenges of meeting basic needs?

3. National-District-Facility harmonisation

- Can you say more about *how* the quality of health services is discussed at national, district, and facility levels? To what extent are quality improvement prioritised and objectives aligned across the levels?

- Are the different levels (national, district, facility) mutually supportive and aligned? Or are they in tension or even conflict?

- Can anyone provide an example of a country where there is harmonisation for quality health services?

4. Learning from experience

- Can we learn from countries such as Rwanda that have made substantial progress in health outcomes over the past 10-20 years?

- In what respects has change been implemented? Through governance or structural changes, through leadership capacity-building, through specific quality improvement initiatives?

- What do mechanisms to review performance of QI interventions look like?

- What has been others experience in measuring and improving management to drive the needed QI at the facility and district levels?

5. Stakeholder engagement

- How can we encourage and support district leaders to engage with the full range of stakeholders? What should be done at the district level to ensure multi-level coordination with the national level and the facility level to enhance quality of care?

- What stakeholders are involved in these mechanisms?

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (224) Improving quality of care at the facility level (3) Measuring quality of care

8 August, 2021
The message below is forwarded from our sister forum CHIFA (child health).

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I have followed with interest the ongoing discussion on quality of care in district hospitals. In my own experience one important tool is proper monitoring of patients and good registration routines during patient care, in addition to proper infrastructure. In a recent study, I with colleague assessed improvement of infrastructure for neonatal care in Mangochi District Hospital, Malawi. Compared to the old premises, neonatal mortality declined significantly in the new department that had more and better qualified staff and better space and equipment. Yet, despite improvement, the registration of patient clinical care and outcome was still deficient. There is a need to find ways how to constructively engage health care professionals in proper registration of admitted patients, e.g., with regular staff meetings and feed-back on what is being done in the department.

See Haraldsdattir I et al. Assessment of improved neonatal ward infrastructure on neonatal health outcomes in southern Malawi. Journal of Global Health Reports 2021;5: e2021057. https://doi.org/10.29392/001c.24587

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Join CHIFA (child health and rights): http://www.hifa.org/joinchifa

Quality (225) Improving quality of care at the facility level (4) Measuring quality of care (2)

8 August, 2021
How to measure quality of care? Two aspects of quality have been highlighted in our discussions to date: health outcomes (morbidity and mortality) and patient experience. What is the relative importance of these two aspects? Does one become more important than the other in low-resource settings as compared with high-resource settings?

The provider-patient interaction and its associated outcomes and experience primarily happens in facilities. What are the most important indicators that a facility should measure? How should this align with district and national level measurement? How is quality measured in your health facility (hospital, primary health centre)? Can you recommend technical guidance for measuring quality?

Below are some extracts from WHO's 'Quality health services: a planning guide (2020)' https://www.who.int/publications/i/item/9789240011632

1. 'Measurement mechanisms are required to track the delivery of quality health services and promote accountability' is one of the five foundational requirements for quality health services (page 3)

2. 'Measurement is complex and needs to be adapted to different contexts. The national team responsible for quality needs to draw on measurement expertise to optimally define an adapted measurement framework that supports the national strategic direction for quality. This clearly defines what data should be collected from the facility and district levels and how they will be used to drive improvement. Focused attention on measurement capacity across the system is required. Detailed planning is necessary to define what data should be collected and when, the sources of data and the basic tools to be applied.' (p4)

3. One of the five key activies at national level is to 'develop a pragmatic quality measurement framework' (p8) and at the facility level 'undertake continuous measurement of outcomes' (p9)

4. The responsibility at district level is to:

'-f Collect data pertaining to patient outcome measures and process measures at the facility level.

f- Collect district-level performance measures based on aggregate data from facilities.

f- Analyse data emerging from both the facility and district levels to inform facility-level support and district-level planning.

-ƒ Share emerging data on quality of health services with community stakeholders and into national levelreporting systems.' (p28)

5. Key activities at facility level include:

'- Define measures related to the identified aims and set up the measurement process for data collection, compilation, analysis and synthesis, drawing from existing measures and measurement processes where possible.

ƒ- Define a reporting process to share results with facility management and district leadership.

- Feedback is important – also consider feeding back to the local community.

-ƒ Consider whether the QI team requires additional facilitation, training, coaching or supportive supervision to conduct measurement e.g. district level/partner support if available.

-ƒ Develop job aids to support measurement.' (p44)

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Quality (226) Improving quality of care at the facility level (5) Water, sanitation and hygiene (WASH)

8 August, 2021
Dear HIFA

Improving quality of care at the facility level – role of WASH and the case of Ethiopia

WASH in health care facilities (WinHCFs) is critical for quality health service delivery, patient and heath care workers safety and the wider community. Also, for health security, resilience, preparedness and response to health emergencies needs. Though, the SDG aim to attain 80% by 2025 and 100% by 2030 in all countries, the progress towards the target seems not promising. For instance, the JMP SDG baseline report (2019) indicated, 49% of the health care facilities and 24% of the hospitals in sub-Saharan Africa lack basic water service provision i.e improved source supply within a facility; 77% of the facilities lack basic sanitation and 40% of the hospitals lack basic health care waste management (HCWM) in 2016. Hand hygiene practice is the other gap linked to infrastructural and behavioral problems. Inadequate toilet facilities cause patients and staff to share same toilet and shortage of water affecting service delivery and cleanliness of facility.

The WHO/UNICEF eight practical steps or actions can be an overarching framework to be used at national and sub-national level to improve and sustain WinHCFs services in the context of quality of care improvement effort. The link to this guide can be found at:

https://www.who.int/publications/i/item/9789241515511. At facility level risk assessment and management approach like the WASH FIT (https://apps.who.int/iris/bitstream/handle/10665/254910/9789241511698-en...) is helpful tool.

The Clean and Safe Health Facilities (CASH) initiative in Ethiopia which was introduced since 2014, with the national level commitment brought striding progress in some of the health care facilities particularly hospitals. CASH is a decentralized and facility-based engagement approach which includes the leadership, staff, patient and community for driving improvements in the facilities. It emphasizes behavior and attitudinal change, mentorship and peer-to-peer learning, intervention for built environment including WASH and HCWM and full engagement of staff. These brought improvements in quality of service, decrease in HAIs, creating conducive environment, staff morale and user satisfaction. WHO documentation on this can be found at:
https://apps.who.int/iris/rest/bitstreams/1083779/retrieve

Regards,

Kebede Eticha

HIFA profile: Kebede Eticha is a PhD candidate and has over 10 years experience working for UN agencies and INGOs as consultant in the fields of WASH and IPC in development and humanitarian program contexts. He is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (227) National commitment (28) What are the biggest challenges to enhance national commitment to quality of care? (2)

8 August, 2021
Neil thank you for your post and for inviting me to make a comment.
[https://www.hifa.org/dgroups-rss/quality-215-national-commitment-25-what...]

And I appreciate many of the points that Ibrahima made too, like saying 'the motivations of policymakers are not always driven by public health priorities'. And, that '----- policy makers are often not health professionals but politicians'. [https://www.hifa.org/dgroups-rss/quality-200-national-commitment-22-four...]

When in 2004, I 'brain reversed' from the NHS UK (opposite of 'brain drain' plaguing low and middle income countries, even today) to Nigeria to Head and manage a ministry of

Health of one of the states in the country (population of the state - 3.1 million), our first step was to do a comprehensive situation analysis of the state's health system. Richard Smith described it well in his review of my book titled 'Whole system Change of failing health systems': he wrote in the BMJ: 'Imagine that one day you're a general practitioner in Luton (UK) and the next you are responsible for the health of the three million people of Cross River state, one of the poorest in Nigeria, where child mortality is 20% and maternal mortality 1%, childhood immunisation rates are under 20%, and you have only 72 doctors. And you'd be facing this challenge in a country where corruption is among the worst in the world, with power cuts ubiquitous and everything a struggle. Could you cope? Where would you start?' (*BMJ* 2010 ; 341 doi: https://doi.org/10.1136/bmj.c5520).

The findings were appalling, so we decided to introduce 'Clinical Governance' but we also knew that the '7 Pillar Clinical Governance' version of Liam Donaldson and his team in the UK was not appropriate for a low resource country like Nigeria, hence we localized it by adding additional five (5) pillars to take account of very basic but overlooked essentials for a strong and performing health system (essentials that are always ignored or given low priority when politicians, policy makers, unfortunately including the medical / health qualified ones, talk about quality and safe health care. By so doing, the 12-Pillar Clinical Governance version is context aware and driven, and home-grown for LMICs like Nigeria. Next, we had to create awareness and change attitudes to delivering care within our colleagues, the health workers by using a multidisciplinary team engagement ('charity begins at home'), and then extended the advocacy and education to policy makers and politicians, many of whom were not health practitioners, as Ibrahima noted. For the latter step, we redefined what 12- Pillar clinical governance means in a language that they (policy makers and politicians) can easily understand and embrace: every human being at some point shall be a patient and in 2004, most patients (majority of 160 million Nigerians) were very dissatisfied with the care they receive whenever they fell ill.

We simplified the original definition by Sir Liam Donaldson, former Chief Medical Officer of England and his team, ''Clinical governance is "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish", to a more easily comprehended and therefore more likely to gain the support of policy makers and politicians, which is, '12-Pillar clinical governance programme is about *'Protecting patients and supporting practitioners in tandem'* to strengthen the health system.''. It worked and very quickly the State gained support and assistance from many local and international sources, which enabled the State to positively transform the State health and development indices.

We demonstrated that with 'reliable, relevant, easy-to-understand, practical evidence and home grown tools to improve quality, policymakers and politicians can be made to use such evidence to drive real transformative changes that lead to delivery of quality and safe health care even in LMICs.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA

Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

http://www.hifa.org/support/members/joseph-0
http://www.hifa.org/people/steering-group
Email: jneana AT yahoo.co.uk

Quality (228) What is quality of care? A 3 minute video from WHO

8 August, 2021
Thanks to Shams Syed, Quality Team Lead, Department of Integrated Health Services, WHO Headquarters. See the video: http://youtu.be/erei6SZjcck

Please retweet:

1. https://twitter.com/Shams_Syed/status/1424143086326845445

'What is quality of care? Would a simple 3 minute video be helpful so you can explain it to others? Well here you go: http://youtu.be/erei6SZjcck

As @DrTedros reminds us repeatedly « quality is not a given. - Urgent action required! #quality #change #healthcare '

2. https://twitter.com/hifa_org/status/1424293227654430723

'TY @shams_syed All welcome to join our ongoing discussion on HIFA global forums - Quality health services - supported by WHO Global Learning Laboratory for Quality #hifa #UHC'

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (229) National commitment (28) How can leadership and national

commitment to quality of care be sustained? (3)

8 August, 2021
Dear HIFA members,

The concept of 'quality care' must start from medical teaching institutions of different categories of health care providers. Each student is a fresh mind whenever they enter any institution, so it's easy for them to grasp and deep dive into the quality concept. This will help in creating future healthcare workforce which are stronger in beliefs and actions.

Best regards,

Sanchika Gupta

HIFA profile: Dr. Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international non-government organizations. In 2021, HIFA nominated her as Global Country Representative Coordinator and Social Media Coordinator. She is based in New Delhi, India and can be reached on sanchika12 AT gmail.com https://www.hifa.org/support/members/sanchika

Quality (230) Improving quality of care at the facility level (6)

8 August, 2021
"From your experience, what are the biggest challenges for improving quality of care at the facility level? Have you seen any practical solutions that should be shared wider?"

In our discussion to date, we recognise two dimensions of quality health care: health outcomes and patient experience. Both are in turn dependent on whether the basic needs of healthcare providers are met.

HIFA has previously summarised the basic needs as:

- Skills
- Equipment
- Information
- Systems/infrastructure
- 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. https://www.hifa.org/about-hifa/hifa-universal-health-coverage-and-human...

If these needs are not met, quality health care is impossible. Negative health outcomes (avoidable suffering and death) and poor patient experience are inevitable.

This aligns with the 12-Pillar clinical governance programme which is about *Protecting patients and supporting practitioners in tandem*, as described by Joseph Ana.

Patients cannot be protected unless practitioners are supported. Too many frontline health workers are undersupported. HIFA is about one need: the need for reliable, relevant healthcare information. We are proactively engaging with other global health communities of practice to address the full range of needs. https://www.hifa.org/dgroups-rss/communities-practice-global-health

In answer to the question, 'What are the biggest challenges for improving quality of care at the facility level?', and based on my experience listening to others' concerns over the past few decades, I would offer that one of the greatest challenges is to provide an enabling environment where the basic needs of healthcare providers are progressively realised.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (231) Empowering healthcare providers and patients with reliable healthcare information

8 August, 2021
One driver of quality, both in terms of health outcomes and patient experience, is that both healthcare providers and patients are empowered with the reliable healthcare information they need to protect their own health and to provide safe and effective care. This new paper from NHS England shows a substantial, national-policy-driven shift in the role of health libraries to meet not only the needs of healthcare providers, but also the needs of patients and the public.

CITATION: Increasing participation by National Health Service knowledge and library services staff in patient and public information: The role of Knowledge for Healthcare, 2014-2019. Eleanor Ruth Carlyle, Louise Goswami, Sue Robertson. Health Info Libr J. 2021 Jul 31. https://onlinelibrary.wiley.com/doi/10.1111/hir.12388

ABSTRACT

Background: The strategy lead for the National Health Service (NHS) knowledge and library services withn the NHS in England is held by Health Education England, working with 184

local NHS libraries based predominantly in hospitals OBJECTIVES: As part of the strategic framework Knowkedge for Healthcare, the objective was to increase the role NHS knowledge and library services staff play in both indirect an direct support for evidence-based information for patients and the public.

Methods: The study took an integrated multi-level approach: encouraging local staff to share their expertise through Task and Finish groups, developing tools, offering training and reviewing levers available through Health Education England's quality assurance role.

Results: Between 2014 and 2019, the percentage of services supporting patient and public information increased from 27% to 78%. Qualitative evidence demonstrates a wide range of roles played by local services, working either indirectly or directly to ensure access to evidence-based health information for patients and the public.

Discussion: The study shows the benefits of engaging people with local expertise in developing the skills and resources for system-wide change.

Conclusion: Similar system-wide change programmes should also consider an integrated approach, involving people, developing tools, offering training and drawing on incentive structures such as quality assurance measures. Apologies for previous errors to Background, Objectives, Methods.

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Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (232) Equity issues in inter-level quality health communication

9 August, 2021
EQUITY ISSUES IN INTER-LEVEL QUALITY HEALTH COMMUNICATION

Hello Everyone,

Here are some personal observations - as a Stakeholder - on the inequities found to be embedded in unqualified acceptance of exclusive norms and assumptions that generally guide planning for Healthcare education and Patient Engagement Strategies at the organizational (District) and Service delivery (Facility) levels. As a Quality metric, equity, is typically recognized almost everywhere at the National level for consideration and design of systemic policies but seldom critically calibrated for aligned purposes (Fit for Purpose: External Review of the Pan- Canadian Health Organizations, Govt of Canada, March 2018) of delivering contextually desirable health outcome for diverse and dynamic patient populations and communities.

The WHO “Second Draft: Global Patient Safety Action Plan 2021-2030 (Nov 2020)“ had identified the development and sustenance of “multi-sector synergies and partnerships that have the expertise and influence for improving patient safety and quality of care” (Strategic Objective 7, Second Draft, p.64). The distinct people-centered measures of the suggested District level key activities in the “Quality Health Services: a planning guide” (WHO 2020), affirm that the systems approach of the Guide continues to recognize the interdisciplinary synergies and the collaboration of interdependent sectors leveraging system-wide “Foundational Requirements” notably through “Sharing and Learning” and “Stakeholder and Community Engagement” - two important dimensions of patient/person’s active and meaningful partnership with the healthcare system

Yet, despite the insightful analysis in the Section: Further Considerations For Adapting Quality Interventions At The District Level “(Quality Health Services - a Planning Guide, pp 31-32), the Key Considerations (Table 2. P 33) seemingly do not attempt to delve deeper to explore either the multi-sector synergies of Learning or stratified identities of patients or communities as partners to enhance the equitable context. Perhaps the current scope of the Guide - largely a paradigmatic review of the macro-mezzo-micro levels of the Healthcare system - did not permit this transformative analysis! However, compelling schisms in general and harmful inequities in particular, continue to persist in misaligned dynamics of the exclusive norms and inclusive visions of People-centered Care.

Consider, for example, the alarming yet common situation where, at the point of Care in the Facilities level, some seriously ill patients learn, often for the first time, about ethical and legal norms - familiar to some but fundamentally different from values and beliefs of others - which typically determine clinical decision-making. Within an ideal Equity scenario, the district level organizations could certainly design specific learning initiatives or promote awareness-raising public events informing all Stakeholders about the inherent risks of normative disparities preventing critical harm and enhancing equitable safety.

The example of the information gap indicates a common divergent pattern of inter-level communication where national level commitment to equity and district or facility level implementation of the same may fail to agree. A paradigm shifting perception of the exclusive norms as equity risks however could help in understanding the principle of Systemic Qualitative thinking: “Today's problems come from Yesterday's solutions." and that our collective effort at Quality Care planning can succeed within this dynamic global mindset.

Sincerely

Esha Ray Chaudhuri
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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

Quality (233) BMJ Open: A systematic review of evidence on the links between patient experience and clinical safety and effectiveness

9 August, 2021
This systematic review confirms 'consistent positive associations between patient experience, patient safety and clinical effectiveness, and argues that these three 'central dimensions of quality should be looked at as a group and not in isolation'. Citation, abstract and a comment from me below.

CITATION: Doyle C, Lennox L, Bell DA systematic review of evidence on the links between patient experience and clinical safety and effectivenessBMJ Open 2013;3:e001570. doi: 10.1136/bmjopen-2012-001570. Correspondence to Dr Cathal Doyle; c.doyle@imperial.ac.uk. http://dx.doi.org/10.1136/bmjopen-2012-001570

ABSTRACT

Objective: To explore evidence on the links between patient experience and clinical safety and effectiveness outcomes.

Design: Systematic review.

Setting: A wide range of settings within primary and secondary care including hospitals and primary care centres.

Participants: A wide range of demographic groups and age groups.

Primary and secondary outcome measures: A broad range of patient safety and clinical effectiveness outcomes including mortality, physical symptoms, length of stay and adherence to treatment.

Results This study, summarising evidence from 55 studies, indicates consistent positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease areas, settings, outcome measures and study designs. It demonstrates positive associations between patient experience and self-rated and objectively measured health outcomes; adherence to recommended clinical practice and medication; preventive care (such as health-promoting behaviour, use of screening services and immunisation); and resource use (such as hospitalisation, length of stay and primary-care visits). There is some evidence of positive associations between patient experience and measures of the technical quality of care and adverse events. Overall, it was more common to find positive associations between patient experience and patient safety and clinical effectiveness than no associations.

Conclusions: The data presented display that patient experience is positively associated with clinical effectiveness and patient safety, and support the case for the inclusion of patient experience as one of the central pillars of quality in healthcare. It supports the argument that the three dimensions of quality should be looked at as a group and not in isolation. Clinicians should resist sidelining patient experience as too subjective or mood-oriented, divorced from the 'real' clinical work of measuring safety and effectiveness.

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COMMENT (NPW): It is notable that *all* of the studies identified were done in high-income countries (especially USA), suggesting there is a serious lack of such research in LMICs. Also, all the studies were in English and it isn't clear whether the reviewers sought to identify papers in languages other than English.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (234) Improving quality of care at the facility level (7) Engaging senior health leaders and clinicians

9 August, 2021
"What are the biggest challenges for improving quality of care at the facility level? Have you seen any practical solutions that should be shared wider?"

I do agree with others that resources, especially finance and materials, are key challenges facing quality improvement (QI) efforts. However, leaving financial and material resources aside, one of the biggest challenges for improving quality of care at the facility level I'd believe is lack of favorable leadership culture towards quality and safety management. It is not that leaders and workers dislike QI works, but they lack the determination to demonstrate the culture needed to uphold quality healthcare. Countries need to support quality of services and build/embed a system that enables internal and external bodies monitor safety incidents and learning processes in health care organizations including teaching institutions. Building systems favorable for quality and safety need to be a key deliverable expected of leadership positions at all levels. A targeted learning opportunities need to be created to educate and engage senior health leaders and clinicians, and continuously coach them on clinical and non-clinical safety standards and measurement metrics.

The other challenge is the lack of accountability for patient outcomes and other safety incidents. I would say, in general, there is weak accountability frame in both public and private health facilities, and it is rather punitive and rarely data-driven. This not only creates fear and leaves poor-quality of work uncorrected but also dissatisfies the majority of motivated heath workers who are dedicated to serve their patients and organization

Regards,

Manuel K. Sibhatu (MD, Int. Med., MPH)

Quality (235) Improving quality of care at the facility level (8)

9 August, 2021
Dear GLL community,

We hope this email finds you well.

Quality health services are critical to achieving universal health coverage (UHC): Between 5.7 and 8.4 million deaths are attributed to poor quality care each year in low- and middle-income countries, accounting for up to 15% of overall deaths in these countries. Improving access to health services must go hand in hand with improving the quality of these services. Further, poor quality health services can decrease people's trust in the health system. There is an urgent need to place quality at the centre of national-, district- and facility-level actions in order to progress towards UHC.

As you know, a new thematic discussion on the HIFA forums - Learning for quality health services - was launched a few weeks ago [https://www.hifa.org/news/learning-quality-health-services-new-thematic-...]. We are now approaching week 7 of the discussion, where we explore the question "What are the biggest challenges for improving quality of care at the facility level? Have you seen any practical solutions that should be shared wider?".

To date, we have already exchanged 230 substantive messages on quality health services from more than 60 quality professionals and general health professionals in various countries (Australia, Cambodia, Cameroon, Canada, Croatia, DR Congo, France, India, Iraq, Ireland, Malawi, Mexico, Mozambique, Nepal, Netherlands, Nigeria, Singapore, Sudan, Switzerland, Tanzania, Trinidad and Tobago, UK, USA, Zimbabwe). You can review messages them here: https://www.hifa.org/rss-feeds/17

Best wishes,

WHO Global Learning Laboratory for Quality Universal Health Coverage

Sharing knowledge and experiences, challenging ideas and sparking innovation

To learn more, visit: https://www.who.int/initiatives/who-global-learning-laboratory-for-quali...

To register or sign up for our mailing list,
contact: gll4QUHC@who.int<mailto:gll4QUHC@who.int>

Quality (236) National commitment (29) How can leadership and national commitment to quality of care be sustained? (4)

9 August, 2021
Lani Marquez notes: 'I fully agree with Nicole Spieker that the key to sustaining leadership and national commitment to improving quality of health care is for "leaders in healthcare quality to join forces with leaders in healthcare financing, healthcare contracting and healthcare insurance" to ensure UHC.'

The WHO Quality Planning Guide notes (inter alia): 'To ensure that the national strategic direction on quality is translated into actions that improve care, the national level has a key role in operational planning... The strategy might also be supplemented by a more detailed resourcing plan specifying the financial and human resources required across the system for implementing the quality interventions, identifying current funding sources, and outlining how any further required resources can be mobilized.'

A question for HIFA: In what other respects do leaders in healthcare quality need to join forces with leaders in healthcare financing?

Lani also makes the point: 'Moreover, community and civil society leaders must be part of the dialogue as well, to demand both quality of care and access.'

Can anyone on HIFA share your experience of community or civil society helping to shape policy and practice, whether at global, national, district/subnational or facility levels? Who are the key actors at each level? What are the drivers and barriers to their effectiveness to ensure equitable, quality health services?

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (237) BMJ Open: A systematic review of evidence on the links between patient experience and clinical safety and effectiveness (2)

10 August, 2021

Thank you Neil for your perceptive comment related to the scope of the Review [https://www.hifa.org/dgroups-rss/quality-233-bmj-open-systematic-review-...

]. The points about both the HIC context and the selective nature of data are very important for equity analysis in general and more specifically for research about patient experience.

Indeed, with the heightened focus on the SDH [Social Determinants of Health] variables in most pandemic studies it helps to remember that patient experiences of safety and effectiveness - even in clinical settings - is best understood within the lens of their profile as persons, influenced by individual upstream factors that guide their behaviour in dealing with illness.

Thus, your comment identifies a very important aspect of the "local" nature of most patient oriented research today.

Esha Ray Chaudhuri

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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

Quality (238) Self-Care and Strengthening the Patient-Provider Dynamic: The evolving role of healthcare providers in advancing self-care and user autonomy for health

10 August, 2021
Thursday, 12 August 2021 from 8.00–10.00hrs EDT | 12.00–14.00hrs BST | 15.00–17.00hrs EAT

Register for the Self-Care Learning and Discovery Series <https://discoverselfcare.community.tc/> so you don’t miss this session on Thursday, 12 August: Self-Care and Strengthening the Patient-Provider Dynamic <https://discoverselfcare.community.tc/t/2021/events/self-care-and-streng.... We will explore how provider attitudes and competencies need to shift to support clients in safe, quality self-care, and how to support providers in this evolving role. Participants will gain various perspectives on questions like; “how does self-care fit into clients’ health goals and where do providers fit into this journey? How can midwives support and promote self-care among

young people? What factors help healthcare providers facilitate client uptake and continuation of preventive self-care behaviors and products?" Participants will also engage in discussion and Q&A with panelists, and partake in small-group exercises to unpack the barriers and benefits for provider-supported self-care, the shifts needed among healthcare providers, and what support is needed to assist healthcare providers in this evolution of their role.

Speakers:

* Dr. Helen Blackholly, Vice President and Director Technical Services for MSI Reproductive Choices

* Prof. Issa Wone, President Senegalese Association of Public Health, Professional, Senegal

* Harriet Nayiga, ICM Young Midwife Leader and Director of Midwife-led Community Transformation, Uganda

* Mercy Muthoni Kamau, Program Manager Oral PrEP, Jhpiego Kenya

* Raveena Chowdhury, Head of Integrated Services at MSI Reproductive Choices, UK

Hosted by the International Confederation of Midwives, International Federation of Medical Students Association, Jhpiego, MSI Reproductive Choices UK, and PATH in collaboration with the Self-Care Trailblazer Group and White Ribbon Alliance.

Register for this and other sessions on self-care hot topics
at https://discoverselfcare.community.tc/

Cet événement sera offert en français grâce à l'interprétation simultanée. [*see note below]

#DiscoverSelfCare with us

HIFA profile: Beth Balderston is Communications Officer, Reproductive Health, at PATH in the USA. Email: bbalderston AT path.org

[*Note from HIFA moderator (Neil PW): Thanks Beth. You may like to send a message about this also to HIFA-French. The email address is hifa-fr@dgroups.org]

Quality (239) Improving quality of care at the facility level (9) Primary healthcare facilities

10 August, 2021

The University of Manchester studied our patient centred family practice in 2001 and found that we had changed the culture - basic assumptions, values, norms and artefacts - of our practice.

Sharing the tools, training knowledge, attitudes and practices of health promotion and healthcare with patients and families is part of the future of healthcare that remote mobile phone and online communities may help provide.

Here is a quote from the decision-maker implementer led research:

Dr Richard Fitton, staff and patient volunteers at the HMC have worked hard to promote and to maintain the momentum of patient participation for over seven years. The focus of change has been emergent change – an open-ended and continuous process of adaptation to changing conditions and circumstances. The main aspects of emergent change are discussed;

- Organisational structure; the practice has become increasingly patient-focused through the formation of a patient participation group (PPG) in 1993 to meet regularly with the GP and practice staff to consider all aspects of the practice operation. In particular, commissioning and computer strategy have been considered. Internal support has been gained through collaboration on the design of a new practice building, and in particular the setting up of a patient information room, including a touch screen computer for patient information. Synergy between the various parties has been demonstrated by the formation of self-help groups for patients with heart problems, and those who take their own blood pressure readings.

- Organisational culture; defined as "*the particular set of values, beliefs, customs and systems that are unique to that organisation*" [1]. Culture is shown through the basic assumptions that people work in a team, and each person's skill and knowledge is valued.; people are considered to be very important and valued whatever they can contribute.

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[1] Burnes. B. (2000), *Managing Change – A Strategic Approach to Organisational Dynamics *(3rd edition), Pearson Education Limited: Essex

- Organisational learning; demonstrated by patients who challenged the norm, and pushed for the development of the patient information room, and by the involvement of the practice in the current ERDIP project

- Managerial behaviour; relevant in the context of the commitment to teamworking shown in all aspects of the practice. The GP and practice manager work together and their skills complement each other to provide all aspects of leadership – the GP taking the role of transformational leader in both the everyday activities of the practice and the PPG.

Power and politics; the open nature of the organisation means that these have not to date been crucial factors in development, although politics are undoubtedly present, as in any organisation.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

Quality (240) National commitment (30)

10 August, 2021
Re leadership: Expenditure on health is rising in every OECD country but life expectation is falling in many because of unhealthy lifestyles related to unhealthy sales economies. As Neil commented in a recent email exchange "thanks Richard, yes... There is a key sentence relevant to health misinformation: 'Because the attention economy is designed to prioritise whatever's most compelling – instead of whatever's most true, or most useful – it systematically distorts the picture of the world we carry in our heads at all times.'" [*See note below]

It is my hope that through medical records, medical communications, relationships and conversations, we can go some way to obstruct the inadvertent unhealthy consequences of selling.

"7/11/2019 - Health expenditure will outpace GDP growth over the next 15 years in almost every OECD country, according to new OECD forecasts. Health spending per capita will grow at an average annual rate of 2.7% across the OECD and will reach 10.2% of GDP by 2030, up from 8.8% in 2018, according to a new OECD report.

https://www.oecd.org/health/health-spending-set-to-outpace-gdp-growth-to...

Health at a Glance 2019: OECD Indicators <https://www.oecd.org/health/health-at-a-glance-19991312.htm> says that the United States spent the most on health care in 2018, equivalent to 16.9% of GDP, above Switzerland, the next highest spending country, at 12.2%. Germany, France, Sweden and Japan all spent close to 11% of GDP, while a few countries spent less than 6% of their GDP on health care, including Mexico, Latvia, Luxembourg, and Turkey at 4.2%.

Health at a Glance outlines areas where spending could be more effective:

- Increased use of generic drugs could save costs, but at the moment are only half the volume of pharmaceuticals sold across OECD countries. Generics accounted for more than three-quarters of the volume of pharmaceuticals sold in Chile, Germany, New Zealand and the United Kingdom, but less than one-quarter in Luxembourg and Switzerland in 2017.

- Health and social systems employ more workers now than ever before, with about one in every ten of all jobs in OECD countries found in health or social care. Shifting tasks from doctors to nurses and other health professionals can alleviate cost pressures and improve

efficiency.

- Increasing patient safety not only improves health, it can also save money. Almost 5% of hospitalised patients had a health care associated infection in 2015-17.

Health at a Glance 2019 highlights some worrying patterns in health outcomes and unhealthy lifestyles.

A person born today can expect to live almost 81 years on average in OECD countries. But life expectancy gains have slowed recently in most OECD countries, especially in the United States, France and the Netherlands. 2015 was a particularly bad year, with life expectancy falling in 19 countries.

The causes include rising levels of obesity and diabetes that have made it difficult to maintain previous progress in cutting deaths from heart disease and stroke. Respiratory diseases such as influenza and pneumonia have also claimed more lives in recent years, notably amongst older people.

Opioid-related deaths have increased by about 20% across OECD countries since 2011, and have claimed about 400,000 lives in the United States alone. Opioid-related deaths are also relatively high in Canada, Estonia and Sweden.

Smoking, drinking and obesity continue to cause people to die prematurely and worsen quality of life:

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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[*Note from HIFA moderator (Neil PW): By way of explanation, Richard had forwarded me a link to this article in The Guardian (UK)https://www.theguardian.com/books/2021/aug/07/on-earth-4000-weeks-so-why...]

Quality (241) Improving quality of care at the facility level (10) Water, sanitation and hygiene (WASH) (2)

10 August, 2021
Kebede Eticha notes that, according to JMP SDG baseline report (2019), '49% of the health care facilities and 24% of the hospitals in sub-Saharan Africa lack basic water service

provision'.

https://www.hifa.org/dgroups-rss/quality-226-improving-quality-care-faci...

The same report states 'An estimated 896 million people [worldwide] use health care facilities with no water service and 1.5 billion use facilities with no sanitation services'.

Without water or sanitation, it is impossible to provide safe and effective quality care.

This raises the question: If a healthcare facility lacks access to water, or sanitation, or any of the other basic neeeds for delivery of care, then how can the facility be supported to improve quality of care? Presumably quality improvement in such cases is largely about addressing fundamental needs. On the other hand, a quality improvement mindset may be just as important in such a facility ("doing the best with what we have") as in more well-resourced facilities? I would be interested to hear from frontline health workers who have experience in rural, underserved areas. What were the biggest challenges to provide quality health services? What were you able to do to help maintain quality?

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (242) National commitment (31) Promoting a culture of quality

10 August, 2021
Sanchika Gupta notes: "The concept of 'quality care' must start from medical teaching institutions of different categories of health care providers. Each student is a fresh mind whenever they enter any institution, so it's easy for them to grasp and deep dive into the quality concept. This will help in creating future healthcare workforce which are stronger in beliefs and actions."

https://www.hifa.org/dgroups-rss/quality-229-national-commitment-28-how-...

This is an important point and I don't think it is mentioned specifically in the WHO Quality Planning Guide, although the Guide does emphasise repeatedly the importance of 'promoting a culture of quality'. https://www.who.int/publications/i/item/9789240011632

Below are some points made in the Guide, followed by a comment from me.

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'Attention is required to the practical steps needed to promote a culture of quality within health system leadership. In addition, careful attention is required to build the capacity of managers at all levels in the concepts and methods related to quality improvement.'

'preferences and engagement of the people served by health workers can be a powerful step to institutionalize a quality of care culture'

'Planning for improvements in health service quality requires special attention to developing and institutionalizing a culture of quality – in organizations and across the health system – as a means to sustainable and meaningful change. There is no one definition of what a culture of quality entails. It is generally understood to mean that, at all levels of a health system, there is an inherent and explicit recognition of the value of efforts to improve the quality of health services provided – and such efforts are systematically promoted within an enabling enviroment that encourages engagement,

dialogue, openness and accountability. Some of the features of a culture of quality are outlined in Box 4...

'Box 4: Culture of quality: key features

- Leadership for quality at all levels
- Openness and transparency
- Emphasis on teamwork
- Accountability at all levels
- Learning embedded in system
- Active feedback loops for improvement
- Meaningful, comprehensive and sustainable staff, service user and community engagement
- Empowering individuals and groups while recognizing complex adaptive systems
- Alignment of professional, organizational and individual values
- Fostering pride in care
- Valuing compassionate care
- Coherence between quality improvement efforts, service organization and planning'

--

Comment (NPW): In terms of promoting a culture of quality I agree with Sanchika that this is important to start at the level of healthcare provider training. Indeed, as a student I would find the concept easier to grasp when reduced to its three basic elements: health outcomes, safety, and patient experience. In medical and nursing training, all three elements are addressed, although perhaps not all are addressed adequately. Does anyone have any reflections on the extent to which a culture of quality is developed during training? In addition to these three elements of quality culture, more technical skills are needed such as principles of evidence-informed policy and practice, quality improvement, and patient safety, as well as communication and leadership skills. In effect, the basis for many of these approaches are generic and go beyond the health sector. In addition, compassion has been noted by the WHO Global Learning Laboratory for Quality UHC as being 'the heart of quality people-centred health services'. All in all, the development of these attitudes and skills have their basis in primary and secondary schools, well before professional training.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (243) National commitment (32) Promoting a culture of quality (2)

11 August, 2021
Neil thank you for sharing and your comments at the end. It is evidentially easier and better to ‘catch them young’, when promoting important issues like ‘quality health care’ and ‘culture of safety’. For us we advocate starting at the ‘pre-service training institutions’ level, including the selection of students, which made us introduce ‘in-person interview’ of candidates in the admission process into the schools of nursing, midwifery, colleges of health technology, gauging aptitude, spirit and understanding of vocation of the candidates. No process is perfect but our process means we do not miss all the way.

We also engaged the Medical and Dental Council of Nigeria to include the subjects in its Red Book / ‘minimum standards’ from which the individual medical schools develop their own curriculum. In practice, as we promote the 12-pillar Clinical Governance programme (for the whole health system), and PACK Nigeria programme (specifically for the primary health care tier), we work closely in a multi-sectoral approach, especially with the Ministry of Education so that even children are taught to be aware of the importance of taking care of their health, e.g. washing hands frequently, first aid like cardiac resuscitation/chest compression, calling for help, etc.

It is amazing how quickly children learn and comply, unlike the adults who are slower because they have access to all the mis/disinformation and other distractions. Basically, we tailor our implementation into : ‘pre-facility’ (from home to surroundings including transportation), ‘in the facility’, and ‘after the facility’ (post discharge including rehabilitation)

Joseph Ana

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HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF

(Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

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Quality (244) National commitment (33) WHO's Quality health services: a planning guide

11 August, 2021
Esha Chouhuri (Canada) notes: 'Despite the insightful analysis in the Section: Further Considerations For Adapting Quality Interventions At The District Level â€œ(Quality Health Services - a Planning Guide, pp 31-32), the Key Considerations (Table 2. P 33) seemingly do not attempt to delve deeper to explore either the multi-sector synergies of Learning or stratified identities of patients or communities as partners to enhance the equitable context. Perhaps the current scope of the Guide - largely a paradigmatic review of the mmacro-mezzo-micro levels of the Healthcare system - did not permit this transformative analysis! However, compelling schisms in general and harmful inequities in particular, continue to persist in misaligned dynamics of the exclusive norms and inclusive visions of People-centered Care.' https://www.hifa.org/dgroups-rss/quality-232-equity-issues-inter-level-q...

She refers to the WHO's Quality health services: a planning guide (2020), which informs our discussion on Quality.

https://www.who.int/publications/i/item/9789240011632

I would like to invite further thoughts on how the Guide can be applied in policy and practice, perhaps with recommendations on other publications (from WHO or elsewhere) that might complement the Guide.

With thanks, Neil

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Quality (245) Improving quality of care at the facility level (9)

11 August, 2021
Many thanks for the very interesting exchange so far.

"From your experience, what are the biggest challenges for improving quality of care at the facility level? Have you seen any practical solutions that should be shared more widely?"

I work predominantly in health systems in upper middle-income countries where I find the following to be the main challenges to quality in facilities that I have encountered:

1) Inequalities in structural quality - In many of these countries, facilities in urban areas pass minimum standards in terms of the supply of health worker, equipment, medicines, and infrastructure. There are often lagging rural and remote areas where facilities do not have sufficient inputs to deliver high quality care. These challenges, for example, motivated a large scale primary health reform supported by the World Bank in Romania, where an initial iteration identified a financing mechanism to allow providers to shore up structural quality, especially in rural areas.

2) Discordance between purchasing incentives and quality - As countries become richer and (often) mobilize more public funds for health care, there is a tendency towards setting up agencies responsible for allocating funds to pre-specified services and providers. Often, these purchasing arrangements pay inadequate attention to quality of care at the facility level. E.g. the conditions for contracting providers tend to focus on financial management systems to process claims, less so on the adequacy of inputs to provide quality care, and even less so on outcome quality (e.g. avoidable complications) or process quality (e.g. adherence to guidelines). The result is often that facilities do not have adequate incentives to address quality gaps at the facility level.

One practical solution we are testing out in Armenia at the moment, to address the second challenge, is a twinning arrangement with a high-performing purchaser, in this case the Korea HIRA, that has built a reputation via the Value Incentive Program for defining, monitoring, reporting, and rewarding quality improvements in the facility level. The process started by identifying an agency with the right experience in implementing the processes Armenia wants to take on, signing a memorandum of understanding, identifying focal points, and then a series of joint exercises to diagnose the bottlenecks to linking purchasing to quality in Armenia, draw on the Korean experience and tailor a roadmap for implementation to Armenia. The partnership extends into implementation and problem-solving as obstacles arise.

Best Wishes,

Adanna Chukwuma

HIFA profile: Adanna Chukwuma is a Senior Health Specialist at the World Bank Group, United States. She is a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services achukwuma AT worldbank.org

Quality (246) Improving quality of care at the facility level (10)

11 August, 2021
This new paper in The Lancet Global Health found that a multifaceted intervention to improve clinical quality of care did *not* improve clinical quality as assessed by compliance with IPC practices and correct case management.

Citation, abstract and a comment from me below.

CITATION: Effect of a multifaceted intervention to improve clinical quality of care through stepwise certification (SafeCare) in health-care facilities in Tanzania: a cluster-randomised controlled trial

Jessica J C King et al. Lancet Global Health 2021. Published:August 04, 2021
DOI:https://doi.org/10.1016/S2214-109X(21)00228-X

SUMMARY

Background: Quality of care is consistently shown to be inadequate in health-care settings in many low-income and middle-income countries, including in private facilities, which are rapidly growing in number but often do not have effective quality stewardship mechanisms. The SafeCare programme aims to address this gap in quality of care, using a standards-based approach adapted to low-resource settings, involving assessments, mentoring, training, and access to loans, to improve clinical quality and facility business performance. We assessed the effect of the SafeCare programme on quality of patient care in faith-based and private for-profit facilities in Tanzania.

Methods: In this cluster-randomised controlled trial, health facilities were eligible if they were dispensaries, health centres, or hospitals in the faith-based or private for-profit sectors in Tanzania. We randomly assigned facilities (1:1) using computer-generated stratified randomisation to receive the full SafeCare package (intervention) or an assessment only (control). Implementing staff and participants were masked to outcome measurement and the primary outcomes were measured by fieldworkers who had no knowledge of the study group allocation. The primary outcomes were health worker compliance with infection prevention and control (IPC) practices as measured by observation of provider–patient interactions, and correct case management of undercover standardised patients at endline (after a minimum of 18 months). Analyses were by modified intention to treat. The trial is registered with ISRCTN, ISRCTN93644888.

Findings: Between March 7 and Nov 30, 2016, we enrolled and randomly assigned 237 health facilities to the intervention (n=118) or control (n=119). Nine facilities (seven intervention facilities and two control facilities) closed during the trial and were not included in the analysis. We observed 29 608 IPC indications in 5425 provider–patient interactions between Feb 7 and April 5, 2018. Health facilities received visits from 909 standardised patients between May 3 and June 12, 2018. Intervention facilities had a 4·4 percentage point

(95% CI 0·9–7·7; p=0.015) higher mean SafeCare standards assessment score at endline than control facilities. However, there was no evidence of a difference in clinical quality between intervention and control groups at endline. Compliance with IPC practices was observed in 8181 (56·9%) of 14 366 indications in intervention facilities and 8336 (54·7%) of 15 242 indications in control facilities (absolute difference 2·2 percentage points, 95% CI −0·2 to −4·7; p=0·071). Correct management occurred in 120 (27·0%) of 444 standardised patients in the intervention group and in 136 (29·2%) of 465 in the control group (absolute difference −2·8 percentage points, 95% CI −8·6 to −3·1; p=0·36).

Interpretation: SafeCare did not improve clinical quality as assessed by compliance with IPC practices and correct case management. The absence of effect on clinical quality could reflect a combination of insufficient intervention intensity, insufficient links between structural quality and care processes, scarcity of resources for quality improvement, and inadequate financial and regulatory incentives for improvement.

COMMENT (NPW): In the full text the authors note 'Quality of care was poor in both intervention and control groups. Less than a third of standardised patients in both groups received the correct care for their condition, with particularly low rates for those presenting with asthma and upper respiratory tract infection... These findings indicate that a higher burden of proof should be placed on policy makers and funders looking to invest in such interventions.' It's not clear why such a wide variety of healthcare facilities was included, ie why did the study focus on both primary health centres and hospitals? I look forward to hear from HIFA members about other efforts to improve quality of health care at facility level. For example, what has been the experience of PACK (Practical Approach to Care Kit) in primary health care? At the level of the district hospital, Mike English and colleagues have done considerable research on quality of child health care in Kenya, and it would be good to hear from them also.

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Quality (247) Improving quality of care at the facility level (11) Improving quality of surgical care

11 August, 2021

This new paper in Global Health: Science and Practice promotes the World Health Organization Surgical Safety Checklist and Non-Technical Skills for Surgeons (NOTSS) framework. We have frequently referred to the WHO Surgical Safety Checklist on HIFA and it is a well established tool to improve safety and reduce mortality. The NOTTS framework is less well known and is described here as 'social (leadership, communication, and teamwork) and cognitive (situational awareness and decision making) skills that underpin medical knowledge, technical skills, and appropriate use of resources.' Note that this paper is a Viewpoint article rather than a research paper. I would be interested to hear about the effectiveness of NOTTS in a clinical research setting.

CITATION: Strategies for Improving Quality and Safety in Global Health: Lessons From Nontechnical Skills for Surgery Implementation in Rwanda. Daniel Josef Lindegger et al. Global Health: Science and Practice August 2021, https://doi.org/10.9745/GHSP-D-21-00042

KEY MESSAGES

- Efforts to increase access to surgical care will achieve improved health outcomes only if those efforts are intertwined with efforts to increase surgical safety and quality.

- The World Health Organization Surgical Safety Checklist and Non-Technical Skills for Surgeons (NOTSS) framework are 2 tools to increase surgery quality and safety.

- The NOTSS for variable resource contexts is a new 1-day educational course developed in Rwanda that integrates contextually appropriate behaviors and values and can be implemented with low costs in any health care context.

- Program managers should provide context-specific NOTSS training for surgeons and operating theater staff.

- Policy makers should implement NOTSS framework into health care policy focusing on modern virtual teaching methods.

- Surgeons and operating theater staff should be familiar with the NOTSS framework and regularly update their knowledge through didactic courses, simulation, and online trainings.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (248) Improving quality of care at the facility level (12) National Quality Assurance Standards

12 August, 2021
Thank you Adanna for sharing your experience from health systems in upper middle-income countries [https://www.hifa.org/dgroups-rss/quality-245-improving-quality-care-faci.... Situation in Lower and Middle Income Countries is somewhat different than what you have mentioned. In many LMIC countries, facilities in urban and rural areas do not have minimum standards in terms of the adequate number of health worker, equipment, medicines, and supporting infrastructure. Situation in urban area is somewhat better than rural area. In India, in last couple of years, the current government has pushed reforms to improve quality in primary care centres both urban and rural areas by setting up about 150K Health and Wellness Centres across the country. Further, government through National Quality Assurance Standards is leading quality improvement in public facilities from primary care to district hospitals, however the biggest challenge remains the sustainability of such efforts over a period of time. In private healthcare facilities, accreditation system has been instrumental in improving quality and been successful. It was challenging to bring facilities into the fold of accreditation, however it was overcome to a greater extent by linking

financial incentives of government insurance and a push by insurance regulator to have minimum standards in place for facilities providing cashless treatment. However, we have a long way to go considering the numbers of healthcare facilities.

Another important regulatory instrument to overcome the challenge of improving quality is to set the basic infrastructure in place by both public and private facilities is Central Clinical Establishment Act. The Act prescribes minimum standards for each type of facility from primary care to tertiary care. The challenge remains the implementation of this Act in different States as Health is a State matter and many State governments have not yet enforced this Act or build their own Act of similar nature. While in place, it can ensure availability of minimum structures (human resources, equipment, physical facility etc.) and some of the critical process. Certainly, such facilities would deliver better services than what is being delivered now.

In summary, in last couple of years healthcare has received significant attention and of course much attention after pandemic, and several initiatives are being taken to improve quality of healthcare services in India.

With regards,

Bhupendra Kumar Rana |MSc PhD PGDHHM MAHA

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Our Vision: Nurturing the largest global pool of organisations and people through quality improvement and accreditation framework.

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Quality (249) WHO's Quality health services: a planning guide (2)

12 August, 2021
Dear HIFA colleagues,

Have you had a chance to look at WHO's Quality health services: a planning guide (2020)? It is freely available here:

https://www.who.int/publications/i/item/9789240011632

An important part of the remit of our work with WHO is to promote awareness and uptake of the guide and to share experience on tangible examples of its use. The Guide is set out in three sections: National, District and Facility - as we have been doing in the current HIFA discussion.

I look forward to hear your observations.

With thanks, Neil

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Quality (250) Improving quality of care at the facility level (13) National-District-Facility harmonisation (3)

12 August, 2021
Dear HIFA colleagues,

WHO's Quality health services: a planning guide (2020) notes at the beginning of the section on 'Facility-level activities for improving quality of health services at the point of care'.

'A critical early step is for facility leadership to commit to district and/or national quality aims where these exist. Where a national quality policy or strategy and operational plan are in place, consider how to adapt the goals and associated priorities for the facility aligned with the district-level aims. Working towards the national goal or district aims allows facilities to start fast, and to learn from and share learning across districts and facilities. It can also present an opportunity to shape national and district priorities.'

https://www.who.int/publications/i/item/9789240011632

To what extent is there alignment between facility and district/national priorities in your setting? What have been the benefits (or disadvantages) of such alignment (or non-alignment)?

To what extent do private sector health facilities align with national and district facilities, or do they operate autonomously within the overall regulatory framework?

What about health care provided by NGOs and faith based organisations? We have previously discussed on HIFA the importance of the international NGOs (in particular)

operating in tandem with national priorities and structures, and my impression is that this is a continuing trend. Nevertheless given the complexity and fragmentation of healthcare delivery, there is considerable lack of coordination.

Whether you are in the public, private, NGO or faith-based sector it would be good to hear your views on whether/how quality of care can be improved through better alignment and coordination.

With thanks, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (251) Improving quality of care at the facility level (14) Situational analysis

12 August, 2021
Dear HIFA colleagues,

WHO's Quality health services: a planning guide (2020) underlines the importance of situational analysis at the facility level:

'The purpose of facility situational analysis is to understand the current ‘state of quality’ within the facility before starting implementation. While important to align facility improvement aims with those at the district and national levels, these aims are more specific and grounded in the local context and data. Through situational analysis the QI team gathers detailed information on different aspects of quality such as infrastructure, availability of policies, guidelines, standards and related resources in the facility. This is key to identifying gaps and effectiveness of applied quality

interventions to inform improvement.'

'Key activities:

Conduct facility situational analysis to identify priority areas for action and inform improvement aims at the facility level.

Use recent assessment results, where available.

Based on the results of the assessment, undertake a gap analysis to identify where priority actions are needed.

Actively engage facility staff, district leadership, the community and other stakeholders to identify gaps. Share results of the gap analysis with district and community stakeholders for feedback, and to support their advocacy and mobilization efforts both nationally and locally.'

https://www.who.int/publications/i/item/9789240011632 (p42)

I would like to invite HIFA members to share a situational analysis and the approach you used. What technical guidance did you use? What were the challenges? How were you able to apply the findings?

With thanks, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (252) Increasing health worker productivity in Ethiopia

12 August, 2021
The WHO Quality Planning Guide recognises efficiency as a domain of quality. One aspect of efficiency is health worker productivity, and this is addressed in a new paper from Ethiopia in Human Resources for Health. Citation, abstract and a comment from me below.

CITATION: A practical measure of health facility efficiency: an innovation in the application of routine health information to determine health worker productivity in Ethiopia. Md. Zabir Hasan, Girmaye D. Dinsa & Peter Berman. Human Resources for Health volume 19, Article number: 96 (2021). Published: 05 August 2021.

ABSTRACT

Background:

A simple indicator of technical efficiency, such as productivity of health workers, measured using routine health facility data, can be a practical approach that can inform initiatives to improve efficiency in low- and middle-income countries. This paper presents a proof of concept of using routine information from primary healthcare (PHC) facilities to measure health workers' productivity and its application in three regions of Ethiopia.

Methods: In four steps, we constructed a productivity measure of the health workforce of Health Centers (HCs) and demonstrated its practical application: (1) developing an analytical dataset using secondary data from health management information systems (HMIS) and human resource information system (HRIS); (2) principal component analysis and factor analysis to estimate a summary measure of output from five indicators (annual service volume of outpatient visits, family planning, first antenatal care visits, facility-based deliveries by skilled birth attendants, and children [< 1 year] with three pentavalent vaccines); (3) calculating a productivity score by combining the summary measure of outputs and the total number of health workers (input), and (4) implementing regression models to identify the determinant of productivity and ranking HCs based on their adjusted productivity score.

Results: We developed an analytical dataset of 1128 HCs; however, significant missing values and outliers were reported in the data. The principal component and factor scores developed from the five output measures were highly consistent (correlation coefficient = 0.98). We considered the factor score as the summary measure of outputs for

estimating productivity. A very weak association was observed between the summary measure of output and the total number of staff. The result also highlighted a large variability in productivity across similar health facilities in Ethiopia, represented by the significant dispersion in summary measure of output occurring at similar levels of the health workers.

Conclusions: We successfully demonstrated the analytical steps to estimate health worker productivity and its practical application using HMIS and HRIS. The methodology presented in this study can be readily applied in low- and middle-income countries using widely available data—such as DHIS2—that will allow further explorations to understand the causes of technical inefficiencies in the health system.

COMMENT (NPW): Instinctively I feel slightly uncomfortable with approaches to human resources that focus on efficiency and 'maximising performance' as compared with 'supporting' and 'meeting the basic needs of health workers', although I realise I am making a false distinction: both are needed. I look forward to hear your views, whether from a human resources, public health or frontline health worker perspective.

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Quality (253) The Correlation of Communication Effectiveness and Patient Satisfaction

12 August, 2021
We have noted that health outcomes and patient experience are fundamental aspects of quality. This paper makes the surprising conclusion that 'there seems to be no association between illness (PROMs) and experience (PREMs)'. The title talks of different comparators (communication effectiveness and patient satisfaction) and I'm not quite clear how these relate. Citation, abstract and a comment from me below.

CITATION: The Correlation of Communication Effectiveness and Patient Satisfaction. Yvonne Versluijs, Maartje Lemmers, Laura E. Brown. First Published March 3, 2021. https://doi.org/10.1177/2374373521998839

ABSTRACT

This study assessed the correlation of 9 questions addressing communication effectiveness (the Communication Effectiveness Questionnaire [CEQ]) with other patient-reported experience measures (PREMs; satisfaction, perceived empathy) as well as patient-reported outcome measures (PROMs; pain intensity, activity tolerance) in patients with musculoskeletal illness or injury. In a cross-sectional study, 210 patients visiting an orthopedic surgeon completed the CEQ and measures of satisfaction with the visit, perceived empathy, pain intensity, and activity tolerance. We evaluated correlations between CEQ and other PREMs and CEQ and PROMs. We measured ceiling effects of the PREMs. Communication effectiveness correlated moderately with other PREMs such as satisfaction

(ρ = 0.54; P < .001) and perceived empathy (ρ = 0.54; P < .001). Communication effectiveness did not correlate with PROMs: pain intensity (ρ = −0.01; P = .93) and activity tolerance (ρ = −0.05; P = .44). All of the experience measures have high ceiling effects: perceived empathy 37%, satisfaction 80%, and CEQ 46%. The observation of notable correlations of various PREMs, combined with their high ceiling effects, direct us to identify a likely common statistical construct (which we hypothesize as “relationship”) accounting for variation in PREMs, and then develop a PREM which measures that construct in a manner that results in a Gaussian distribution of scores. At least within the limitations of current experience measures, there seems to be no association between illness (PROMs) and experience (PREMs).

COMMENT (NPW): In their introduction the authors note that 'A genuine, trusting relationship between clinician and patient is associated with better adherence, a stronger placebo effect (which enhances both inert treatments and active treatments), and fewer disputes or lawsuits'. My limited knowledge of this subject is that other studies have found a substantial correlation between illness and experience, suggesting that some specific factors may be causing the observed result in this case.

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Quality (254) Improving quality of care at the facility level (15) Quality improvement and patient experience

12 August, 2021
Citation, abstract and comment from me below.

CITATION: Patient experiences: a systematic review of quality improvement interventions in a hospital setting. Carla M Bastemeijer, Hileen Boosman, Hans van Ewijk, Lisanne M Verweij, Lennard Voogt, and Jan A Hazelzet. Patient Relat Outcome Meas. 2019; 10: 157–169. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6535098/

ABSTRACT

Purpose: In the era of value-based healthcare, one strives for the most optimal outcomes and experiences from the perspective of the patient. So, patient experiences have become a key quality indicator for healthcare. While these are supposed to drive quality improvement (QI), their use and effectiveness for this purpose has been questioned. The aim of this systematic review was to provide insight into QI interventions used in a hospital setting and their effects on improving patient experiences, and possible barriers and promoters for QI work.

Methods: Prisma guidelines were used to design this review. International academic literature was searched in Embase, Medline OvidSP, Web of Science, Cochrane Central, PubMed Publisher, Scopus, PsycInfo, and Google Scholar. In total, 3,289 studies were retrieved and independently screened by the first two authors for eligibility and methodological quality.

Data was extracted on the study purpose, setting, design, targeted patient experience domains, QI strategies, results of QI, barriers, and promotors for QI.

Results: Twenty-one pre–post intervention studies were included for review. The methodological quality of the included studies was assessed using a Critical Appraisal Skills Program (CASP) Tool. QI strategies used were staff education, patient education, audit and feedback, clinician reminders, organizational change, and policy change. Twenty studies reported improvement in patient experience, 14 studies of the 21 included studies reported statistical significance. Most studies (n=17) reported data-related barriers (eg, questionnaire quality), professional, and/or organizational barriers (eg, skepticism among staff), and 14 studies mentioned specific promoters (eg, engaging staff and patients) for QI.

Conclusions: Several patient experience domains are targeted for QI using diverse strategies and methodological approaches. Most studies reported at least one improvement and also barriers and promoters that may influence QI work. Future research should address these barriers and promoters in order to enhance methodological quality and improve patient experiences.

COMMENT (NPW): It is notable that every single study identified was from a high-income country. This suggests a lack of comparable research from LMICs.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (255) National commitment (34) Webinar: Decision-maker-led implementation research for strengthening health systems in LMICs (2)

13 August, 2021
Report - Decision-maker-led implementation research (DELIR) for strengthening health research in low and middle income countries (webinar held 10 August 2021)

I attended this webinar of behalf of HIFA in order to learn and develop a better understanding of research approaches relevant to health equity in LMICs and share my notes with you. The focus was on research into vaccination programs in these countries.
[https://www.hifa.org/dgroups-rss/quality-217-national-commitment-26-webi...]

Two case studies were presented – one from Nigeria and one from Pakistan.

In the Nigerian case, we were told about a research study which used Participatory Action Research (PAR) and involved local decision-makers with the research about vaccination. From this research they learnt about the power of joint planning; that collecting evidence in itself can lead to change; the PAR works well for structural effectiveness in

Nigeria; and that the context of commitment is important. They also discussed whether or not the approach is sustainable over a long period, and noted that their project needed a longer time period than the short-term research allowed.

In the Pakistan case study, DELIR research into childhood vaccination in the slums of Pakistan wanted to understand what the barriers are to childhood vaccination and where poor coverage was occurring. The research outcomes showed that there are barriers to successful vaccination programs; household barriers; gender insensitive services; vaccine hesitancy and social/religious barriers. They felt a significant success in the research was the engagement among various stakeholders.

In the round-up towards the end of the webinar, the Global Alliance for Vaccination and Immunization (GAVI) noted a number of their learnings from the DELIR research including that LMI countries have limited institutional capacity, and saw the need for better coordination between various parties.

I value this opportunity as a learner who wants to support HIFA and WHO GLL's work. I learnt how valuable and important locally-inspired research is in understanding health equity and vaccination programs in low and middle income countries. I learnt that there are many barriers but also that dedicated and engaged people can - and do - and are - changing inequity into potential success through locally-relevant research and partnerships among multiple stakeholders. It reminded me that we are travelling a very rough road but we get there together, and that I personally want to continue to learn and be involved as a global health citizen.

Here is a link to related DELIR research conducted in Ethiopia, from the website for Alliance for Health Policy and Systems Research:

Building capacity to take embedded implementation research to scale in Ethiopia (who.int)

https://ahpsr.who.int/newsroom/news/item/04-08-2021-building-capacity-to...

Here is a link to a special edition of Health Research and Policy Systems (vol 19, supp 2, August 2021) which published the research from Nigeria and Pakistan but also from related projects in Ethiopia, Chad, India and Uganda.

Health Research Policy and Systems | Decision maker led implementation research on immunization (biomedcentral.com)

https://health-policy-systems.biomedcentral.com/articles/supplements/vol...

I appreciated the chance HIFA gave me to attend the webinar and share this report with you. I continue to learn (ancora impara!) [*see note below]

Dr Ann Lawless, Perth, Western Australia, Australia.

HIFA profile: Ann Lawless is a sociologist and patient representative, currently based in Australia. She has worked in a community health centre as a health worker, has taught health issues at university level including Indigenous health; and has an active and long term interest in health advocacy. She is a member of the HIFA-WHO working group on Learning for quality health services.

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[*Note from HIFA moderator (Neil PW): Ann, thank you so much for representing HIFA and preparing this excellent report. I invite HIFA members to explore the issues raised. Email: hifa@hifaforums.org One thought I have is that the scope of implementation research is so broad, and the studies so contextually varied, that it is challenging to learn and apply from one setting to another? Also, implementation research itself is a heterogenous approach, so that methodological differences can make comparisons challenging also. On the latter point, I would be interested to hear from anyone who has attempted to do a systematic review of IR studies.]

Quality (256) Equity issues in inter-level quality health communication (2)

13 August, 2021
Advance Care Planning International: Digital Exchange Conference

Hello Everyone,

I would like to share information about a small but important access initiative of the ACP-i 2021 (Advance Care Planning International) Digital Exchange Conference (Aug 23-24), that I had mentioned earlier. They have decided to waive the registration fees for volunteers and provide full participation opportunities. [https://www.hifa.org/dgroups-rss/quality-178-acp-i-digital-exchange-adva...]

(Dr. Jessica Simon, a member of the ACP-i digital exchange organizing committee informs me that even if the details are not up on the Conference website, interested persons including unpaid volunteers who may wish to attend the international event can do so by sending an email to info@acp-i.org with details about the volunteer's name, email address, and a letter by the organisation formally confirming the application and particularly its association with Advance Care Planning and /or Palliative Care. Once the Conference Organizers receive the confirmed list, they will contact the volunteers (from August 16th) to access the special registration category.)

Access opportunities, particularly in Quality Health Learning and Information events, present some of the biggest participation challenges for various socio-economically disadvantaged groups in both HICs and the LMICs. I believe a facility based systematic adaptation of the

familiar model could prove to be an effective and inclusive approach for Stakeholder and Community Engagement at all levels of Quality Health planning.

Sincerely,

Esha Ray Chaudhuri, 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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

Quality (257) National commitment (35) Promoting a culture of quality (3)

13 August, 2021
Dear Joseph,

You note: "It is evidentially easier and better to 'catch them young', when promoting important issues like 'quality health care' and 'culture of safety'. For us we advocate starting at the 'pre-service training institutions' level..."

Would it not be true to say that the three pillars of quality - health outcomes, patient safety and patient experience - are already embedded to some extent in the curricula of medical, nursing and other frontline health worker training? The caveat here is 'to some extent': would anyone like to comment on what is currently missing or underrepresented in the training curriculum in your country? Looking back to my own medical training in the UK in the early 1980s, I think the emphasis was on health outcomes, then patient safety and then patient experience - in that order. Patient safety and patient experience have since rightly moved up the agenda.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (258) Improving quality of care at the facility level (16)

13 August, 2021
Adanna Chukwuma (USA), thank you for sharing your experience as a senior health specialist with the World Bank. You note inequality between quality of care available in urban versus rural areas of upper middle-income countries.

https://www.hifa.org/dgroups-rss/quality-245-improving-quality-care-faci...

There are also clearly inequalities between the few who can afford to pay for private care and the majority who cannot. Would anyone like to comment further on inequalities in quality of care?

Adanna also makes the point that current financing mechanisms do not incentive quality at the level of the individual facility. The senior hospital manager is likely to be focused on meeting targets that will help secure future funding, and these targets do not always align with measures of quality. Do you have experience in running a hospital or clinic? What were the key challenges in the work, and what impact did this have on your ability to focus on quality issues as compared with other issues?

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (259) Improving quality of care at the facility level (17) From the coalface of neighbourhoods and community health in Australia

13 August, 2021
My experience of quality of care at facility level has been as a patient myself, as carer to several friends and neighbours, and as a volunteer and (later) a paid staff member at a community health service. However in this true vignette I explore the issues through first my experience as a community member and second in a brief stint as a health worker. This true vignette explores issues for facility level service.

I saw an advert in a local newspaper for local community members to come to a neighbourhood house for a community picnic with the aim of developing a health support group in the area in which I lived. I had to talk myself out of reluctance to go alone as I was aware I knew no-one else who was going. Once I got there, I found it difficult to open the child-safe gate into the neighbourhood house! I thought it was a great chance to escape and indulge my introvert! But I heard a friendly warm voice calling to me to come join the community picnic, and a smiling health worker came and helped me open the gate and invited me in, introducing me to others who like me had come alone. The group got talking, first with some hesitation but then with growing comfort as the health worker facilitated the conversation with a smile and encouragement. By the end of the picnic several of us had made a commitment to help the health workers set up a health support group for unemployed workers and people with multiple disabilities, and we left with a diary entry for our next meeting. In the months that followed the health workers continued to meet locally with us. They had a short-term grant to concentrate their community health program in our neighbourhood, used a community development model for their work and had the support of their managers. The grant covered some costs for the neighbourhood program but not all, and the health workers asked us to approach local businesses to be sponsors for the picnics, which resulted in the local businesses donating food and drinks for community picnics (with meetings embedded in the process of picnicking!). We succeeded in being able to continue to put on community picnics and to a degree it allowed us to continue after the health grant ran

out but all our efforts were done frugally and with careful management of resources by community members and the health staff. Community members asked a local homeless woman to be our spokesperson, and she agreed and was given practical support from the office base of the health workers. This included access to a telephone, some stationery, access to office equipment, and occasional transport support. She spoke to the local press about our work in supporting improved health for unemployed and people with disabilities in our area and was active in all our group work.

There was a change of management and the new manager, appointed for his financial skills, had no experience in community health. We learnt that he was dismayed to find (in his words) a “dishevelled bag lady” was our spokesperson and he blocked her access to office facilities and to other managers, saying she was not suitably dressed or groomed. We refused to appoint anyone else but tensions rose both within the staff team supporting us, and within our group itself. We continued, and set up several successful community projects using short-term grants, but our earlier ease with each other now had become strained. Volunteers left when they secured work or jaded with the demands of community volunteering, and we had a rapid turnover of volunteers. One of the short-term grants allowed them to appoint a casual project officer, and they invited me to apply for the job of a short-term hourly-paid junior-grade community health worker. I was delighted and accepted. On my first day the local project team talked with me about the Ottawa Charter, community health and community development! As a junior project officer most of my job involved carrying furniture and setting up meetings, but I also had the chance to work with women with multiple disabilities and homeless women. Later the staff asked me to help write up reports!

As a result of a state election a new state government re-aligned health services and we learnt that most of the community health staff would face redundancy - being the first appointed, I was the first to go. The change of government also brought in different styles of management and a focus on financial accounting and justification of projects without reference to community health principles.

The biggest challenges for improving quality of care at the facility level that we encountered included insecure short-term funding for projects; insecure employment for casual and hourly paid staff; realignment of health funds to primary care and away from community health due to the political changes in governance at district and national level; and a change in management style which gave primary emphasis to financial accountability in health services and facilities. A major asset was the dedication, compassion and hard work of local staff in the health service, their willingness to devote their careers to areas which were value-inspired but where promotion was unlikely. Their long-term commitment to valuing humanity before all else was an asset. Also an asset was a local community which was both strong in a sense of community (it had strong community cohesion), but also one which was able to maximise the benefit of adherence to the principles and values of community health, particularly the Ottawa Charter. The local community was already fairly cohesive, but was further enabled by the values and principles of community health and community development.

Dr Ann Lawless, Perth, Western Australia, Australia.

Quality (260) National commitment (36) Promoting a culture of quality (4)

13 August, 2021
Thank you Neil for your comment on my post. You actually hit the nail on the head because your comment illustrates why I have always said that 'context is everything especially in our bipolar world of Global North and South. In most of global south the concepts you said were clear in your undergraduate medical are not so clear and in fact may be missing altogether in the curriculum: concepts and what they actually mean in practice after graduating like 'health outcomes', 'patient safety' and 'patient experience' are not taught until at post graduate CPD (continuing professional development) workshops.

Some medical students that we sponsor on attachments and observerships report back that their contemporaries in some LMICs in their penultimate year before graduation, are unaware of 'evidence based practice' and what it means, and that faculty seniors feel that clinical audit is a witch hunt a trap set by the managers of facilities to 'catch' them out, for instance.

In the North, quality and all its domains are part of the undergraduate curriculum but that is not the case in many countries in the South, in our experience. That is why we are working to change it, to catch them young so that they graduate already aware of quality care and what it means in practice.

Joseph Ana.

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National Healthcare Standards and Quality Monitor and Assessor
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HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.

Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

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Quality (261) Improving quality of care at the facility level (18)

13 August, 2021
This new paper in Global Health: Science and Practice 'aimed to synergize evidence-based technical interventions with quality improvement (QI) processes, respectful maternity care, and health system strengthening efforts'. The authors note: 'The Government of India has made efforts to improve the quality of care through various national policy initiatives, but the challenge of translating operational guidelines and plans to on-the-ground implementation remains.'

Citation, abstract, key findings and a comment from me below.

CITATION: Care Around Birth Approach: A Training, Mentoring, and Quality Improvement Model to Optimize Intrapartum and Immediate Postpartum Quality of Care

Gunjan Taneja, Enisha Sarin, Devina Bajpayee, Saumyadripta Chaudhuri, Geeta Verma, Rakesh Parashar, Nidhi Chaudhry, Jaya Swarup Mohanty, Nitin Bisht, Anil Gupta, Shailendra Singh Tomar, Rachana Patel, V.S. Sridhar, Anurag Joshi, Chitra Rathi, Dinesh Baswal, Sachin Gupta and Rajeev Gera

Global Health: Science and Practice August 2021, https://doi.org/10.9745/GHSP-D-20-00368

ABSTRACT

Background: With the highest risk of maternal and newborn mortality occurring during the period around birth, quality of care during the intrapartum and immediate postpartum periods is critical for maternal and neonatal survival.

Methods: The United States Agency for International Development’s Scaling Up Reproductive, Maternal, Newborn, Child, and Adolescent Health Interventions project, also known as the Vriddhi project, collaborated with the national and 6 state governments to design and implement the Care Around Birth approach in 141 high caseload facilities across 26 high-priority districts of India from January 2016 to December 2017. The approach aimed to synergize evidence-based technical interventions with quality improvement (QI) processes, respectful maternity care, and health system strengthening efforts. The approach was designed using experiential training, mentoring, and a QI model. A baseline assessment measured the care ecosystem, staff competencies, and labor room practices. At endline, the approach was externally evaluated.

Results: Availability of logistics, recording and reporting formats, and display of protocols improved across the intervention facilities. At endline (October–December 2017), delivery and newborn trays were available in 98% of facilities compared to 66% and 55% during baseline (October–December 2015), respectively. Competency scores (> 80%) for essential newborn care and newborn resuscitation improved from 7% to 70% and from 5% to 82% among health care providers, respectively. The use of partograph in monitoring labor improved from 29% at the baseline to 61%; administration of oxytocin within 1 minute of delivery from 35% to 93%; newborns successfully resuscitated from 71% to 96%; and postnatal monitoring of mothers from 52% to 94%.

Conclusion: The approach successfully demonstrated an operational design to improve the provision and experience of care during the intrapartum and immediate postpartum periods, thereby augmenting efforts aimed at ending preventable child and maternal deaths.

KEY FINDINGS

1. Adopting an integrated implementation framework that combined training, mentoring, and quality improvement processes to improve the quality, equity, and dignity of care during the intrapartum and immediate postpartum periods, the Care Around Birth approach addressed key drivers of maternal and newborn mortality.

2. The approach refocused energy on facility-based quality processes that are currently central to efforts in reducing mortality and achieving Sustainable Development Goal targets.

KEY IMPLICATIONS

1. Integrated implementation frameworks need to be aligned to the resources available and tailored to the ecosystem in which health programs operate.

2. Facility-level ownership and accountability by optimizing the engagement of health staff remain the fulcrum for any improvement effort. This however needs to be adequately supported by district and state-level health systems.

COMMENT (NPW): I have not had a chance to study this paper in depth, but I wonder how easy it is to apply the findings to other settings. Also, the multimodal approach makes it difficult to know which are the most important elements to implement. It's also not clear why there is such a long gap between the end of the intervention (December 2017) and publication (August 2021).

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (262) Improving quality of care at the facility level (19) QI tools; COVID-19; Communities/families

13 August, 2021
Greetings Everyone,

I hope that you are all well.

Thank you for your participation in the discussion so far, I have enjoyed reading your posts. We are now entering the final week of our discussion exploring quality improvement issues at the facility level and we invite you to consider the below questions. All messages in the discussion to date are available here for review: https://www.hifa.org/rss-feeds/17

- Actions at the facility level to improve quality of care are based on an iterative approach to quality improvement that supports refinement over time. QI approaches that are utilized at the facility level, in a cyclical manner include (WHO Quality Health Services: a planning guide <https://scanner.topsec.com/?t=934ec951efb4fbbd9f51f5a557efc3aedcde6406&d..., Figure 4, page 39): commitment to district and/or national QI aims and identification of facility aims; establishment, organization and support of QI teams; identification of gaps; adoption of standards of care; action plan development; implementation of plans; measurement of quality and outcomes; and continuous improvement, sustainability and refinement of plans.

Many different approaches, tools and resources may be employed to improve the quality of health services at the facility level.

What quality improvement tools have been most useful as you improve care at the facility-level?

- The COVID-19 pandemic has presented challenges at the facility level in terms of responding to the pandemic and maintaining quality health services. We now invite you to share your experiences and insights with respect to these challenges.

How has the COVID-19 pandemic challenged quality of care in your health facility? How have you responded to these challenges? Do you see particular solutions to maintain quality in the current COVID-19 context?

- The health facility is the place where health services are delivered to the patients, their relatives and the local community, including community-based organizations and workers. Communities should be active partners in the development, implementation, and evaluation/monitoring of QI projects in transparent and sustainable ways (WHO Quality Health Services: a planning guide, page 38).

We invite you to consider the below question:

What could be the role of communities/families in improving quality of care at the facility level?

As always, I look forward to reading your posts.

Best wishes,

Treasa.

HIFA profile: Treasa Kelleher is a Specialist Registrar in Public Health Medicine at the Health Service Executive, Ireland. She is currently working with the Quality Team in the WHO Department of Integrated Health Services. Professional interests: Global Health and Quality of Care. She is a member of the WHO-HIFA working group on Learning for quality health services.

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Quality (263) Improving quality of care at the facility level (20) Changes in health worker knowledge and motivation in Ethiopia

13 August, 2021
A new paper in Health Policy and Planning finds that 'although QI programmes can increase health worker knowledge, there may be little effect on motivation'. Citation, abstract and a comment from me below.

CITATION: Changes in health worker knowledge and motivation in the context of a quality improvement programme in Ethiopia

Matthew Quaife, Abiy Seifu Estafinos, Dorka Woldesenbet Keraga, Julia Lohmann, Zelee Hill, Abiyou Kiflie, Tanya Marchant, Josephine Borghi, Joanna Schellenberg

Health Policy and Planning, https://doi.org/10.1093/heapol/czab094

Published: 10 August 2021 Article history

ABSTRACT: A knowledgeable and motivated workforce is critical for health systems to provide high-quality services. Many low- and middle-income countries face shortages in human resources and low health worker motivation but are also home to a burgeoning number of quality improvement (QI) programmes. This study evaluates whether and how motivation and clinical knowledge in three cadres of health workers changed in the context of a QI programme for maternal and newborn health in Ethiopia. This mixed-methods study used a pre–post comparison group design with matched comparison areas. We interviewed 395 health workers at baseline in April 2018 and 404 at endline in June 2019 from seven districts (woredas) with QI and seven comparison woredas. Three cadres were interviewed:

health extension workers, facility-based skilled midlevel maternal and newborn care providers, and non-patient-facing staff. A qualitative component sought to triangulate and further elucidate quantitative findings using in-depth interviews with 22 health workers. Motivation was assessed quantitatively, exploratory factor analysis was used to categorize motivation dimensions, and regression-based difference-in-difference analyses were conducted. Knowledge was assessed through a clinical vignette. Qualitative data were analysed in a deductive process based on a framework derived from quantitative results. Although knowledge of the QI programme was high (79%) among participants from QI woreda at endline, participation in QI teams was lower (56%). There was strong evidence that health worker knowledge increased more in areas with QI than comparison areas. Three motivation dimensions emerged from the data: (1) ‘helping others’, (2) ‘pride and satisfaction’ and (3) ‘external recognition and support’. We found strong evidence that motivation across these factors improved in both QI and comparison areas, with weak evidence of greater increases in comparison areas. Qualitative data suggested the QI programme may have improved motivation by allowing staff to provide better care. This study suggests that although QI programmes can increase health worker knowledge, there may be little effect on motivation. Programme evaluations should measure a wide range of outcomes to fully understand their impact.

COMMENT (NPW): Our discussion on quality to date has focused on the three elements of 'health outcomes, patient safety, patient experience'. These elements are not measured in the current study, which measures health worker knowledge and motivation. These latter two characteristics are presumably determinants of quality, rather than measures of quality itself. I would like to invite your thoughts on the concept of 'quality' and the 'determinants of quality'. One of the determinants of quality, which is closely linked to motivation, is compassion. There are many others...

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (264) Reflections on "Challenges" as "Solutions" in planning Quality Care

14 August, 2021
Covid Vaccines for Kids Can't Wait

(Opinion : The New York Times Aug. 9, 2021)

[https://www.nytimes.com/2021/08/09/opinion/covid-vaccine-children-fda.html]

Hello All,

In the Final Reflections Section (p.48 Quality health services: a planning guide [https://www.who.int/publications/i/item/9789240011632]) we learn about the critical role of 'Challenges' and 'Barriers' as important measures of solutions: 'Challenges and barriers to

progress are manifold and varied. These will continue to be collated by WHO as part of efforts to learn from frontline experiences across the world. It is often when examining these challenges and barriers that solutions emerge.'

The article cited above and more importantly comments on its implications in the Hastings Center Report: (The F.D.A. and the Moral Distinction Between Killing and Letting Die

https://www.thehastingscenter.org/the-f-d-a-and-the-moral-distinction-be...

I believe, engage, *all five* "outstanding implications" of the systems approach to enhance quality of care, (1) the foundational requirements, (2) the health systems levers, (3) the culture of quality, (4) implementation of quality interventions and (5) the diversity of priorities - as described in the Guide (p.48).

The article on COVID and Kids and the Ethical Comments posted by the renowned Hastings Centre, also provide an interesting example of the interplay of ethical and clinical dimensions of Quality Care planning particularly within the lens of Stakeholders whose Care experiences, especially in situations of serious illness, are typically framed within an asymmetrical context of interaction at the Facility level.

Perhaps the insights, expertise and experience of the global community of HIFA Forum participants would identify a solution through revisiting the Plans for Quality care within the lens of its ELSI profile - the ethical, legal and social implications of health and healthcare in all parts of the world.

Sincerely,

Esha Ray Chaudhuri

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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

Quality (265) Improving quality of care at the facility level (21) Patient experience

14 August, 2021
The message below is forwarded from our child health forum CHIFA, with thanks to Nisha Bhatta, Nepal.

The main challenges are

1. Access.

Accessibility and availability of both the hospital and the health worker should be assured to all those who require health care

2. Waiting.

Waiting times for all services should be minimized.

In most developing countries, the high demand for services often makes this a huge problem. nevertheless, it has to be addressed effectively through continual review of patient response and other data and using this feedback to make the necessary change

3. Information.

Patient information and instruction about all procedure, both medical and administrative should be made very clear. Well trained patient counsellors from an effective link between the patient and hospital staff and make patient's experience better and health worker task much easier.

4. Administration

Check-in and check-out procedures should be "patient friendly". For example, for in-patient, we have instituted system of discharging patient in their rooms, eliminating the need for the patient or the family member to g to another office or counter in the hospital and waiting there for a long time. This has been favorably received by patient.

5. Communication. Communicating with patient and the family about possible delays is a factor that can avoid a lot of frustration and anxiety. The creation of a special "patient care department" with a full time administrator or person designated for that depending on the facility level will helped facility health services and will enhance interactions with patient and their families

6. Ancillary services. Other services such as communication, food etc should be accessible both to patient and to attending families

HIFA profile: Nisha Bhatta is professor in Division of Neonatology, Department of Pediatrics in B.P. Koirala Institute of Health Science (BPKIHS), Dharan, which is Largest Tertiary Care University Teaching Hospital in Nepal. She is involved in teaching Neonatology and providing support to policy issues and academic initiatives related to newborn health in close association with Government of Nepal and other International partners. She is passionately interested in Quality Improvement (QI) Science. She is a member of the HIFA-WHO working group on Learning for quality health services.

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Join CHIFA: https://www.hifa.org/join/join-chifa-child-health-and-rights

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (266) Improving quality of care at the facility level (22) Measuring quality: patient experience

14 August, 2021
When discussing actions at the facility level to improve quality of care, Treasa rightly pointed out that it has to be based on an iterative approach to quality improvement that supports refinement over time. There is no doubt that an important facet of that is quality measurement, and recently a paper was published analysing healthcare services provided by 18 departments in one university hospital centre in Croatia. The authors based their approach on the Gaps Model of Service Quality and the SERVQUAL instrument. The paper (Ozretic Dosen et al. Acta Clin Croat 2020;59:285-93, doi: 10.20471/acc.2020.59.02.12) is freely accessiblee here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7808225/

The aforementioned Gaps Model of Service Quality (and its SERVQUAL instrument) represent one of the most pervasive multidimensional models for measuring service quality. What is underneath this model is the definition of service quality as a salient comparison between what is provided and what was expected in order to recognize and understand the gaps occurring in the service delivery process. In that regard, SERVQUAL has basically been used to measure the quality of different healthcare services on a facility level for more than 30 years.

In a nutshell, SERVQUAL basically offers a very convenient approach for recognizing the patient perceptions and expectations across different hospital departments, which are indispensable 'nuggets' of information for future managerial decisions. This paper found that patients' expectations exceeded the perception of the actual service received; hence, on a facility level, patients should be considered as main actors when gauging service quality. The authors also underscore that hospital managers should be by far more interested and receptive to the information provided by patients in order to increase the overall quality of care in an institution.

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering

initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. He is also a member of the HIFA-WHO working group on Learning for quality health services.

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Quality (267) Improving quality of care at the facility level (23) Patient information

15 August, 2021
Good day Neil

I do agree with the statement that "Patient information and instruction about all procedure, both medical and administrative should be made very clear."

In my opinion, the information provided to a client is an important measure of the quality of care provided. In my experience in the retail pharmacy sector l have noticed a disparity in this aspect of care between the public and private sector.

A client serviced in the public sector often has no clue what their prescription or condition diagnosed is about. The pharmacy counter becomes the point from which they get their questions answered but this requires giving them time and then balancing the waiting time for those in line to access services.

Clients from the private sector generally have more information about their prescription or condition. However, some will ask the pharmacist for confirmation or will indicate that they were not comfortable bothering the doctor with their enquiries.

To adress this information gap, at the private specialist oncology pharmacy l managed, we had to create a counselling room in which a dedicated member of staff took time to discuss patient questions and concerns. This service especially catered for clients that came from the public sector to purchase their medications. Unfortunately, this was not documented. We even went to the extent of joining the medical teams in the oncology wards for grand rounds in order to understand the context from which clients came from so that we could provide better quality information and service to them.

However, it was clear to us that information provision to the patient should form an integral part of holistic quality care.

In the public sector in Zimbabwe,the HIV/AIDS program has introduced a cadre called a Primary Care Counsellor who is trained to provide information and counselling to People

Living with HIV. l think this model should be expanded to cater for all clients visiting health facilities.

It would be good if colleagues from other regions of the world could share publications that could assist in adopting health delivery models that cater for provision of health information to clients in a health facility setting.

Thank you.
Regards,
Venus

HIFA profile: Venus Mushininga is a pharmacist with the Ministry of Health and Childcare in Zimbabwe. She is a founder and President of the Zimbabwe Society of Oncology Pharmacy and the Zimbabewan delegate to the European Society of Oncology Pharmacy. Professional interests: Oncology, Dissemination of information through to Health Professionals and the public, Research. She is co-coordinator of the HIFA working group on information for Prescribers and Users of Medicines.

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Quality (268) Patient engagement in health service design and policy

15 August, 2021
Patient engagement presentation Professor Sima Marzban, Gillings School of Global Public Health, University of North Carolina, Chapel Hill, USA.

https://www.youtube.com/watch?v=Plnvc85o3GM

https://irispublishers.com/ijnc/pdf/IJNC.MS.ID.000565.pdf

COVID-19 pandemic draws stakeholders' attention to strategies highlighting the patients' potential role and responsibilities in improving healthcare outcomes.

There has been a constant effort to inform and educate patients to be compliant and adhere to the pre-planned treatment pathways/protocols based on existing evidence, insurers' policies, and providers' preferences. But after-Covid healthcare market transition reveals the game-changing impact of patients' priorities and personal behaviors on how they respond to surrounding decisions. Facts support the crucial need to update patient-oriented paradigms like Patient Engagement (PE) that prefer valued, informed, heard, and activated patients to contribute to all aspects of care, including healthcare policies, and processes. The current healthcare industry perception of PE incompletely addresses the patients' rights to access and

share health records, prescriptions, transparent prices, billings, and information sources to take responsibility and control over the care.

This, while patients can influence not only their personal care but also the peer population policies for future services.

On the other hand, patients' contribution to the service design and interventions helps us acknowledge diverse values and personalize the care process based on individual variables. As a result, passive unilateral patient engagement efforts such as patient and family education should evolve to active two-ways hearing of the patient voices incorporating their needs and expectations in individual care planning as much as health systems design and development. This evolution will be built on two fundamental changes;

- How patient-centeredness and engagement is directed and objectified by payors, providers, and supplier industries,

- How accreditation and healthcare quality institutions measure, assess, and evaluate patient-oriented interactions and quality measures.

Patient engagement requires exploring clinical and non-clinical insights from patients' eyes in addition to other stakeholders to reduce the gaps between therapeutic systems' and patients' actual needs and preferences.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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Quality (269) Promoting a culture of quality (34) Quality of care in rural areas of sub-Saharan Africa

15 August, 2021
This is a very interesting topic.

In my very particular experience, "quality" is absent from the medical or health sciences training curriculum. I would like to emphasise two ideas: first that "quality" should be ideally seamlessly embedded into health services delivery; it is "a way" of doing things. Of course, quality has dimensions, has to be measured and some interventions may need to be put into place. But at the very heart, it should run (almost) unnoticed. Second, that "quality" refers to a service; however, in many situations, health workers conditions are so precarious, infrastructures so deteriorated, drugs and supplies so lacking, that it can hardly be conceived

as a service to the community. I think we cannot argue that situations of flagrant deprivation can aim at having some "formal" quality initiative without considering the very minimum requirements to deliver a service with dignity. I am thinking of remote, rural areas in Sub-Saharan Africa, were isolated health workers have the responsibility of health status of large communities. I would call for a clear spell out of inequities and unfairness in the delivery of services.

Xavier

Xavier Bosch-Capblanch. MD, MSc, PhD - Specialist in Public Health
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Is poverty a 'natural disaster' or a human-made phenomenon?

Consequences for ethics in Public Health

The International Journal of Tuberculosis and Lung Disease<https://www.ncbi.nlm.nih.gov/pubmed/30606310>

[PHISICC] <http://phisicc.org/> Paper Health Information Systems in Child Care<http://phisicc.org/>

Quality (270A) Promoting a culture of quality (35) Quality of care in rural areas of sub-Saharan Africa (2)

15 August, 2021
Xavier, thank you for your observation about 'quality' in SubSaharan Africa (SSA).

Precisely why in 2004 we had to develop the 12Pillar Clinical Governance Programme ('˜Protecting Patients, supporting practitioners in tandem') advocating the very points that you observed. In high income countries the availability of equipment, medicines, commodities, water, power, sanitation and waste management is guaranteed, so the practitioners can concentrate on 'protecting patients', rightly so.

In SSA these basic fundamentals for quality are often missing or if present are non functional.

Joseph Ana

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

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Quality (270B) Improving quality of care at the facility level (24) Patient information (2)

16 August, 2021
Venus, I believe that some of your answers are in the Institute of Medicine's "Crossing the Quality chasm" IOM report: Crossing the Quality Chasm: A new Health System for the twenty first millennium.

The report finds that the current system is unable to provide safe, high quality care in a consistent manner. It consists of 10 rules to redesign the health system and a series of recommendations, including the allocation of $1 billion by Congress to support reform efforts. Crossing the quality Chasm can be read or ordered on line at www.nap.edu [https://www.nap.edu/catalog/25152/crossing-the-global-quality-chasm-impr...]

Although it was thought by some that this report would not catch as much attention as the first, it has created quite a splash in the media. Headlines such as "US Health Care System said lacking" and "IT must BE used to reform US Health System" can be found in both the trade and popular press.

New rules to redesign and improve care

Private and public health purchasers, health care organisations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

1. "Care based on continuing healing relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health

care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the internet, by telephone, and by other means in addition to face-to-face visits.

2. Customisation based on patient needs and values. The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

3. The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over the health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision-making.

4. Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

5. Evidence-based decision-making. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

6. Safety as a system property. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

7. The need for transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based-practice, and patient satisfaction.

8. Anticipation of needs. The health system should anticipate patient needs, rather than simply responding to events.

9. Continuous decrease in waste. The health system should not waste resources or patient time.

10. Co-operation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and co-ordination of care.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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Quality (271) Quality of care in the COVID-19 era: a global perspective

17 August, 2021
Greetings all -

An important piece just published.

Quality of care in the COVID-19 era: a global perspective

https://buff.ly/3xgjeVI

Its a quick read.

Shams

HIFA profile: Shams Syed is the Quality Team Lead within the Department of Integrated Health Services in the UHC & Life Course Division at WHO Headquarters in Geneva. He is a member of the HIFA working group on Essential Health Services and COVID-19. https://www.hifa.org/support/members/shams https://www.hifa.org/projects/essential-health-services-and-covid-19 syeds AT who.int

Quality (272) GHCR Report: Compassion, WASH, and Quality of Care

17 August, 2021
Now available! Read the newly released report from the Global Health Compassion Rounds on Compassion, WASH and Quality of Care.

Compassion, WASH, & Quality of Care
Report & webinar recording available now!
View recording https://www.youtube.com/watch?v=E8887NMLhWc
Download report https://taskforce.org/global-health-compassion-rounds-volume-6-report/

This Global Health Compassion Rounds explored how WASH interventions are vectors for compassion and why recognizing this can accelerate urgent action in quality of care improvements.

Thank You to Our Panelists

Sheillah Simiyu
African Population & Health Research Center

Sheillah is a public health researcher focused on WASH issues in urban settings, informal settlements, and child nutrition. In addition, she has consulted for over 10 years with organizations such as World Vision, Action Against Hunger, and SNV Netherlands Development Organization. She is interested in gendered aspects of WASH, as well as psychosocial well-being in relation to WASH.

Omar El Hattab
WASH Regional Advisor,
UNICEF Middle East & North Africa Region

Omar's regional portfolio with UNICEF includes over 10 countries, including Yemen, Syria, Iraq, and others. With over 25 years of experience, he has also served as Chief WASH with UNICEF in several duty stations, as well as Technical Advisor for UNDP and the Kuwait Fund for Arab Economic Development. He is keenly interested in human-centered and sustainable WASH interventions for vulnerable, conflict-affected populations.

Stephanie Ogden
Water Team Director, CARE

Stephanie leads CARE's water and development work, focused on systems strengthening and institutional development to ensure sustainable, equitable water and sanitation services for all. She began her career in WASH as a Peace Corps volunteer in rural El Salvador, where she focused on WASH and women's empowerment. With over 18 years experience, she has lived and worked with organizations in Latin America, Africa, and Central Asia.

Bruce Gordon
Unit Head of WASH
World Health Organization

Bruce oversees a global portfolio of water and health-related work ranging from development of norms on drinking-water and wastewater/sanitation to global monitoring of access to WASH and burden of disease. He has contributed to WHO's work on sustainable development with a focus on children's health and environment.

Maggie Montgomery
Technical Officer, World Health Organization

As the "WASH Settings" team lead, Maggie focuses on WASH in health care facilities, household water treatment technology performance, and WASH in emergencies. In addition to global efforts, she supports a number of country-focused WASH efforts in sub-Saharan African and southern Asia. She is also a licensed civil engineer in the State of California with experience developing recycled wastewater projects.

Stay Tuned!

The next Global Health Compassion Rounds will be held in September, when we explore Compassion & Neglected Tropical Diseases (NTDs).

GHCR is hosted by the Focus Area for Compassion and Ethics (FACE) at the Task Force for Global Health and the Global Learning Laboratory (GLL) at the World Health Organization.

Questions? Email us at face@taskforce.org

Focus Area for Compassion and Ethics (FACE)
330 Ponce de Leon Ave NE
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Quality (273) Patient experience and health outcomes (13)

17 August, 2021
Dear Tomislav and all,

Thank you for your message: 'Quality (266) Improving quality of care at the facility level (22) Measuring quality: patient experience'

You refer to the paper from Croatia: Ozretic Dosen et al. Acta Clin Croat 2020;59:285-93, doi: 10.20471/acc.2020.59.02.12) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7808225/

"This paper found that patients' expectations exceeded the perception of the actual service received; hence, on a facility level, patients should be considered as main actors when gauging service quality."

It is interesting that quality is seen primarily through the lens of patient experience. I would be keen to know what is the gap between patients' expectations and reality across different countries. I suspect that patients' expectations will inevitably increase as health systems become stronger, and that there will always be a gap between expectations and reality.

More generally, our discussion on quality has looked at two perspectives: patient experience and health outcomes.

I invite HIFA members to consider these (and other) perspectives on quality. (As I write 'other' I think, for example, in terms of equity and justice.)

It can be argued that patient outcomes (morbidity and mortality) should be the primary measures of quality. In weak health systems where morbidity and mortality are high due to poor quality of care, this is perhaps especially the case. Perhaps the most important indicator of quality is that the healthcare provider makes the right diagnosis and provides the right treatment? And yet, from the patient's perspective, it is their experience that matters. Some

healthcare providers, whether allopathic or traditional, can consistently provide a positive experience, with or without the 'correct' diagnosis and treatment.

I look forward to hear people's views.

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (274) Improving quality of care at the facility level (25) Patient information (2)

17 August, 2021
Dear Venus,

Thank you for your message. https://www.hifa.org/dgroups-rss/quality-267-improving-quality-care-faci...

"It was clear to us that information provision to the patient should form an integral part of holistic quality care."

Indeed, empowering people with the information they need to protect their own health is surely an essential part of 'quality care'. And yet this is often neglected, or impossible, in the time constraints of a consultation that may last only a few minutes. All credit to you and your colleagues that 'at the private specialist oncology pharmacy I managed, we had to create a counselling room in which a dedicated member of staff took time to discuss patient questions and concerns'. In a fair and equitable society, all patients, private and public sector, should be able to discuss their concerns.

Meeting information needs is one aspect of quality health care. It is important not only in terms of patient experience but also in terms of health outcomes.

How can we better meet the information needs of patients in low-resource settings?

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (275) Quality of care in rural areas of sub-Saharan Africa (3)

17 August, 2021
Dear Xavier,

You say: "In many situations, health workers conditions are so precarious, infrastructures so deteriorated, drugs and supplies so lacking, that it can hardly be conceived as a service to the community. I think we cannot argue that situations of flagrant deprivation can aim at having some "formal" quality initiative without considering the very minimum requirements to deliver a service with dignity. I am thinking of remote, rural areas in Sub-Saharan Africa, were isolated health workers have the responsibility of health status of large communities."

You make a really important point. The implication is that the approach for quality improvement may be different for a low-resource environment as compared with a well-resourced environment.

Can other HIFA members provide insights about this? In situations where the basic needs of healthcare providers are not met - where they lack (for example) skills, equipment, information, systems support, medicines, incentives, and/or communication facilities - should the emphasis be on trying to bridge the gaps? Can quality improvement approaches be introduced successfully in such situations? I look forward to hear examples and case studies.

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (276) Patient experience and health outcomes (14)

18 August, 2021
Patients will find it easier to match expectations and reality when they are treated like adults and when patients, too, routinely have access to the clinical guidelines and care pathways that they are put on - a very easy but rarely practised process.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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Quality (277) Improving quality of care at the facility level (26) Patient information (3)

18 August, 2021
One method of improving retention of information and understanding is to promote the attendance of partners and friends to consultations. When patients hear bad or good news they lose concentration of the next part of the consultation. Friends and partners can facilitate recall and the maintenance of successful retentive communication. This can be difficult for younger inexperienced clinicians and maybe could be taught?

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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Quality (278) Improving quality of care at the facility level (27)

18 August, 2021
"From your experience, what are the biggest challenges for improving quality of care at the facility level? Have you seen any practical solutions that should be shared more widely?"

As previously discussed, the greatest challenge to quality at the facility level are available resources. Without resources, the responsibility passes to the training, commitment, and spirit of the health care providers. In this context, positive feedback from funders, MoH, and the community makes a big difference to the spirit and positive energy of the health care providers, therefore improving quality of care.

HIFA profile: Sebastian Kevany is a former consultant with the World Health Organisation (WHO), Ireland & USA. Professional interests: Global health security and diplomacy. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems.

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Quality (279) Improving quality of care at the facility level (28) Patient information (4)

18 August, 2021
[*see note below]

https://www.england.nhs.uk/atlas_case_study/introducing-group-consultati...

Group Consultations are very effective and time saving and create peer group support for patients

Leading change

General practice nurses (GPN) in the Premiere Health Team, Leigh (Wigan CCG) and West Gorton (Manchester CCG) medical practices introduced group consultations for adults with Type 2 Diabetes. This new approach has led to better outcomes, experiences and use of resources locally.

Where to look

Uncontrolled diabetes can lead to serious complications, but personalised care-planning enables people to manage their diabetes more effectively. [...]

What to change

There were many patients with Type 2 diabetes registered with GP practices. The GPNs knew they spent significant time in consultations with patients about managing their diabetes and were aware that their repetition of information and advice was not impacting on health outcomes. It was identified that group consultations could be an opportunity to improve outcomes and access, whilst engaging patients in a different way that offered the potential to provide a more social and less medical model of planned care. Experience in other parts of England suggested that it could also improve staff experience by reducing repetition and creating more time to care and support patients [...]

Adding value

Better outcomes – Across the two practices, 31 patients that were followed up at 3 months achieved an average 10% reduction in HBA1c, indicating an improvement in blood glucose management [...]

Better experience – Patients reported high satisfaction rates and that they learnt more in the group compared to 1:1 consultations, even if their diabetes was already well controlled. [...]

Another Patient's feedback said: "you've listened to these people talking and you go away thinking I'm not the only diabetic in the world. Even though we are all different, we are in the same group... it's brilliant. I don't know where I would be without it." [...]

Better use of resources – West Gorton practice calculated significant efficiency gains in clinician time. The nurse consulting saw 8-9 patients in 60 minutes; the same time it would have taken to see 4 patients in a 1:1 clinic.

HIFA profile: Richard Fitton is a retired family doctor - GP, British Medical Association. 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

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[*Note from HIFA moderator (Neil PW): The text above is reproduced from the NHS website. The full version is available at the URL above.]

Quality (280) Patient experience and health outcomes (15)

18 August, 2021
Dear Neil,

Many thanks for highlighting some very important points relevant for this topic. I agree there are other important measures of health quality, and especially patient outcomes when weaker health systems are considered. In my view, patient experience measures should be viewed as a complement to health outcomes and clinical quality measures, and not as a primary point of interest.

Furthermore, I believe that patient experience, akin to other quality measures, has to be evaluated with standardized instruments and protocols, and continual oversight has to be implemented to ensure reliability. There is also an inherent subjectivity, which is why the ability of such surveys to evaluate healthcare quality is often questioned.

That being said, surveys of patient experience can capture an essential dimension of care quality, irrespective of the correlation between patient experiences and other measures of health care quality. I believe as healthcare systems around the world continue to develop, measuring patient self-reports in routine healthcare may become a standard process in evaluating quality of care.

HIFA profile: Tomislav Mestrovic is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. Tomislav is the current holder of the HIFA Country Representative of the Year award (2020) and is also the European coordinator for HIFA Country Representatives. He is also a member of the HIFA-WHO working group on Learning for quality health services.

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Quality (281) Quality of care in the COVID-19 era: a global perspective (2)

18 August, 2021
Dear Shams and all,

Many thanks for the link to the paper 'Quality of care in the COVID-19 era: a global perspective' https://buff.ly/3xgjeVI

The Key Messages from the paper are reported as:

1. This article traces the progression of the COVID-19 pandemic from inception through to the present.

2. Even before COVID-19, previous pandemics tested health services and had trouble keeping patients safe and providing quality care especially during the height of the crisis.

3. There is a strong requirement for health care systems to simultaneously deal with the pandemic and provide safe, high-quality care.

4. This means being resilient, and supporting the natural capacities health systems have to be adaptable, flexible, and responsive.

However, for me the central message of the paper is the need to fully engage the skills and experience of specialists in quality improvement and patient safety, even in (especially in) the midst of the pandemic. They refer to another paper by Staines et al:

'Over the time that the pandemic has been challenging health systems, there may have been a tendency to overlook the contribution that quality and safety staff could provide to support efforts. This is especially so when caring environments had to be reorganized to cope with the immediacy of the accelerating numbers of infectious patients. Staines et al suggested that it was important not to fail to harness patient safety and quality of care personnel who had much to offer and who might otherwise be underutilized or even marginalized. Their article was a plea for creating leverage and liberating expertise...

'All in all, even during dire times when almost everything must be COVID-19 focused and everything else deemed non-urgent is de-prioritized, we ought to not neglect everyday care and the quality of care provided to all patients.'

What is missing (for me) is a situational analysis and practical steps forward. As Treasa asked a few days ago on HIFA, "How has the COVID-19 pandemic challenged quality of care in your health facility? How have you responded to these challenges? Do you see particular solutions to maintain quality in the current COVID-19 context?"

I invite everyone, and especially specialists in quality improvement and patient safety, to share your views on these questions.

Quality is bound to be affected when weak health systems are put under the huge pressures of the pandemic. But have there been *avoidable* impacts on quality and can ongoing impacts be minimised more effectively? What is the current situation with regards to the availability

of quality and safety professionals at the national, district and facility levels in different countries and especially in LMICs? Has their potential contribution to maintain quality during the pandemic been 'overlooked'?

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (282) Improving quality of care at the facility level (29) Publications to support hospital managers

18 August, 2021
Treasa (WHO) asked: "What quality improvement tools have been most useful as you improve care at the facility-level?"

She notes that 'Many different approaches, tools and resources may be employed to improve the quality of health services at the facility level'

I would like to ask HIFA members what you use, or have used, to support quality improvement in your hospital (or facility)? Is there a particular practical guide that is outstanding in this respect?

We have heard from Joseph Ana about the 12 pillars of clinical governance. What other publications exist that can support managers, especially those in low-resource settings?

How might the WHO Quality Planning Guide
[https://www.who.int/publications/i/item/9789240011632] be used together with existing hospital management guides and quality improvement technical guides?

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (283) Improving quality of care during conflict situations

18 August, 2021
(This contribution is forwarded from Chiabi Bernard Ful, HIFA member in Cameroon, with thanks. Neil PW)

In conflict situations, quality health care is deteriorating. In such cases, health facilities and health workers are targeted by armed men. Health facilities are even closed down and health workers are even killed. Some health workers have lost their lives in providing or offering health services to patients. Some have resigned while others have fled for safety as the

conflicting situation is prevailing while some have done so due to low pay or lack of incentves.

Continuous road blocks by Non State Armed Groups (NSAGs) also render movement difficult for patients to travel to the hospital or health centre. This is the case in Anglophone Cameroon. Some humanitarian organisations that have been working to improve on quality health services have been suspended from carrying out their services. Medicins sans Frontieres (MSF) has been suspended from carrying out her services in North West Cameroon, one of the conflict zones in anglophone Cameroon by the administration.

To improve on the quality of services,

- Staff should be motivated through incentives. This will avoid private practice (PP).

- Armed groups both state and non state should stop targeting health units and their workers.

- Humanitarian organisations should be allowed to offer their services without any intervention or interference. They work under the humanitarian principles. They should continue to train health care providers, while building their capacities through training and transfer of knowledge and skills.

- Community health workers should be empowered with knowledge and skills to improve on quality health care in their communities.

HIFA profile: Chiabi Bernard Ful is Director of Boyo Association for Rural Development (BARUDEV--Cameroon). This is a local NGO found in Boyo district of North Western Cameroon. Our activities are to empower women, protect the sexual and reproductive health for women and girls, and protect the rights of children. We have been training community health workers to follow up patients, pregnant women, sick children and refer them to the hospital. barudev AT yahoo.co.uk

Quality (284) Improving quality of care at the facility level (30) Staff absenteeism

19 August, 2021
One of the most significant challenges to the delivery of quality health services in Kurdistan region of Iraq's health facility is related to staff absenteeism. Large percentages of healthcare workers engage in dual practice spending only few hours in the public health sector.

After the Iraq war of 2003, the for-profit- private sector has expanded exponentially. The not-for-profit sector was also considerable during the years of sanctions 1991-1996 and the Oil for food programme 1996-2003 and continued to play a role after 2003.

Both the for and not-for-profit sectors resulted in a brain drain from the public sector. Doctors and nurses engaged in dual practice. They started spending less time in the salary

based public sector to spare them more time to spend in the fee-for-service based private sector.

With the financial crisis associated with the ISIS conflict of 2014 even more health workers engaged in dual practice to cushion the losses resulting from that crisis and it's ongoing ramifications.

As a result people usually cannot see a doctor in the mornings or because the demand is so high, they receive suboptimal care. Patients are obliged to purchase medicines in the private market because drugs are in short supply.

The case of Iraq demonstrates the devastating impact on quality of limited investment in public health facilities and the resulting supply-induced demand for private for profit services.

HIFA profile: Goran Zangana is a medical doctor and Associate Research Fellow with the Middle East Research Institute, Iraq. He is a HIFA country representative for Iraq and is currently based in the UK.

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Quality (285) Improving quality of care at the facility level (31) Role of patient/family engagement

20 August, 2021
Enhancing the role of Patient/Family engagement at the Facility Level

With reference to the theme of Patient/ Family /community engagement at the Facility level, I believe the Guide [*] has provided a comprehensive roadmap.

As a stake-holding consumer I would offer the following insights based on personal experience of a “patient” and reflections on the same as a professional.

The biggest challenge , I believe, lies in our ability to perceive the theme, based on the model of a (r)evolving “Wheel” rather than that of a “Totem Pole”; where recognition of the realities of diversities and dynamism of patients/families/communities at the Facility level informs the priorities of the District through integration with National goals, which in their turn are continuously revived through awareness of the Facility level realities.

The Solution relates to realization of the critical role of (re) Learning:

Revisiting the assumptions of the conceptual “north-south” polarities in formal health education and promoting awareness of diverse and dynamic perspectives as a benefit where, as I had mentioned earlier, a rabbi in TelAviv can equitably quote a monk in India to improve the quality of a local Health Compassion approach within the lens of global ethics

Esha Ray Chaudhuri
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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

[*Note from HIFA moderator: I think Esha refers to WHO's Quality health services: a planning guide (2020) https://www.who.int/publications/i/item/9789240011632]

Quality (286) Patient experience and health outcomes (16) Patient information (5)

20 August, 2021
Dear Richard (Fitton) and all,

Thank you for your interesting message on 18 August where you said: "Patients will find it easier to match expectations and reality when they are treated like adults and when patients, too, routinely have access to the clinical guidelines and care pathways that they are put on - a very easy but rarely practised process."

I would like to invite HIFA members to consider what we may mean when we say 'treat patients like adults'. Can anyone provide examples of where patients are (or were) not treated like adults?

The suggestion that patients should 'routinely have access to the clinical guidelines and care pathways that they are put on' is very interesting. 'Good' medicine involves shared decision making where the benefits and risks of different options are explored. For a patient to access and understand clinical guidelines goes a step further. I would be interested to hear your experience with this. Is there perhaps a need for some guidelines to be written with the patient in mind as the reader? How would this differ from existing patient information resources? What are the challenges, including for those with low health literacy?

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (287) Improving quality of care at the facility level (32) Patient information (6)

21 August, 2021
Good day Neil

You ask a very critical question: "How can we better meet the information needs of patients in low-resource settings?"

In my opinion there is no standard way we can prescribe as to how this can be done. This will depend on a number of factors including but not limited to the availability of human and other resources and the cultural contexts in which we operate. Within the context of limited resource settings I think the best way to do this will be through integration of health information provision services into the service delivery model. It should start when we train cadres who will ultimately provide services in health facilities. Training curricular should incorporate customer care modules that encourage sharing information with clients. This should apply to both preservice and in-service training. Monitoring and evaluation systems should then be able to incorporate indicators that track the provision of information to clients. It is critical to have feedback mechanisms that can assist facilities to identify gaps and address them. The Result Based Framework has been used in Zimbabwe to track and incentivize achievement of certain outputs and this can be a system which can be leveraged on to incorporate provision of health information to clients in the public sector.

HIFA profile: Venus Mushininga is a pharmacist with the Ministry of Health and Childcare in Zimbabwe. She is a founder and President of the Zimbabwe Society of Oncology Pharmacy and the Zimbabewan delegate to the European Society of Oncology Pharmacy. Professional interests: Oncology, Dissemination of information through to Health Professionals and the public, Research. She is co-coordinator of the HIFA working group on information for Prescribers and Users of Medicines.

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Quality (288) District-level activities (28) Using the WHO safe childbirth checklist

21 August, 2021
Hello!

Sharing with HIFA team an evidence from a work in Ethiopia that "Using WHO-SCC paired with a system-wide quality improvement approach improved and sustained quality of EBPs delivery" : Using the WHO safe childbirth checklist to improve essential care delivery as part of the district-wide maternal and newborn health quality improvement initiative, a time series

study | BMC Health Services Research | Full Text (biomedcentral.com) [*see note below]

Thanks,Zewdie

HIFA profile: Zewdie Mulissa is Senior Performance Monitoring & Improvement Advisor at IntraHealth International, Ethiopia. Professional interests: Quality of Care; Monitoring; Evaluation. He is a member of the Catalyst Group for the WHO/HIFA project on Learning for quality health systems. https://www.hifa.org/projects/learning-quality-health-services

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[*Note from HIFA moderator (Neil PW): Thank you Zewdie and congratulations on this paper. Here is the citation, link and abstract:

CITATION: Using the WHO safe childbirth checklist to improve essential care delivery as part of the district-wide maternal and newborn health quality improvement initiative, a time series study

Befikadu Bitewulign 1, Dereje Abdissa 2, Zewdie Mulissa 3, Abiyou Kiflie 3, Mehiret Abate 3, Abera Biadgo 3, Haregeweyni Alemu 3, Meseret Zelalem 4, Munir Kassa 4, Gareth Parry 5, Hema Magge 6 7 8

https://pubmed.ncbi.nlm.nih.gov/34399769/

ABSTRACT

Background: Care bundles are a set of three to five evidence-informed practices which, when performed collectively and reliably, may improve health system performance and patient care. To date, many studies conducted to improve the quality of essential birth care practices (EBPs) have focused primarily on provider- level and have fallen short of the predicted impact on care quality, indicating that a systems approach is needed to improve the delivery of reliable quality care. This study evaluates the effect of integrating the use of the World Health Organization Safe Childbirth Checklist (WHO-SCC) into a district-wide system improvement collaborative program designed to improve and sustain the delivery of EBPs as measured by "clinical bundle" adherence over-time.

Methods: The WHO-SCC was introduced in the context of a district-wide Maternal and Newborn Health (MNH) collaborative quality of care improvement program in four agrarian Ethiopia regions. Three "clinical bundles" were created from the WHO-SCC: On Admission, Before Pushing, and Soon After Birth bundles. The outcome of each bundle was measured using all- or- none adherence. Adherence was assessed monthly by reviewing charts of live births. A time-series analysis was employed to assess the effectiveness of system-level interventions on clinical bundle adherence. STATA version 13.1 was used to analyze the trend of each bundle adherence overtime. Autocorrelation was checked to assess if the assumption of independence in observations collected overtime was valid. Prais-Winsten was used to minimize the effect of autocorrelation.

Findings: Quality improvement interventions targeting the three clinical bundles resulted in improved adherence over time across the four MNH collaborative. In Tankua Abergele collaborative (Tigray Region), the overall mean adherence to "On Admission" bundle was 86% with $\beta = 1.39$ (95% CI; 0.47-2.32; $P < 0.005$) on average monthly. Similarly, the overall mean adherence to the "Before Pushing" bundle in Dugna Fango collaborative; Southern Nations, Nationalities and People's (SNNP) region was 80% with $\beta = 2.3$ (95% CI; 0.89-3.74; $P < 0.005$) on average monthly.

Conclusion: Using WHO-SCC paired with a system-wide quality improvement approach improved and sustained quality of EBPs delivery. Further studies should be conducted to evaluate the impact on patient-level outcomes.]

Quality (289) Improving quality of care at the facility level (33) Staff absenteeism (2)

21 August, 2021
Thank you Goran for highlighting the problem of staff absenteeism in Kurdistan region of Iraq. I understand this is a major issue worldwide, particularly in countries where public sector salaries are insufficient to meet the basic needs of healthcare providers.

I invite HIFA members to share your experience of this issue. It seems especially challenging to address as long as salaries remain inadequate. How were you able to deal with it?

We come back to the question of meeting the basic needs of healthcare providers in low-resource settings 'versus' quality improvement approaches. What is the role of quality improvement approaches in situations where basis needs cannot be met? Can they be tackled together?

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (290) Improving quality of care at the facility level (34) Staff absenteeism (3)

22 August, 2021
Neil thank you for sharing Goran's post. And you asked, 'What is the role of quality improvement approaches in situations where basis needs cannot be met? Can they be tackled together?'.

Well Goran is right absenteeism (and if I may add, bad attitude and behaviour, truancy, work-to-rule, full strike, etc often are consequences of poor governance and lack of staff motivation and incentives often so common in LMICs, unfortunately.)

But to your question, that is why we introduced the 12-Pillar Clinical Governance programme and defined it as, 'Protecting patients, supporting practitioners in tandem'.

Extensive advocacy, education on a continuous and systematic manner 'converts' the politicians, policy makers and all stakeholders who control the resources that make implementation possible.

Satisfied and motivated workers do not play absenteeism and truancy. If they do the management have the sanctions anyway.

Joseph Ana.

AFRICA CENTRE FOR CLINICAL GOVERNANCE RESEARCH & PATIENT SAFETY

@Health Resources International (HRI) WA.
National Implementing Organisation: 12-Pillar Clinical Governance
National Healthcare Standards and Quality Monitor and Assessor
National Implementing Organisation: PACK Nigeria Programme for PHC
Publisher: Medical and Health Journals; Books and Periodicals.
Nigeria: 8 Amaku Street, State Housing & 20 Eta Agbor Road, Calabar.
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HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.
Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

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Quality (291) Improving quality of care at the facility level (35) Patient information (7)

23 August, 2021

Dear Venus an all,

In response to the question "How can we better meet the information needs of patients in low-resource settings?" you noted: 'Within the context of limited resource settings I think the best way to do this will be through integration of health information provision services into the service delivery model.

In a previous message you talked of your own experience, 'To address this information gap, at the private specialist oncology pharmacy l managed, we had to create a counselling room in which a dedicated member of staff took time to discuss patient questions and concerns.'

This is commendable, and I suspect exceptional. I would be interested to learn more about what information is available to customers of pharmacies in the public sector in different settings and countries. To what extent does the packaging of medicines meet people's information needs? What if the patient does not read or speak the language used on the packaging? In some cases medicines are sold without any packaging. What can pharmacies do to promote rational use of medicines in such situations? Presumably, as in Venus's pharmacy above, there is a need for the pharmacy staff to provide information orally, but what is the level of reliability of such information from staff who may be underqualified?

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (292) Improving quality of care at the facility level (36) Patient information (8)

25 August, 2021
Good day Neil

Thank you for the questions. I will share my experience as a Pharmacist who has practised in both the public sector in Zimbabwe.

"To what extent does the packaging of medicines meet people's information needs? What if the patient does not read or speak the language used on the packaging?"

In the private sector setting and in a few of the public sector facilities, specialised pharmaceutical software is used to create labels for medicines that are dispensed and it provides the instructions and special warnings in English.

For non-prescription medicines instructions are written on the packages in English.

The local language instructions are given to the patient at the point of dispensing. Trained pharmacy and dispensary assistants and nurses assist the pharmacist in giving out information to the patient.

A gap still exists in terms of household remedies which the patient can buy directly from supermarkets and other retail outlets. The patient has to figure out how to use the medicine from the instructions on the package. However, a new line of retail outlets called Health Shops which is only allowed to stock Household Remedies is growing and these can assist in covering this gap if manned by trained personnel. Also, pharmacies do not charge a fee for providing information hence some community pharmacies do provide guidance on medicines purchased elsewhere by the client.

The requirements for getting permission and registering a medicine to be sold in Zimbabwe is approved by the Medicines Control Authority of Zimbabwe. From the perspective of the distributor it may be expensive to register medicines with packages with multiple local languages. Some local suppliers have made efforts to fill this gap as a number of locally manufactured remedies now have the local languages. For imports however, this has not been the case.

In my opinion there is a need to look at the whole supply chain and determine the full costs of a client using medicines incorrectly because they cannot understand the instructions. Research is required to generate scientific evidence in this area. This gap can be addressed from a regulatory perspective, advocacy from patient groups and from ensuring that persons interacting with patients are adequately trained and have continuous on the job training as the field of medicine is dynamic.

Regards,

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Quality (293) Improving quality of care at the facility level (37) Quality of care in Tanzania and MEDBOX

27 August, 2021
Hello, thank you for having me here today. I am very happy to share with you about topics on the quality of care.

Briefly about my person: I am Co-worker from Germany, a public health specialist, and I have been working in Tanzania for 6 years in a cancer institute. There I am responsible for prevention with a focus on cancer in women. Quality of care is a major concern for me in this area.

As I have noticed, the quality of Tanzanian health care still remains behind of the expectations of the Tanzanians. This is particularly noticeable in the numbers of medical tourists. Many people still travel to India to receive better health care.

We are convinced that the country needs more investment in the quality of care and in the training of medical staff.

So far, our staff has been working with www.MEDBOX.org, an online medical aid library.

MEDBOX.org provides free and easy access to quality-assessed guidelines and training tools. In this way, local health care workers can quickly increase their medical expertise.

Here I would like to introduce you to the website: www.medbox.org

I am looking forward to hear from you

warmly Antje Henke

Dipl.-Pol. Antje Henke, MPH
Public Health Specialist
Cancer Care Centre
Kilimanjaro Christian Medical Center
P.O. Box 3010 Moshi, Tanzania

HIFA profile: Antje Henke is a Public Health Specialist at the Cancer Care Centre, Kilimanjaro Christian Medical Center, Tanzania, and MEDBOX, Germany. Professional interests: Public Health, Planetary Health, OneHealth, Cancer, Community Health Care Workers, Africa. Email address: antje.henke AT medmissio.de

Quality (294) BMJ Global Health: Epistemic injustice in academic global health

28 August, 2021
A new paper in BMJ Global Health notes that 'common practices in academic global health (eg, authorship practices, research partnerships, academic writing, editorial practices, sensemaking practices, and the choice of audience or research framing, questions, and methods) are peppered with epistemic wrongs'.

CITATION: Viewpoint|online first

Epistemic injustice in academic global health

Himani Bhakuni, Seye Abimbola

Open Access Published: August 09, 2021

DOI: https://doi.org/10.1016/S2214-109X(21)00301-6

SUMMARY

This Viewpoint calls attention to the pervasive wrongs related to knowledge production, use, and circulation in global health, many of which are taken for granted. We argue that common practices in academic global health (eg, authorship practices, research partnerships, academic writing, editorial practices, sensemaking practices, and the choice of audience or research framing, questions, and methods) are peppered with epistemic wrongs that lead to or exacerbate epistemic injustice. We describe two forms of epistemic wrongs, credibility deficit and interpretive marginalisation, which stem from structural exclusion of marginalised producers and recipients of knowledge. We then illustrate these forms of epistemic wrongs using examples of common practices in academic global health, and show how these wrongs are linked to the pose (or positionality) and the gaze (or audience) of producers of knowledge. The epistemic injustice framework shown in this Viewpoint can help to surface, detect, communicate, make sense of, avoid, and potentially undo unfair knowledge practices in global health that are inflicted upon people in their capacity as knowers, and as producers and recipients of knowledge, owing to structural prejudices in the processes involved in knowledge production, use, and circulation in global health.

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Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (295) New journal: IJQHC Communications (1) Widening the scope of research on quality of care

29 August, 2021
With thanks to a tweet from Shams Syed, WHO, I learned about this new open-access journal: IJQHC Communications. The contents of volume 1, issue 1 are available here:

https://academic.oup.com/ijcoms/issue/1/1

'IJQHC Communications is an open-access, peer-reviewed, international journal that publishes research related to quality and safety in health care, with a focus on implementation science, for a worldwide readership.'

Here is an example paper:

CITATION: Widening the scope of research on quality of care

Dena Javadi. IJQHC Communications, Volume 1, Issue 1, 2021, https://doi.org/10.1093/ijcoms/lyab002

Published: 06 July 2021

KEY MESSAGES

- Leveraging the strengths of different methodologies to widen the scope of research on quality of care enhances the range of tools and approaches for quality improvement.

- Health provider perspectives on implementing quality metrics can be captured through embedded implementation research and used to strengthen and contextualize metrics while also addressing risk factors for burnout.

- The evidence base on quality of care would benefit from further research on topics such as the use of quality metrics in interprofessional teams, quality of care in emergencies, and equity in the design and implementation of metrics

Best wishes, Neil

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (296) BMJ: Building compassionate and joyful workplaces

13 September, 2021
With thanks to Richard Fitton, a viewpoint on the UK National Health Service (with global relevance). It's notable that Compassion is one of the three pillars of the WHO Global Learning Laboratory for Quality Universal Health Coverage (GLL) [https://www.who.int/initiatives/who-global-learning-laboratory-for-quali...]. HIFA is proud to be currently working with WHO GLL to run a series of discussion on Learning for quality health services. Recognising and nurturing compassion in the workplace is critical.

CITATION: Rammya Mathew: Building compassionate and joyful workplaces

BMJ 2021; 374 doi: https://doi.org/10.1136/bmj.n2148 (Published 07 September 2021) Cite this as: BMJ 2021;374:n2148

https://www.bmj.com/content/374/bmj.n2148

'Whether we like it or not, work is what we spend most of our waking hours doing. So, finding joy in work isn't a nice to have: it's a necessity. An organisation such as the NHS—the world's largest employer of highly skilled professionals—should conceivably have a highly developed approach to ensuring that people have fulfilling and rewarding jobs that they want to keep coming back to. This is key in terms of reducing staff turnover, increasing employee productivity, and improving overall organisational performance...

'The most unforgivable acts can almost always be traced back to a basic lack of kindness. Such as when senior staff don't bother to learn the names of the more junior staff working for them. Or when we forget to thank or show any appreciation for team members who go above and beyond. Or when acts of bullying or discrimination get swept under the carpet or are diminished because it's easier than dealing with them head on.

'A failure to cultivate compassionate leadership is what has predominantly zapped the joy from our workplaces... It's high time we moved on from myopic short term strategies and made compassion and joy the central tenets of our long term vision for the NHS.'

Comment: In LMICs there are many barriers to 'compassionate and joyful workplaces'. One of these is the failure to meet the basic needs of frontline health workers and to ensure these needs are progressively met. HIFA describes these needs with the acronym SEISMIC: https://www.hifa.org/about-hifa/hifa-universal-health-coverage-and-human...

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Quality (297) Lancet GH: Seizing the moment to rethink health systems

14 September, 2021
A new paper in The Lancet Global Health, and a comment from me below.

CITATION: Seizing the moment to rethink health systems

Kojo Nimako, Margaret E Kruk

Lancet Global Health 2021

Published: September 07, 2021

DOI: https://doi.org/10.1016/S2214-109X(21)00356-9

SUMMARY

The COVID-19 pandemic has made vivid the need for resilient, high-quality health systems and presents an opportunity to reconsider how to build such systems. Although even well resourced, well performing health systems have struggled at various points to cope with surges of COVID-19, experience suggests that establishing health system foundations based on clear aims, adequate resources, and effective constraints and incentives is crucial for consistent provision of high-quality care, and that these cannot be replaced by piecemeal quality improvement interventions. We identify four mutually reinforcing structural investments that could transform health system performance in resource-constrained countries: revamping health provider education, redesigning platforms for care delivery, instituting strategic purchasing and management strategies, and developing patient-level data systems. Countries should seize the political and moral energy provided by the COVID-19 pandemic to build health systems fit for the future.

COMMENT (Neil PW): I'll be interested to hear comments from HIFA members. I'm not a health system specialist and I found the paper quite challenging. What do we mean by 'redesigning platforms for care delivery'? Are 'strategic purchasing' and a 'national data platform with individual-level data' the answer to strengthening health systems? From a non-specialist perspective, there is one glaring priority in LMIC health systems: to better understand and address the basic needs of frontline health workers so they are empowered to deliver the care for which they are trained. The problem is not so much the pre-service training, it is the failure of health systems to meet the needs of frontline health workers. On HIFA we have described these as SEISMIC needs:

• Skills

• Equipment

• Information

• Systems support

• Medicines

• Incentives

• Communication facilities.

Support health workers and they will deliver.

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

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (298) Lancet GH: Seizing the moment to rethink health systems (2)

15 September, 2021
This is an interesting viewpoint about 'rethinking health systems'.
[https://doi.org/10.1016/S2214-109X(21)00356-9]

I find it easier to agree with, 'countries should seize the political and moral energy provided by the COVID-19 pandemic to build health systems fit for the future.' because in our experience political will is key in LMICs where prioritisation of health has been lacking. Also it is important to 'revamping health provider education, redesigning platforms for care delivery, instituting strategic purchasing and management strategies, and developing patient-level data systems.'

We found that to strengthen the Whole Health sector of which the system is a part, the LMICs must establish Health Act to give legal underpinning to the whole idea, establish a mandatory health insurance scheme to cover all the population including the most vulnerable such as unemployed, students, disabled sections of the population, provide appropriate physical infrastructure, basic and advanced appropriate equipment, 24/7 utilities such as water and electricity, and ensure adequate sanitation and hygiene of the facilities. Without these foundational necessities, every other intervention cannot succeed in delivering quality and safe health care. To crown them all, the welfare and motivation of personnel must come tops too, which is why in 2004 we defined the 12-Pillar Clinical Governance programme as, 'protecting patients and supporting practitioners in tandem'. Motivated and enabled health workers deliver consistent quality and patient centred care.

Joseph Ana.

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007.

Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.

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Quality (299) Global Health Compassion Rounds, Sept. 22 (2) Registration issues resolved

15 September, 2021
We have resolved our technical difficulties. Registration for the Global Health Compassion Rounds on Sept. 22 now open!

https://taskforce.org/face/

https://www.who.int/initiatives/who-global-learning-laboratory-for-quali...

Dear Colleagues and Friends,

Thank you for your patience! We have resolved the technical difficulties some were experiencing with registration. Click the button below to join us for the upcoming Global Health Compassion Rounds.

For those who have already successfully registered and received email confirmation, you're all set. We look forward to seeing you!

Register Now!
(https://emory.zoom.us/webinar/register/WN_uBLbiRT_SyWX1z4wUzwDvQ)

Wednesday, September 22, 2021

11:00 am-12:30 pm EDT (GMT -4)

The movement to eliminate NTDs: Successes & challenges of a foundation in compassion

The NTD community also emphasizes human rights approaches in its programming, ensuring that affected persons have a prominent voice in the design and evaluation of programs. Nevertheless, critics have sometimes perceived the NTD community's efforts as being characterized by 'pity' or 'charity,' rather than compassion.

Throughout its history, compassion has been prominent in the NTD movement. While the eradication of diseases, such as polio and smallpox, has focused almost exclusively on prevention, the goals of NTD elimination are to both interrupt disease transmission and provide care to those already affected. Compassion is integral to both.

This GHCR will explore these dimensions of compassion in the NTD community through an impassioned conversation with persons affected by NTDs, NTD experts from around the world, and global public health authorities.

PANELISTS

Dr. Mwelecele Ntuli Malecela

Director, Dept. of Control of Neglected Tropical Diseases, WHO

Dr. Malecela's demonstrated commitment to NTDs is evident through her leadership at the African Regional Program for NTDs, membership on WHO's Strategic and Technical Advisory Committee for NTDs, and founding of the Tanzanian Lymphatic Filariasis Elimination Program. She also previously served as the first female Director General of the National Institute for Medical Research for Tanzania where she led the launch of mass treatment campaigns. This catalyzed massive global scale-up to target the 120 million people affected by lymphatic filariasis and blazed a trail for control and elimination strategies for the majority of the 20 NTDs.

Dr. Uche Amazigo

Retired Director,

African Programme for Onchocerciasis, WHO

Dr. Amazigo has devoted most of her academic, public, and international career to the elimination of NTDs through community participation and strengthening health systems. Her accomplishments include groundbreaking research that contributed to the creation of the WHO's African Programme for Onchocerciasis Control, as well as the revolutionary "community-directed treatment (CDT)" strategy—heralded as one of the most effective strategies of community participation in public health. She has been instrumental in moving the fight against river blindness from control to elimination.

Dr. Suma Krishnasastry

Professor of Medicine & Director of Filariasis Research Unit, Government Medical College, Alappuzha, India

Dr. Krishnasastry has been an active researcher and educator in lymphatic filariasis for over three decades. Under her leadership, the Filariasis Research Unit plays a central role in creating policies, developing simple techniques to alleviate the suffering of patients with lymphoedema, and providing training for health care workers around the world in the optimal

care of these patients. This work resulted in WHO designating the Unit as a WHO Collaborating Centre for lymphatic filariasis morbidity management and disability prevention. Dr. Krishnasastry is also a member of WHO's panel of experts on parasitic disease.

Rev. Mathias Duck

Global Advocacy Manager,

Leprosy Mission International

Mathias was a pastor/chaplain at a reference hospital for leprosy in Paraguay from 2010-2015; five years later he was diagnosed with leprosy and completed multi-drug therapy. Now he is focused on improving leprosy services by raising the voices and participation of people affected in decision-making and in the delivery of these services. He is also the Chair of the International Federation of Anti-Leprosy Association's advisory panel of persons affected by leprosy.

** What are Global Health Compassion Rounds?

The Rounds are a quarterly gathering of a global community to share experiences, challenge ideas, and spark thinking on compassion in global health. We explore the role of compassion in health systems, policy, programs, and service delivery. Each webinar centers on a specific theme that features insights and perspectives from practitioners in the field, subject matter experts, scholars, and contemplative thinkers. We invite you to join our growing community!

Register Now
(https://emory.zoom.us/webinar/register/WN_uBLbiRT_SyWX1z4wUzwDvQ)

Hosted by the Focus Area for Compassion and Ethics (FACE) (https://taskforce.org/face/) at the Task Force for Global Health and the WHO (https://www.who.int/initiatives/who-global-learning-laboratory-for-quali...) Global Learning Laboratory (GLL) (https://www.who.int/servicedeliverysafety/areas/qhc/gll/en/index6.html) .

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Quality (300) Equity and healthcare quality

16 September, 2021
To enhance our ongoing discussion about Quality health care dimensions I would like to share with you all the New Perspectives Discussion Paper of the National Academy of Medicine (NAM) - formerly the Institute of Medicine - emphasizing the role of Equity as a priority for improving the quality of health care in the next 20 years!

The Discussion Paper entitled *"An Equity Agenda for the Field of HealthCare Quality Improvement (Sep 15, 2021) *"was just released today by NAM to commemorate the20th anniversary of its seminal publication, *To Err is Human: Building a Safer Health System* (IOM 2000) and *Crossing the Quality Chasm: A New Health System for the 21st Century (IOM 2001). *Focused on the theme, "Centering Equity is imperative in delivering high quality health care" the Paper identifies the most important priorities for the healthcare quality movement in the next 20 years, and describes equity as the area of most urgent and cross-cutting concern for the field.

NAM suggests the following points from the Paper for continuing the conversation:

- "Providing high-quality health care means ensuring systems equitably support care delivery. The new NAM Perspectives highlights implementable actions, starting with improving data collection and quality, fostering trust & engaging the community:"

*- "*Equity must be embedded at the core of the health care system in order to provide the best outcomes for patients and communities. The new NAM Perspectives highlights priorities for increasing care delivery quality by putting health equity first":

* -"* Effective and diverse leadership is crucial for every aspect of performance in health care organizations – especially in supporting sustained movement toward centering and improving health equity in care"

-“Achieving equity in care quality and health outcomes requires listening to and learning from communities to devise systemic solutions that solve multiple problems.”

The Paper can be accessed" at https://doi.org/10.31478/202109b

Esha Ray Chaudhuri

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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

Quality (301) Global Health Compassion Rounds, Sept. 22 (3) Reflections

25 September, 2021
[Note from HIFA moderator (Neil): Our thanks to Esha for attending this event on behalf of HIFA and sharing her observations below]

The Global Health Compassion Rounds (GCHR), the Compassion hub of FACE (Focus Area for Compassion and Ethics) held its latest “Round” on Sept 22, 2021 on “The movement to eliminate neglected tropical diseases (NTDs): The successes and challenges of a foundation in compassion". Moderated perceptively by Shams Syed (WHO) and David Addiss (FACE) the session once again presented an unique opportunity to learn about and reflect on the challenging opportunities of Compassion and Ethics framed Care based on the Presenters’ engagement with Community Foundations in three continents of Africa, (South) Asia and South America.

Uche Amazigo, Retired Director of the African Program for Onchocerciasis (WHO) spoke passionately about patients of River Blindness experiencing pain and stigma and regaining self confidence with healing provided through the Community Directed Treatment Strategy (CDT). Suma Krishnasastry ,Professor of Medicine & Director of Filariasis Research Unit, Government Medical College, Alappuzha, India described the committed work of her clinical team to improve the quality of life for patients by addressing the critical dimensions of

psychological benefits, stigma reduction and social inclusion. Girija Sankar, Vice Chair, NTD NGO Network, Head of NTDs, CBM International made an interesting observation of Compassion, integrating the three elements of awareness, empathy and action – within the lens of human rights rather than only on technical clinical metrics. Rev. Mathias Duck, Global Advocacy Manager, Leprosy Mission International spoke ardently how his own diagnosis with leprosy from working with a leprosy hospital in Paraguay helped change perspectives about people suffering from the disease from being a vulnerable group to that of an uniquely resilient community.

In keeping with the GCHR tradition of challenging ideas, and inspiring reflections on compassion in health systems, the moderated discussion raised some important questions about limitations of conventional notions of disabilities in general noting in particular the implicit power asymmetries in typical NTD care approaches. As Shams Syed had noted earlier, “each element of health service quality has important linkages to compassion” and “the linkages only mean something when it positively affects human lives where services are being provided”. The Rounds, once again, proved to be an excellent forum for exchanging ideas on these critical intersections of Quality Health Care principles.

Esha Ray Chaudhuri

Canada

(1)”The role of Compassion in Health Service Quality”, Is Compassion Essential for Quality Health Care? (Vol. 3) August 2020, https://taskforce.org/global-health-compassion-rounds-volume-3-report

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 a member of the WHO-HIFA Catalyst Group on Learning for quality health services. https://www.hifa.org/projects/learning-quality-health-services Email address: ed.consult3 AT gmail.com

Quality (302) QoC Webinar Series Starts Monday, Sept 27

24 September, 2021
From the Child Health Task Force:

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Dear Child Health Task Force members,

The Quality of Care subgroup is co-hosting a webinar series with the Network for Improving Quality of Care for Maternal, Newborn and Child Health on Integrating Stakeholder and Community Engagement in Quality of Care Initiatives. Join us for the first presentation from Bangladesh on Monday, September 27 at 8am EDT/12pm GMT

Register here! https://who.zoom.us/webinar/register/WN_W-iY1I3dRZuW8mG_lcu43A

27 Sep- Advancing community engagement for quality maternal and newborn health - An example from Bangladesh .png

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Arlington, VA 22202

Tel: 703.528.7373

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Join HIFA: www.hifa.org/joinhifa

Join CHIFA (child health and rights): http://www.hifa.org/joinchifa

Neil Pakenham-Walsh, HIFA Coordinator, neil@hifa.org www.hifa.org

Quality (303) Sustainable Quality Improvement (3)

1 October, 2021
Dear HIFA colleagues,

In July HIFA member and co-founder Rachel Stancliffe (Director of the Centre for Sustainable Healthcare, Oxford) noted 'the objective of improving quality is to deliver the best possible health outcomes with minimum financial and environmental costs, whilst adding positive social value at every opportunity'. https://www.hifa.org/dgroups-rss/quality-155-sustainable-quality-improve...

This new paper from CSH medical director Frances Mortimer and colleagues argues for informed action by clinicians to reduce the environmental harms of health care. Citation, key recommendations and selected extracts below.

CITATION: Net zero healthcare: a call for clinician action
BMJ 2021; 374 doi: https://doi.org/10.1136/bmj.n1323 (Published 20 September 2021)
Cite this as: BMJ 2021;374:n1323
Jodi D Sherman et al.

KEY RECOMMENDATIONS
- Clinicians must work to reduce the incidence and severity of disease to decrease the amount and intensity of care required
- Use of resources must be optimised by ensuring appropriate care and avoiding unnecessary investigations and treatments

- Coordination of care between different providers should be promoted to avoid duplication of services and reduce travel emissions and unnecessary building use
- Health professionals should encourage change through individual practice, influencing healthcare organisations, and contributing to standards and policy

EXTRACTS
'Health professionals are well positioned to effect change by reshaping individual practice, influencing healthcare organisations, and setting clinical standards, argue Jodi Sherman and colleagues...

Healthcare is one of the largest polluting industries, responsible for nearly 5% of total global greenhouse gases...

Inappropriate or low value care, in which harms or costs outweigh benefits, is ubiquitous in health systems in both high and low income settings. It includes overuse and underuse of healthcare services, which often coexist in the same health system (and even for the same patient)...

Globally, a quarter of the total volume of healthcare services is low value. Solutions include clinician education and empowerment, development of and adherence to evidence based standards of care that incorporate environmental harms, de-adoption11 of low value care, shared decision making, care coordination, and continuous quality improvement...

By keeping their knowledge thorough and current, health professionals can protect against "technology creep" — the application of technologies or treatments to expanded indications without supporting evidence...

Continuous quality improvement

Environmental performance should be integrated into the core definition of quality care, with best practices established for clinicians and health systems and reinforced through regulatory and oversight processes that overcome obstacles to change. Investigations of appropriateness of care and resource consumption lend themselves to quality improvement initiatives, which can be designed, initiated, and carried out by individual clinicians within their professional settings. Electronic health records can provide feedback to clinicians on resource use, costs, and emissions, to gauge performance and drive quality improvement...

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https://www.hifa.org/rss-feeds/17