Inter-Regional Technical Consultation on Best Practices in Patient Safety and Quality of Care in the African and Asia Pacific Regions

Jointly organized by
WHO headquarters and the WHO Eastern Mediterranean Regional Office
in collaboration with and with the support of
the Governments of Japan and Oman

8-10 February 2016, Muscat, Oman
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Executive summary

The Inter-Regional Technical Consultation on Best Practices in Patient Safety and Quality of Care, which took place on 8-10 February 2016 in Muscat, Oman, was jointly organized by WHO headquarters and WHO’s Eastern Mediterranean Regional Office (EMRO), in collaboration and with the support of the Governments of Japan and Oman. Its aim was to create an international network for sharing of best practices, experiences and knowledge among the key stakeholders in the area of patient safety and quality of care from different regions of the world.

A total of 100 participants and experts from 22 countries, including senior policy-makers from ministries of health, and representatives from key institutions, agencies and stakeholders in patient safety and quality of care joined the consultation.

The three days of work provided a common platform for dialogue and information exchange on international experiences and know-how, and enhanced critical reflection on contextually successful processes to promote patient safety, and how patients can be further involved in these improvement processes.

Drawing from the country presentations, and discussions of the event, the premises of the global network in the area of patient safety and quality of care were agreed, and a number of key recommendations were formulated.

**Leadership commitment for patient safety:** Patient safety and quality of care should be considered a health priority and given the required resources for scaling up successful patient safety implementation programmes and interventions.

**Evidence to inform policies and practice:** Effective reporting and learning systems must be established as a live monitoring mechanism for safety and quality of care, and a tool to learn from errors, supported by a set of indicators to evaluate the needs and monitor progress achieved.

**Knowledge and reinforced technical capacity:** Training in patient safety and communication, using tools such as the WHO patient safety multi-professional curriculum guide should be part of under- and post-graduate health care staff curricula and included in continuous professional development programmes.

**Patient empowerment and engagement for patient safety:** Building the capacities of patients as informed partners in safer care includes establishing a basic level of health literacy and ensuring effective patient and community engagement in the process of health care.

**Institutionalization for sustainability:** Institutionalization mechanisms include the availability of resources, having a culture of reporting and improvement, developing know-how and a receptive environment for patient safety, with the active involvement of patient communities.

**Effective communication means:** Developing a communication strategy for patient safety through trustworthy and effective media channels, needs preliminary steps of building understanding of the media on the root causes of safety problems.

**Encouragement of best practices sharing and applying:** The Global Patient Safety and Quality Network will be established as a common platform for communication, alert and sharing of best practices in patient safety and quality of care to promote efficient and cost-effective solutions.
Introduction

Safety and quality of care contribute to improved health service delivery and population health. Health services can today treat and cure ever more diseases, but the toll of preventable healthcare related patient harm is also high.

There is already a wealth of experience (shaped around knowledge, information and tools) available in the field of patient safety and quality of care. A result of multiple initiatives undertaken at the national and international level to help establish safety and quality management systems in health care, this wealth of experience, best practices and lessons learned needs to be shared, to enhance progress and collaborative approaches in implementation.

The Inter-Regional Technical Consultation on Best Practices in Patient Safety and Quality of Care, held on 8-10 February 2016 in Muscat, Oman, was jointly organized by WHO headquarters and WHO’s Eastern Mediterranean Regional Office (EMRO), in collaboration and with the support of the Governments of Japan and Oman. Its aim was to create an International network for sharing of best practices, experiences and knowledge among the key stakeholders in the area of patient safety and quality of care from different regions of the world. Four WHO regions were represented in this inter-regional consultation, namely the African, Eastern Mediterranean, South-East Asian and Western Pacific Regions.

The event was attended by more than 100 participants and experts from 22 countries/territories: Cambodia, China, Egypt, India, Iran, Italy, Japan, Jordan, Kenya, Mongolia, Morocco, Oman, Occupied Palestinian territory, Philippines, Saudi Arabia, Sri Lanka, Sudan, Thailand, Tunisia, United Republic of Tanzania, Uganda and Zambia. The participants included senior policy makers from ministries of health, and representatives from key institutions, agencies and stakeholders in patient safety and quality of care at national, regional or hospital level and professional bodies.

Meeting proceedings

This consultation was part of the initiative for establishing the WHO Global Patient Safety and Quality Network as a platform for shared experience, knowledge and collaboration, in response to an increasing high-level interest for strengthening patient safety and quality of care across the world.

The meeting was structured into six parts, with an inauguration session and five technical sessions.

Inaugural session

During the inaugural session of the meeting, opened with verses from the Quran, participants were welcomed by Dr Ahmed Al Mandhari on behalf of the Ministry of Health Oman, as host country, Dr Sameen Siddiqi on behalf of WHO and Dr Shinten Sakurai on behalf of the Government of Japan, which co-funded the event. All speakers emphasized the importance of patient safety and quality of care on the political agendas and the need to share experience and use existing resources and know-how to promote its implementation.
Dr Neelam Dhingra, WHO HQ, introduced the objectives and modus operandi of the event. Drawing from the existing huge range of safety and quality of care strategies and interventions, and the need to create a global platform of technical awareness and shared knowledge in this complex field, so that existing experience is properly used, the meeting’s objectives included: provision of a common platform for dialogue and information exchange on local initiatives in preventing health care-related harm; critical reflection on contextually successful processes that could strengthen patient safety and quality of care; stimulating patient and family engagement in patient safety and quality of care improvement; using the latest evidence from international experiences, including monitoring and alert mechanisms in this field. Establishing the premises of the global network in the area of patient safety and quality of care by consolidating multi-stakeholder approaches and support to meaningful access to health services and care was the ultimate expected outcome of this consultation.

The international consultation was chaired by Dr Ahmed Al Mandhari. The chairs of the technical sessions (see Annex 1, programme of work) guided the thematic discussions.

**Key note speech: Implementing the patient safety and quality agenda in Oman**

Mapping the progress achieved and lessons learned in the process of developing and implementing patient safety and quality of care processes in Oman was the keynote speech of this inaugural session.

The Oman Ministry of Health was established in 1971, and prompted the high-speed development of the health care system. Phase one (cycles of three five-year plans) saw the establishment of the health service infrastructure, that in phase two expanded geographically, and then national health service programmes were initiated. Health services were decentralised and phase three concluded recently with a record of health care reforms that established milestones in training and education of health care professionals, quality of care and patient safety and research. Phase four which began this year, foresees work on national accreditation, patient safety and patient engagement. All this work led to a substantial increase in access to services and quality of prevention and care delivered. The number of hospital beds, public and private hospitals and health care workers has increased greatly since the 1970s. Infant mortality and under-five mortality has decreased dramatically, with similar downward trends being recorded for severe diseases like leprosy, malaria, and TB.

Patient safety and quality started in 2007, with the Directorate for Patient Safety and Quality being set up in 2010, and the Directorate General for the Quality Assurance Center in 2014. There is a good electronic patient file system, and the patient safety assessment manual is currently being implemented in five hospitals. Following the situational analysis performed in 2011, a ‘Health vision 2050’ was developed to guide the process of continuous improvement of health care services for improved population health.

**Session 1: Advancing the patient safety and quality of care agenda across the world**

This session provided an overview of current progress in patient safety and quality of care globally, through WHO lens.
Global overview of the patient safety and quality improvement journey

The magnitude of the patient safety problem (e.g. 1 in 10 patients harmed, 14 out of 100 patients affected by health care-associated infections) prompted action at the global level. Resolution WHA 55.18 on Quality of care: patient safety prompted initiation of the World Alliance for Patient Safety and subsequently the WHO patient safety programme. WHO has thus been providing global leadership and strategic direction in matters critical to safety, by enhancing awareness across the world, developing guidance and tools, fostering collaboration and best practice networks to support translation into practice of this work. The First Global Patient Safety Challenge ‘Clean Care is Safe Care’ focused on hand hygiene and reducing health care-associated infections. The Second Global Patient Safety Challenge ‘Safe Surgery Saves Lives’ promoted the WHO surgical safety checklist. A Patient Safety Global Summit was organized by the UK in March 2016, as a declaration of commitment to the global patient safety movement. A WHO Global Consultation on Patient safety will follow. The Third Global Patient Safety Challenge, dedicated to medication safety, will be launched in 2017.

Discussion: Participants considered medication safety as a global patient safety challenge and raised the issue of existing differences in regulatory frameworks (e.g. prescriptions and free access to certain groups of medicines) between countries, as part of it.

Regional overview on patient safety and quality improvement in WHO regions

African Region overview

The African Region counts 47 countries and hundreds of local languages, other English, French, Portuguese and Spanish. It is subject to major health system challenges, and generally has limited resources. The recent Ebola epidemic highlighted a number of health system weaknesses, with life loss of both patients and health care workers. A guide for developing national patient safety policy and quality plans was produced and its translation into practice advances slowly. Ongoing national initiatives include an assessment of patient safety standards in Kenya. The most used patient safety tools have been the hand hygiene/infection prevention and control ones, and the surgical safety checklist. Patient health literacy and engagement face important cultural barriers, however, and so remain long-term endeavours. Capacity-building/training in patient safety of different audiences (health care workers, patients and communities), and the patient safety regional network are top priorities for the regional patient safety agenda.

Discussion: The issues of coordination between field stakeholders, as well as obsolete infrastructure and insufficient supplies in particular resource-limited settings in particular (jeopardizing the safety of patients and care-givers) were raised.

Eastern Mediterranean Region overview

The 22 countries of the Region are highly diverse, and each intervention has to be customized to context. Up to 80% of hospital admissions are associated with harm, with a 62% preventability rate, based on a recent prospective study. Medication safety is also a real problem in the Region. The regional strategy uses five axes to enhance patient safety, mirroring the quality improvement continuous cycle. The Patient Safety-Friendly Hospital Initiative was piloted in 2009-2010.

The institutionalization of patient safety and quality improvement faces insufficient dedicated budget, incentives and training (13 countries surveyed). A tool to assess quality
and safety at the primary care level (with 34 core indicators) was developed and piloted. A meeting on health care accreditation will follow in December 2016.

Work on patient engagement and education is progressing, particularly through the Patients for Patient Safety network.

Discussion: Even if WHO is not an accreditation body, hospitals would like to get recognition for their efforts in patient safety. Concern was expressed that due to limited understanding of the issue and public pressure, governments might look for medical liability law against making the system safer.

South East Asia Region overview
The region includes 11 countries, with large population over 20 official languages (with over 700 local languages in India alone) and an average of 3.7% of GDP (between 1.4 and 11.4) being spent in a great diversity of health systems. Several resolutions were issued in the last 10 years promoting quality and safety in health care. Interventions have mostly focused on the development of human resources for health, such as the recent curriculum work and training for the prevention of health care-associated infections.

Health care quality committees have been established at the national level in several countries (India, Indonesia, Maldives, Sri Lanka and Thailand). Sri Lanka established the Healthcare Quality Secretariat and India initiated a patient safety programme in all central government hospitals.

A dashboard-based patient safety assessment tool developed for regional purposes has recently been piloted in Sri Lanka. The Regional Strategy for Patient Safety 2016-2025 was adopted during the last WHO Regional Committee in 2015, and the Regional Plan 2016-2020 including cross-sectional patient safety and quality of care is being developed along a people-centered, universal health care practice.

Discussion:
Sri Lanka shared the experience of its recent pilot study of a patient assessment dashboard. Four meetings have already been held and mandatory standards on infection control assessed. Patient experience research (e.g. patient satisfaction surveys) will be implemented next year across the national system.

It was noted by the Chair that the prevalence of adverse events represents a yardstick for strategic planning and field interventions. The current frequency of adverse events in the regions reviewed is very high (every 5th patient suffers from one) while the adverse event reporting system is weak. It is therefore essential to establish critical indicators in all hospitals and to strengthen surveillance and reporting. Giving voice, dignity and respect to the patient is equally important. Patient safety is a cross-cutting issue, and interventions must be articulated within a system approach, with WHO providing direction in response to needs and expectations identified on the ground.

Reporting and learning systems – a case for progress
The Japanese experience was presented as a case for progress in the field of patient safety and quality of care. Quality and safety are implemented at the institutional and national levels in Japan. The Japan Council for Quality Health Care (neutral third party leading projects for quality improvement and reliability of health care) was established in 1995,
and became a foundation of public interest in 2011. It covers a range of interventions, including hospital accreditation, reporting and learning systems, and evidence-based medical information. Japan has several alert investigation and prevention systems for medical accidents that operate nationwide: the web-based ‘Adverse event reporting system’ (started in 2004), the Japan obstetric compensation/peer review system (started in 2009) and the Accidental death investigation system (started in 2015).

The Japan Council for Quality Health Care (JQ) produces annual and quarterly reports and monthly alerts for the information collected. A total of 70% of medical institutions are covered by the monthly medical safety alert. Transparency is a requirement in Japan and the number of reports submitted since the initiation of the project has steadily increased. Peer review is encouraged and used to mitigate error and promote constructive change. JQ will co-host the forthcoming annual conference of the International Society for Quality in Healthcare will be held in Tokyo, in October 2016.

Discussion: The role of the patient in the reporting of safety incidents was stated. In Italy, there is a public area for reporting, where patients and families can provide their input. The involvement of patients in the development of accreditation standards for health care settings (from the patient’s perspective) was also mentioned.

Selected evidence-based interventions for patient safety and quality of care

The panel discussion included four short interventions (two video-based) on measures that are producing significant change in strengthening patient safety and quality of care.

Infection prevention and control

At the core of the very first WHO Global Patient Safety Challenge, hand hygiene implementation continues to contribute substantially to the prevention of hospital-acquired infections. Health care workers in over 171 countries have pledged to the ‘Clean your hands’ campaign, yet hand hygiene compliance is still not good enough. The annual 5 May event continues to raise awareness of the importance of hand hygiene in keeping everybody safe at all levels. Performing proper hand hygiene applies to care-givers, patients themselves, their family members and the community at large.

Discussions: Difficulties in ensuring adherence to hand sanitation were enumerated, including cultural barriers and lack of time for the correct number of disinfection procedures due to number of patients cared for. Hand rubs provide a faster disinfection alternative, but might not be always available.

Human factors and ergonomics for the implementation of patient safety practices

The experience of the Tuscany Region in Italy was then presented. Ergonomics or human factors represent interactions between humans and other system elements to optimize wellbeing and performance. This multidisciplinary approach helps to rethink the organization, by creating a collaborative breakthrough model that detects and reduces problems and enhances safer performance of the system. The Academy of Citizens acts as a bridge between patients and institutions. Cognitive support and decision-making tools are made available to health care professionals. The European Union Network for Patient Safety and Quality of Care library has 104 Italian patient safety practices in the database. Additionally, the Tuscany Region supported implementation of WHO-designed patient safety interventions in Kenya, within the framework of the African Partnerships for Patient Safety.
Discussion: The concept of ergonomics is still new in many of the participating countries and needs further consideration, particularly when limited resource-settings are being considered.

Minimal Information Model for Patient Safety
The Minimal Information Model for Patient Safety (MIM PS) presents a core set of data elements of a reporting system. It was developed in response to the lack of standards for patient safety incident reporting and processing, to facilitate data comparison and aggregation for better learning across different reporting systems. It builds on existing WHO work in reporting and learning and extensive expert consultation and input. The patient safety categorial structures stemmed from the International Classification for Patient Safety conceptual framework, which was developed further to constitute the first MIM PS draft. The process was led by the Universities St Etienne, France and Tokyo, Japan, and externally reviewed by four countries across the world. The second draft of the MIM PS was piloted in 10 European countries. The validated tools (the “basic one containing 8 data elements and the “advanced” one, 10 elements) is now undergoing further validation in other regions beyond Europe, or is being pilot-tested in cross-cutting areas for an extended use.

Discussion: The reporting system for maternal mortality (also includes sentinel events) in the Eastern Mediterranean Region could be used to validate the MIM PS using retrospective or prospective analysis. Iran also expressed interest in piloting the MIM PS.

Patient participation and engagement
The short video presentation emphasized the importance of patient participation in preventing and/or reporting safety incidents when these occur.

Discussion: Several participants emphasized the importance of having the necessary time to speak to the patient. The system should ensure a division of roles which balances time and workload and advocates for patient education talks to build health literacy. The constructive role of NGOs in this process (e.g. in Egypt) was mentioned.

Session 2: Best practices in patient safety and quality of care: Stories to tell around key thematic priorities
The six pillars of the patient safety and quality of care strategic framework were considered as key thematic priorities to group dedicated success stories and lessons learned from participant countries.

a) Leadership and governance: policies, regulations and laws

La qualité des services et la sécurité des patients au Maroc: une priorité nationale et un souci permanent. Etat des lieux et perspectives - Morocco
The Moroccan health care system includes 150 public hospitals, 20 university hospitals and over 350 private clinics. With the new constitution, new rights for health were instated. The vision is to provide health services that are patient-centered and respond to patient needs and not to the patient’s purchasing power. The current strategy for health care quality and safety has three pillars: continuous improvement of services, safety of care and vigilance, and regularization/institutionalization of quality and safety in health care. Accreditation of health care institutions (public and private) is now mandatory. An electronic reporting system for adverse events and medical errors was launched in 2014, and progress is being monitored. The feedback provided to the reporter is an incentive to report more. The reporting system is ‘blame-free’. Work is based on a team approach. The
keys to successful implementation of patient safety initiatives were strong leadership, strategic alignment with Ministry of Health priorities, coordination at the national level of planned interventions, use of information technologies and the institutionalization of patient safety as a priority programme. Patient safety and quality are considered a social responsibility.

Leadership safety walk-rounds: walk the talk - Oman
In Oman, leadership quality and safety walk-rounds take place on a weekly basis in selected areas. Leadership quality and safety walk-rounds are a tool to engage senior managers and frontline staff in preventing, detecting and mitigating health care related harm, by fostering improved communication and teamwork around quality and safety. This is a structured process with seven steps: preparation, scheduling, conducting, tracking, reporting, feedback and measurement. It is a proof of management commitment to patient safety and has been instrumental in increasing staff engagement, developing local solutions and an open safety culture. Commitment to safety is considered a value that shapes decision-making in health care.

Patient safety in Japan from the viewpoint of the Medical Service Act - Japan
The health care service in Japan, with its 178,059 medical facilities (1,674,671 beds) has been governed by the Medical Service Act since 1948. Within this framework, patient safety is addressed via three levels of responsibility: national and local government level, administrator of medical institution level and independent third party organizations (involved in accreditation and incident investigation). Information, training and awareness-raising campaigns are run nationally. The medical care safety support centre consults 380 locations nationwide. Administrators of medical institutions bear the responsibility of implementing policies, training staff and reporting patient safety incidents when these occur. It is mandatory for medical institutions to participate in the medical accident information reporting system. The medical accident investigation support centre follows up on filed reports. The Japan Council for Quality in Healthcare collects this information, for further improvement.

Reform efforts in quality in a decentralized health system - Sudan
Sudan’s health system is decentralized with a federal Ministry of Health, state ministries of health and localities. Work in the field of quality and safety is longstanding (accreditation started in 2001, the infection prevention and control programme in 2002, the patient safety programme in 2004), but efforts to promote quality and safety of care were all fragmented and unsustainable. The process of health care reform undertaken in 2014 revamped the patient safety programme and infection prevention and control programme as part of the Programme Directorate, to develop and implement solutions for change. The adoption of ISO 9001 and development of national standards, the updating of existing manuals on infection control, elaboration of accreditation law and of the national quality policy, are some of the interventions applied.

Mass advocacy and stakeholder engagement and empowerment, were part of the mechanisms to enhance visibility and partnership for sustainability. Staff were provided with training opportunities and financial incentives, and resources were pooled to support the process. It was noted that Sudan participated actively in the First Global Patient Safety Challenge, “Clean care is safer care” (2005), tested the WHO Safe Childbirth Checklist and piloted the EMR medication safety standards in two hospitals. The WHO Surgical Safety Checklist, among other tools, is in current use.
Leadership commitment, stability and stakeholder active involvement have been key success factors.

**Common responsibility for patient safety - China**

Patient safety is the core and ultimate goal of the National Center for Medical Service Administration, a public institution established in 2015. The Center runs an expanded work portfolio that addresses implementation of legal and regulatory aspects, training and education, guidance on clinical practice and operation standards, as well as accreditation procedures. A supportive regulatory framework for quality and safety of care has been developed (e.g. 2011 accreditation criteria for 3A comprehensive hospitals). The adverse event reporting system in China was founded in 2008, and is voluntary and anonymous.

The patient safety curriculum was introduced in medical education and draws from the WHO multi-professional curriculum translated into Chinese. The Manual of Patient Safety Priorities 2014-2015 published by the Chinese Hospital Association is currently being updated. The system uses various activities and incentives to ensure adherence to safety practices (e.g. medical quality miles, patient safety conferences). Patient participation in medical activities is encouraged. The huge demand of services addressing unbalanced medical resources is a major system challenge. Top down improvement of system design, and a stronger patient safety culture are planned priorities, along with better reporting and learning systems and training of staff for patient safety and quality.

**b) Health workforce: education, motivation, and human factors**

**Best practices in patient safety and quality of care - Tanzania**

The success story in implementing patient safety and quality of care is multifaceted, and includes standard-based management and recognition of infection prevention and control in all referral hospitals and health centres, focused antenatal clinics in both public and private facilities, and the establishment of an open-heart surgery unit. Computerization was introduced in some health facilities and laboratory management strengthened towards accreditation. The country has also become polio-free. The remaining challenges relate to shortages of human resources and poor infrastructure.

Sustained training and mentoring, peer review and self-assessment of health care staff were essential elements in these achievements. Planned developments focus on building a skilled and motivated workforce, and upgrading infrastructure, including medical equipment and drugs. The National Quality Improvement Fora provides a platform for growth and information exchange in the process of health service improvement. Leadership team work (and resources) is one of the forward forces for progress.

**Interventions to support patient safety - Iran**

Activities of health system reform in Iran started 15 years ago. Different approaches including process reengineering, total quality management, risk management and accreditation have been used to improve quality of care and patient safety. Risk management and patient safety are now part of the country’s 20-year forward plan. Work relates to other quality programmes and interventions and safety experts are assigned at the Ministry of Health level and in hospitals. A positive approach to developing a safety culture is being implemented. The WHO patient safety global challenges (clean care and safe surgery) and solutions were promoted in the country, along with other WHO interventions and tools. The WHO patient safety multi-professional curriculum guide was
also translated and adapted locally. A national strategic plan for patient safety was developed drawing from the assessment performed using the WHO dedicated manual.

Main achievements include the launch of critical patient safety standards, medication safety standards, and a training manual with standard procedures for patient engagement. One of the lessons learned from this experience is the importance of a comprehensive national strategic plan for patient safety developed and led by an inter-sector multidisciplinary committee which includes patients engaged for improving patient safety.

**Quality from rhetoric to design: Nizwa experience - Oman**

The Directorate-General of Health Services Al Dakhliya Governorate develops the strategy and annual plans for quality and patient safety in Nizwa. Quality assurance programmes exist in all hospitals, as a result of a sustained national initiative. A safety incident reporting system has been established as a feedback system for quality assurance, mandatory for all hospitals. The Nizwa experience presents the importance of matching context with strategy and implementation: how rhetoric (advocacy and persuasion for purpose) supported by design, training, and the just culture translate into quality improvement interventions. The main challenges faced in the process relate to inadequate training and resources, bureaucracy, lack of time and communication barriers, and weak motivation. Emotional intelligence proved a success factor in creating cultural change, as was effective management of organizational culture. The forward vision of Al Dakhliya Governorate is systematic implementation (train to know, involve, assess and evaluate impact) of a quality management system with international standards for improved patient safety and quality of care.

c) **Information availability and use: measurement, reporting and learning**

Information has multiple roles in improving system performance and reliability. It helps understand how the system works, identifies weak areas and needs, monitors progress achieved, evaluates systems performance and provides evidence for policy and action.

**Best practices in patient safety and quality of care – Kingdom of Saudi Arabia**

Monitoring quality standards in health care facilities started back in 1994. The Central Board for Accreditation of Healthcare Institutions (CBAHI) was established in 2005, part of the Saudi Health Committee. National standards (hospitals, primary care, home care, ambulatory services, blood banks and laboratories) were developed and accreditation became mandatory in 2014. A set of 16 national essential patient safety requirements, based on international standards were developed and included in the CBAHI standards for hospitals. Accreditation started to be linked to insurance programmes, making this crucial for both the private and public sector. CBAHI obtained ISQua accreditation of its hospital standards in 2012, and of the organization in 2015. 126 hospitals (out of a total of 452) have already been surveyed. Research on medical errors based on incident reports was undertaken in 40 hospitals. To advance quality improvement, CBAHI has developed extensive collaboration with various bodies and institutions nationally. The Saudi Patient Safety Center bridges accreditation and public community work.

**The Ministry of Health incident reporting system - Oman**

The incident reporting system of the Ministry of Health is new, and operates on a national basis. To increase adherence to reporting, data has been analyzed over time (by hospital, by cause, by risk, by time of day). Results pointed that 86% of reporters had misconceptions of what it means to report an incident, and the peak times for incident
reporting were linked to shift change. Indicators were updated, improvement teams established, people were trained. The system was redesigned, leading to a sharp increase in reporting. The main challenges to be addressed in establishing an operational incident reporting system were linked to the reporter – having a common understanding of what and how to report, and linked to the system - ensuring this could be easily accessed and operated (user-friendly).

**Best practices in patient safety and quality of care - Zambia**
The Zambian context is subject to major health challenges with high HIV and TB prevalence, high maternal and under-five mortality and limited resources. 650 out of 1800 sites provide antiretroviral therapy for the 800 000 patients, leading to overcrowded sites, unable to provide quality services.

Several initiatives were undertaken to improve service organization, such as TB 3 Is (intensified TB case finding), and Smart care (data aggregation and health reports). SmartCare is the Ministry of Health designated standard for electronic health records in Zambia. The initial concept was launched in 2003, with several versions developed thereafter. Version 3.15 is recognized as the national standard, and version 4.1 is the most successful in terms of data collection and processing. Implementation of the SmartCare card has led to improvements in patient safety, decongestion of ART clinics and reduced TB incidence due to speedier treatment. It has proved that a carefully designed pilot rollout and scale-up plan could be effective. Limited resources, completeness of data and its use were the main challenges encountered.

d) The patient's role: participation, engagement, empowerment and health literacy

**Engagement for patient safety - Thailand**
Thailand's Healthcare Accreditation Institute is an independent government agency that drives the quality improvement movement. The Patient Safety programme in Thailand bridges knowledge (patient safety education), social movements (Patients for Patient Safety nationwide network) and policy links (hospitals for patient safety – 148 hospitals participating on a voluntary basis) in its strategic approach. Several WHO tools have been translated into the local language. Guidelines, checklists and the multi-professional curriculum are currently being used in everyday practice. Hospital quality indicators and the reporting and learning system for adverse events are part of the safety monitoring mechanisms in place. Patients for Patient Safety and public participation are part of the driving forces for change. Engaging all stakeholders in patient safety is a major challenge and a collaborative agreement between professional associations and involving Ministry of Health representation was recently formalized, to foster coordinated work for improved quality of care and patient safety.

**Patient safety in surgical operations - Uganda**
Implementation of quality and safety practices in Uganda is a longstanding process. This was supported by different aid projects (including through the African Development Bank) upgrading infrastructure, equipment, and human resource development, quality standards for infection control, and laboratories were developed, and ISO certification is in process. Patient safety is considered paramount in Ugandan hospital. The surgical team approach to patient safety was presented. Coordinated work starts in the surgical ward, and continues in the operating room and then in the post-operative period. Safety procedures that include the WHO Surgical Safety Checklist were introduced in routine practice. These include proper information/preparation of the patient for surgery (an important cultural issue due
to reduced health literacy). The development of protocols and standard operating procedures, training staff for compliance and adopting the right attitude, were success factors that have led to a reduction in incidents, and reduced mortality in the operating room.

**Voices of patients - Egypt**
The experience of a volunteer programme (initiated by diplomats' wives) to support patient safety in Egypt was presented. Supported by hospital management, safety walkabouts are performed by volunteers observing care throughout public hospital(s), on a regular basis. Safety and quality problems are identified, recorded in a special book, and discussed with management on a weekly basis. Barriers to patient participation are generated by attitude (culture of blame and miscommunication), staff work overload and lack of training, obsolete infrastructure and lack of patient literacy. As a result of this initiative, the pilot site, a 600-bedded maternity hospital developed specialized functional units and underwent renovation, an electronic reporting system was introduced, health care staff and patient relations were included in evaluation sheets, awareness of patient involvement raised and relations/communication between health care workers and patients improved. In-service training was initiated and educational posters for patients were developed. The success of this initiative started with the patient at the core. It entailed team work, a system view of all issues and the advantage of being an independent neutral body, part of a regional and global 'Patients for Patient Safety' network.

**Safety of care in Tunisia: current situation and challenges - Tunisia**
In the Tunisian context, health is a constitutional right. Nevertheless, 75% of hospitals have problems with sustainable financing and attracting and retaining well-trained staff. There are disparities across the country and limited methodology to regulate the private and public health system mix. The Ministry of Health performed and integrated evaluation of health systems' performance in view of the strategic plan. Research showed a 10% occurrence of adverse events in hospitals, mainly health care associated infections. An Independent National Instance for Health Service Accreditation was created in 2010, with the hospital accreditation programme kicking off in 2014. Success stories include a prenatal care assurance quality programme with national standards, hospital infection control programmes, national standards and surveillance for haemo-vigilance and pharmaco-vigilance. Measuring the magnitude of adverse events occurrence was a challenge to overcome, as well as developing legal aspects of security and patient safety. Success factors have included good governance, leadership and professional implication, supported by a non-punitive culture of security and accountability, strengthening civil society capacities and participation.

e) Safety and quality culture and systems

**Quality and safety in health care: the 5S-CQI-TQM approach - Sri Lanka**
Work on health care quality and safety in Sri Lanka started in 1989, but needing to be reintroduced in 2000. Progress was steadily recorded and the policy of health care quality and safety was developed 2012. The Care Quality Improvement programme is centrally-driven, locally-led, clinically-oriented and patient-centered. The roadmap for quality improvement (total quality management) went through five phases using the 5S-Kaizen-TQM approach, with deep roots in stakeholders’ attitudes. The programme was institutionalized, supported by clinical and national guidelines for quality and safety. The manual for master trainers in health care quality and safety advanced local capacity. Surveillance mechanisms including reporting of adverse events and 23 mandatory
indicators were established. As a result, infection rates have reduced, and quality of care improved, including a reduction of waiting times. An Accreditation Council was recently formed. Challenges include low visibility, politics and limited resources, poor communication, and inadequate data. The lessons learned showed the importance of institutionalization of interventions, culture, confidence and appreciative mechanisms. Top management commitment needs to be complemented with champions and second line leadership to ensure implementation and sustainability.

**Active surveillance systems of hospital-acquired infections - Mongolia**

Infection prevention and control in the Mongolian health care system is addressed at regulatory level: two-fold strategies on prevention of antimicrobial resistance and strengthening of infection control in health care facilities, committees of infection prevention and control, standardized criteria for health care-associated infections and a manual for infection prevention and control components. There is an active surveillance system of health care-associated infections. The pilot project undertaken in three hospitals (total 1500 beds) in 2015, confirmed that 14 out of every 100 patients are affected by health care-associated infections, leading to an increase in hospitalization and costs up to 25%. It also showed adherence to safe practices due to training for awareness, guidelines availability and ward-based protocols and forms. Active and standardized surveillance of health care-associated infections proved feasible in the hospital. Success was achieved by a positive attitude (understanding the importance of prevention), the leadership role of hospital managers, active teamwork and having an available budget.

**Quality improvement through health care quality assessment - Cambodia**

The health care system baseline is poor infrastructure, with random lack of water, electricity and sanitation, poor compliance with guidelines and poor training of staff (different practices, low hand hygiene), poor analysis and planning. To address this overwhelming state of affairs, the approach of quality of care assessment was chosen. Data was collected through direct observation and record review and standards came from expert panels. Performed nationwide, it allowed the establishment of scores by service for each hospital and health centre. The intervention was successful due to political commitment, nationwide assessment, economic growth, ASEAN integration and private sector and donor interest. It showed the need to advocate for increased resource commitment for quality of care, and a strengthened regulatory framework to support implementation. Quality improvement measures should be institutionalized in public programmes and included in the research and development agenda. Information on quality improvement progress should be part of the public domain, as a measure of transparency, awareness-raising and support.

**The patient safety-friendly hospital initiative: journey of implementation in Occupied Palestinian territory - OPT**

The national public health law (2004) regulates the functioning of health services. A renewed commitment of the Ministry of Health to quality and safety was expressed in 2014, to implementing the Patient Safety-Friendly Hospitals Initiative. Quality and patient safety were institutionalized with the appointment of coordinators, the development of a national strategy, the formation of committees, training of surveyors, and standardized approaches. A dedicated software (assessment and complaint system) was developed and the patient safety curriculum (using the WHO manual) was translated into an online course. An initial assessment at one year of implementation showed that critical quality and safety standards were fully implemented. A total of 13 hospitals are currently
implementing the Patient Safety-Friendly Initiative. The lessons learned from this experience are that compliance with patient safety standards and leadership commitment are the lever for nurturing a patient safety culture. The contextual constraints include political instability, leadership turnover and unpredictability of resources; however, an expansion to the Patient Safety-Friendly Hospital Initiative is foreseen at the national level and the formation of an independent body for monitoring and evaluating quality and patient safety in health services.

f) Infrastructure: facility, technology, ergonomics and waste management

Success stories of quality improvement initiatives in a tertiary hospital - India
The quality improvement experience in the All India Institute of Medical Sciences in New Delhi was presented. The quality improvement movement started in August 2015 with dedicated projects in six hospital departments. Work was initiated in teams and four basic training sessions were held, in collaboration with IHI and USAID. The quality improvement projects focused on ophthalmology (to reduce waiting times in the eye operation theatre), obstetrics (establishing mother-baby skin-to-skin contact as the standard of care in the Labour ward), neonatology (improve maternal breastfeeding practices) and nurse informatics (on going – achieve completion of infection control e-learning course). Flow charts, root cause analysis and the Plan-Do-Study-Act cycle were used to improve the quality of services and reach the planned outcomes. All interventions were completed successfully, proving that quality improvement is a common-sense approach, based on simple changes that can make a huge difference, when implemented by motivated teams.

Infection prevention and control in patient safety and quality of care - Kenya
Improved quality of service delivery is part of the Health Sector Strategic Plan 2014-2018, and of the Kenya Health Policy 2012-2030. Patient safety is a Ministry of Health programme. A patient safety impact evaluation involving 500 health facilities was performed to identify priorities for action. It found close to zero application in most units surveyed, and considered the Kenyan quality model for health quality standards for community health as the ‘first level’ impact. Patient standards and Joint inspection checklist (both for inpatient and outpatient services) tools were developed. Implementation of an infection prevention and control programme was conducted at national, county and health facility level, using a strategic plan, training and supervision. National guidelines, national policy and a national communication strategy for infection prevention and control were produced. The main barriers to implementation were limited resources, lack of knowledge and competing priorities. Achievements included a Patient Safety Unit at the Ministry level, support from partners to strengthen infection prevention and control, collaboration and coordination. Lessons learned proved the importance of leadership commitment and support, clear structures for implementation and monitoring of all stages in development. Enhancing public awareness, an updated patient safety policy and strategy, use of the WHO training model and the initiation of pilot accreditation are part of the forward plan.

Can technology improve patient safety? - Jordan
The experience of the Hakeem National Health Programme for creating an effective and affordable e-health infrastructure was presented. To create a comprehensive national patient database, the Electronic Health Record System was launched in October 2009, with a rollout plan aiming at national coverage by 2018. It received the Excellence Award in IT Healthcare at the Arab Hospital Federation Congress, in 2015. To facilitate health service access for remote and underserved populations, the CISCO Health Presence Solution
network was developed (collaboration between the Jordanian Government and CISCO). It received the Network Innovation Award 2015. To engage patients and families in their health and improve care coordination a mHealth application was launched. Additional IT tools introduced for safer practice that are in current use are a clinical decision support, a computerized physician order entry, computerized clinical reminder and barcoded medication administration. These quickly led to significant reductions in medication errors after implementation. Though the potential of harm from IT in health must not be overlooked (Joint Commission Sentinel Event Alert 54 on safe use of health information technologies) careful consideration is given to the impact on culture, care process, workflow, and safety. A toolkit for developing a national e-health strategy was made available for this purpose.

Patient safety and quality of care – The Philippines
Access to quality health care, coordinated by the Department of Health of the Ministry, entails upgraded health facilities, deployment of human resources for health and better access to medicines. The national policy on patient safety towards a culture of safety and quality was issued (Department of Health order No. 2008-0023) to institutionalize patient safety as a fundamental principle of health care delivery. The continuous quality improvement programme, infection prevention and control interventions, hospital standards, medication safety, reporting of sentinel events, professional development, patient involvement and participation are among the interventions successfully deployed. Lessons learned show the importance of social preparation (which needs time), cooperation and collaboration (which need awareness, knowledge and negotiation) in moving the safety and quality agenda forward. Patient advocates and feedback mechanisms are proven mechanisms that ensure civil participation for sustainable change. Next steps include strengthening patient safety and quality of care in all health facilities (PhilHealth accreditation), wider community support and stronger patient voices, integration of the WHO multi-professional curriculum guide into health courses and expansion of reporting and learning system at the national level.

Session 3: Key challenges in patient safety and quality: the biggest barriers to be addressed (Group work)

The participants, distributed in three working groups, worked on crystalizing lessons learned from thematic country presentations and their own country experience, in order to identify shared challenges and effective interventions that could enhance adherence to patient safety and quality of care principles and promote the quality and safety agenda in health care. The feedback from the groups, organized around the three common topics proposed for discussion, is summarized below.

a) Main challenges in getting patient safety more recognized in the health care facility
Lack of leadership and limited knowledge of patient safety and quality of care were the main barriers identified, in a general context of limited resources, inadequate organization and weak safety culture.

Institutionalization of patient safety and quality creates the prerequisites for implementation, but requires substantial training and education of all actors involved: policy-makers, health care professionals and patients, through various means.
The WHO multi-professional patient safety curriculum should be part of health care studies and continuous medical education schemes to build awareness of the issue and knowledge required to address this.

An open learning non-punitive safety culture will foster progress and encourage adherence to the reporting of patient safety incidents, as tools for surveillance and continuous improvement. Data availability and transparency should be part of the awareness raising mechanisms.

If properly sensitized to the costs carried by unsafe practices (i.e. health care-associated infections and the burden of medical-related harm) leaders will ensure adequate financing for sustainability of quality and safety approaches that are initiated.

b) Main challenges in getting patients involved and engaged in their own care

Limited health literacy and patient ignorance and fear of contributing are important barriers that are enforced by the attitudes of health professionals based on historical beliefs. The limited time available for the medical encounter is an additional challenge in adequately engaging patients in their own care. Regulatory frameworks with weak provisions on patient protection do not create an enforcement background for patient empowerment.

Proposed solutions combine top down and bottom up approaches that foresee leadership commitment to patient safety and quality of care, training for patient management (including communication) and broad advocacy campaigns to raise awareness about patient rights, health literacy and societal involvement in safer and better care.

Educating and involving the patient has to be done in a structured way to address deep cultural roots and ensure proper understanding of the medical responsibility and the role the patient should play to improve their own health outcomes. Expert patients, patient safety champions and the media must be involved in building better understanding and create a positive patient – health care professional dialogue.

The role of patient networks, such as the WHO Patients for Patient Safety global network, in promoting a good platform for information exchange, shared experiences and solutions, as well as visibility of patient voices was stated as an additional enhancing mechanism.

c) Most efficient tools to overcome barriers to implementing patient safety

Tools to overcome barriers to implementing patient safety and quality of care were addressed in the previous subheadings. The generic approach to implementation includes: advocacy, awareness-raising, training, implementing best practices, monitoring and evaluation of progress, under the overarching umbrella of good governance and leadership, supported by adequate resources.

It proved difficult for meeting participants, when faced with the comprehensive interventions entailed by implementing patient safety and quality of care at the system level, to limit their choices to only a few tools. Interventions/tools listed included: national legislation mandating patient safety; regulatory aspects fostering standards and accreditation of health facilities; training and education of health care professionals in patient safety and communication, and of the patient in health literacy and engagement in their own care; implementation of best practices and use of reporting and learning systems
as surveillance mechanisms, monitoring and evaluation of progress based on critical indicators, evaluation of patient experience, as well as reimbursement procedures.

Teamwork/team approaches/collaboration was considered as prerequisites for developing and translating all of the above into practice. The role of the media (and of the nongovernmental sector) in fostering transparency, building understanding and promoting a positive and just safety culture for advancing patient safety in context was underlined.

**Session 4: Establishing best practice networks for patient safety and quality of care**

The session shaped discussions towards the meeting’s expected outcome, namely the establishment of an inter-regional best practice safety and quality network.

**Best practice networks: an affordable approach to implementing field tested solutions for patient safety and quality of care**

Networks provide a good platform for dialogue and information exchange between stakeholders. Different types of networks (e.g. professional, geographical) operate at different levels (e.g. institutional, national, regional and global). How these are designed depends on profile, and there are many examples of networks providing valuable operational resources. A best practice network will generate a global community of learning for patient safety and quality of care.

The WHO Patient Safety and Quality of Care Best Practice Network (PSQC_BPN) aims to connect national and international patient safety and quality agencies and institutions, including Ministries of Health and focal points for WHO Member States across all six WHO regions. The Patient Safety and Quality Improvement Unit, Service Delivery and Safety Department, WHO Geneva, will be its secretariat.

The WHO PSQC_BPN will have a double focus: improve patient safety and quality of care and function as a rapid alert platform, raising immediate awareness on identified potential safety threats. Members of the network will be able to discuss and share experiences, problems and solutions in real time, as well as share resources, tools, reports and publications, participate in ad hoc training sessions and seminars and access a library with downloadable resources.

**The role of best practice networks in addressing key patient safety and quality challenges identified (Group work)**

Participants were distributed into three working groups to provide more opportunity for discussion about the methods for establishing and sustaining a functional inter-regional network for best practices in patient safety and quality of care and foster information exchange and potential technical support, drawing from country experiences. The feedback from the groups, organized around the three common topics for discussion proposed, is summarized below.

**a) The most efficient approach to establish PQSC_BPN as an active information exchange tool**

Considering the broad coverage of the technical field, and the great expectation generated by such a network, the set-up process has to address issues like governance, smart
technologies, evidence of validity, feasibility and viability of information shared, as well as access.

Several specific approaches in this process were enumerated, including national patient safety champions, the development of communication strategies to encourage adherence, and identification of specific patient safety areas to sharpen technical focus. The network should complement exchange programmes between countries and become a collaborative breakthrough with web-based tools. The issue of language of communication for the network was raised, considering that materials will be mainly available in local languages. The network should start and link national, regional and global levels, and promote, optimize and foster equity for patient safety.

b) **Main partners and stakeholders in the establishment of an inter-regional PSQC_BPN**

A phased model of engaging stakeholders was proposed. Phase 1 should reach actors placed at the core of the issue: ministries of health, health care providers, patients and health institutions. Phase 2 should expand to include insurance companies, associations, academia/universities and civil society. The outreach during Phase 3 should draw media, external regulatory bodies, human rights agencies, religious institutions and the medical industry.

The establishment of a National Committee with representation of stakeholders was proposed, as a consultative local coordination structure. Regional Committees should bring together national focal points from countries in the region. The International Patient Safety Committee (with a WHO-hosted secretariat) will oversee global network coordination and bridge international organizations, institutions, and patient representation. It will re-define agendas every two years.

c) **Mechanisms to ensure network coordination and its long-term sustainability**

An enumeration of mechanisms to ensure network functionality includes leadership commitment and strategic support, financial support and accountability, incentives and rewarding systems, monitoring and evaluation mechanisms.

The existing (infra) structure in each country should be used for promoting and carrying out network activity. The organizational structure (e.g. national focal points as country gatekeepers, supported by national experts) and the strategic plan will set the operational framework for the task. It was proposed that some global patient safety indicators should be defined and progress regularly reviewed (via peer and external review). Developing international awards could be a social visibility incentive for participation. Regular meetings of the network to provide updates/review of the strategic plan and potentially organize on-site educational sessions will ensure sustainability.

**Discussion:** Participants defined the vision of the network as encouraging/disseminating patient safety practices and culture to optimize services and interactions and promote equitable access to care. The tools should be adequate to support the mission of the network: creating coordinated reporting systems, learning and sharing of best practices, supporting proactive programmes to enhance patient safety and patient empowerment, establishing online resources and repository.
Several issues were raised, in particular from resource-limited settings where existing technology will require further investment to ensure participation in the network. Clear guidelines on the network format (formal vs. informal), criteria for accessing the network and taking part, were requested. It was underlined that the assumed workload generated by network participation must be given careful consideration, to ensure its efficiency. The benefits of shared learning, tools and online training courses were noted.

Session 5: Thinking about the way forward

Examination of the mechanisms for ensuring network functionality continued. The Patients for Patient Safety network which provides a platform for patients' voices has already proven its value. Several examples of successful networks in all WHO regions were shared.

The main scope of the network being sharing, WHO publications will be made available and distributed. It was agreed that monthly reminders to initiate discussions will be sent by the WHO secretariat. Participation in network discussions will be based on self-motivation. A summary report with achievements of the network will be prepared on an annual basis.

The foundation of the global network will use existing structures or be founded at national level, so that the network does not remain with individuals. The national board (committee), regional and international boards will provide regular follow-up on information exchange.

It was also suggested that anchoring the initiative at ministry of health level in countries, might provide political endorsement of this initiative. The PSQC_BPN should become the platform for international experience exchange, increase awareness and funding opportunities and stimulate research on patient safety.

Participants requested that WHO should facilitate high-level discussions nationally and internationally, and stimulate advancement of the health safety and quality agenda in countries. Civil society should be empowered and given the opportunity to contribute to the national and/or global discussion.

To ensure fast progress of this initiative, it was suggested that tasks be immediately allocated to meeting participants. A number of important issues were identified and recommendations formulated.

Conclusions and recommendations

Leadership commitment to patient safety

Patient safety and quality of care require strong leadership to promote and move forward the implementation agenda. Political commitment to patient safety is essential and so is the commitment of executive management of health care institutions and health care professionals. This should be considered a health priority and given the required resources for scaling up successful patient safety implementation programmes and interventions.

Evidence to inform policies and practice

Effective reporting and learning systems must be established as a live monitoring mechanism for safety and quality of care and learning from error tool. Regulations should ensure that the system is non-punitive, so that errors can be accurately reported and system failures corrected. Establishing a set of indicators for patient safety and quality of
care is required to evaluate the needs and monitor progress achieved.

**Knowledge and reinforced technical capacity**
Training of staff on patient safety and communication should be promoted to support implementation of planned work. The WHO patient safety multi-professional curriculum guide can be used as a good resource to update undergraduate and postgraduate health care professional training curricula and in continuous professional development programmes too.

**Patient empowerment and engagement for patient safety**
Building greater capacity in patients is needed so that they become actively involved as informed partners in their safer care. This includes establishing a basic level of health literacy in the patient and community at large and ensuring effective patient and community engagement in health care.

**Institutionalization for sustainability**
Ensuring the sustainability of patient safety interventions through the establishment of institutionalized mechanisms that include the availability of resources, a culture of reporting and improvement, building capacity, developing know-how and a more receptive environment for patient safety, with the active involvement of patient communities.

**Effective communication means**
Developing a communication strategy for patient safety through trustworthy and effective media channels requires the preliminary steps of building understanding of the media on the root causes of health care safety problems.

**Encourage best practice sharing and applying**
The Global Patient Safety and Quality Network will be established as a common platform for communication, alert and sharing of best practices in patient safety and quality of care. This is expected to enable a translation of innovative approaches applicable to resource-constrained settings to promote efficient and cost-effective solutions.

**Immediate next steps**
- The Global PSQC_BPN generated by this initiating meeting will be expanded progressively to include new participants.
- The WHO secretariat will host and administer the electronic platform supporting the network.
- The organization of an annual meeting bringing together members of the network will be planned.
- The report of the event will reflect these recommendations.

The important contribution and commitment of hosts, partners and meeting participants in generating the premises of the best practice network for patient safety and quality of care was acknowledged, and gratitude expressed. A common pledge to zero tolerance for preventable harm in health care was the closing statement of the event.
Annex 1: Programme of Work

Inter-Regional Technical Consultation on Best Practices in Patient Safety and Quality of Care in the African and Asia Pacific Regions
8-10 February 2016, Muscat, Oman

Jointly organized by WHO headquarters and WHO-EMRO, in collaboration and with the support of the Governments of Japan and Oman

Programme of Work

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<tr>
<th>Day 1 - Monday 8 February 2016</th>
<th>Inauguration Session</th>
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| 09:00 – 10:00 | Verses from the Quran  
Opening Remarks, Ministry of Health, Oman – Dr Ahmed Al Mandhari  
Welcome Address, WHO – Dr Sameen Siddiqi  
Welcome Address, Ministry of Health, Labour and Welfare, Japan – Dr Shinten Sakurai  
Introduction of participants |
| Objectives of the Inter-Regional Technical Consultation  
Adoption of the Programme of Work | Dr Neelam Dhingra |
| 10:00 – 10:30 | Key Note speaker: Implementing the Patient Safety and Quality Agenda in Oman | Dr Ahmed Al Mandhari |
| 10:30 – 11:00 | Group photo & Break | |

Session 1: Advancing the Patient Safety and Quality of Care agenda across the World

| 11:00 – 11:20 | Global Overview on Patient Safety and Quality Improvement Journey | Dr Neelam Dhingra |
| 11:20 – 12:30 | Regional Overview on Patient Safety and Quality Improvement in Participant Regions – Roundtable  
Structured 10’ presentations followed by guided discussion on global and regional achievements and challenges | Chair: Dr Sameen Siddiqi  
Presenters:  
AFR – Dr Martin Monono Ekeke  
EMR – Dr Mondher Letaief  
SEAR – Dr Sunil Senanayake  
WPR – Presentation |
| 12:30 – 13:00 | Reporting and Learning Systems – a Case for Progress | Dr Shin Ushiro |
| 13:00 – 14:00 | Lunch | |
### 14:00 – 15:00
Panel Discussion on Selected Evidence Based Interventions for Patient Safety and Quality of Care
- Infection Prevention And Control
- Human Factors and Ergonomics for the Implementation of Patient Safety Practices
- Minimal Information Model for Patient Safety
- Patients Participation and Engagement

*Structured 10’ presentations followed by guided discussion on implementation challenges*

**Chair:** Dr Shin Ushiro  
**Presenters:**  
- Prof Didier Pittet (Video)  
- Dr Giulia Dagliana  
- Ms Maki Kajiwara  
- Video

### Session 2: Best Practices in Patient Safety and Quality of Care: Stories to Tell around Key Thematic Priorities

| 15:00 – 17:15 | **Leadership and Governance:** Policies, Regulations and Laws  
*Session Chair: Dr Mondher Letaief* |
|----------------|---------------------------------------------------------------|
| 1530 – 1600 | La Qualité des services et la sécurité des patients au Maroc : Une priorité nationale et un souci permanent. Etat des lieux et perspectives – Morocco  
**Dr Nejoua Belkâab**  
Leadership Safety Walk-rounds: walk the talk – Oman  
**Dr Khalfan A-Kharosi**  
Patient Safety in Japan: from the viewpoint of Medical Service Act – Japan  
**Dr Shinten Sakurai**  
Reform Efforts in Quality in a Decentralized Health System – Sudan  
**Dr Elmuez Eltayeb Ahmed**  
Common Responsibility for Patient Safety – China  
**Dr Zhao Minggang**  
Successful Intervention Requirements  
Plenary discussions |

| 17:15 – 18:00 | **Health Work Force:** Education, Motivation and Human Factor  
*Session Chair: Mrs Fanaz Mostofian* |
|----------------|-----------------------------------------------------------------|
| 09:00 – 09:15 | Summary of Day 1  
**Rapporteur** |

### Day 2 - Tuesday 9 February 2016

| 09:00 – 09:15 | Summary of Day 1  
**Rapporteur** |

**Session 3: Best Practices in Patient Safety and Quality of Care: Stories to Tell around Key**
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<tr>
<td>09:15</td>
<td><strong>Information Availability and Use</strong>: Measurement, Reporting and Learning</td>
<td>Dr Valentina Hafner</td>
<td>Kingdom of Saudi Arabia</td>
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<tr>
<td>09:45</td>
<td>Best Practices in Patient Safety and Quality of Care</td>
<td>Dr Abduleelah Al Hawsawi</td>
<td>Kingdom of Saudi Arabia</td>
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<tr>
<td>10:15</td>
<td>The Ministry of Health Incident Reporting System: from Challenges to Success</td>
<td>Dr Ahmed Al-Mandhari</td>
<td>Oman</td>
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<td>10:45</td>
<td>Best Practices in Patient Safety and Quality of Care</td>
<td>Dr Crispin Moyo</td>
<td>Zambia</td>
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<td>Successful Intervention Requirements</td>
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<td>10:30</td>
<td><strong>Break</strong></td>
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<td>11:00</td>
<td><strong>Patients' Role</strong>: Participation, Engagement, Empowerment and Health Literacy</td>
<td>Dr Sunil Senanayake</td>
<td>Thailand</td>
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<td>11:30</td>
<td>Engagement for Patient Safety</td>
<td>Dr Piyawan Limpanyalert</td>
<td>Thailand</td>
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<td>11:45</td>
<td>Best Practices in Patient Safety and Quality of Care</td>
<td>Dr Amone Jackson</td>
<td>Uganda</td>
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<td>12:15</td>
<td>Best Practices in Patient Safety and Quality of Care</td>
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<td>Tunisia</td>
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<td>12:30</td>
<td>Patients Participation and Engagement</td>
<td>Ms Nagwa Metwally</td>
<td>Egypt</td>
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<td>12:45</td>
<td>Successful Intervention Requirements</td>
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<td>12:00</td>
<td><strong>Safety and Quality Culture and Systems</strong>: Enabling (non-punitive) Environment, Risk Management, Accreditation, Infection Control and Prevention and Specific Safety and Quality Areas, such as medications, blood transfusion, injections and medical devices</td>
<td>Dr Salem Al Wahabi</td>
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<td>12:30</td>
<td>Quality and Safety in Healthcare: 5S-CQI-TQM approach. An experience from a developing country</td>
<td>Dr Sathasivam Sridharan</td>
<td>Sri Lanka</td>
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<td>14:30</td>
<td>Successful Intervention Requirements</td>
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<td>13:00</td>
<td><strong>Infrastructure</strong>: Facility, Technology, Ergonomics and Waste Management</td>
<td>Dr Safaa Qsoo</td>
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<td>13:30</td>
<td>Infection Prevention and Control in Patient Safety and Quality of Care</td>
<td>Dr Evelyn Wesangula</td>
<td>Kenya</td>
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<td>Success stories from quality improvement initiatives in a tertiary hospital – India</td>
<td>Dr Parijat Chandra</td>
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<td>Can Technology Improve Patient Safety? – Jordan</td>
<td>Dr Rajaa Khater</td>
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<td>Leadership and Governance in Patient Safety and Quality Care – Philippines</td>
<td>Dr Criselda G. Abesamis</td>
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<td>Successful Intervention Requirements</td>
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| 15:30 – 17:00 | **Group Work (Three groups)** |
| **Introduction** – Dr Valentina Hafner |
| **Key Challenges in Patient Safety and Quality: the Biggest Barriers to be addressed** |

| 17:00 – 18:00 | Reporting from the Groups |
| 18:00 | Conclusions of the Day |

### Day 3 - Wednesday 10 February 2016

| 09:00 – 09:10 | Summary of Day 2 |

#### Session 4: Establishing and activating best practice networks for patient safety and quality of care

| 09:10 – 09:30 | Best Practice Networks: an affordable approach to implementing field tested solutions for patient safety and quality of care | Dr Valentina Hafner |

| 09:30 – 11:30 | **Group Work (Three groups)** |
| **Introduction** – Dr Ruth Mabry |
| **The Role of Best Practice Networks in Addressing Key Patient Safety and Quality Challenges identified** |

| 11:30 – 13:00 | Reporting from Group Work |
| 13:00 – 14:00 | Lunch |

#### Session 5: Thinking the way forward

| 14:00 – 15:00 | Reaching agreement on the initiation and functioning of the BPN Network |
| 15:00 – 15:30 | Conclusions and Next Steps |
| 15:30 – 16:00 | Break |
| 16:00 | Closure of the Technical Consultation |

| Dr Ahmed Al Mandhari |
| Dr Mondher Letaief |
| Dr Neelam Dhingra |
## List of Participants

<table>
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<tr>
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<th>Cambodia</th>
<th>China</th>
<th>Jordan</th>
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<td><strong>Nominated Representatives</strong></td>
<td><strong>Dr Sok Po</strong></td>
<td><strong>Dr Li Dachuan</strong></td>
<td><strong>Dr Rajaa Khater</strong></td>
<td><strong>Dr Veronica Kamau</strong></td>
<td><strong>Dr Lamjav Sarantsetseg</strong></td>
<td><strong>Dr Nejoua Belkaab</strong></td>
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<td><strong>Nominated Representatives</strong></td>
<td><strong>Deputy Director of Hospital Services</strong></td>
<td><strong>Director, Division of Medical Care and Nursing</strong></td>
<td><strong>Director of Quality Directorate</strong></td>
<td><strong>Ministry of Health</strong></td>
<td><strong>Head of Ambulatory Services</strong></td>
<td><strong>Chargée de la Qualité et de la Sécurité des soins</strong></td>
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<td><strong>National Health and Family Planning Commission</strong></td>
<td><strong>National Center for Medical Service Administration</strong></td>
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<td><strong>State Central Hospital of Mongolia</strong></td>
<td><strong>Direction des Hôpitaux et des Soins Ambulatoires</strong></td>
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<tr>
<td><strong>Additional Professor of Ophthalmology, Dr R. P. Centre for Ophthalmic Sciences, AIIMS, New Delhi</strong></td>
<td><strong>Quality Directorate</strong></td>
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<td><strong>Dr Rajaa Khater</strong></td>
<td><strong>Dr Haitham Dweiri</strong></td>
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<td><strong>Dr Veronica Kamau</strong></td>
<td><strong>Dr Evelyn Wesangula</strong></td>
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<td>Dr Rabii Faouzi</td>
<td>Pharmacien à la Division des Hôpitaux Direction des Hôpitaux et des Soins Ambulatoires Ministère de la Santé</td>
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<td></td>
<td>Aza Al-Nabhani</td>
<td>Head, Quality Management and Patient Safety Department D.G. Health Services, Al Dakhliyah Governorate</td>
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<td></td>
<td>Samra Al-Barwani</td>
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<td>Dr Khalid Abilmaged</td>
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<td>Khalfan A-Kharosi</td>
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<td>Mardhyaia Abdullah Al Kharusi</td>
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<td>Dr Ismail Al Rashdi</td>
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<td>Dr Dalal Rashid Abdullah Alghafri</td>
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<td>Dr Criselda Abesamis</td>
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<td>Dr Sathasivam Sridharan</td>
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<td>Dr Mudiynselage Ratnayake</td>
<td>Director / Teaching Hospital</td>
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<td>Dr Elmuez Eltayeb Ahmed Elnaem</td>
<td>Director General of Curative Medicine Federal Ministry of Health</td>
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<td>Dr Ayda Abdien HagoTaha</td>
<td>Head of Patient Safety and Infection Control, Directorate General of Quality, Development and Accreditation Federal Ministry of Health</td>
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<td>Thailand</td>
<td>Dr Udom Krairittichai</td>
<td>Medical Officer, Advisory Level Rajavithi Hospital Department of Medical Services Ministry of Public Health</td>
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| Tunisia                      | **Dr Piyawan Limpanyalert**  
Deputy Chief Executive Officer  
Healthcare Accreditation Institute (Public Organization) |
|                              | **Mr Mansour Njah**  
Professor in Community Medicine  
Farhat Hached |
|                              | **Mrs Olfa Jouini**  
Senior Technician in Hygiene at the Directorate of Hygiene & Environment Protection  
Ministry of Health |
| Uganda                       | **Dr Amone Jackson**  
Asst. Commissioner Health Service  
Ministry of Health |
|                              | **Dr Doreen Male Birabwa**  
Deputy Executive Director  
Mulago National Referral Hospital |
| United Republic of Tanzania  | **Dr Joseph Hokororo**  
Head of Infection Prevention and Control and Safety Unit (under the Health Services Inspectorate and Quality Assurance Section) in the Health Quality Assurance Division  
Ministry of Health and Social Welfare |
|                              | **Dr Margatet Mhando**  
Director of Curative Services  
Ministry of Health and Social Welfare |
| Zambia                       | **Dr Crispin Moyo**  
Clinical Care Specialist  
Ministry of Health |

**Experts/Temporary Advisers**

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|                              | **Ms Nagwa Metwally**  
Egypt Red Crescent Society  
Egypt |
|                              | **Dr Giulia Dagliana**  
Laboratorio per le attività di studio e ricerca applicata  
Centro Gestione Rischio Clinico e Sicurezza dei Pazienti, Patient Safety Research Lab  
Italy |
|                              | **Dr Shin Ushiro**  
Director  
Japan Council for Quality Health Care  
Japan |
|                              | **Dr Shinten Sakurai**  
Ministry of Health, Labour and Welfare  
Japan |
|                              | **Dr Safaa Qsoos**  
Quality and Patient Safety Expert  
Jordan |
|                              | **Abed Alra’oof M. Saleem**  
Director of Quality Department  
O.P.T. |
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<td>Dr Ahmed Al Mandhari</td>
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<td>Mrs Fanaz Mostofian</td>
<td>Expert and Focal Point for Patient Safety</td>
<td>Hospital Management and Clinical Excellence Office&lt;br&gt;Ministry of Health and Medical Education&lt;br&gt;Iran</td>
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<td>Dr Salem Al Wahabi</td>
<td>Director-General</td>
<td>Central Board for Accreditation of Health Care Institutions&lt;br&gt;Saudi Arabia</td>
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<td>Dr Mohammed Tarawneh&lt;br&gt;WONCA president for EMR</td>
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<td>Prof Mohammed Shafee&lt;br&gt;WONCA’s EMR executive board</td>
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<td>Dr Neelam Dhingra-Kumar&lt;br&gt;(Organizing Secretary)&lt;br&gt;Coordinator&lt;br&gt;Patient Safety and Quality Improvement Unit&lt;br&gt;Service Delivery and Safety Department</td>
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<td>Dr Valentina Hafner&lt;br&gt;Consultant&lt;br&gt;Patient Safety and Quality Improvement&lt;br&gt;Service Delivery and Safety Department</td>
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<td>Ms Maki Kajiwara&lt;br&gt;Technical Officer&lt;br&gt;Service Delivery and Safety</td>
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<td>Dr Martin Monono Ekeke&lt;br&gt;Regional Adviser&lt;br&gt;Health Systems and Services&lt;br&gt;Health Policies and Service Delivery</td>
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<td>Dr Sameen Siddiqi&lt;br&gt;Director&lt;br&gt;Health System Development</td>
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<td>Dr Mondher Letaief&lt;br&gt;Technical Officer&lt;br&gt;Hospital Care and Management</td>
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<td>Dr Sunil Gunasena Senanayake&lt;br&gt;Regional Adviser&lt;br&gt;Health Systems Management</td>
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Annex 3 - Group photo