HEALTH CLUSTER

Quality of Care in Humanitarian Settings

Global Health Cluster

Quality Improvement Task Team

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Contents

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1. Background

Improving the quality of humanitarian health response has been a continuous goal for the humanitarian community. The development of global standards such as Sphere, the Inter Agency Field Manual for Reproductive Health in Emergencies and IASC Guidelines for Mental Health and Psychosocial Support (MHPSS) in Emergency Settings are one part of this and are widely used and accepted as standards to achieve in humanitarian settings.

Quality of Care is also a key component of the right to health (2) and access to quality health care services is critical to achieving Universal Health Coverage. Globally new momentum has gathered to address quality of care especially in fragile, conflict and vulnerable settings.

In recognition of the all these efforts and the need to assure and improve quality of health care in humanitarian settings where the Cluster system is activated, in 2019 the Global Health Cluster established a Quality Improvement Task Team to consider how this may be addressed.

In September 2019, 36 partners and agencies convened to discuss and agree on what quality of care entails in humanitarian settings, its definition, scope, and key issues that should be considered in a humanitarian response.

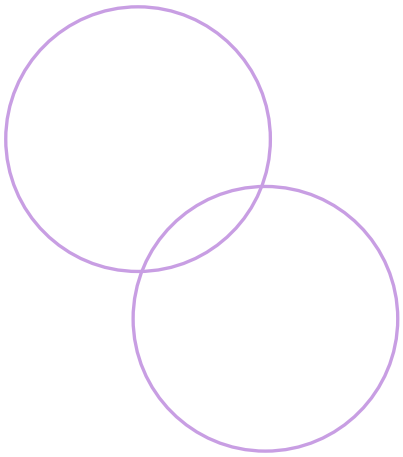
Between 5.7 and 8.4 million deaths occur annually in low- and middle-income countries due to inadequate quality of care (1)

Sustainable Development Goal 3.8
"Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, & access to safe, effective, quality, & affordable essential medicines & vaccines for all"

2. Purpose

Quality of Care is a large concept for which no single focus will adequately encompass it in its entirety. Although elements will be common across settings, priorities within this may vary between contexts and crises. This position paper serves as a guide to both Health Cluster Coordination Teams as well as Health Cluster Partners as they develop mechanisms to address and improve quality of care in their settings. This paper defines the scope and minimum issues that must be considered when addressing quality of care in humanitarian settings and should be referred to where the Cluster system has been established. It is relevant for both acute and protracted crises and throughout the response phases.

This document complements key technical guidance for humanitarian settings such as IASC guidance, Sphere, IAWG Reproductive Health in Crises, Newborn Health in Humanitarian Settings Field Guide, other GHC position papers, and other standards adopted at country level. These will not be examined here but should be referred to. Further tools and guidance will be developed by the Global Health Cluster Quality Improvement Task Team to help Health Clusters and Partners assess quality of health care and develop quality improvement methods at country level.



3. Definition and key concepts

Quality health care must be provided to all parts of the population, throughout their life course and in any health care setting. Health care ranges from preventive, promotive, curative, rehabilitation and palliative care which may be provided at various levels of care from primary level (which includes self, home and community care) to secondary and tertiary (specialised) levels of care, as well as during referrals. It is important to note health care is wider than clinical encounters and includes provision of services to communities and the population. Furthermore, people centred care encompasses the health of the people in their communities and incorporates their role in shaping health policy, health services and delivery (3).

Ensuring the provision of quality health care in humanitarian settings follows the same approach and also key tenets to deliver principled[a] and quality humanitarian response. It is important therefore that when defining quality of health care in humanitarian response it is examined within the lens relevant to the operational environment. Intersections already occur and are described throughout this document.

3.1 Definition of Quality of Care

Domains:

People centred responding to an individual's preference, needs and values

Safe avoiding harm to people for whom the care is intended

Equitable care does not vary according to age, sex, gender, race, ethnicity, geographical location, religion, socio economic status, disability, sexual orientation, linguistic or political affiliation etc

Effective providing evidence-based health care services to those who need them

Timely reducing waiting times and harmful delays for both those who receive and those who give care

Integrated such that care is coordinated across levels and providers (as well as between sectors) and makes available the full range of health services throughout the life course

Efficient Maximizing the benefit of available resources and avoiding waste

Figure 1: Definition and domains of quality of care

Source: adapted from *Quality of Care in fragile, conflict affected and vulnerable settings: taking action.* WHO 2020 to be published 2020 (4)

Quality of care is defined as given above (Figure 1) and has seven interrelated domains. As such to meet this definition, for health services to improve health outcomes it is necessary to ensure not only that the quality of clinical care delivered within a health care setting is of the required standard, but also that the provision of health care adequately meets the needs of the population it is meant to serve.

[a] See Humanitarian Principles page 5

3.2 Key humanitarian guiding principles

Humanitarian response is steered by International Human Rights Law, International Humanitarian Law, and other key international legal instruments[b]. Central guiding principles have been established by the IASC and other bodies to improve the accountability and quality of humanitarian response. These are intended to be adopted in country Humanitarian Response Plans and Health Cluster response. These commitments similarly overlap and re-iterate the general principles of Quality of Care that should be provided by health actors in any situation.

Humanitarian Principles Of humanity, impartiality, neutrality, and independence were codified in UN General Assembly Resolutions6/182 (5) and Res 58/114 (6). Within these it highlights that humanitarian response should be based on need alone and provided to all the affected population without discrimination.

IASC policies and guidance

Accountability to Affected Populations (AAP) (7) puts people in the centre of the response, and ensures that all parts of the affected population are involved in programme design, implementation, monitoring and feedback of any humanitarian response

Protection against sexual abuse and exploitation (PSEA)(8) is a commitment that all humanitarian partners will introduce policies and practices that aim to end sexual exploitation and sexual abuse by humanitarian workers (and their own personnel) and to ensure that allegations of SEA are responded to in a timely and appropriate manner.

Centrality of Protection (9), **the IASC Protection Policy** (10) and **protection mainstreaming** (11) commits organisations to ensure that the provision of aid does not itself create risk or harm to the affected population. Furthermore, it stipulates that all parts of the population, including those at risk, have meaningful access to the full range of services they are entitled to. This involves having to understand and address the various needs of all.

[b] For further information see Annex I, IASC Policy on Protection in Humanitarian Action IASC 2016 and Annex I, The Sphere Handbook, Sphere 2018

Other guidance and commitments

Medical ethics and patient's rights as defined in the in the World Medical Association Medical Ethics Manual (12) have been adopted by Sphere Health Standards (13), and EMT Classification and Minimum Standards for Foreign Medical Teams (14). It relates to commitments and codes of conduct for reducing harm, on a range of issues including medical professionalism, patient care, research on human subjects and public health.

The Core Humanitarian Standards (15) place communities and people at the center of humanitarian action. It outlines policies and practices that an organization needs to achieve to deliver quality assistance while first being accountable to communities and people affected by crisis

3.3 Quality of care in humanitarian settings

In humanitarian settings the same definition and domains of quality of care apply and intersect with **and complement key obligations in humanitarian response**. For example, 'people centredness' and 'accountability to affected populations', 'safe' care and 'centrality of protection', 'equitable' care and 'impartiality' overlap .The specificities of these and 'key issues to consider' in humanitarian settings are described in further detail under each domain in this document.

Action to improve quality of care can therefore be seen as a core aspect of humanitarian response and for Health Clusters to address. When developing mechanisms to do so, Health Clusters and partners will first need to develop and agree upon a local definition of quality of care appropriate to the context and crisis. When doing so humanitarian concepts and obligations described above, and key issues under each 'domain' of quality of care in the subsequent sections must be considered.

4. The domains of quality of care

People centred

Providing care that responds to individual preferences, needs and values

A people-centred approach can engender **appropriate and relevant** health care programming, helping to increase community trust and acceptance of health care provided.

Understanding **the various needs of affected populations**, **including those at risk,** such as children, girls, women, older people, people living with disability, mental health conditions, stigma, marginalised communities etc, and how they would like to receive their care addresses aspects of *protection* (see page 5). This should be assessed by engaging individuals and groups at the community level, as well as within a health care setting.

Being people centred requires that the **rights, dignity and privacy** of affected populations is ensured, and **compassionate, survivor-centred health care** is provided.

People-centredness similarly incorporates principles of *accountability to affected populations* (see page 5). This entails that healthcare providers understand the needs of affected populations (including those at risk), systematically engaging individuals and communities in programme **design, implementation and monitoring** of health programmes, and **jointly developing feedback and complaints** mechanisms they are willing to use. Partnering with the community to support their health care journey will improve provision of care.

Key issues to consider

To understand individual, household community (including from groups at risk):

- coping mechanisms, barriers to health care, health seeking behaviour
- perceptions on health needs and desired health response
- preferences on how to
  - participate in the design of health programmes
  - participate in the monitoring of health programmes
  - give feedback and complaints

And their satisfaction on all the above when mechanisms are established and implemented

Tools and mechanisms for collecting information and understand all the above

Heath care provided is

- dignified
- compassionate
- appropriate
- accessible
- relevant
- meets their specific needs (including for groups at risk)

People and patients **know their rights**

People and patients' **satisfaction** with the **health care experience** is assessed within the healthcare setting and community level

Safe

Avoiding harm to people for whom the care is intended

The concept of safety in humanitarian settings also relates to addressing aspects of '**protection'** and is recognized in the '*IASC commitment to the Centrality of Protection in Humanitarian Action (9)'* the '*IASC Policy on Protection in Humanitarian Action' (10)* and '*protection mainstreaming' (11)* (see page 5). These emphasise that **the provision of health care itself must not increase risk or cause harm.** Providing safe health care therefore relates not only to **patient safety,** such as reducing the risk of medical errors, adverse events or health care-acquired infections but also addressing the **safety and security** of those accessing or providing care.

Patient safety is the absence of preventable harm to a patient during the provision of health care, and the reduction in risk of unnecessary harm associated with health care to an acceptable minimum. In low- and middle-income countries (LMICs), evidence suggests that 134 million adverse events occur each year due to unsafe care in hospitals, contributing to 2.6 million deaths annually (1). The main contributors to patient harm are patient misidentification, communication failures, medication errors, unsafe surgical care, diagnostic errors, health care-associated infections, unsafe injection practices, unsafe transfusion practices, radiation errors, and venous thromboembolisms. Patient safety is built on an understanding of human factors and systems design to prevent and reduce risks, errors and harm.

2.6 million deaths occur annually in LMICs due to unsafe clinical care (1)

Safety and security should be considered throughout a person's health care journey, from trying to access care through to receiving it and discharge**.** Hazards can be faced when leaving one's home to reach the health care setting for example journeying through insecure areas due to conflict or areas affected by floods. Mitigating these risks through adapted programming, such as community case management or mobile clinics, should be considered. The health care setting itself must not be unsafe for example due to earthquake damage. Within it the safety and security of patients should also be addressed. For example mitigating the risk of violence by having appropriate security personnel, adequate lighting and locked toilets; ensuring safe access for those with limited mobility; implementing safeguarding mechanisms for children such as to prevent separation from caregivers if kept in isolation during an outbreak. Health actors should consider taking appropriate security measures to mitigate risk of attack in conflict settings.

There were 1005 attacks on health care in 11 countries in 2019 (16)

Clear policies and mechanisms should exist to ensure the affected population and patients are protected from sexual exploitation and abuse (PSEA) by health care staff. In conflict settings affected populations and patients should be safe to receive impartial care, where health care providers understand, follow and promote humanitarian principles *(see page 5).*

Key issues to consider

SAFETY AND SECURITY

Safe access from leaving residence en-route to, entering and within the healthcare setting

Safe infrastructure and design
Safe building, power supply, WASH etc. Waiting area, patient flow designed to reduce crowding

Safety and security within health care setting
Lighting, safe paths, lockable toilets, walls to protect from attack etc
Safeguarding mechanisms exist

Disaster preparedness and risk mitigation
Facility has emergency contingency plans and SOPS in place. All hazard risk mitigation measures taken e.g. elevated floors in flood prone areas, appropriate measures to protect patients, staff, and health care facility during conflict etc

Safe movement of patients during medevac, referral, documenting movement of unaccompanied or separated children

Patient rights upheld
Informed consent addressing special considerations that can influence it e.g. age, gender, disability, language etc.
Data is protected and kept confidential. Patient informed of any mandatory reporting laws e.g. for GBV that may limit confidentiality and influence decision to seek care
Patients informed of opening hours, services available, treatment to be received
Consultations held in private rooms or areas
Patients informed on how to feedback or complain

Patient is safe from violence, harm, from healthcare workers
HCW trained and comply with PSEA mechanisms, HCW trained on humanitarian principles e.g. neutrality in conflict settings

Staff are safe
Occupational health, immunisations, security
Know disaster preparedness SOPs
Whistle blowing mechanisms exist

PATIENT SAFETY

Patient safety
Standardized patient identification: two identifiers
Safe medication practices: medication accuracy at transitions of care, high alert medications, medication reconciliation, look alike sound alike medications
Injection safety, diagnostic safety, radiation safety, blood safety principles and practices
Safe childbirth and safe surgery principles and practices

System improvement
Establishment of a patient safety culture, where patient safety issues openly and fairly discussed
Adoption of risk management tools and quality improvement tools to address other cases of risks e.g. morbidity and mortality meetings, reporting and learning systems, executive walk rounds

General Infection Prevention Control (IPC) interventions including standard precautions, transmission-based precautions, clinical aseptic techniques, availability of PPE, surveillance of healthcare associated infections and antimicrobial resistance, appropriate staffing to workload, bed spacing, facility design for patient flow, isolation, ventilation. Focal point / team for **IPC programming** providing guidance, implementing multi-modal strategies, with training, monitoring, feedback mechanisms available

IPC WASH interventions including maintaining a clean environment, hand hygiene, infrastructure for availability of safe water, safe sanitation, and medical waste management

Safe treatment protocols utilised and followed
Safe medicine management from procurement, storage, distribution to the end user according to WHO Good Storage and Distribution Practice (17) and Good Pharmacy Practice (18)

Safe devices, consumables and equipment procurement and management throughout supply chain including maintenance

Equitable

Providing health care that does not vary according to gender, age, ethnicity, disability, religion, sexual orientation, linguistic or political affiliation etc

Impartial care should be given so that **all parts of the population have meaningful access to health care** based on need. This includes at risk groups such as neonates, children, girls, women, older people, those living with disabilities, mental health conditions, conditions associated with stigma, survivors of GBV, marginalised groups of different ethnicities, religion, socio-economic or other factors, as well as those living in hard to reach, geographically inaccessible or opposition controlled conflict areas. This is articulated in *protection mainstreaming* and in the *IASC Policy on Protection in Humanitarian Action* (see page 5). It requires **understanding the specific needs of different groups, consideration of how health care should be provided to address these needs** (*see also people centredness)* **and the monitoring of inequity and discrimination**.

In humanitarian settings it is important to **avoid exacerbating conflict dynamics or power disparities** that occur in crises. Neutrality should be promoted in conflict settings. When working with the military, for example if providing armed escort or directly delivering health care services in conflict areas, consideration must be given on the impact this has on community perceptions of the neutrality and impartiality of health care provided, their trust, acceptance and wish or ability to access health care services. See *Global Health Cluster Position Paper on Civil Military Coordination for further guidance on risk mitigation approach* (19).

Key issues to consider

Conflict sensitive programming
Activities / services do not exacerbate existing divisions within or between communities e.g. affecting the position of armed groups or other actors

Monitoring of programmes occur to understand:

- Equitable utilisation
- Discrimination within healthcare settings by health care providers

Data disaggregated by
Age, gender, diversity
Other characteristics if necessary, relevant to context and if safe

Equitable access
Delivery of care is sensitive to the needs of at-risk groups
Assessments conducted to understand the needs of groups at risk, how they wish health care to be provided, satisfaction with healthcare experience *(see also people centred)*
Overcoming socio-economic barriers to access

Equitable service availability and service delivery mechanisms care is provided to all parts of the populations e.g. in hard-to-reach areas through mobile services, community case management programmes

Communication done is in languages, formats, media, easily understood, respectful and culturally appropriate to different parts of the community including at risk and marginalised groups

Effective

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

In humanitarian settings the essential package of health services (EPHS) i.e. services to be provided at each level of health care, should be agreed upon and made relevant to the crises, context and epidemiological risk *(see Health Cluster Guidance on EPHS*(20)). Health partners should utilise standardised treatment protocols using national protocols or those adjusted to international standards made appropriate to the crisis where needed. Essential medicines list, and devices should also be agreed. The establishment and availability of these and other inputs as well as ensuring health care workers are supported in their training are essential to the provision of effective care.

Key issues to consider

Performance of clinical care
Triage, assessment, diagnosis, rational prescribing practice, treatment, advice, laboratory management, further investigations, referral and follow up is according to standard guidelines and protocols

Advice given by health care staff (e.g. clinician, drug dispenser) is appropriate to patient and condition and per standard guidelines, given by staff with requisite communication skills in language and format fully understandable to patient

Patient discharge plan
Patients discharged in a timely manner with information on next steps, follow up or proper referral arrangements to ensure a smooth transition from one level of care to another

Health information
is complete, timely and analysed
Health care workers receive feedback on HMIS
Medical records are accurate, complete, legible

Audits
Frequently conducted with feedback

Availability of services
Is as defined in the essential package of health services (EPHS) including referral mechanisms (especially where there are gaps)
Open as stated and at convenient times,

Availability of essential medicines that are appropriately selected, manged and stored according to WHO Good Distribution Practice and Good Storage Practice (18) . With evidence-based information on the effectiveness, risks, drug reactions / interaction and benefits of different products (e.g. contraceptive methods) given

Availability of essential devices and consumables (including lab reagents, equipment etc)

Availability of context relevant clinical standards, guidelines, and protocols e.g. diagnostic, therapeutic, pharmaceutical, laboratory guidelines, referral pathways, job aids, algorithms, and checklists

Availability of health care staff
With adequate number, skills mix, with appropriate diverse languages, ethnicities, at least 50% female

Training and supervision of health care staff
On clinical decision-making pathways, antibiotic stewardship, standard treatment guidelines based on EPHS Receive in service and refresher training and follow up support

Integrated

Health care is coordinated across levels and providers (as well as between sectors) and makes available the full range of health services throughout the life course

A person has the right to the **full range of health care services throughout their life course**. Health care should be available, affordable and consistent with the essential package of health services (EPHS) (20). Unmet needs within a health care setting means that a person needs to be referred to another provider with relevant technical expertise and mandate. Health care providers thus need to ensure coordination occurs between services, levels of care as well as between sectors and the community.

The health facility, especially at the primary care level, is a model for continuum of care that includes a coordinated, multidisciplinary team (where relevant) and coordinates with other sectors such as MHPSS, protection, legal services, education, nutrition, WASH and should include the participation of patients and their families.

Providing integrated care necessitates that services by other different providers are also timely and complementary.

Key issues to consider

Referral system
Mapped, well planned, and agreed upon by multiple providers to avoid delays. Using innovative mechanisms as necessary especially where services, logistic support unavailable

Referral pathways available and standardised protocol in place
Referral forms documenting patient's history utilised e.g. during movement from one health care setting to another, or between departments
Mechanism for referral, including contact points, communication, mechanism of transport known and available in referral pathway
Feedback given to the referrer

Mapping of actors and services performed
Across all levels of care
Across different sectors

Monitoring
Regular monitoring should occur including using integrated indicators i.e. common between providers

Primary Health Care
Key for coordinating with networks
Providing mutual support

Timely

Reducing waiting times and harmful delays for both those who receive care and those who give care

Examining a **patient's health care journey from home through the health care setting to discharge** is important to better understand the factors that may prevent patients from receiving timely care causing harmful delay.

In humanitarian crises where the need for urgent or emergency care is often needed operational constraints may result in affected populations being unable to receive necessary health care in a timely manner. Insufficient surge capacity, challenging procurement systems, poor organisational or country readiness, political or geographical constraints for example may contribute to this but is important to understand and strategically address.

Key issues to consider

Time taken to access health care
Is linked to community behaviour, health promotion and education on when to seek health care
Time to reach healthcare setting

Patient flow
Is organised such that registration process, triage, consultations, and further management occurs smoothly

Patient waiting times

Timely clinical decision making and management
Appropriate amount of time is spent with each patient i.e. consultation time
Diagnosis, administration of first medicines to stabilise patient, receive further investigations e.g. laboratory testing, final prescription, and discharge, and follow up is timely

Referral mechanisms
are in place and functional (see 'integrated care' also)

Patient perceptions on all these e.g. time taken to seek, access, and receive care, etc is understood

Complaints and feedback mechanisms
Timeframes to investigate and resolve complaints are agreed upon, documented and respected

Health information and data
Medical records are well organised
Health surveillance especially EWAR reporting, analysis, feedback, and response is timely

Public health decision making
Decisions affecting programming and public health impact are taken and acted upon in a timely manner, without unnecessary delay

Operational programming
Establishing, adjusting, or scaling up services should be timely though finance, HR, procurement, political and geographic constraints may hinder this

Monitoring
should include joint integrated indicators, i.e. between referrer and receiver to measure achievement

Efficient

Maximizing the benefit of available resources and avoiding waste

Ensuring efficient health care services are provided incudes **understanding how resources are used to achieve their intended purpose and how waste is minimised**. It includes ensuring patients receive appropriate evidence-based care and that over utilisation e.g. for laboratory tests or prescribing does not occur. Adjusting human resource capacity and team composition to maximise efficiency should also be considered. Where challenges exist, integrating care or sharing resources such as infrastructure with other services and sectors may prove effective. For example, integrating health promotion and prevention programmes, or protection and health services for women in 'one stop' programmes or engaging with the community networks to support household and community level care.

Key issues to consider

Evidence based health care
Rational use of antibiotics, medicines, lab tests etc

Logistics and stock management
including medicines, devices, and equipment
Medicines should be appropriately selected, forecasted, procured, forecasted, stored, and distributed

Health information
Analysed by appropriate staff and in a timely manner to adjust programming
Harmonised information management systems

Collaboration between providers to synergise programming
With other health care services, or even sectors e.g. health promotion and community case management
Share planning, procurement, services where appropriate

Building in existing guidelines in country

Cost effective value for money, focused interventions with high impact

Governance mechanisms exist to review efficiency, verification of accounts e.g. by village health committee, others

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