health program managers and (5) national monitoring and evaluation staff. We organized and interpreted the data using "framework analysis" methods. Preliminary results are shared below.

Findings: Data quality concepts described by health systems actors include completeness, timeliness, representativeness, and correctness with an emphasis on data reflecting the disease burden within facilities and their districts. According to respondents, good data quality is linked with feedback, partner support, and collaboration of program coordinators and HIS staff at district-level. Additionally, respondents highlighted that innovations, including tools for data aggregation and activities around data use, played a key role in improving quality. Identified barriers to good data quality included resource constraints, training/knowledge gaps, problems with tools for collection, and other systems issues. Data use was reported to be driven by availability of data and responsiveness to stakeholders' needs. Respondents indicated that data use leads to improvements in data quality, but use is low when the HIS is perceived to provide poor quality data.

Interpretation: Our study points to important structural barriers to use of data in Malawi. Innovative activities that can improve data quality are already being tried in some locations and could be shared more widely in Malawi. Common barriers to data quality may be partially addressed through targeted support, including training and material resources, and stakeholder collaboration.

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Evaluating the Process and Impact of Global Health Education in a Social Accountability Perspective

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Program/Project Purpose: Global Health (GH) Education initiatives are numerous and diverse. They include initiatives for students in multiple health professions who may be at different levels of their educational pathway. They all aim to consider GH competencies in their professional disciplinary development. Competencies include a wide array of knowledge, skills and attitudes focussing on how to optimally work with vulnerable, marginalized and underserved populations, with an emphasis on equity, social justice and consideration of social determinants of health, more particularly cultural diversity. The challenge faced by program leaders is to adequately evaluate the process and impact of programs of the inclusion of GH perspective on students' competencies, change of attitudes and ultimately on their future career pathway.

Structure/Method/Design: Since 2012, the *Université de Sherbrooke* Faculty of Medicine and Health Sciences has progressively implemented a comprehensive process to integrate GH competencies in its programs in Medicine, Nursing Sciences, Occupational Therapy and Physical Therapy. An evaluation framework was designed by a collaborative team of GH experts, education and evaluation specialists and students.

Outcome & Evaluation: The evaluation framework is built on the value of social accountability. It includes an ongoing monitoring process. This framework targets students' development of GH competencies; follows programs' changes and adaptation; aims to look at the influence GH education on students' attitudes and interest to practice with vulnerable communities or patients in the future.

Going Forward: The framework will be progressively implemented in future years with a scholarly approach. Major challenges will be: to adopt or develop relevant tools to reach our evaluation goals; to use the framework strategically to prioritise actions; to reinvest the evaluation results in order to improve programs and GH competencies development; to follow graduates into their practice. The development of GH education and its process and impact evaluation will contribute to the social accountability mandate of our medical school.

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A WHO Surgical Safety Checklist-based Infection Prevention Program in Ethiopia: Using Process Mapping to Identify Barriers for Implementation

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Background: The WHO Surgical Safety Checklist (SSCL) is proven to reduce post-operative morbidity and mortality, though it can be difficult to implement, particularly in low resource settings. Since surgical site infections (SSIs) account for substantial postoperative morbidity and mortality, we developed CLEAN CUT - Checklist Expansion for Antisepsis and Infection Control: Customization, Use, and Training - with two goals: (1) increase adherence to evidence-based perioperative infection prevention measures and (2) decrease post-operative infectious complications. We used process mapping of infection prevention measures to elucidate barriers to implementation.

Methods: This mixed methods health services research project involves implementation and evaluation of CLEAN CUT at Jimma University Specialized Hospital (JUSH), a 432 bed tertiary hospital in Ethiopia. The Consolidated Framework for Implementation Research (CFIR) and the Interactive Systems Framework (ISF) for Dissemination and Implementation were used to develop a tailored intervention strategy of checklist introduction, baseline data collection, and interrupted time-series analysis for data processing and feedback. The checklist was introduced to clinical staff through two-half day sessions in the operating theater (OT). Data was collected in all OTs: main (3), obstetric (2) and pediatric (1). Infection prevention standards were: (i) hand & patient skin decontamination, (ii) tracking of surgical gauze, (iii) timing of prophylactic antibiotics, (iv) instrument sterility, (v) integrity of gowns and drapes, and (vi) checklist compliance. Data sources included direct observation, patient chart review follow-up (infections, reoperations, length of stay, and mortality), qualitative interviews, and process mapping of all measures.