



# Thematic Discussion on Learning for Quality Health Services (2021)

Prepared by:

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## **LONG THEMATIC EDIT (ALL MESSAGES)**

Healthcare Information for All (HIFA) is collaborating with the World Health Organization (WHO) to promote sharing and learning of experience and expertise around the topic of learning for quality health services. Below is the structured summary of the discussion from messages numbered 1 to 303 shared from July 5, 2021 through October 11, 2021. Also provided is a list of citations (resources that HIFA members have pointed us to) and the profiles of contributors.

General comments on messages:

- The discussion was held on HIFA forums ([www.hifa.org](http://www.hifa.org)).
- The total number of messages analyzed was 303 from 55 contributors in 28 countries.
- The number of contributors (55) is very solid for the purposes of this discussion. There was a respectable geographical spread and representation of health workers in the discussion.
- Although many contributions pointed to new publications, services, or events, there were also an adequate number of relevant messages sharing personal experience and expertise.
- A disproportionate number of messages (98/303) were sent by the moderator, but this was deemed necessary for guiding the discussion and pointing to publications relevant for this topic (hence, only the most relevant comments from the moderator were included in this document).
- The analysis has implications for further thematic discussions in the field.

The 55 contributors, listed below, represented 28 countries (in alphabetical order: Australia, Cambodia, Cameroon, Canada, Croatia, Democratic Republic of Congo, Ethiopia, France, Iceland, India, Iraq, Ireland, Kenya, Malawi, Mexico, Mozambique, Nepal, Nigeria, Senegal, Singapore, South Africa, Sudan, Switzerland, Tanzania, The Netherlands, United Kingdom, USA, Zimbabwe).

Adanna Chukwuma, USA  
Ann Lawless, Australia  
Antje Henke, Tanzania  
Balogun Stephen Taiye, Nigeria  
Bernard Seytre, France  
Bhupendra Kumar Rana, India  
Bistra Zheleva, USA  
Chiabi Bernard Ful, Cameroon  
Chris Zielinski, United Kingdom  
David Chandler, United Kingdom  
Esha Ray Chaudhuri, Canada  
Frank Nduu Naweji, Democratic Republic of Congo

Geir Gunnlaugsson, Iceland  
Goran Zangana, United Kingdom  
Hewa Mhammad, Iraq  
Ibrahima Sall, Senegal  
Indira Narayanan, USA  
Isabel I Keshavji, Mozambique  
Ivan Teri, USA  
Joseph Ana, Nigeria  
Karen Zamboni, United Kingdom  
Kebede Eticha, Ethiopia  
Lani Rice Marquez, USA  
Lisa Hirschhorn, USA  
Manu Gupta, India  
Manuel K. Sibhatu, Ethiopia  
Marion Lynch, United Kingdom  
Mark Cantor, Australia  
Massimo Serventi, Tanzania  
Matthew Neilson, United Kingdom  
Meena Cherian, Switzerland  
Moses Kumaoron Orfega, Nigeria  
Nicole Spieker, Kenya  
Nisha Bhatta, Nepal  
Nkwan Jacob Gobte, Cameroon  
Oriane Bodson, Switzerland  
Paulina Pacheco Estrello, Mexico  
Peter Jones, United Kingdom  
Rachel Stancliffe, United Kingdom  
Rajinder Kaur, India  
Rebecca C Ngalande, Malawi  
Richard Fitton, United Kingdom  
Ruth Davidge, South Africa  
Sanchika Gupta, India  
Sebastian Kevany, USA  
Santosh Kumar, India  
Siamola Murundo, Kenya  
Suad Eltahir Ali Ahmed, Sudan  
Subhadra Rai, Singapore  
Tineke de Groot, The Netherlands  
Tomislav Meštrović, Croatia  
Treaasa Kelleher, Ireland  
Venus Mushininga, Zimbabwe  
Xavier Bosch-Capblanch, Switzerland  
Zewdie Mulissa, Ethiopia

The following selected extracts are from 55 contributors and the moderator, organized by the discussion themes. These contributors included 26 health workers/health professionals, 28 public health professionals, and the moderator, representing universities, NGOs, and healthcare facilities.

## Discussion themes

The discussion followed four themes. Full comments from the 55 contributors and the moderator are presented below, grouped by theme.

### ***Q1. What does quality of care mean to you, in your particular context? Why is it important to make the case for quality of care?***

**Neil-Pakenham-Walsh (United Kingdom)** A huge but unknown number of deaths are the direct or indirect result of lack of availability of reliable healthcare information.

**Neil-Pakenham-Walsh (United Kingdom)** 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. 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?

**Neil-Pakenham-Walsh (United Kingdom)** 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 waste<sup>1</sup>. In Least Developed Countries, the gaps are even greater, where twice as many facilities lack basic water and sanitation services.

**Neil-Pakenham-Walsh (United Kingdom) (citing Elisabeth Muench)** 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 to be as follows: Incomplete standards, Inadequate monitoring, Disease-specific budgeting, Disempowered workforce, Poor WASH infrastructure. Regarding practical steps, improving and maintaining infrastructure is probably the hardest one and requires the most funds.

**Richard Fitton (United Kingdom)** 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 lifelong 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.

**Ibrahima Sall (Senegal)** Our commitment on quality of care is necessary. One topic I would like to share is about trust on quality care in low- and middle-income countries. 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?

Maybe in some aspects it may be true according to the type of disease complexity. However, if we do not reverse the way of thinking, no real political engagement or financial investment will ever be a priority in our country. Does someone have already something that works in a kind of awareness or methodology to improve this topic?

**Sebastian Kevany (USA)** During the pandemic, data privacy was often prioritized over epidemic control. Would less data privacy and more 'information for all' have helped to both improve quality of care and control the epidemic?

**Bistra Zheleva (USA)** 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.

**Tineke de Groot (Netherlands)** Thinking on quality of care, I really would like to emphasise the patient's perspective on quality of care. One relevant article states that health systems in low- and middle-income countries must recognize that the patient journey for non-communicable diseases starts long before the onset of symptoms and signs. Strategies designed to improve the patient journey must incorporate the patient-centred 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.

**Sebastian Kevany (USA)** 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.

**Siamola Murundo (Kenya)** Within the context of quality of care, 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.

**Richard Fitton (United Kingdom)** 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;

and 4. Preventative health care. Points 1 and 4 are, by necessity, mainly executed by service providers and health professionals, point 2 is executed jointly by service provider and patient, while point 3 is mainly executed by individuals, families, patients and communities through their culture, diet, exercise, relationships etc. Patient orientated/partnered/centered care is essential for points 2 and 3.

**Joseph Ana (Nigeria)** 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.

**Tineke de Groot (Netherlands)** Self-management interventions seem to be under researched in low- and middle-income countries (LMICs), and that is one of the reasons that I deliberately choose for the patients' perspective. I believe there is still a lot to gain in the area of self-management and patient engagement in research, specifically in LMICs and on for non-communicable diseases. However, the patients' perspective will automatically bring in service delivery and the health system as a whole.

**Mark Cantor (Australia)** WHO fact sheet states that 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. Questions from the naive and new member 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 contributors 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??

**Neil-Pakenham-Walsh (United Kingdom)** Dear Mark, you ask important questions. 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'. 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. 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.

**Neil-Pakenham-Walsh (United Kingdom)** 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.

**Joseph Ana (Nigeria)** 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.

**Tomislav Meštrović (Croatia)** An improved understanding of quality of care is an indispensable step not only to improve patient-centred 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 (giving 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.

**Marion Lynch (United Kingdom)** 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.

**Suad Eltahir Ali Ahmed (Sudan)** Quality of care directly affects the outcome of all efforts exerted to control diseases and health conditions commencing from services at community level and extending to the level of programs, policy and decision making.

**Venus Mushininga (Zimbabwe)** 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 mind-set, a paradigm shift from the frontliner providing a service in all areas that make up a health system.

**Paulina Pacheco Estrello (Mexico)** I am convinced that providing medical care which does not comply with the required quality standards may be more harmful than not providing it at all.

**Frank Nduu Nawej (Democratic Republic of Congo)** 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 both human and autonomous character of the person who receives them. Ultimately, this care must be effective, economical, continuous, integrated, equitable and safe.

**Nkwan Jacob Gobte (Cameroon)** 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. 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.

**Lani Rice Marquez (USA)** 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, behavioural incentives — as well as the engagement of broader community stakeholders in improving care.

**Sanchika Gupta (India)** 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.

**Ann Lawless (Australia)** Regarding quality of care, 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.

**Tomislav Meštrović (Croatia)** I had an interesting discussion with another HIFA member, paediatrician 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.

**Isabel I Keshavji (Mozambique)** Quality of care must have these 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 because 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.
- 8) Health personnel must be efficient, efficacy of diagnose tools and medicines on place and privacy to attend patients.

**Karen Zamboni (United Kingdom)** In my experience the definition of quality of care 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.

**Tomislav Meštrović (Croatia)** 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. actually showed that non-existent 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.



**Hewa Mhammad (Iraq)** 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.

**Moses Kumaoron Orfega (Nigeria)** 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.

**Nkwan Jacob Gobte (Cameroon)** 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 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.

**Adanna Chukwuma (USA)** 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.).

**Joseph Ana (Nigeria)** 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 unpredictable 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.

**Ruth Davidge (South Africa)** 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. 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.

**Neil-Pakenham-Walsh (United Kingdom)** Thank you Moses Orfega (Nigeria) and Marion Lynch (UK) for introducing the concept of compassion into our discussion on quality health services. 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 and the Focus Area for Compassion and Ethics. In essence, we need to promote compassion at all levels of the health system, from national planning through to clinical care.

**Neil-Pakenham-Walsh (United Kingdom)** 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.

**Subhadra Rai (Singapore)** I would like to add my two-cents worth on this issue of empowered staff and the ability to ask questions, as 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.

**Esha Ray Chaudhuri (Canada)** 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 1) People centeredness and 2) Compassion.

**Kebede Eticha (Ethiopia)** 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.

**Meena Cherian (Switzerland)** 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.

**Neil-Pakenham-Walsh (United Kingdom)** 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.

**Rebecca C Ngalande (Malawi)** This is a very important topic more especially now with the COVID pandemic. It's 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 it's 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.

**Peter Jones (United Kingdom)** 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-19 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. This model can assist in reflection and critical thinking about research (mixed-) methods, methodologies, ethics, standards (local - global) and governance.

**Mark Cantor (Australia)** 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 of 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. I believe the difference between these two worlds (healthcare and non-healthcare industry) offers a fantastic opportunity for improving quality in healthcare. Specifically in the considerable proportion of healthcare that is not clinical but costs lives.

**Joseph Ana (Nigeria)** 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.

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.

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!

**Manu Gupta (India)** Health information system is one of the building blocks for patient centred care. 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. 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.

**Bernard Seytre (France)** 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.

**David Chandler (United Kingdom)** 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 behavior 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.

**Mark Cantor (Australia)** He expressed 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?

**Mark Cantor (Australia)** 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.

**Richard Fitton (United Kingdom)** 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, socialising 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 continuing 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.

**Neil-Pakenham-Walsh (United Kingdom)** 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'. 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?

Message from David to CHIFA: 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.

**Ivan Teri (USA)** You may be interested in the United Nations ID2020 which aims to give every citizen a digital identity - ref below. Although privacy lobbies 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 Augustus written in "ComeReasonMinistries".

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.

ID2020 (<https://en.wikipedia.org/wiki/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.

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. 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. In 2019, ID2020 started a new digital identity program in collaboration with the government of Bangladesh and Global Alliance for Vaccines and Immunization.

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. 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." I am for each individual globally having an identity.

**Neil-Pakenham-Walsh (United Kingdom)** The points raised by David about the state of - and perception about - COVID-19 in Africa (and perhaps more precisely in West Africa) are sadly true.

I agree with 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?

**Neil-Pakenham-Walsh (United Kingdom)** 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. 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).

**Manu Gupta (India)** 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.

**Mark Cantor (Australia)** 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. Sadly, the breast cancer research he was doing never ever 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.

**Richard Fritton (UK)** 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 the 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 parts 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.)

**Mark Cantor (Australia)** 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 your words in CAPITALS.

AND NOW THAT I HAVE FINISHED, PLEASE EXCUSE MY SOMEWHAT OVERWHELMING TREATMENT OF YOUR COMMENT.

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 INDUSTRY 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 IS 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.

**Sebastian Kevany (Ireland)** 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?

**Chris Zielinski (United Kingdom)** 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 no one, 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....

**Balogun Stephen Taiye (Nigeria)** 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 power 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.

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 and 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 (Nigeria)** The second day of the ISQua conference appeared to be centered around safety. 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.

**Richard Fitton (United Kingdom)** At a recent 1969 alumni meeting in London two doctors who had successfully practiced private medicine quoted the adage for successful practice as the three "A"s - Accessibility, Affability and Ability - and in that order!

**Sebastian Kevany (Ireland)** 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)?" 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.

**Tineke de Groot (the Netherlands)** 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. Tzelepis 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>

**Shabina Hussain (USA)** 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.

**Richard Fitton (UK)** 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? 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. 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.

**Neil-Pakenham-Walsh (United Kingdom)** New report from WHO recently revealed stark inequalities in access to HIV prevention and treatment services for children, so partners call for urgent action (UNAIDS, PEPFAR, UNICEF, Elizabeth Glaser Pediatric AIDS Foundation). 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 (United Kingdom)** There is an important 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. But a question needs to be asked: 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'.

**Neil-Pakenham-Walsh (United Kingdom)** For me, sustainability links closely with quality health services:

1. The healthcare industry in general, from the macro level through to specific interventions, 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)

**Richard Fitton (United Kingdom)** 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, 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 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 Cameroon, Gabon, Gambia, Laos, Jamaica, India, Pakistan, Mexico, Argentina, Tanzania and Brazil to see how they fit the ten recommended domains of the WHO.

**Esha Ray Chaudhuri (Canada)** The key points in my previous HIFA submission was 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 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!

**Sanchika Gupta (India)** 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.

**Neil-Pakenham-Walsh (United Kingdom)** 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?

**Neil-Pakenham-Walsh (United Kingdom)** A recent 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'. 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.

**Nicole Spieker (Kenya)** 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.

**Neil-Pakenham-Walsh (United Kingdom)** Compassionate leadership and a compassionate approach by all those who work in the health system is an important foundation for quality. 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.

**Neil-Pakenham-Walsh (United Kingdom)** We have noted that health outcomes and patient experience are fundamental aspects of quality. One recent paper made the surprising conclusion that there seems to be no association between illness (PROMs) and experience (PREMs), while its title talks of different comparators (communication effectiveness and patient satisfaction) and I'm not quite clear how these relate. 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.

**Xavier Bosch-Capblanch (Switzerland)** 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, where 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.

**Neil-Pakenham-Walsh (United Kingdom)** The implication is that the approach for quality improvement may be different for a low-resource environment as compared with a well-resourced environment.

**Neil Pakenham-Walsh (United Kingdom)** This article traces the progression of the COVID-19 pandemic from inception through to the present. 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. There is a strong requirement for health care systems to simultaneously deal with the

pandemic and provide safe, high-quality care. 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. What is missing (for me) is a situational analysis and practical steps forward.

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'?

## ***Q2. 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?***

**Massimo Serventi (Tanzania)** 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 young paediatrician 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.

**Rajinder Kaur (India)** 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: 1) Quality of Care as you have mentioned, and 2) knowledge and Health Seeking Behaviour of patients. I believe that along with focusing on the quality of care provided to pregnant women, health seeking behaviour of women and their families has to be worked up on.

**Marion Lynch (United Kingdom)** I recently worked with the Ministry of Health (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 the eight points from the document 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, and now in 2021, we can use them to build on these foundations and count each level we work at, and each clinical encounter we have. And the gaps.

**Nkwan Jacob Gobte (Cameroon)** Experience from 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.

**Esha Ray Chaudhuri (Canada)** The intersectoral and inter-level dynamics in Canada 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.

**Paulina Pacheco Estrello (Mexico)** There are gaps identified between the supply and demand of acute myocardial infarction treatment in Mexico. In one paper that I have collaborated on, 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.

**Joseph Ana (Nigeria)** A comprehensive situational analysis of the health system of a State in Nigeria 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).

**Joseph Ana (Nigeria)** 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.

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

thank goodness, 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.).

**Moses Kumaoron Orfega (Nigeria)** The information 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](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)

**Joseph Ana (Nigeria)** 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 (Nigeria)** I was glad to read Kingsley George's comments from Nigeria and the various points he made, which are useful because they 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.

**Moses Kumaoron Orfega (Nigeria)** 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.

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. The second is the National Quality Assurance Policy for MEDICINES & OTHER HEALTH PRODUCTS (NQAP)

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 be 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.

**Tomislav Mestrovic (Croatia)** 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.

**Oriane Bodson (Geneva)** 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" 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 is a useful resource to view for this discussion.

**Matthew Neilson (United Kingdom)** 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.

**Neil-Pakenham-Walsh (United Kingdom)** I am very interested to hear about the work being done by 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. It is impressive that this is 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](http://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.

**Ann Lawless (Australia)** 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, regional (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.

**Joseph Ana (Nigeria)** 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.

**Mark Cantor (Australia)** I support Ann's description of the Australian system. 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.

**Neil-Pakenham-Walsh (United Kingdom)** 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.

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 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 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 system and 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 (especially 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.

**Tomislav Mestrovic (Croatia)** 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.

**Joseph Ana (Nigeria)** 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 several key 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](http://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 Africa, 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.

**Ivan Teri (USA)** 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. In the last 13 years of supporting more than 14 countries in sub-Saharan institute national quality improvement 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.

**Richard Fitton (United Kingdom)** 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."

**Oriane Bodson (Switzerland)** 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). We have touched on issues of national commitment in the past week, and 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!

**Neil Pakenham-Walsh (United Kingdom)** 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 components of the health system as needed?

One of the five principles of quality health 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 result 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 complex and multifaceted issue that benefits from everyone's experience and views.

**Sanchika Gupta (India)** 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.

**Esha Ray Chaudhuri (Canada)** In response to Richard Fitton on Patient Experience and Health Outcomes: 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.

**Manu Gupta (India)** 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 daunting 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.

**Moses Kumaoron Orfega (Nigeria)** 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.

**Ann Lawless (Australia)** Australia has a very strong commitment to quality health care. As a health 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!

**Richard Fitton (United Kingdom)** 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 affability 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.

**Rachel Stancliffe (United Kingdom)** 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, as 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](http://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](http://www.susqi.org)

**Ann Lawless (Australia)** In my own country accreditation is a significant and prominent feature of quality in Australian health care. Accreditation bodies are major stakeholders worthy of note in our global conversation about quality and national commitment. 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 organization 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.

**Ann Lawless (Australia)** 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](http://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.

**Tineke de Groot (the Netherlands)** 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 setting 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.

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 is as follows: participants often return from trainings motivated, but behaviour is not applied back at the workplace, because training does not meet job requirements. Also, there is an issue of length of time between learning and application, and the lack of support from management and/or working environment.

**Ibrahima Sall (Senegal)** 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 the current 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.

**Neil-Pakenham-Walsh (United Kingdom)** 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." 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.

**Sanchika Gupta (India)** Mera Aspatal (i.e., '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.

**Nicole Spieker (Kenya)** 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. 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.

**Neil-Pakenham-Walsh (United Kingdom)** In previous discussions on HIFA we have discussed 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 priorities. Over the past 18 months we have even seen heads of state actively ignoring 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, policymakers will continue to find it easier to ignore the evidence and continue to pursue non-evidence-informed policymaking, with disastrous consequences.

**Neil-Pakenham-Walsh (United Kingdom)** A few years ago HIFA worked with the Special Programme on Research for Tropical Diseases (TDR) to explore the topic of Implementation Research. 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

**Lani Rice Marquez (USA)** 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. Moreover, community and civil society leaders must be part of the dialogue as well, to demand both quality of care and access.

**Richard Fitton (United Kingdom)** 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. 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.

**Neil Pakenham-Walsh (United Kingdom)** 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.

**Joseph Ana (Nigeria)** 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.

**Sanchika Gupta (India)** 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.

**Neil Pakenham-Walsh (United Kingdom)** 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'.

In terms of promoting a culture of quality I agree 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.

**Joseph Ana (Nigeria)** 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 (Nigeria)** This is an interesting viewpoint about 'rethinking health systems'. 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.

**Esha Ray Chaudhuri (Canada)** 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 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.

**Indira Narayanan (USA)** 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.

**Lani Rice Marquez (USA)** I just wanted to applaud Ann Lawless for her impassioned treatise 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.

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.

**Joseph Ana (Nigeria)** 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'.

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.

**Joseph Ana (Nigeria)** 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.

**Adanna Chukwuma (USA)** 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.

**Antje Henke (Tanzania)** 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](http://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.

**Q3. 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?**

**Treasa Kelleher (Ireland)** In accordance with the 'WHO Quality Health Services: a planning guide', 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.

**Neil-Pakenham-Walsh (United Kingdom)** 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 delivery 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?

**Venus Mushininga (Zimbabwe)** 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.

**Tomislav Meštrović (Croatia)** In accordance with the 'WHO Quality Health Services: a planning guide', 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.

**Lani Rice Marquez (USA)** 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.

**Bhupendra Kumar Rana (India)** 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 cannot be ruled out.

**Venus Mushininga (Zimbabwe)** Lani draws our attention to critical areas we need to address to ensure quality improvement: 1) the experience and perspective of the patient, 2) involvement of multiple stakeholders including the private sector, 3) 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.

**Richard Fitton (United Kingdom)** There is an example of using community Facebook page by a district matron and district manager during the recent COVID-19 vaccination campaign. A total 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.

**Nicole Spieker (Kenya)** There are challenges for district health managers in tackling quality of care issues. For example, 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.

**Venus Mushininga (Zimbabwe)** 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.

One example is 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?*" This study has showed 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. Finally, the study concluded that the 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?

**Santosh Kumar (India)** In India, different States such as Tamil 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. 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? Please give your reflection on the following monitoring of the Quality initiatives.

**Lisa Hirschhorn (USA)** Often, quality improvement 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 out 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?

**Joseph Ana (Nigeria)** 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 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!.

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.

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 funding 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.

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. 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.

**Tineke de Groot (the Netherlands)** 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.

**Kebede Eticha (Ethiopia)** 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 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.

**Treasa Kelleher (Ireland)** 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?

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)?

Stakeholder engagement at the district level - including health 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?

**Neil-Pakenham-Walsh (United Kingdom)** Thank you, Nisha Bhatta, 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?

**Joseph Ana (Nigeria)** 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.

**Ann Lawless (Australia)** 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.

**Sanchika Gupta (India)** 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. Furthermore, the 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.

**Neil-Pakenham-Walsh (United Kingdom)** 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?

**Neil-Pakenham-Walsh (United Kingdom)** A new WHO publication identifies six challenges that are highly relevant to our discussion (WHO: Quality in primary health care, 2018). These are: 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 (United Kingdom)** 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.

**Ann Lawless (Australia)** 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 are 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.

**Sanchika Gupta (India)** 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.

**Tomislav Meštrović (Croatia)** 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.

**Ann Lawless (Australia)** 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 resonating 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.

**Zewdie Mulissa (Ethiopia)** Sharing with HIFA team an evidence from a work in Ethiopia that using the WHO-Safe Childbirth Checklist paired with a system-wide quality improvement approach improved and sustained quality of EBPs delivery.

**Neil Pakenham-Walsh (United Kingdom)** WHO's 'Quality health services: a planning guide (2020)' highlights the responsibility at district level to:

- Collect data pertaining to patient outcome measures and process measures at the facility level.
- Collect district-level performance measures based on aggregate data from facilities.
- Analyse data emerging from both the facility and district levels to inform facility-level support and district-level planning.
- Share emerging data on quality of health services with community stakeholders and into national level reporting systems.

**Esha Ray Chaudhuri (Canada)** 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 of delivering contextually desirable health outcome for diverse and dynamic patient populations and communities.

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, the Key Considerations 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.

**Q4. *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?***

**Marion Lynch (United Kingdom)** 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.

**Ann Lawless (Australia)** 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. Pilot programs in hospitals are already underway.

**Ruth Davidge (South Africa)** Focusing specifically on nursing care, the challenges I am finding is that nurses are very dependent on the historical practices in their unit and on doctors' 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.

**Joseph Ana (Nigeria)** 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. 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.

**Kebede Eticha (Ethiopia)** 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.

**Joseph Ana (Nigeria)** 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.

**Manu Gupta (India)** At the level of the facility, 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.

**Sanchika Gupta (India)** 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.

**Geir Gunnlaugsson (Iceland)** 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.

**Neil Pakenham-Walsh (United Kingdom)** 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?

**Kebede Eticha (South Africa)** WASH in health care facilities (WinHCFs) is critical for quality health service delivery, patient and health 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.

**Neil Pakenham-Walsh (United Kingdom)** 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.

**Esha Ray Chaudhuri (Canada)** 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.

**Manuel K. Sibhatu (Ethiopia)** 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 health workers who are dedicated to serve their patients and organization.

**Neil Pakenham-Walsh (United Kingdom)** Kebede Eticha notes that 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 needs 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?

**Adanna Chukwuma (United States)** 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.

**Bhupendra Kumar Rana (India)** The situation in Lower and Middle Income Countries is somewhat different than what you have mentioned. In many LMICs, 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.

**Neil Pakenham-Walsh (United Kingdom)** 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. 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.

**Neil Pakenham-Walsh (United Kingdom)** You note inequality between quality of care available in urban versus rural areas of upper middle-income countries. There are also clearly inequalities between the few who can afford to pay for private care and the majority who cannot.

Adanna also makes the point that current financing mechanisms do not incentive quality at the 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.

**Ann Lawless (Australia)** 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.

**Neil Pakenham-Walsh (United Kingdom)** 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. One of the determinants of quality, which is closely linked to motivation, is compassion. There are many others...

**Nisha Bhatta (Nepal)** The main challenges to improving quality of care at the facility level 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 go 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 help 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.

**Neil Pakenham-Walsh (United Kingdom)** 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. 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.

**Richard Fitton (United Kingdom)** 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.

**Sebastian Kevany (United States)** 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.

**Chiabi Bernard Ful (Cameroon)** 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 incentives.

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. Medecins 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.

**Goran Zangana (United Kingdom)** 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 its 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.

**Esha Ray Chaudhuri (Canada)** 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 Tel Aviv can equitably quote a monk in India to improve the quality of a local Health Compassion approach within the lens of global ethics.

**Neil Pakenham-Walsh (United Kingdom)** Thank you 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.

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 basic needs cannot be met? Can they be tackled together?

**Joseph Ana (Nigeria)** 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.

**Neil Pakenham-Walsh (United Kingdom)** 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?

**Venus Mushininga (Zimbabwe)** Thank you for the questions. I will share my experience as a Pharmacist who has practised in both the public and private sectors in Zimbabwe.

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.

**Indira Narayanan (United States)** 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!

**Neil Pakenham-Walsh (United Kingdom)** WHO's 'Quality health services: a planning guide (2020)' highlights the key activities at facility level:

- 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.
- Define a reporting process to share results with facility management and district leadership.
- Feedback is important – also consider feeding back to the local community.
- Consider whether the QI team requires additional facilitation, training, coaching or supportive supervision to conduct measurement e.g. district level/partner support if available.
- Develop job aids to support measurement.

**Kebede Eticha (South Africa)** 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 WASH in Health Care Facility services in the context of quality of care improvement effort. At facility level risk assessment and management approach like the WASH FIT 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 behaviour 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 hospital-acquired infections, creating conducive environment, staff morale and user satisfaction.

**Neil Pakenham-Walsh (United Kingdom)** 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.

**Esha Ray Chaudhuri (Canada)** The points about both the high-income country 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 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.

**Richard Fitton (United Kingdom)** 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.

**Neil Pakenham-Walsh (United Kingdom)** 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.

**Treasa Kelleher (Ireland)** 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, 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.

- The COVID-19 pandemic has presented challenges at the facility level in terms of responding to the pandemic and maintaining quality health services.

- 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).

**Esha Ray Chauduri (Canada)** In the Final Reflections Section (p.48 Quality health services: a planning guide we learn about the critical role of 'Challenges' and 'Barriers' as important measures of solutions.

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), 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.

**Tomislav Mestrovic (Croatia)** 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 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.

**Venus Mushininga (Zimbabwe)** 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 I 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 address this information gap, 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. 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. I 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.

**Richard Fitton (United Kingdom)** 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 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 patient engagement 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.

**Joseph Ana (Nigeria)** Precisely why in 2004 we had to develop the 12-Pillar 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 Sub-Saharan Africa these basic fundamentals for quality are often missing or if present are non functional.

**Richard Fitton (United Kingdom)** 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.

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. 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.

**Neil Pakenham-Walsh (United Kingdom)** 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.

**Richard Fitton (United Kingdom)** 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?

**Richard Fitton (United Kingdom)** 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. [...]

**\*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.

**Tomislav Mestrovic (Croatia)** 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.

**Venus Mushininga (Zimbabwe)** 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.

**Neil Pakenham-Walsh (United Kingdom)** It's notable that Compassion is one of the three pillars of the WHO Global Learning Laboratory for Quality Universal Health Coverage (GLL). 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. 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 (Skills, Equipment, Information, Systems/infrastructure, Medicines, Incentives, Communication facilities).

**Neil Pakenham-Walsh (United Kingdom)** 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.

## [HIFA profiles of contributors and the moderator](#)

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