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PRIMARY HEALTH  
CARE PROJECT



**وزارة الصحة**  
دائرة الصحة العامة

HANDBOOK OF QUALITY STANDARDS  
AND OPERATIONAL GUIDELINES FOR

# CLINICAL SERVICES DELIVERY

IN PRIMARY HEALTH CARE CENTERS IN IRAQ

**DISCLAIMER**

This guideline has made possible through support provided by the U.S. Agency for International Development (USAID) under Primary Health Care Project in Iraq (PHCPI) implemented by University Research Co., LLC. This guideline has been developed in Iraq in close collaboration with the Ministry of Health (MoH) in April, 2013

## Table of Contents

Table of Contents .....	1
Acronyms .....	2
Introduction .....	3
Chapter One: Clinical Guidelines.....	4
1-Early Management of Trauma and Life Support .....	4
2- Non Communicable Diseases: Diabetes .....	6
Algorithm 1: Diabetes Management .....	7
3- Non Communicable Disease: Asthma.....	9
Algorithm 2: Asthma Management .....	12
4- Non communicable Diseases: Hypertension.....	13
Algorithm 3: Hypertension Management.....	15
5- Early detection of breast and cervical cancer.....	17
Algorithm 4: Triple assessment pathway chart .....	19
Algorithm 5:Breast mass management in primary health care center.....	20
Algorithm 6:Breast pain and negative exam .....	21
Algorithm 7:Nipple discharge .....	22
6- Management of obesity for Primary Health Care workers.....	23
Six steps for management of overweight/obesity in adults .....	23
Indication for Referral .....	23
Algorithm 8: Obesity management .....	24
7- Premarital Counseling.....	25
Algorithm 9: Premarital Counseling .....	26
8- Instruments Sterilization .....	28
Algorithm 10: Sterilization of equipment and instruments .....	29
9- Maternal and Child Nutrition.....	30
Algorithm 11: Maternal and Child Nutrition Assessment.....	31
Chapter 2: Community Partnerships in PHC.....	33
Suggested Activities for Local Health Committees .....	33
Group Work: Guidance for Facilitation .....	34
Effective qualities of CHP facilitation .....	35
Planning for Conducting Group Talks .....	36
Checklist for Major Health Issues .....	37
Interview Guidance (applies to semi-structured and open interviews) .....	38
Chapter 3: Supportive Supervision.....	39
Chapter 4: Referral System .....	54
Iraq MoH Referral Form .....	61
Annex 1: Basic Primary Health Clinic Supervision Checklist.....	62
Annex 2: Instructions for Supervisors.....	78

## Acronyms

ATLS	Advance Trauma Life Support
ANC	Ante Natal Care
BLS	Basic Life Support
BMI	Body Mass Index
BSE	Breast Self-Exam
CVD	Cardiovascular Disease
CBE	Clinical Breast Exam
CNB	Core Needle Biopsy
ECG	Electro Cardio-Graphy
FNAC	Fine Needle Aspiration Cytology
GCS	Glasgow Coma Scale
HDL	High Density Lipids
ISH	International Society of Hypertension
LOC	Level of Consciousness
LDL	Low Density Lipids
MRI	Magnetic Resonance Imaging
MoH	Ministry of Health
NSAIDs	Non Steroidal Anti-Inflammatory Drugs
PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCPI	Primary Health Care Project Iraq
QI	Quality Improvement
USAID	United States Agency of International Development
WHO	World Health Organization

## Introduction

Ministry of Health in collaboration with USAID/PHCPI developed this Handbook of Quality Standards and Operational Guidelines for Clinical Service Delivery in Primary Care Clinics to improve the utilization of the guidelines developed, it represents continuation of the joined effort accomplished previously to scale up with the health services in Iraq.

This clinical handbook is designed to assist primary health care service providers in their daily practice. It consists of three main chapters:

- Chapter One: Clinical Standards/Protocols – easy-to-use clinician’s reference collection of treatment protocols, job aids/tools according to national standards for each category of primary care services offered in the clinic.
- Chapter two: Community Partnership and BCC.
- Chapter Three: roles and responsibilities of clinical supervisory staff at the local (clinic/district) and provincial levels to provide supportive feedback and mentoring to promote better quality of care in MoH clinics.
- Chapter Four: instructions and tools for referrals to/from primary health care and higher level facilities, ensuring confidential transmission of patient information and effective communication between health care providers.

The goals of developing this handbook are:

- Support a streamlined and effective system which provides up-to-date, clear, useful clinical practice guidelines to primary health care providers.
- Build MoH capacity to implement the modern approach of quality improvement to strength clinical services in the clinics
- Develop systematic supportive supervision of primary care providers by MoH staff from the provincial and local/clinical levels
- Implement secure, timely, systematic exchange of patient information for referrals between health care facilities, ensuring better continuity of care and follow up.

## Chapter One: Clinical Guidelines

### 1-Early Management of Trauma and Life Support

#### Important Information on the Algorithm

All resuscitations should be performed using **Basic Life Support** (BLS) and **Advanced Trauma Life Support** (ATLS) guideline

#### Primary Survey include

- Airway Maintenance and Cervical Spine Protection
- Breathing
- Circulation and Hemorrhage Control
- Disability
- Exposure and Environmental Control

#### Secondary Survey include

- History
- Head and Skull Examination
- Maxillofacial Examination
- Neck and Cervical Spine Examination
- Chest Examination
- Abdominal Examination
- Pelvic Examination
- Genitourinary Examination
- Extremities Examination
- Back Vertebral Column and Spinal Cord

- For more details please refer to PHCPI “ Guideline for Early Management and Life Support of Trauma in PHC Centers”

## 2- Non Communicable Diseases: Diabetes

### Classification of Diabetes

Diabetes can be classified into four clinical categories, which include:

1. Type I – this is found most commonly in children and young people. It is characterized primarily by almost total deficiency of insulin. Approximately 10% of all diabetics have Type I diabetes.
2. Type II – this is characterized by relative resistance of cells to insulin, and is strongly associated with obesity, especially abdominal obesity. It is found primarily in older adults. Approximately 80% of all diabetics have type II diabetes, and most of these will also develop the metabolic syndrome as they age.
3. Gestational Diabetes – This is characterized by a relative glucose intolerance with hyperglycemia during pregnancy,

### Diagnosis of Diabetes Mellitus:

- Diabetes should be suspected with any of the following symptoms:
  - Polyuria (frequent urination)
  - Polydipsia (thirst and frequent drinking of water or other fluids)
  - Weight loss
  - Intermittent blurring of the vision
- Diagnosis is established with one of four possible tests, as follows:
  - Fasting plasma glucose  $\geq 126$  mg/dl (7.0 Mmol/L), which is confirmed with a second elevated reading on a separate day. Fasting should be for minimum of 8 hours.
  - 2 hour postprandial (ideally 75 mg. glucose in water) plasma glucose  $\geq 200$  mg/dl (11.1 Mmol/L)
  - Casual (without regard to the time since the last meal) plasma glucose  $\geq 200$  mg/dl (11.1 Mmol/L), together with any of the above suspicious symptoms
  - HbA1c measurement  $\geq 6.5\%$  using a standardized method of testing

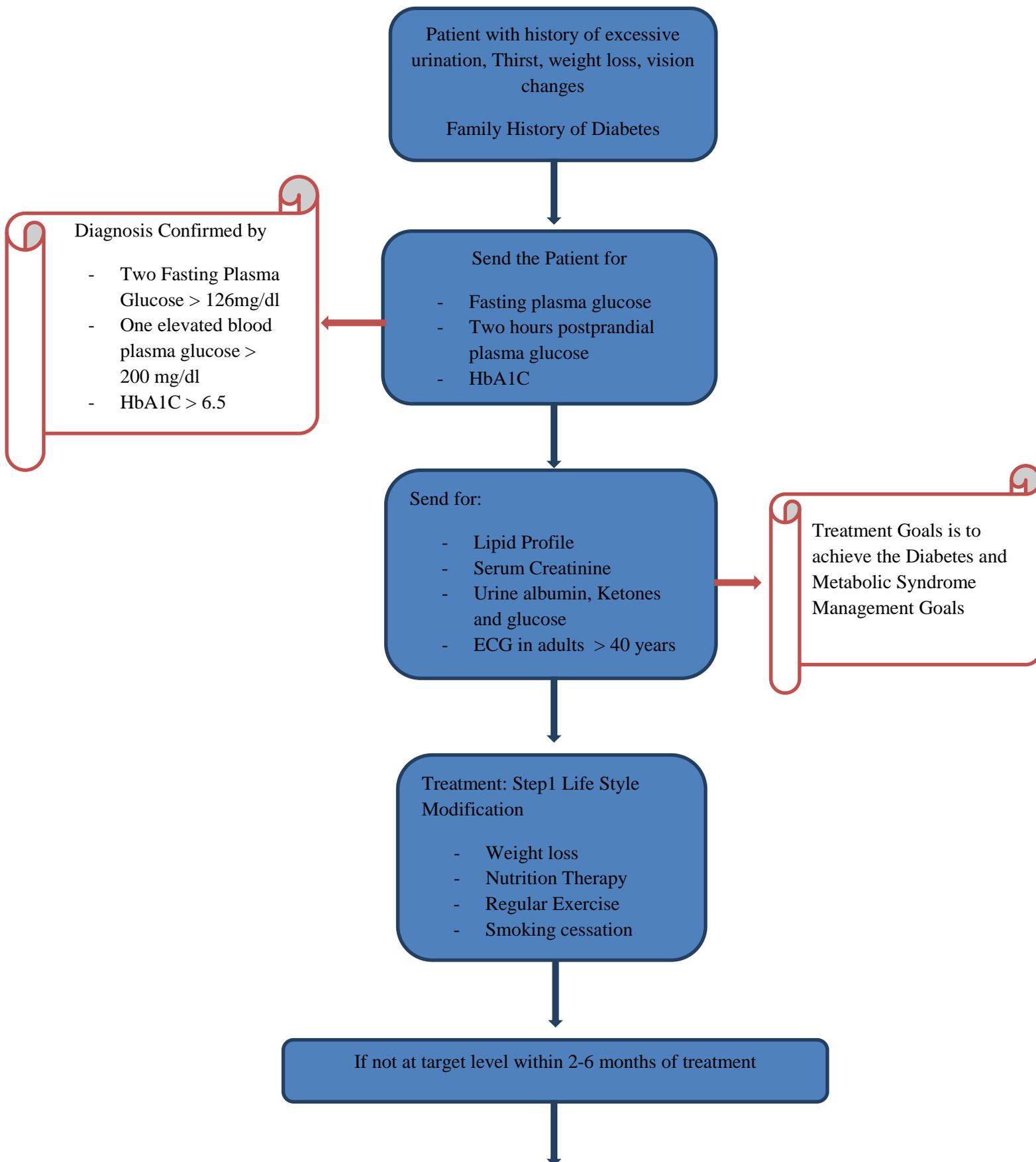
### Goals of Diabetes and Metabolic Syndrome Management

The goals for chronic diabetes and the metabolic syndrome may be different from the goals of those who are normal or non-diabetic

Parameter	Goal
Fasting blood sugar	80- < 126 mg/dl. (4.4 – <7.0 mmol/L)
HbA1C	<7.0%
Blood pressure	<130/80 mmHg
Serum total cholesterol	<200 mg/dl. (< 5.2 mmol/L)
LDL cholesterol	<100 mg/dl. (< 2.6 mmol/L)
HDL cholesterol	Men > 40 mg/dl (>1.0 mmol/L) Women > 50 mg/dl. (>1.3 mmol/L)
Triglycerides	< 150 mg/dl. (<1.7 mmol/L)
Stop smoking	No smoking
Decrease weight	BMI <25
Waist circumference	Men < 102 Cm. Women <88 cm.
Daily Exercise	Daily 30-60 min.

**NOTE – MUST WORK SIMULTANEOUSLY TOWARD ACHIEVEMENT OF ALL TARGET GOALS**

## Algorithm 1: Diabetes Management



Step 2: add oral hypoglycemic agents, start with one drug (metformin 500-2500mg/day) and add others as needed

- Confirm the presence of hypertension and manage
- Confirm the presence of dyslipidemia and manage

Follow up

Monthly

- Blood pressure
- Weight
- Waist circumference
- Fasting plasma glucose
- Foot examination
- Neurological examination
- Medicines dose review
- Patient education

Every 6 months

- HbA1c
- Lipid profile
- Ophthalmic examination
- Quantitative albumin/creatinine ratio

Every Year

- ECG for adults older than 40 years
- Screen for stress, anxiety and depression

### 3- Non Communicable Disease: Asthma

**Definition:** Asthma is a chronic inflammatory disorder of the airways resulting in, variable airflow bronchial obstruction which is potentially reversible with appropriate therapy or spontaneously. It is typically characterized by episodic attacks of breathlessness, cough, and wheezing (“asthma triad”).

#### Classification of Asthma severity: Clinical features before treatment

	Days with Symptoms	Nights with Symptoms	PEF or FEV1 *
<b>Mild Intermittent</b>	≤2 symptomatic episodes/week	≤2 nights/month	≥80%
<b>Mild Persistent</b>	3-6 symptomatic episodes/week	3-4 nights/month	≥80%
<b>Moderate Persistent</b>	Daily symptoms	≥5 nights/month	>60% - <80%
<b>Severe Persistent</b>	Continual symptoms	Frequent	≤60%

#### Goals of Management of Asthma

When the diagnosis of chronic asthma has been established, the goals of the management strategy need to be carefully defined and discussed with the patient. At a minimum, these goals should include the following:

- Prevent chronic asthma symptoms and asthma exacerbations during both the day and night, which should include:
  - No sleep disruptions
  - No missed school or work
  - No visits to the Emergency department
  - No hospitalization
- Maintain normal or near-normal activity throughout the day, including exercise and other physical activities
- Achieve normal or near-normal lung function as measured by spirometer or peak flow
- Minimal use of the short acting  $\beta_2$  agonist inhaler(salbutamol) for acute asthma symptoms
  - Less than one usage per day
  - Less than one  $\beta_2$  agonist inhaler container used per month
- Tolerable or no side effects from medications used for control

#### Follow-up Activities and Schedule

For each follow-up visit, the following parameters should be investigated:

- Weight and Height measurement – graphed on percentile growth chart (children)
- Number of visits to Emergency or for hospitalization
- Number of school absences due to asthma or illness

- Number of nights with cough
- Chest examination
- Current classification of asthma

At each follow-up visit, the following topics should be reviewed with the patient and family members

- Current medications and appropriate dose
- Need for “Step-up” or “Step-down” medication changes depending on frequency of asthma symptoms
- Appropriate use of medications
  - Emergency use of RELIEVER medication (salbutamol inhaler)
  - Need to continue with daily CONTROLLER medication
- Recognition of Danger Signs that indicate emergency visit to hospital
- Review of avoidance or control of known triggering factors for this patient
- Proper use of inhalers with a spacing device

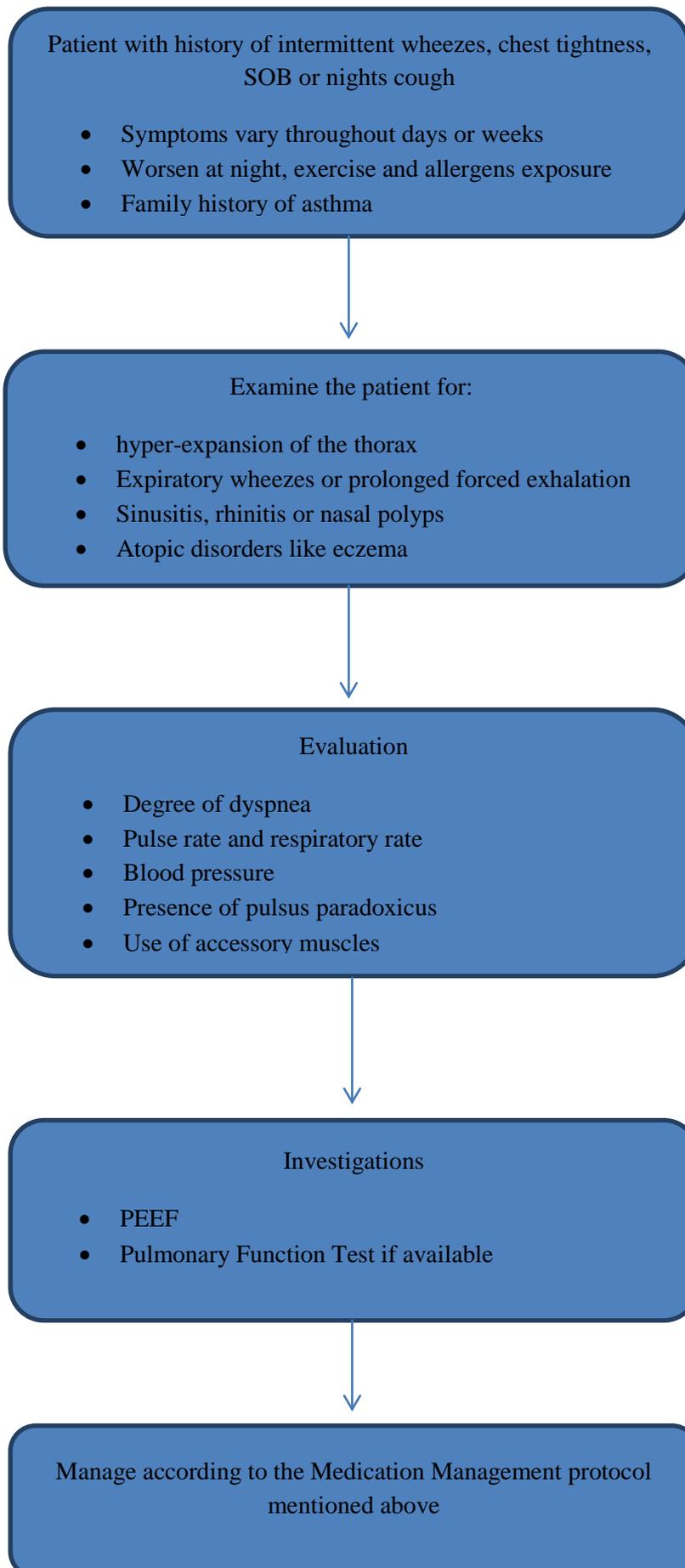
The frequency of follow-up visits to the physician or clinic will vary from patient to patient, depending on the level of severity of the asthma, the ability of the patient or parents to comply with home management of the medication, and the progress toward the goals of minimal disruption of normal life and minimal use of the RELIEVER inhaled medication. Follow-up visits may be weekly during an unstable and severe level, but may diminish to every 3-6 months when the patient has been stable for several months.

#### Medication Management by Classification of Asthma Severity

Level of Severity of Asthma	Medication Protocol
<b>Step 1: Mild intermittent asthma</b> (<2 symptomatic episodes/week)	No daily medication needed Use short acting inhaled $\beta_2$ agonist (salbutamol or albuterol) as needed (1-3 puffs every 4 hours)
<b>Step 2: Mild persistent asthma</b> (3-6 symptomatic episodes/week)	One daily CONTROLLER medication, which could be ONE of the following: <ul style="list-style-type: none"> <li>• Low-dose inhaled corticosteroid (50 <math>\mu\text{gm}</math>. 1-4 puffs/day)</li> <li>• Cromolyn (Intal) or nedocromil (Tilade) inhaler</li> <li>• Zafirlukast (Accolate) or Montelukast (Singulair)</li> </ul> <p style="text-align: center;"><b>OR</b></p> Sustained –release theophylline to serum concentration of 5-15 mg/dl. (not preferred therapy)
<b>Step 3: Moderate persistent asthma</b> (Daily symptoms)	One daily CONTROLLER medication : Medium-dose inhaled corticosteroid. (50 $\mu\text{gm}$ . 2-4 puffs twice daily) <p style="text-align: center;"><b>OR</b></p> Two daily medications: Low-to-medium dose inhaled corticosteroid <p style="text-align: center;"><b>AND</b></p> Long-acting bronchodilator especially for night time symptoms - sustained-release theophylline or long-acting $\beta_2$ agonist (Salmeterol inhaler).
<b>Step 4: Severe persistent asthma</b>	Three daily CONTROLLER medications:

(continual symptoms)	<p>High-dose inhaled corticosteroid (250µgm. 1-2 puffs twice daily)</p> <p style="text-align: center;"><b>AND</b></p> <p>Long-acting bronchodilator (Salmeterol or sustained-release theophylline).</p> <p style="text-align: center;"><b>AND</b></p> <p>Oral corticosteroid in dosage of 0.25 – 1 mg per Kg per day with the dose generally not exceeding 60 mg/day</p>
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## Algorithm 2: Asthma Management



## 4- Non communicable Diseases: Hypertension

**Definition of Hypertension:** Based on WHO/ISH recommendations, as well as JNC7 guidelines, the definition of hypertension in adults aged 18 years or older is:

- Systolic blood pressure  $\geq 140$  mmHg and/or diastolic blood pressure  $\geq 90$  mmHg on the average of two or more readings taken at each of two or more visits after initial screening.

### Classification of hypertension

Blood pressure class	Systolic blood pressure (mmHg)	Diastolic blood pressure (mmHg)
Normal	<120	And <80
Prehypertension	120 – 139	Or 80 – 89
Stage 1 hypertension	140 – 159	Or 90 – 99
Stage 2 hypertension	$\geq 160$	Or $\geq 100$

### Cardiovascular Risk Factors

- Hypertension BP  $\geq 140/90$
- Age men >55 years; women >65 years
- Cigarette smoking
- Overweight or Obesity
  - Body mass index  $\geq 25$  Kg/M<sup>2</sup>
  - Abdominal obesity (waist circumference of >102 cm for men; >88 cm. for women)
- Physical inactivity
- Dyslipidemia
  - Total Cholesterol > 200 mg/dl. (5.2 mmol/L)
  - High density lipoproteins (HDL) in men <40 mg/dl (<1 mmol/L); and in women < 45 mg/dl. (<1.2 mmol/L)
  - Triglycerides > 150 mg/dl. (1.7 mmol/L)
- Diabetes Mellitus or impaired glucose tolerance
- Renal dysfunction
  - Microalbuminuria (urine albumin >300 mg/dl.)
  - Estimated glomerular filtration rate (GFR) <60ml/min

Family history of premature cardiovascular disease (man <55 years or woman <65 years ) in first degree relative

### Risk Stratification for Hypertension Management

There are specific factors that are known to complicate hypertension and increase the overall risk of cardiovascular diseases.

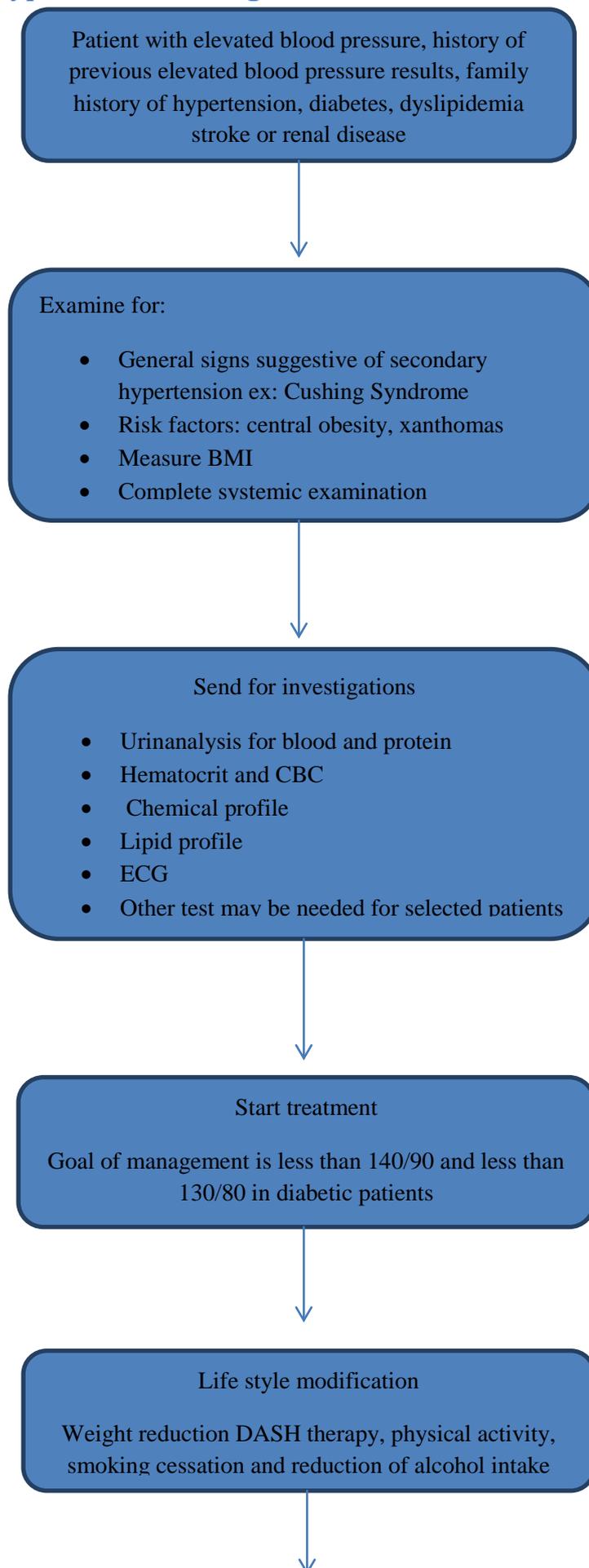
Cardiovascular risk can be expressed as the percentage chance of an individual experiencing a cardiovascular event over a pre-defined period of time, usually the next 10 years. It mainly

depends on the presence of CVD risk factors such as smoking, average blood pressure, cholesterol levels, age, and presence or absence of diabetes. The two charts below can be used based on the availability of cholesterol measurement to estimate cardiovascular disease risk over the next 10 years.

### Treatment of hypertension

Blood pressure classification	SBP mmHg	DBP mmHg	Life style modification	Initial drug therapy	
				Without compelling indication*	With compelling indication
<b>Normal</b>	<120	and <80	Encourage	No antihypertensive indicated	Drugs for compelling indication
<b>Pre-hypertension</b>	120-139	or 80-89	Yes		
<b>Stage 1 Hypertension</b>	140-159	or 90-99	Yes	Thiazide type diuretic, may consider ACEI, ARB, BB, CCB or combination	Drugs for compelling indications. Other types of antihypertensive drugs (diuretics, ACEI, ARB, BB, CCB) as needed
<b>Stage 2 Hypertension</b>	≥160	or 100	Yes	Two-drug combination for most (usually thiazide-type diuretic and ACEI or ARB or BB or CCB)	

### Algorithm 3: Hypertension Management



Pharmacological treatment  
Start with thiazides diuretics and manage according to the hypertension treatment table above

Follow up

- Each Visit
- Diet/ salt intake
  - Smoking
  - Adherence to medication protocol
  - Blood pressure
  - Weight and BMI
  - Cardiac examination
  - Pulmonary examination
  - Optic fundi examination
  - Medication side effects

- Every 6 months
- Creatinin/ Urea Nitrogen
  - Serum Potassium
  - ECG

- Every 12 months
- Full fundoscopic examination
  - ECG- 12 leads
  - Echo
  - Lipid profile
  - Blood sugar

## 5- Early detection of breast and cervical cancer

### Breast Cancer Screening Program

#### A. Breast self-examination (BSE)

This test is preferred to be done after the end of menstruation and more specifically after 7-10 days from the start of menstrual cycle as the breasts are not swollen or tender.

#### B. Clinical Breast Examination (CBE):

Family physicians are expected to do CBE for women from the age of 20, as a part of her routine check-up every three years, increasing to once a year from the age of 40 and above.

#### Clinical Breast Examination Technique:

The patient should be examined in both the upright and supine positions. She must be disrobed from the waist up allowing the examiner to visualize and inspect the breasts.

#### C. Screening Mammography:

This is an X-ray study of the breast. , it is advisable that all primary health care physicians refer women for screening mammography at the age of 40 years. After that age, annual screening is recommended specifically in high risk women

#### Other Diagnostic Techniques:

There are additional tests and investigations that are used to follow up women with positive or suspicious screening tests results. These include the following:

#### I. Imaging Modalities:

1. Ultrasonography
2. Magnetic resonance imaging (MRI)

#### II. Non-Imaging Modalities:

##### Needle biopsy

- 1-Fine needle aspiration cytology (FNAC)
- 2-Core needle biopsy (CNB)

#### Triple Diagnosis Test:

The triple test uses a combination of physical examination, imaging studies, and FNA cytology as an alternative to surgical excision to establish that a breast mass is benign. The triple test is considered to identify the mass as benign if the physical examination, mammogram, and FNA all indicate a benign process. If the lesion cannot be visualized on mammogram or if the FNA contains insufficient cells for diagnosis, the triple test cannot be confirmatory for a benign lesion.

## **Means of Early Detection of Premalignant Lesions**

### **A. Visual inspection methods:**

This involves staining of the cervix with either acetic acid or Lugol's iodine and search for certain abnormalities in staining of cervix.

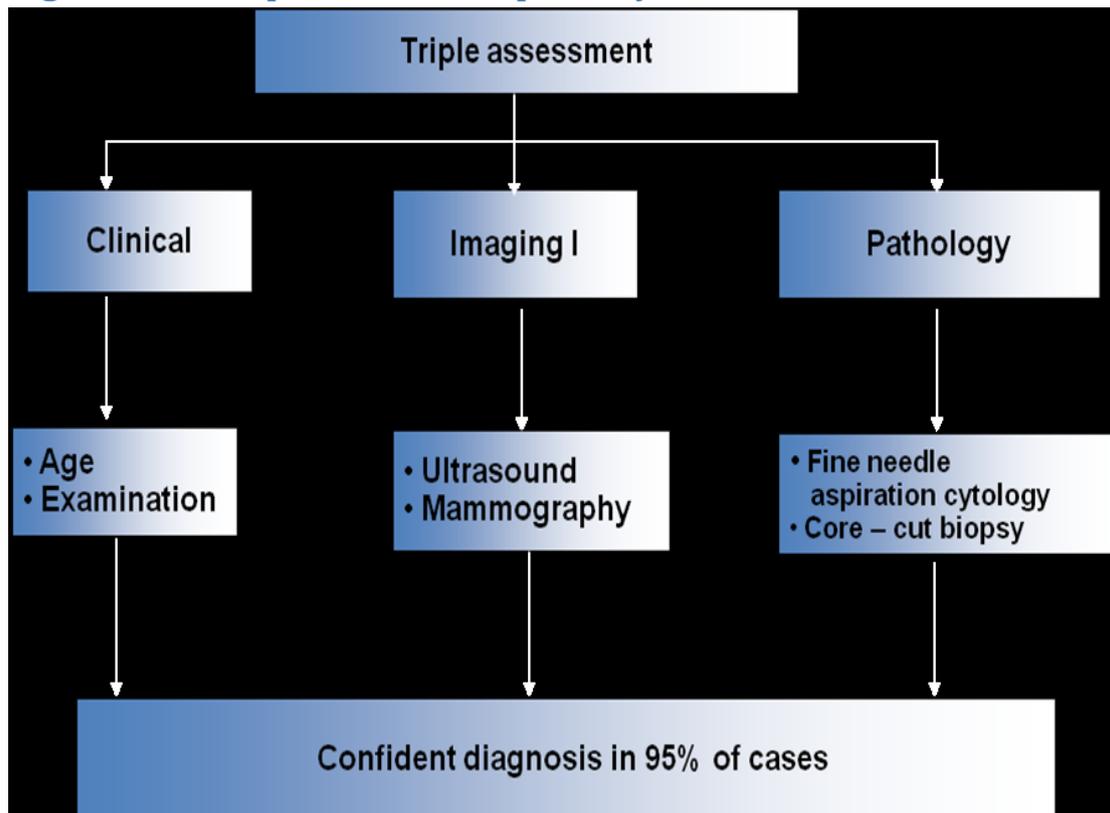
### **B. Cytology:**

Involves scraping the cervix, immediately fixing the scrape on a slide and sending it to a competent cytology lab to be stained and read.

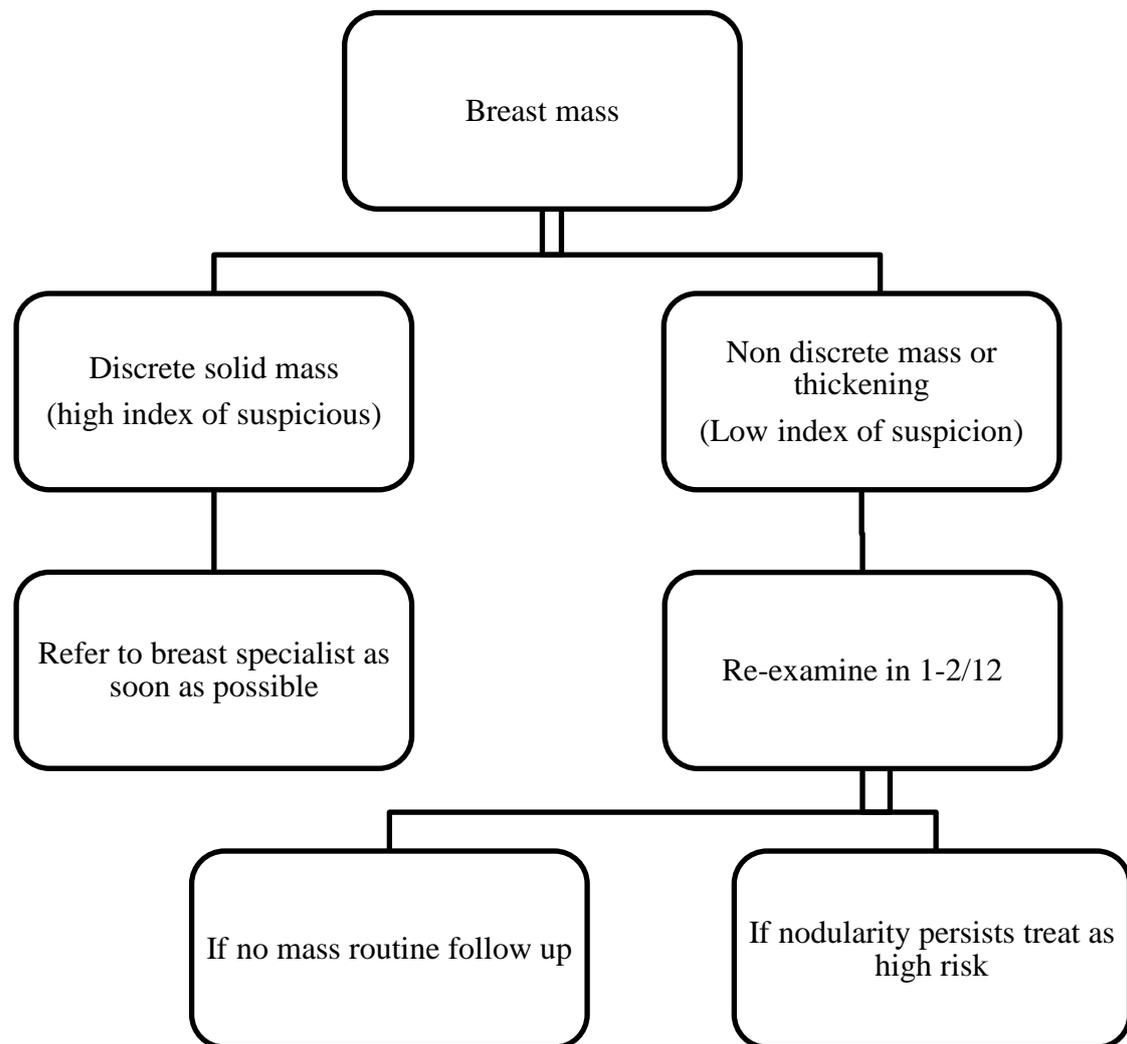
### **C. HPV TESTING:**

This means is becoming more widely applied in combination with either visual inspection methods or cytology because means of detecting HPV in cervical specimen are becoming increasingly available and take shorter time for results to appear making it suitable to increase the specificity of other tests.

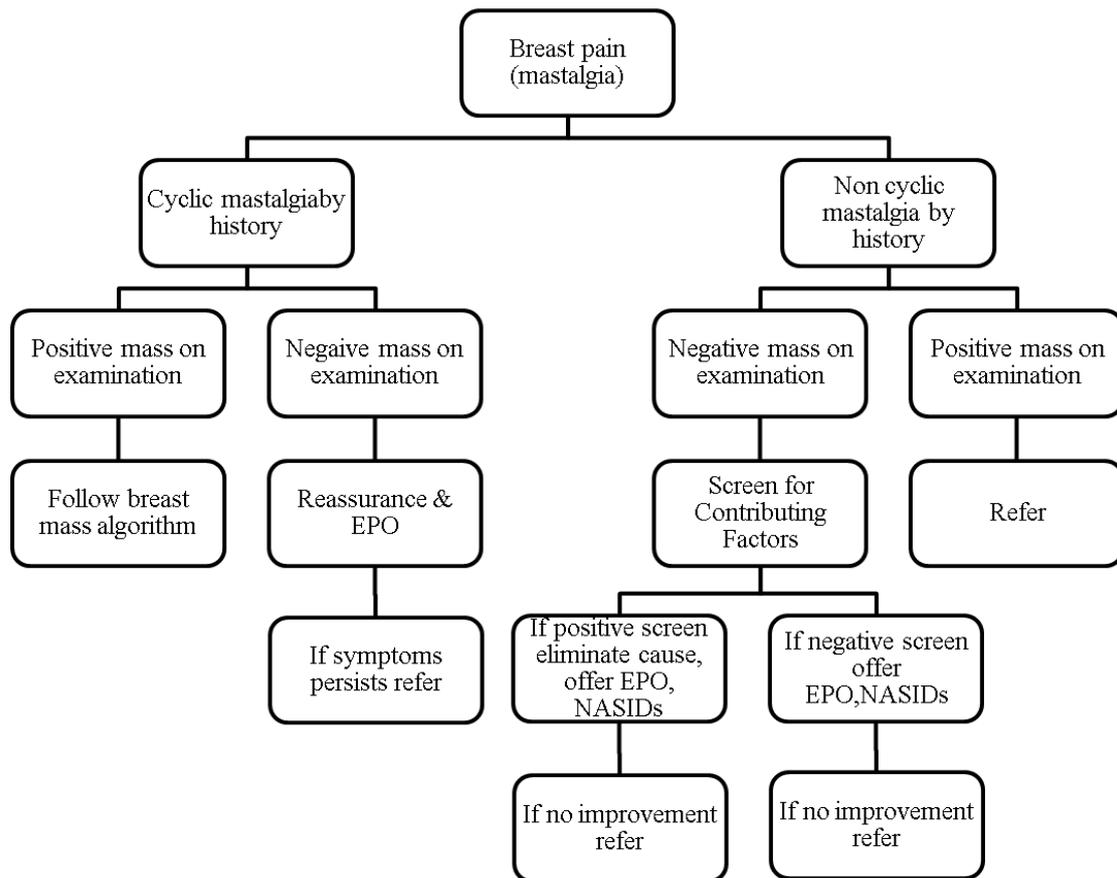
#### Algorithm 4: Triple assessment pathway chart



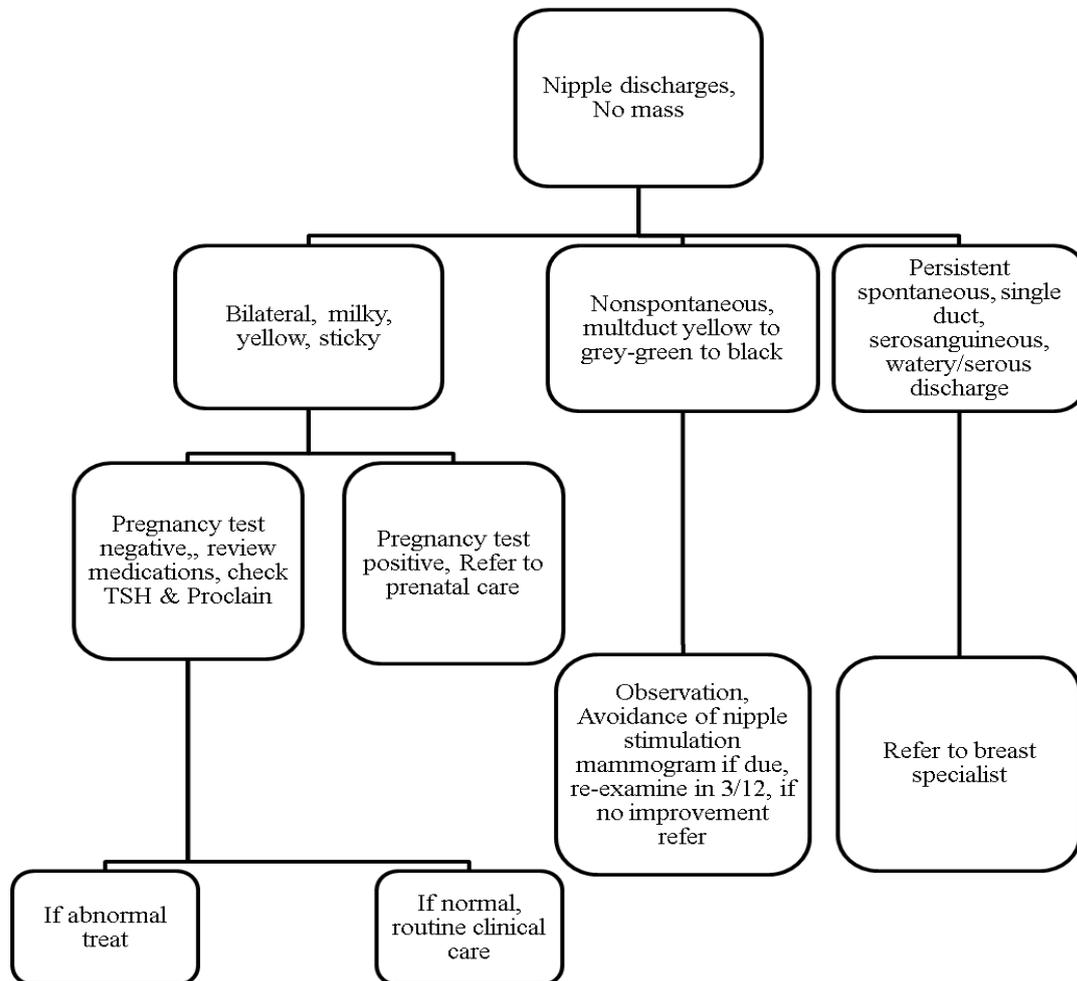
Algorithm 5: Breast mass management in primary health care center



## Algorithm 6: Breast pain and negative exam



## Algorithm 7:Nipple discharge



## 6- Management of obesity for Primary Health Care workers

### Definition

Obesity is defined as abnormal or excessive fat accumulation that presents a risk to health

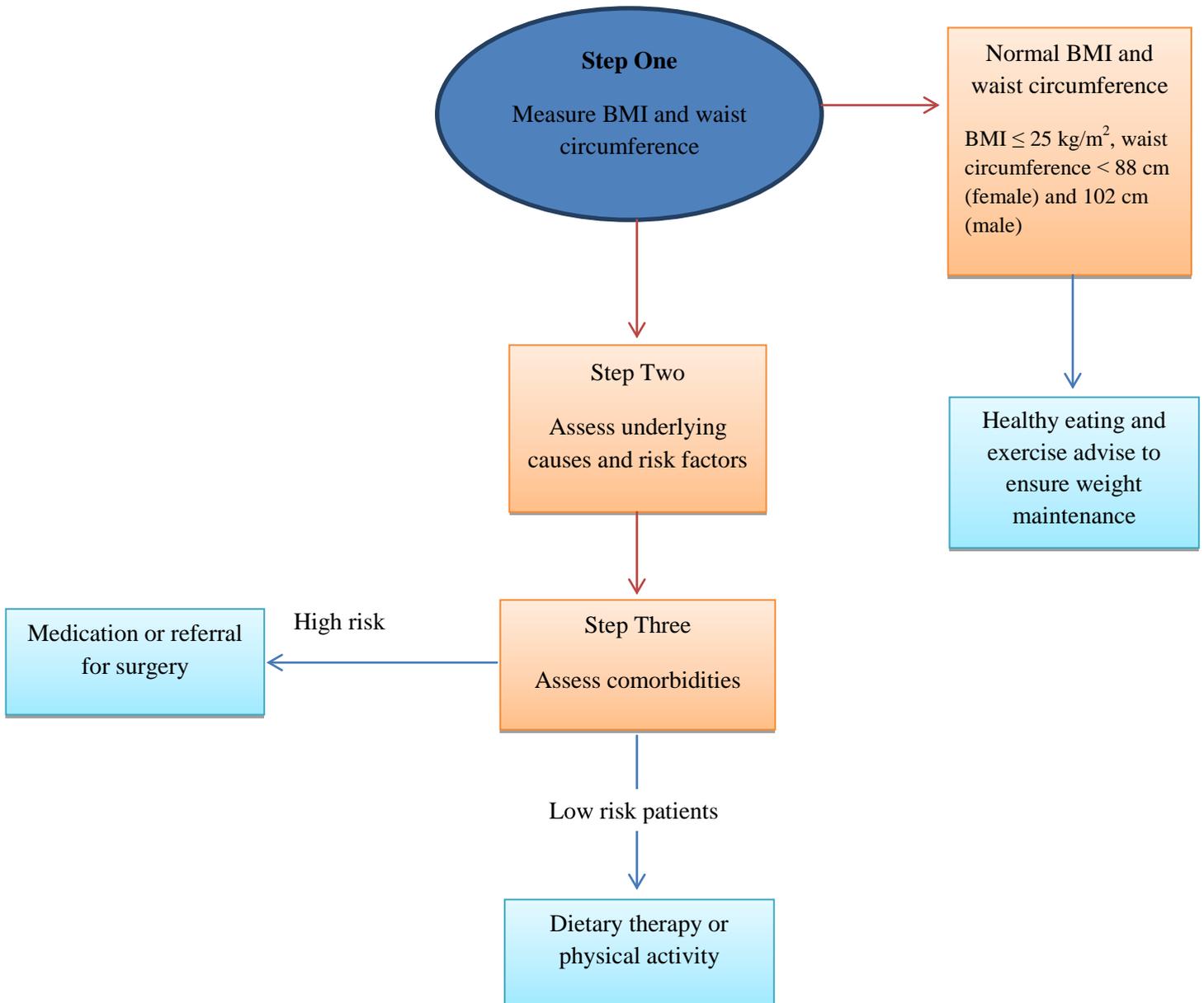
### Six steps for management of overweight/obesity in adults

- **Step one:** Measure BMI and waist circumference
- **Step two:** Assess underlying causes and risk factors for overweight/obesity
- **Step three:** Assess co-morbidities
- **Step four:** Determine the goals and levels of management
- **Step five:** Advice for dietary therapy and physical activity
- **Step six:** Medication or refer for obesity surgery

### Indication for Referral

- 1- Presence of clinical indications of underlying medical causes:
  - Poorly controlled diabetes despite optimal therapy.
  - Risk of CVD.
  - Established CVD on optimum secondary prevention.
  - Poorly controlled hypertension on 3 or more agents (persistent Hypertension above 150/90 mmHg).
  - Sleep apnea.
  - Established significant joint disease.
  - Respiratory disease (significant dyspnea, asthma, etc.).
- 2- Previous attempts of weight loss, evidence of having participated in at least 6 different weight interventions, each for at least 3 months.

## Algorithm 8: Obesity management



## 7- Premarital Counseling

Premarital counseling (PC) is a method of advice and guidance for those intending to marry to enhance their understanding and selection and to improve their quality of life.

### Objectives

1. To reduce the incidence of common haemoglobinopathies in Iraq, e.g. thalasseмии and sickle cell anemia.
2. To reduce other hereditary disorders by identifying problems followed by counseling.
3. Counseling regarding high-risk behaviors, including those related to HIV, Hepatitis B, and other infectious diseases.
4. Early detection and treatment of some sexually transmitted diseases.
5. To promote awareness regarding reproductive health, family planning, and healthy lifestyles.
6. To provide couples with medical, social, and psychological support.
7. To provide immunizations as required.

### Premarital Counseling in Special Consultations

- Partner with abnormal finding/s or result/s, which needs further assessment, evaluation, management and counseling will be offered treatment locally or referred to secondary care.
- Extra appointment/s can be arranged if necessary.
- Couples found to have a risk of an affected offspring will be referred for genetic counseling at the secondary care.
- Both partners should be advised to share data by themselves.
- If they agree, an appointment is booked for counseling both partners together.
- In the cases required referral to secondary care, issue the Premarital Counseling Certificate based on a written feedback from the secondary care.
- When there is a documented reproductive genetic risks from this marriage, it is advised that the doctor to write “from medical aspect, this marriage may lead to the following disease in the next generation:”
- The partner of person with sexually transmitted disease should be notified with registration of actions and outcomes.

### Indications for Referral to Genetic Department

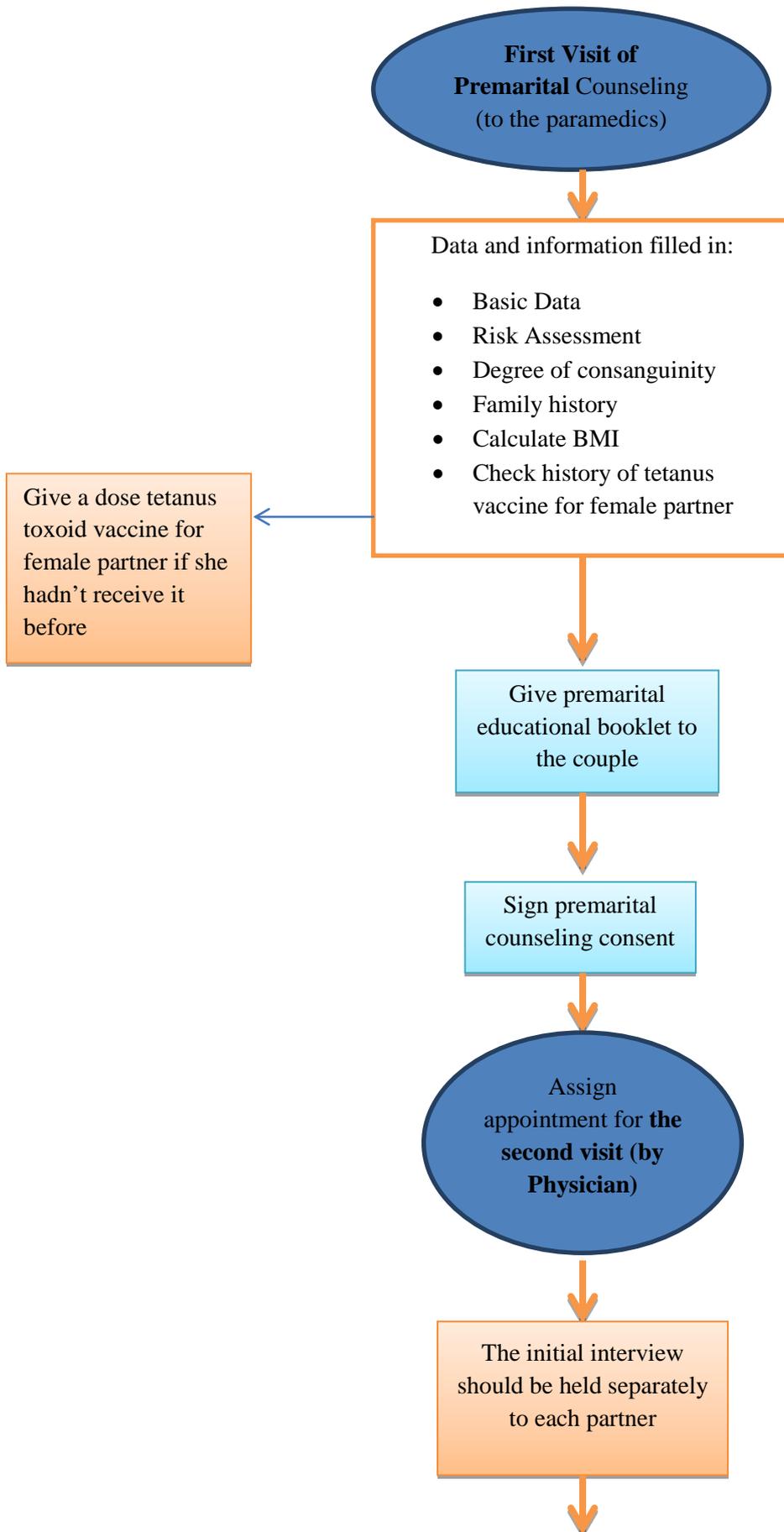
#### I. Couples at High Risk

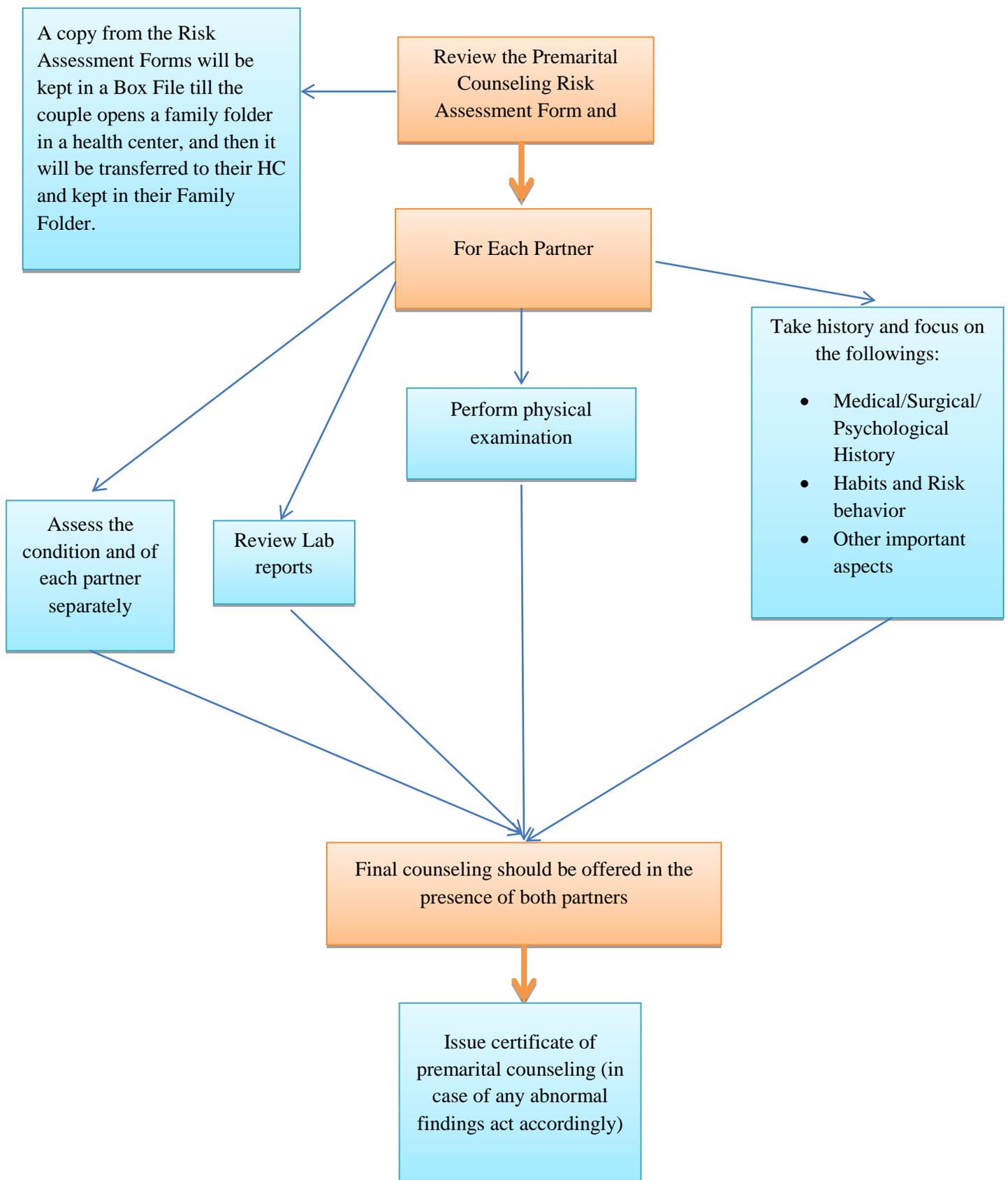
1. Both partners are carrier of sickle cell disease (sickle cell trait).
2. Both partners are carrier of B-thalassemia (B-thal trait).
3. Each partner has different abnormal Hb, e.g. one has sickle cell trait and the other has B-thal trait.
3. Blood results need clarification.
4. Family history of other genetic diseases.
5. Family history of congenital or chromosomal abnormalities.

#### II. Couples Who May Be at Risk

One partner has sickle cell trait or B-thal trait and the other partner has hypochromia microcytosis and/or HBA2 between 3.4-3.7

## Algorithm 9: Premarital Counseling





## 8- Instruments Sterilization

- **Stage 1: Soak (Decontamination)**

Soaking in water or soapy water is a process that makes organic material on objects softer **for easier cleaning**. All surgical instruments and reusable items such as suction cannulae, tubing, and all other instruments, should *go through the sterilization process* after the operating procedure even if they were not used.

- **Stages 2 & 3: Clean and Dry equipment**

After soaking, cleaning, is the second step in processing, removes organic material, dirt, and foreign matter that can interfere with sterilization or HLD. Cleaning also drastically reduces the number of micro-organisms, including bacterial endospores, on instruments and other items. Cleaning is a crucial step in processing. If items have not first been cleaned, further processing might not be effective because:

- Micro-organisms trapped in organic material may be protected and survive further processing

Organic material and dirt can make the chemicals used in some processing techniques less effective

- **Stage 4: Sterilize**

**Sterilization** ensures that instruments and other items are free of **all** micro-organisms (bacteria, viruses, fungi, and parasites), including bacterial endospores<sup>1</sup>. Sterilization of inanimate objects is done either by:

- high-pressure steam (autoclave or pressure cooker)
- dry heat (oven)
- chemical sterilants

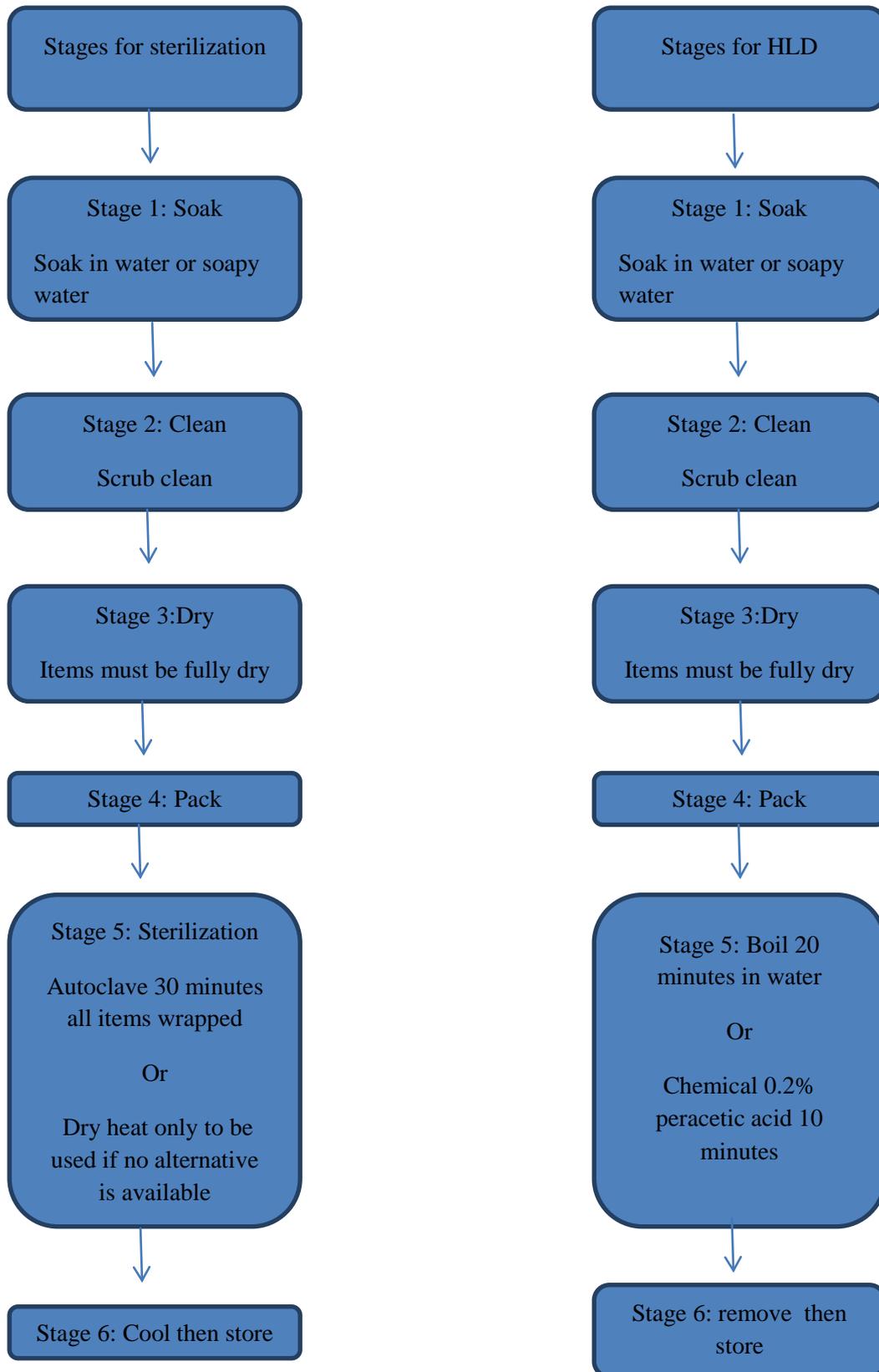
The most common methods of sterilization are **high pressure steam** (autoclave or pressure cooker) and **dry heat** (hot air oven).

**The safest and most reliable method for sterilisation is steam sterilisation. Facilities and donors should provide steam sterilizers rather than dry heat ovens.**

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<sup>1</sup> **Endospores** are a dormant form of a bacterium that allows it to survive sub-optimal environmental conditions and are found in soil and water, where they may survive for long periods of time. They cause tetanus and gas gangrene.

## Algorithm 10: Sterilization of equipment and instruments



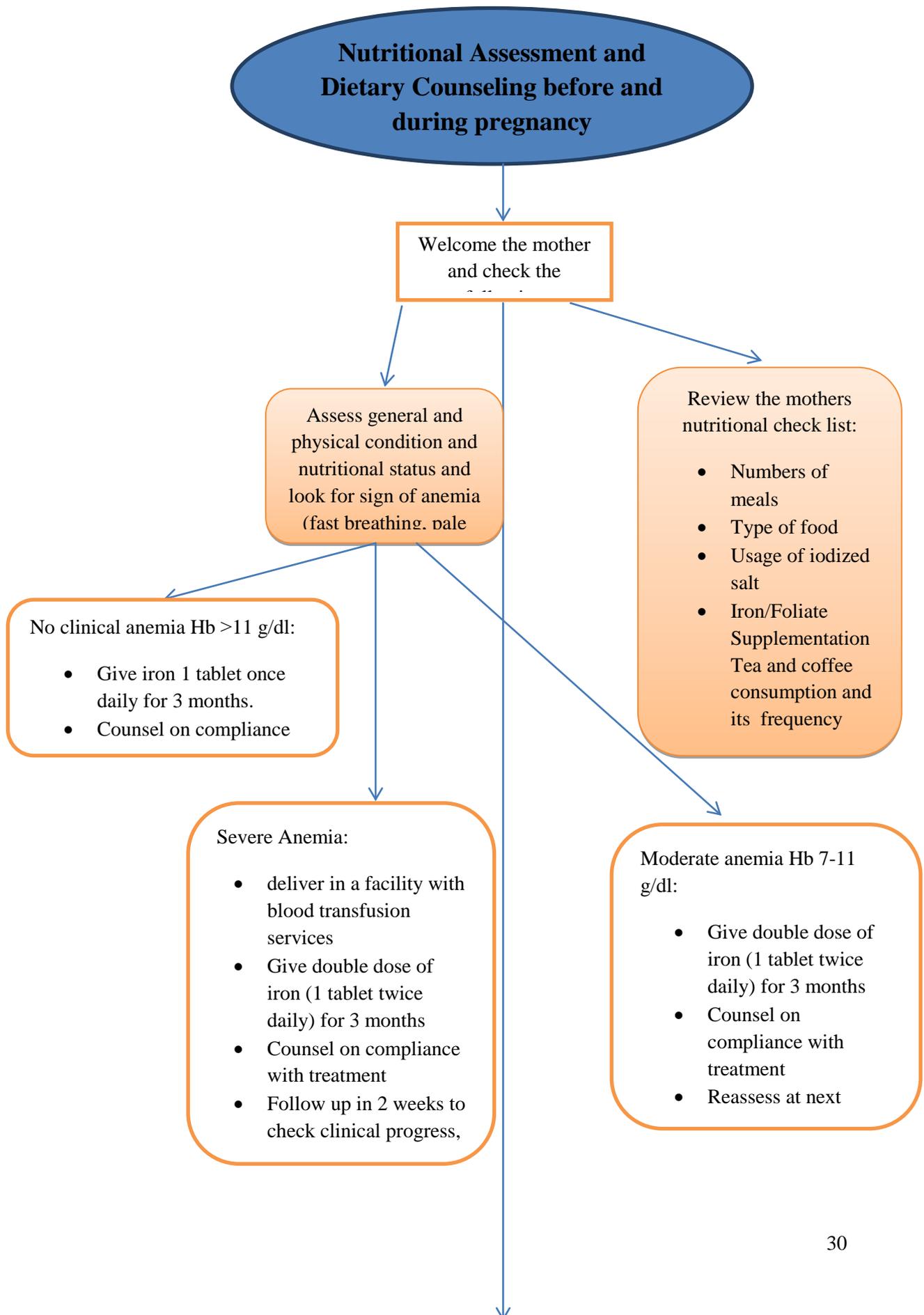
## **9- Maternal and Child Nutrition**

### **Elements of Care**

#### **A. ANTENATAL BREASTFEEDING EDUCATION**

1. Assess where the woman is in relation to breastfeeding including past experience.
  - If the woman has no concerns, reinforce the positive experience
  - If the woman has concerns, address them
2. Ask the woman if she is planning to breastfeed and whether she has any concerns about breastfeeding.
  - If the woman says she does not want to breastfeed, find out the reasons and address any concerns using messages such as the ones presented in the following box
3. Screen women who have decided to breastfeed for any medical or physical conditions that could impair breastfeeding.
4. Provide the woman with available, appropriate educational materials.
5. Set an appointment for follow up visit.
6. Record the appropriate information in the appropriate record.

## Algorithm 11: Maternal and Child Nutrition Assessment



Ask the woman about her obstetrical history, and revise the antenatal and/or postpartum card:

- If she is pregnant, ask about history of anemia and weight gain during previous pregnancies, and history of hemorrhage at delivery.
- If she is breastfeeding, ask about her recent pregnancy and childbirth, particularly any difficulties in childbirth or recovery and about the birth weight of the baby

If the woman is lactating:

- Determine the period of time from delivery
- Ask the woman about her original weight before pregnancy
- Correctly weighing the woman
- Ask if she is taking adequate extra amount of energy-dense foods according to time in months from delivery (with examples)
- Determine any problem prevent proper feeding (e.g. postpartum depression)
- Reduce the consumption of tea, coffee, and soft drinks

If the woman is pregnant:

- Determine the gestational age
- Ask the woman about her original weight before pregnancy
- Correctly weighing the mother
- Ask the woman about her original weight before pregnancy
- Correctly weighing the mother Determine any problem that prevent proper feeding (e.g. hyperemesis gravidarum)
- Diversified diet and supplements and tea,

## Chapter 2: Community Partnerships in PHC

### Suggested Activities for Local Health Committees

- Refuse disposal
- Water chlorination and supply
- Environmental sanitation
- Family and personal hygiene
- Provision of WC at family level
- Food safety
- Presence of iodized salt
- Smoking
- Health promotion
- Reporting births and deaths
- Logistically providing transportation for referred persons
- Presence of vaccines in PHCC in immunization campaigns
- Ante and post natal care
- Child vaccinations
- Growth monitoring for the under fives
- Oral rehydration
- Vitamin A supplementation
- Iron deficiency anemia
- DOTS (Direct oral tuberculosis therapy)
- Malaria
- Detecting and follow up of diabetics, hypertensive and renal conditions
- Recognizing the physically disabled and supporting them by the community
- Mapping different risk areas in the area inhabited by the community and preventing deaths
- Recognizing groups and persons affected by chronic diseases and disorders , malnutrition and under nutrition, the aged , mentally ill
- Premature labor
- Occupational health
- Emergency conditions and preparedness to deal with it
- Village mapping
- First aid in the community
- School involvement
- Or any other relevant local health problem
- Social service for the displaced and the disabled

Emergency health services: like community preparedness or first aid or ambulatory first aid services

## Group Work: Guidance for Facilitation

### *Knowledge of the Subject Matter:*

- Introduces the topic of CHP and guides discussion.
- Answer questions as the situation demands.

### *Monitors Group Work:*

- Starts group work by giving clearly defined group tasks and time allowed;
- Motivates, keeping attention and interest high;
- Keeps time and checks the progress of the groups, shortening or expanding time, if necessary;
- Introduces rules for group work, if necessary.

### *Monitors Group Dynamics:*

- Encourages equal participation of group members;
- Handles opposition, protest and doubts regarding the subject matter;
- Handles conflicts between group members;
- Handles difficult group members.

In addition to the information garnered from group meetings, a number of direct interviews with key stakeholders will be necessary at the outset of the partnership process (i.e. to develop health issues checklist and other tools used). Interviews should be conducted with community leaders and other key informants who should be knowledgeable about the community's makeup and dynamics. It is important that open-ended questions be used during interviews so that new information or queries can be included in group work specific to that community.

Interview questions for key informants/community leaders should include:

- How is the community organized?
- What is your role in this community makeup?
- Are there informal/formal community leaders? How do they relate to each other/interact with each other?
- Has the community been able to incorporate new community members/groups? Have these new groups affected the daily dynamics of the community?
- What do you see as the most important priorities for the community?
- Has the community previously been involved in addressing health issues?
- Do you utilize the local PHC Center? Do you feel confident that the local PHC Center can address your health needs and those of your family?
- Do you rely more on secondary/tertiary care centers?
- What might prevent you from utilizing the PHC Center nearest to your community?

## Effective qualities of CHP facilitation

<b>Efficient</b>	<ul style="list-style-type: none"> <li>organizes, conducts, directs health education activities according to the needs of the community</li> <li>he/she is knowledgeable about everything relevant to his/her practice; has the necessary skills expected of him/her</li> </ul>
<b>Good listener</b>	<ul style="list-style-type: none"> <li>facilitator hears what's being said and what's behind the words</li> <li>facilitator is always available for the participant to voice out their sentiments and needs</li> </ul>
<b>Keen observer</b>	<ul style="list-style-type: none"> <li>keep an eye on the process and participants' behavior</li> </ul>
<b>Systematic</b>	<ul style="list-style-type: none"> <li>knows how to put in sequence or logical order the parts of the session</li> </ul>
<b>Creative/Resourceful</b>	<ul style="list-style-type: none"> <li>uses available resources</li> </ul>
<b>Analytical/Critical thinker</b>	<ul style="list-style-type: none"> <li>decides on what has been analyzed</li> </ul>
<b>Tactful</b>	<ul style="list-style-type: none"> <li>brings about issues in smooth subtle manner</li> <li>does not embarrass but gives constructive criticisms</li> </ul>
<b>Knowledgeable</b>	<ul style="list-style-type: none"> <li>able to impart relevant, updated and sufficient input</li> </ul>
<b>Open</b>	<ul style="list-style-type: none"> <li>invites ideas, suggestions, criticisms</li> <li>involves people in decision making</li> <li>accepts need for joint planning and decision relative to CHP in a particular situation;</li> </ul>
<b>Sense of humor</b>	<ul style="list-style-type: none"> <li>knows how to place a touch of humor to keep audience alive</li> </ul>
<b>Change agent</b>	<ul style="list-style-type: none"> <li>involves participants actively in assuming the responsibility for his/her own learning</li> </ul>
<b>Coordinator</b>	<ul style="list-style-type: none"> <li>brings into consonance of harmony the needed community's health care activities</li> </ul>
<b>Objective</b>	<ul style="list-style-type: none"> <li>unbiased and fair in decision making</li> </ul>
<b>Flexible</b>	<ul style="list-style-type: none"> <li>able to cope with different situations</li> </ul>

## Planning for Conducting Group Talks

*Source: Interpersonal Communications & Counseling Skills for Reproductive Health*

- Prepare notes for the presentation. Help the audience keep track of what you are saying by organizing the points clearly.
- Think about the words you will use. Use short sentences and words. Avoid long, drawn-out descriptions, jargon, family planning abbreviations, and technical language. Keep your illustrations brief and to the point.
- Time the talk so that it is not longer than 15 minutes.
- Write a list of questions to stimulate discussion and evaluate the talk. Possible questions might include:
  - What are your two biggest priorities for family care?
  - Does anything prevent you from using the Center more often?
- Prepare your flip charts in advance if possible. Don't use light-colored markers not visible from a distance. If you are presenting to a large group, use large print, and do not write on the bottom quarter of the page.
- Take markers and masking tape with you if you anticipate needing them. Take sufficient numbers of printed materials or handouts with you.
- If someone is introducing you, you may want to write out comments for him or her to use. Your suggestions can include rapport builders' with your audience, such as a common group membership, past contact with them, or your knowledge about the community.
- Check the room or place where the talk will be given. Choose a quiet place with enough space. Ideally, the arrangements of the room should be for the comfort of the participants. However, you may have no control over how the participants are arranged, although you can make changes in where you will stand. You do not want to be too distant from the nearest member of the audience.
- If you are using a microphone, make sure it is in good working order so that you do not have to tap it or make adjustments after you begin.
- Position visual aids where you want them. If you are showing a film, make sure the screen is in the proper position and that the projector is functioning properly.

## Checklist for Major Health Issues

Ask the health service provider to help the community prepare a checklist of major health issues for the group to respond to. When risks are identified, produce a list of needs and channels to address them in partnership.

<i>Risk identified</i>	<i>Target groups identified</i>	<i>Appropriate IEC material selected</i>	<i>Appropriate method selected for provision of type of services required</i>	<i>Appropriate channel selected and adopted</i>

## Interview Guidance (applies to semi-structured and open interviews)

Source: *Interpersonal Communications & Counseling Skills for Reproductive Health*

**Reflecting:** Provides a mirror to what a person is communicating. Accurate acknowledgment of client's feelings is necessary and critical to the counseling process. Once client believes that the provider hears and understands her/his feelings and individual needs and concerns, then they are ready and willing to deal with a situation, listen to options, and make an informed and appropriate decision. Noting key feelings and helping the client clarify them can be one of the most powerful, helpful things a counselor can do.

**Paraphrasing:** Reflecting content back provides an opportunity to cross check what was said with what was heard. Feeds back to the person the essence of what has been said by shortening and clarifying client comments. Paraphrasing is not parroting; it is using the counselor's own words plus the main words of the client to check accurate understanding of what the client has said.

**Summarizing:** Confirms mutual understanding and reinforces key points. Is similar to paraphrasing except that a longer time period and more information are involved. Used to begin or end an interview, start a new topic, or provide clarity in lengthy and complex client issues or statements. It recaps what has been said.

### Types of Questions:

Close-Ended Questions	Open-Ended Questions	Probing Questions	Leading Questions
When to use: Begin with close-ended question (for example, a question used in taking a medical history)	Continue with an open-ended question.	Then use a probing question in response to a reply, as a request for further information. NOTE: Out of context, probing questions may sound leading. Explanation of an earlier statement.	<b>Avoid</b> using leading questions
Requires: Brief and exact reply; often elicits yes or no response.	Longer reply; demands thought, allows for explanation of feelings and concerns.	Why do you think that oral contraceptives are difficult to use?	Leads respondents to answer the question in a particular way or tells them about something that they might not otherwise have thought of.
Examples: How many children do you have? Are you married?	What have you heard about the oral contraceptive? What are the concerns of young people today?	What has made you believe your child is sexually active?	Have you heard that oral contraceptives are dangerous? Did you hear that the injectable stops the menses? Don't you prefer this method?

## Chapter 3: Supportive Supervision

### 1. What is Supportive Supervision?

Supportive supervision can be described simply as: The process of objectively assessing the performance of the technical and managerial functions of a health facility for the purpose of improving its performance.

The goal of supportive supervision is to promote effective, efficient, and equitable health care. It improves services by focusing on meeting staff needs for management support, logistics, and training. It involves the supervisor as a partner with the staff at the health clinic level in problem solving.

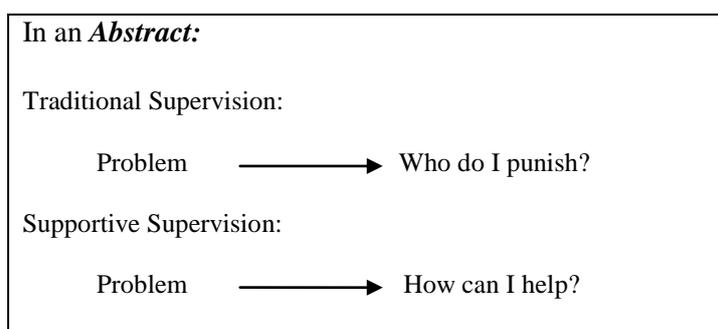
### 2. What are the main differences between Supportive Supervision and Traditional Supervision?

Contrary to supportive supervision, traditional supervision generally involves intermittent supervisory visits to assess performance based on supervisors' opinions. It is notorious for being negatively oriented to find faults in service delivery without providing constructive guidance for problem solving.

Hence the main differences between supportive and traditional supervision can be summarized in the following table:

Action	Traditional Supervision	Supportive Supervision
Who supervises	External supervisors whose role is limited to identifying problems and writing reports.	External supervisors who consider themselves partners with health staff for quality improvement.  Internal (self-assessment) by staff members in the clinic.
When supervision happens	During periodic visits by the external supervisors.	Periodic visits by supervisors and continuous contact with the clinic staff in between.
What happens before supervision	Varies depending on the external supervisor.	Review of clinic statistical reports.  Review of previous supervisory findings and follow up points.  Preparing Supervisory Checklists & other documents (e.g. Guidelines).  Inform the clinic about the date of the visit.
What happens during supervision	Inspection of the facility, review of records and supplies.	Observation of performance and comparison with standards.  Provision of constructive

Action	Traditional Supervision	Supportive Supervision
		feedback.  On site guidance, training, and problem solving.
What happens after supervision	Little feedback mainly focuses on negative findings.  No or irregular follow-up between supervisory visits.	The main findings of the visit are summarized including the positive findings.  Encouragement of staff to continue the good work.  Discussion of the negative findings with constructive guidance for improvement.  Agreeing with clinic staff on action needed for improvement and time frame.



### 3. What is the role of the supervisor?

In the context of supportive supervision, there are at least 2 different levels of supervisors: **External supervisor** from the District/Provincial level, and **internal supervisor** from within the health clinic (Doctor in-charge/Manager).

Role of External Supervisor (District/Provincial):

- **Prepare for the supervisory visit:** This includes reviewing the clinic’s reports and statistics, reviewing previous supervisory forms and checklists, particularly the identified follow up action points, informing/ agreeing with the clinic about the selected date of the supervisory visit, arranging transport for the clinic, and preparing any documents that could be needed during the supervision such as clinical guidelines.
- **During the visit:** The supervisor should introduce him/her self, exchange salutations briefly and as appropriate with staff to set a comfortable non-threatening atmosphere, show respect to staff and patients at the clinic. Use a checklist to

systematically assess the main aspects of the functions of the clinic including: infrastructure, patient reception, examination room, equipment, essential drugs, health workforce (staff), clinical services, infection prevention and control, health management information system, waste management, quality improvement process, referral system, community activities, and patient satisfaction. The supervisor uses direct observation, questions to the staff, interview with patients, and review of clinic records to obtain the necessary information.

The supervisor is to praise the staff when a positive finding is detected and to provide constructive guidance for problem solving, training, coaching, mentoring, and feedback when there is a negative finding. At the end of the visit, the supervisor is to discuss with the clinic's in-charge/manager, and the QI team if possible, the main findings starting with the positive ones. For the negative findings, particularly those needing immediate attention (sometimes referred to as "Red Flag" items), the supervisor should have a constructive discussion with the clinic's staff on how to address and solve problems. A specific line of action and time frame should be agreed upon with roles and responsibilities clarified, including the role of the external supervisor when applicable.

- **After the visit:** The supervisor is to maintain the contact with the clinic's in-charge/manager and QI team to follow up on action items and to provide guidance.

#### ***Setting comfortable environment for supervision***

To put the staff at ease during the supervisory visit and hence set suitable environment for learning, the supervisor is encouraged to:

- Keep a smiling face and shake hands with staff when appropriate. Exchange brief courteous salutations as appropriate. Introduce him/her self and the purpose of the visit.
- Emphasize that the purpose of the visit is for the supervisor to join effort with the clinic staff so that the services are provided with high quality to the population. Hence, the supervisor is a partner with the clinic staff, and can be considered a member of the clinic staff, not an outsider.
- Explain that the visit is not meant to "find mistakes", but to see the good work the clinic is doing and congratulate the staff for it. If there are issues or challenges with the work of the clinic, the supervisor will try to work with the clinic team to address them in a joint and constructive way.

#### **Role of Internal Supervisor (Doctor in-charge/manager)**

The internal supervisor is the mentor, collaborator and supervisor to the staff at the PHC clinic. In this role, S/he will provide input on how to improve functioning of system standards. S/he will collaborate with other managers within and beyond the PHC system to share best practices in advising other providers. S/he will also provide regular supervisory support which will include management observations/ audits, feedback and

follow-up of sites in order to evaluate their performance and support improvements in effective systems management that contributes positively to the management guidelines and standards.

In the context in Iraq, the manager may serve as a supervisor for his/her own clinic in addition to a few other neighboring clinics. All operations supported and overseen by the manager will be assured to be in line with the PHC management protocols. The manager will support staff training and continual professional development through in-person and e-communication mentoring opportunities. S/he will model good workplace behavior including respect for all clinics and their patients and will facilitate the evaluation of system operations including patient records, health commodities management, referral management, and infection prevention and control strategies as they relate to improved systems management. Managers will collaborate with private and public providers and partners within the catchment area to plan, develop, implement and administer sound management systems.

#### **4. What are the methods of collecting information for supportive supervision?**

The supervisor should be as objective as possible in conducting the supervision. To achieve objectivity, the supervisor should gather information accurately and rely on data when possible. The main methods of collective information during a supervisory visit include:

- **Direct observation:** Many of the needed information can be obtained just by observing the clinic, the staff, and the patients. For example, in entering the clinic the supervisor can get valuable information by observing the land surrounding the clinic for the presence of any garbage, medical waste, or any water leakage. Inside the clinic, the supervisor can observe the reception area, the patient flow, the availability of seats for patients, and how comfortable are the waiting area and the temperature in the clinic. The supervisor can check the availability of running water, electricity, the functionality of toilet flushing, the availability of soap and hand drying facility in bathrooms, the presence of written signs such as “no smoking” and educational materials. The supervisor should try to observe interactions between health staff and patients to assess the competency of the health staff in respecting the patient, hand washing, and use of gloves when appropriate, providing services, counseling the patient, and giving the patient a chance to ask questions. Direct observation can also be helpful in verifying the availability of guidelines, essential drugs, the availability and functionality of equipment, the expiration date of drugs and equipment (such as fire extinguishers).
- **Staff questions/demonstrations:** The supervisor can obtain valuable information by asking the different staff members questions related to the processes of providing services and the clinic’s operations. Questions can be also directed to verify the knowledge of the staff member related to the standards and guidelines for service provision. When direct observation during actual service interaction with patient is not possible, the supervisor can ask the staff member to demonstrate a skill, such as hand washing, blood pressure measuring, newborn resuscitation, etc.
- **Review clinic records and statistics:** The review of patient records, clinic records in different department, and aggregated clinic statistics can reveal valuable

information about the completeness and the coverage of health services. Reviewing a sample of patient records can also help the supervisor assess the ability of the clinic staff to follow standard clinical guidelines. For example, the supervisor can check if children presenting with diarrhea were issued ORS, or if a follow up visit was set for a patient with diabetes.

- **Patient/client interview:** Getting the perspective of patients/clients is a very important part of supervision. The supervisor should try to find a private space to talk with a sample of patients, particularly those who just completed their visit, to get their feedback about the experience they had during the visit such as the waiting time, how respectful the staff were, and whether they were generally satisfied with the service they obtained.

## 5. The Basic Primary Health Clinic Supervision Checklist – How It Can Help?

Checklists have been used as basic tools to verify the essential functions of a system. It contains a list of items to be verified to ensure that the most important elements of a system are in place and functioning.

The “**Basic Primary Health Clinic Supervision Checklist**” has been developed by the Primary Health Care Project – Iraq to facilitate effective systematic supervision of primary care clinics. The Checklist is included in the Annex along with specific instructions.

The Checklist is a tool to help supervisors at the provincial, district, and health clinic level conduct a general assessment to all aspects of primary health care services provided by the primary health care clinic for the purpose of quality improvement. **The Checklist is not meant to replace other official reports, checklists, or forms that are required by the MOH.** More in-depth specialized assessments are encouraged for different services offered at the primary care level. The Checklist can be filled by one supervisor, or a team of supervisors who divide the sections among themselves.

The *Basic Primary Health Clinic Supervision Checklist* includes the following sections:

Section 1:	Location and Date
Section 2:	Introduction and setting comfortable atmosphere
Section 3:	Health Facility Environment and Infrastructure
Section 4:	Reception and Waiting Area
Section 5:	Examination Room
Section 6:	Equipment and Supplies (Available & Functioning)?
Section 7:	Essential Drugs (Available?)
Section 8:	Health Workforce
Section 9:	Clinical Services Knowledge and Skills
Section 10:	Infection Prevention and Control (IPC)
Section 11:	Health Management Information System
Section 12:	Waste Management
Section 13:	Quality Improvement Process
Section 14:	Referral System
Section 15:	Community Activities
Section 16:	Patient Satisfaction
Section 17:	Summary and Follow up Points

At the conclusion of the supervisory visit, the supervisor should try to have a meeting with the clinic's leader and QI team to share a summary of the findings and discuss next steps. The supervisor should start **with positive findings** and praise the staff for their good work.

Emphasis should be given to the **Red Flag** items. The supervisor should give the QI team constructive guidance on how to address them and summarize the follow up action needed from the QI team, as well as the supervisor him/her self, with a specific time frame for each action.

## 6. What is the “Red Flag” concept?

In several parts of The Basic Primary Health Clinic Supervision Checklist, the supervisor, based on his/her observation and investigation, is to decide whether the item he/she is investigating is either:

- Satisfactory, by checking the box for “**Yes**”;
- Not satisfactory, by checking the box for “**No**”;
- Not satisfactory and needs urgent attention, by check the box for “**Red F.**” for “Red Flag”.

Introducing a category for “Red Flag” is a way to ensure that the main negative findings detected during the supervisory visit are highlighted for action, problem solving, and improvement. It is up to the supervisor to decide if any of the negative findings deserve to be a “Red Flag” item depending on the importance of the item. For example, a shortage in an essential drug, or basic problems with infection prevention procedures, could trigger the supervisor to select the “Red Flag” space.

**Caution:** Selecting the “Red Flag” item could not be used as a reason to punish the staff and go back to the traditional supervision approach. To the contrary, a “Red Flag” item should trigger the support and the creativity of the supervisor in helping the staff through quality improvement and problem solving.

## 7. What are the documents that could be used for supportive supervision?

There are several Clinical Guidelines developed by the MOH with the help of the PHCP-I that can be of help to the supervisor in checking the knowledge and the skills of the primary health care clinic staff. In addition, there are several other MOH documents describing the policies and procedures for primary health care services, supervision, and referral that can be of help to the supervisor. In addition, there are more in-depth checklists available to help specialized supervisors conduct focused supervision to certain aspect of the primary health care clinic such as the laboratory, the dental section, the pharmacy, etc. As mentioned earlier, The Basic Primary Health Clinic Supportive Checklist” is meant to provide general assessment of the main functions of the clinic as a whole and not in-depth assessment to its individual components.

## 8. Who uses the results of the supervisory visit?

As the title of this section indicates, the purpose of supportive supervision is quality improvement. Hence, all parties that should be involved in the quality of primary health care should be interested in the results of a supervisory visit. These parties include:

- **The clinic in-charge/ clinic manager:** as the team leader of the clinic and the

clinic's first line supervisor (internal supervisor), the in-charge/ manager of the clinic should learn about the positive findings of the visit to continue the good work and the negative findings to take action to address.

- **The Quality Improvement (QI) team in the clinic:** As discussed below, the QI team will take the responsibility of identifying the specific problem/s revealed by the supervisory visit, analyze the causes of the problem, and test innovative interventions/changes to respond to each problem.
- **The Provincial/District level (External) Supervisor:** The supervisor from the district, or Province/Department of Health, as a part of the extended team of primary health care, has responsibilities in problem solving for the primary care clinic. Hence, he or she should take part of using the results of the supervisory visit to identify actions for himself/ herself to contribute to quality improvement and problem solving.

**District level/Provincial level/National level Policy Makers:** The aggregated results of supervisory visits could shed some light on common themes or trends for the strength and the weakness of primary care delivery service that may require a modification of district, provincial, or even national procedures and operations to improve quality of primary care services.

## Quality Improvement

### 1. What is quality health care?

The World Health Organization (WHO) defines the quality of health care as the proper performance (according to standards) of interventions that are known to be safe, that are affordable by the society, and that have the ability to produce an impact on mortality, morbidity, disability and malnutrition.

WHO further suggests that quality health care must be:

- **Safe:** Delivering health care that minimizes risks and harm to service users;
- **Effective:** Delivering health care that adheres to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- **Efficient:** Delivering health care in a manner that maximizes resource use and avoids waste;
- **Accessible:** Delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
- **Acceptable/patient centered:** Delivering health care that takes into account the preferences and aspirations of individual service users and the cultures of their communities;
- **Equitable:** Delivering health care that does not vary in quality by personal characteristics, such as gender, race, ethnicity, geographical location, or socioeconomic status.

### 2. What is Quality Improvement (QI)?

Building on WHO's definition of quality of health care, QI can be defined as *“a cyclical process of measuring a performance gap, understanding the causes of the gap, testing, planning, and implementing interventions to close the gap, studying the effects of the interventions, and planning additional corrective actions in response.”*

This definition can be analyzed as follows:

- **A cyclical process:** QI is not one event. It is a continuous and dynamic process that can be repeated as needed.
- **Measuring a performance gap:** The gap between the evidence based standards of services and the actual service being delivered.
- **Understanding the causes of the gap:** Analyzing the direct causes and the root causes leading to the deviation between the actual service delivery and the standards.
- **Testing, planning, and implementing interventions to close the gap:** Applying interventions or changes in the current system at a small scale and testing, using data when possible, to measure the effect of such interventions.
- **Studying the effects of the interventions and planning additional corrective actions:** based on the results of testing the small scale implementation of the interventions, decision should be made to implement the interventions at a large scale, modify the interventions and test them again, or abandon the interventions all together.

Modern concepts of QI derived from recent literature emphasize certain principles that make the QI successful and durable. Such concepts include:

- **Client/patient center:** The ultimate goal of QI is to provide better services to the clients/patients.
- **Teamwork:** Involving members of the health staff, or sometimes the community, that have the knowledge and the interest in the subject of improvement is important. QI team members bring valuable insights not only in identifying and prioritizing problems, but also in the development of innovative solutions.
- **The use of data:** The use of data allows the QI teams to make objective decisions regarding the effect of the adopted interventions in improving services
- **Shared learning:** Comparing the results and experiences of QI teams addressing the same performance gap allows for the rapid spread of best practices.

### 3. What are the main steps (process) of QI?

The steps or process of any QI effort should start by answering three fundamental questions:

- 3.1. What are we trying to accomplish?** This is to specify the aim (objective) of the improvement effort.

A description of the aim needs to include a measurable, time-specific description of the accomplishments expected to be made from improvement efforts.

- 3.2. How will we know that a change/intervention results in an improvement?** To identify the indicators that will be measured to assess objectively the results of the improvement effort.

The indicators can be divided into three categories:

- |                            |                                                                                                            |
|----------------------------|------------------------------------------------------------------------------------------------------------|
| <b>Outcome indicators:</b> | Indicators that are related directly to the aim of the collaborative.                                      |
| <b>Process indicators:</b> | Indicators that monitor change in the process of delivering services that will affect the service outcome. |

- 3.3. What changes/interventions can we make that will result in an improvement?** To specify the interventions or the activities that will be undertaken to improve the system or services.

**Example: Improving Antenatal Care Coverage in the  
Catchment Area of Clinic A**

**Improvement Aim:** In 18 months, increase the coverage of four antenatal care (ANC) visits from 30% to 70% for all pregnant women in the catchment area of Clinic A.

**Outcome Indicator:**

- % of pregnant women who receive four visits of ANC in the catchment area.

**Process Indicators:**

- % of pregnant women who are registered at the health facility before 16 weeks of pregnancy.
- Number of community meetings held to advocate for the importance of ANC.
- Number of disseminated radio messages encouraging pregnant women to seek care.

**Interventions:**

- Hold community meetings to promote for the importance of ANC.
- Use local radio to disseminate messages encouraging pregnant women to seek care.

#### **4. What is the role of the supervisor in QI of primary health care clinics?**

As discussed above, in the context of supportive supervision, the supervisor plays an extremely important role as **a Coach to the QI team** at the primary health care clinic. In his/her role as coach, the supervisor is to:

- Explain the role of QI team.
- Ensure that each clinic forms a QI team.
- Provide support and on-the-job mentoring and training through the supervisor visits and in between visits to the QI team in their QI efforts. This includes explaining the QI process, how to conduct root cause analysis, or how to conduct patient flow analysis, if needed, how to come up with innovative ideas for improvement, and how to use data to measure results.
- Verify that the QI team is active.
- Find opportunities for different QI teams to share experience among themselves.
- Encourage QI teams and recognize those who have a successful QI effort.
- Summarize important lessons learned from the collective experience of QI teams and disseminate such lessons.

#### **5. Who are the members of the QI team at primary care clinics?**

- The QI team at a primary health care clinic is composed of representatives from different functions of the clinic including clinical staff, paramedics, and administrative staff. The team can include additional members as need depending to

the nature of the improvement activity they are addressing. For example, a problem related to the lab may require adding the lab technician to the team, or a problem related to community participation may require inviting an influential member of the community to participate in the team.

- The QI team leader is the in-charge doctor or manager of the clinic. He or she plays the role of the “internal supervisor/coach to the QI team.

## 6. What is the role of the QI team at primary care clinics?

- Identify the gaps between the standards of service delivery and the actual practice at the clinic.
- Select the specific problem to improve and specify the improvement objective (aim).
- Analyze the problem to identify the causes and the root causes of the problem.
- Select the indicators to measure the results of the improvement effort.
- Suggest interventions/changes to be made to achieve the desired results.
- Measure results over time through the collection of data.
- Use the collected data to endorse or modify the interventions/changes to achieve maxim improvement.

## 7. What are the tools to help the QI teams?

Some useful tools include: root cause analysis, patient flow analysis, run charts , and brain storming for encouraging innovation.

### 7.1. Root Cause Analysis:

Root Cause Analysis (sometimes call “fish bone” analysis) is a simple tool to help the QI team analyze a problem into its main causes and hence guide the group to suggest solutions to the problem and which problem/s they have the ability to solve. First, the team writes down the direct causes and then for each direct cause, the team writes the root causes that led to the direct cause.

#### ***Example:***

**The Problem:** Frequent stockout in Amoxicillin

Direct cause 1: Quantity received from the district is not sufficient.

Root cause 1: District level underestimates the clinic’s need.

Root cause 2: The clinic is prescribing Amoxicillin frequently.

Root cause 3 : Misunderstanding of staff of the role of antibiotics.

Direct cause 2: Patients demand antibiotics.

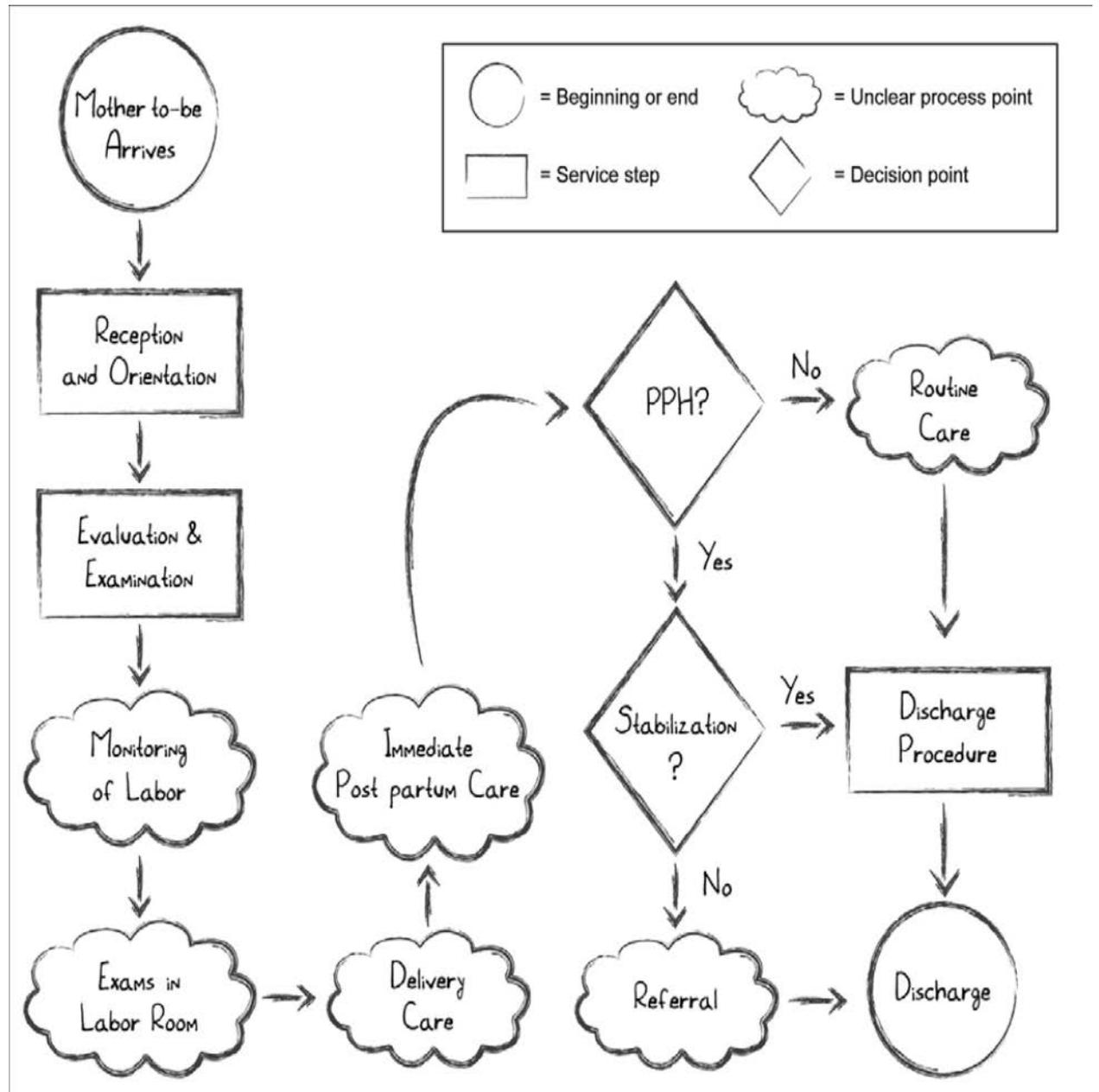
Root cause 1: Patients do not understand the role of antibiotics.

Root cause 2: Patients do not appreciate the value of other measures to

## 7.2 Patient Flow Chart

Sometimes when the clinic staff see indications of over crowdedness in the waiting room, or there are complaints from clients about long waiting time, an analysis of the patient flow can reveal areas where changes can be made to simplify the process of patient organization and save time. An example of the patient flow chart is drawn in symbols explained below:

### Example of Patient Flow Chart in Maternity Clinic:

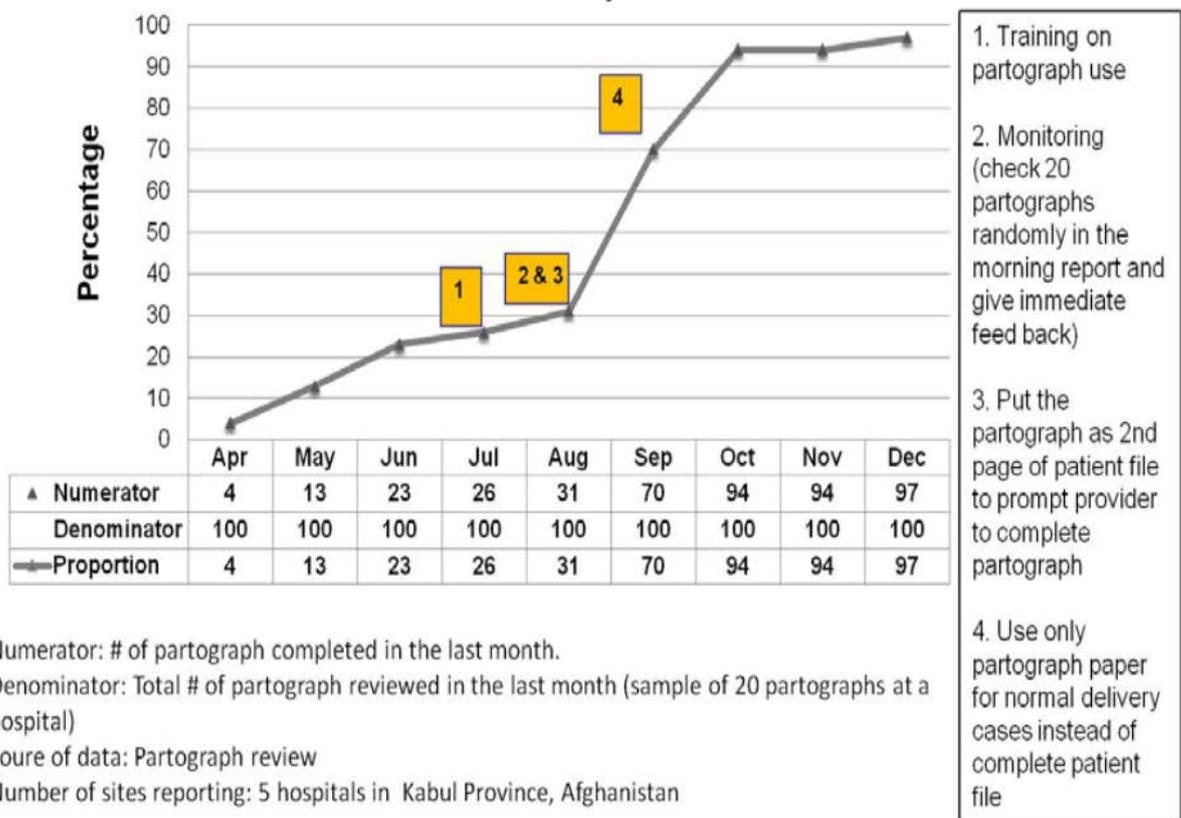


### 7.3. Run Chart to Monitor Improvement Progress

QI Teams may need to collect data to measure indicators that reflect the progress of an improvement effort. The indicators will need to be measured over time. The Run Chart is a tool to help QI Teams depicts visually, through a time graph, the level of an indicator, or more than one indicator over time. Hence, the team can see whether the improvement effort is having an impact or not.

The following example is showing the results of work conducted by a QI Team to improve the use of Partograph in its clinic. The annotations on the graph provide further information on what and when interventions were introduced.

#### Example of the use of Run Chart to monitor improvement of using partograph



### 7.3. Brain Storming for Encouraging Innovation

Brain storming is a technique to engage a group of people in a systematic process to analyze a problem and consider all possible solutions for it before selecting the solution they will finally adopt. The group should not jump into adopting a single solution before they explore openly and freely all other options. After listing all possible solutions, then the group can discuss each solution to evaluate its potential impact and feasibility. The group then concludes which is the most effective and feasible solution to adopt.

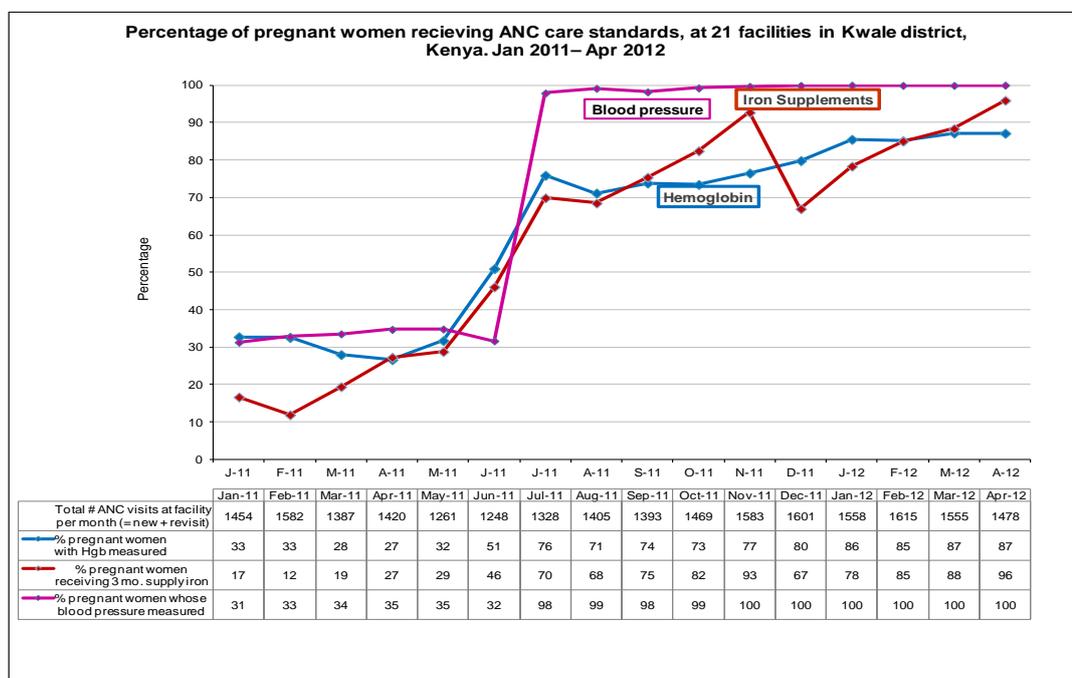
The rules of conducting brain storming sessions include:

- All members of the team can participate equally (no one should dominate the process).

- Each member gets a turn is suggesting a solution.
- During the process of solution listing, no one is allowed to interrupt or comment.
- All solutions should be written down (on a flip chart or other means) for all the groups to see.
- The group should have a discussion on which solution/s to adopt or modify.
- The group should score each solution for its potential effectiveness and feasibility.

The example below shows the improvement achieved through the Brain Storming technique to improve the quality of antenatal care (ANC). Interventions included: assuring the presence of sphygmomanometer at the antenatal care room, mobilizing the clinics resources to purchase Ferrous Sulphate tablets that were out of stock, and adding a simple checklist to remind the health provider with all services to be given during ANC visit.

## Key Results: ANC care standards in Kwale district, Kenya



USAID HEALTH CARE IMPROVEMENT PROJECT

### 8. What is the value of shared learning between QI teams?

Sharing experience between QI teams working in different clinics, especially those working on the same improvement topic has proven to be very helpful in spreading best practices. When a QI team meets with other teams and learn about the progress they have made and how they made it, the team becomes motivated to apply the same intervention to produce similar results.

The supportive supervisor should take opportunities to get QI teams together to share their data and improvement experiences.

## **9. How to motivate primary care staff for QI?**

Creativity of supervisors and managers are highly needed to find ways to recognize the achievement of the best performing QI teams. Some ideas include: certificates of recognition, recognition in published Ministry of Health media, such as newsletters, and recognition during Ministry of Health conferences or meetings

## Chapter 4: Referral System

### Definition

**Referral:** The process of directing, re-directing or transferring, a patient to an appropriate specialist or agency. Usually the referral is done from a unit of lower complexity to a unit with a higher capacity. The Referral is Horizontal when it occurs between units of the same institution and Vertical when it is between units of different institutions.

**Counter-Referral or Return-Referral:** Is the process of re-directing the referred patient back to the originating unit once the reason for referral has been resolved

### Health System in Iraq:

Health services in Iraq are provided through a wide network of health institutions across Iraq. PHCCs are considered to be number one focal point between the citizen and Health institutions in Iraq. These health centers extend to remote areas in order to provide services for small population.

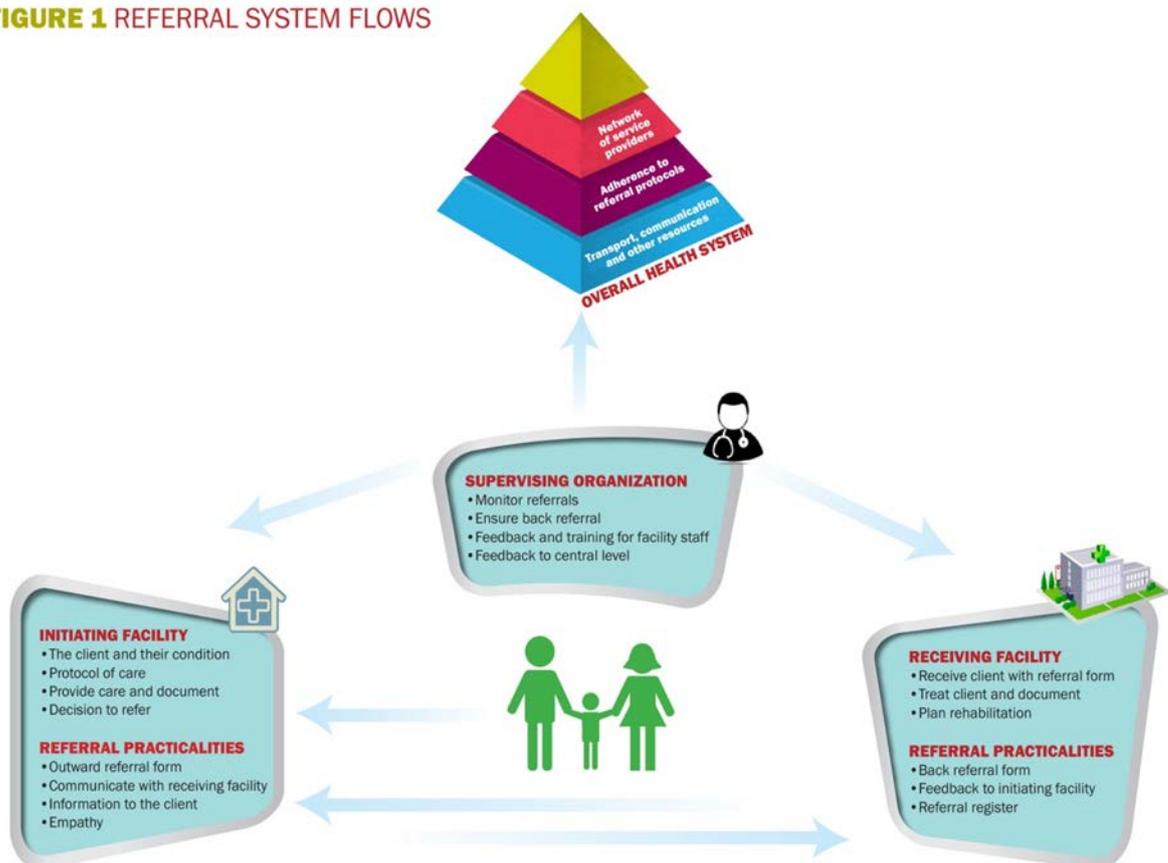
Health care are categorized into the following three levels:

**Level one: Primary Health care**

**Level two: Secondary Health care**

**Level three: tertiary health care**

**FIGURE 1** REFERRAL SYSTEM FLOWS



## **Levels of health care in Iraq**

### **1- First level: Primary Health Care:**

Health services in Iraq are provided through a wide network of health institutions across Iraq including villages and rural areas. Health centers are fiscally, technically and administratively associated with PHC District.

#### **PHC District:**

Administrative formation; organizational level (Department), takes the responsibility of managing and administratively, technically and fiscally supervising a number of health centers (5-15) health centers.

The district is formed of a group of people that handles administration, follow up and organization of the health centers existed in the same geographical area of this district. The number of districts in Iraq is (124).

Organizational Structure:

- Centers section.
- Pharmacy and Supplies section.
- Engineering and Maintenance section.
- Management section.
- Accounting section
- Health Monitoring section

### **2- Second level (Hospitals):**

A- Hospitals are categorized, according to services provided, to:

- Teaching hospitals (61)
- General hospitals (168)
- Special hospitals (92)

B- General hospitals are categorized, according to the hospital's clinical capacity, to: (Clinical capacity of a hospital is determined depending on the population in the hospital's geographical area)

- Hospital with (50) beds capacity
- Hospital with (100) beds capacity
- Hospital with (200) beds capacity
- Hospital with (400) beds capacity or more

### **3- Third level (Specialized Centers)**

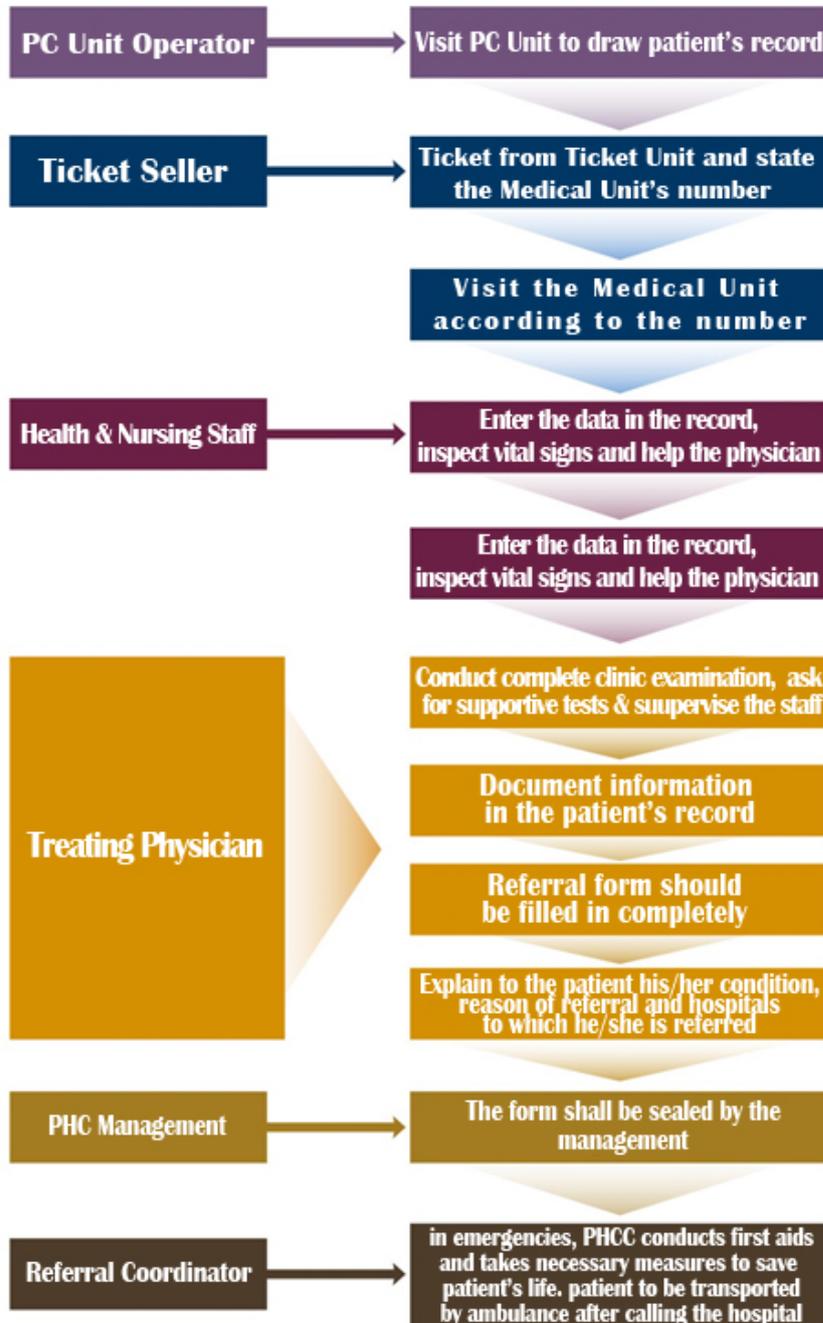
The number of specialized centers are (66). They are distributed in Iraq's provinces according to the following specialties:

- Cardiac and Vascular surgery
- Sterility and In Vitro Fertilization (IVF)
- Endocrine Glands and Diabetes
- Kidney transplantation
- Bone marrow transplantation

- Blood diseases
- Artificial limbs
- Medical rehabilitation and physiotherapy

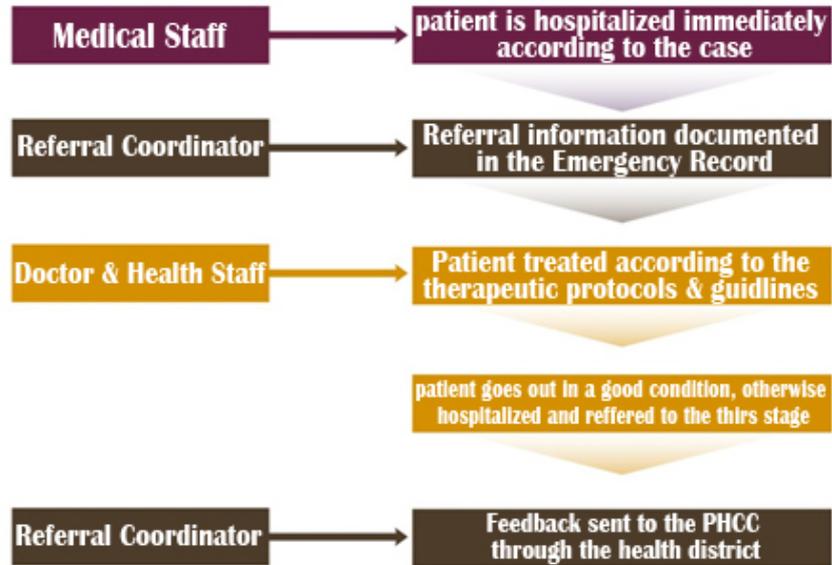
**A. Patient flow inside each of PHC levels**

## Patient Flow Inside the PHC Clinic



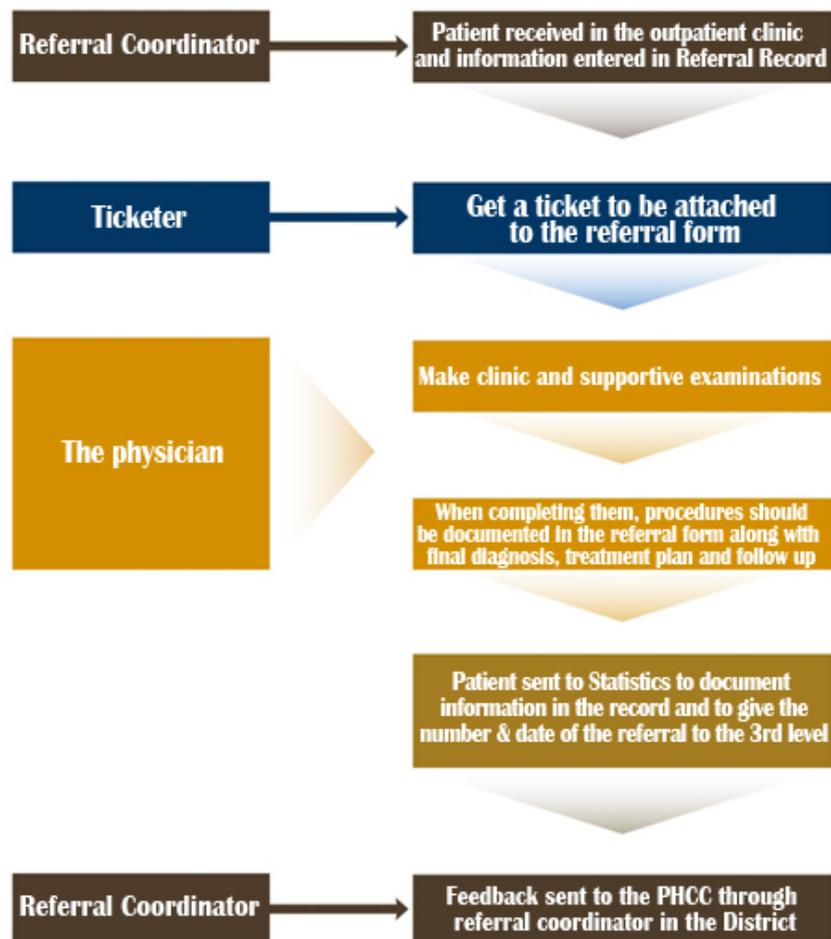
**B. Patient flow in the hospital for emergencies**

## Patient Flow Inside the Hospital



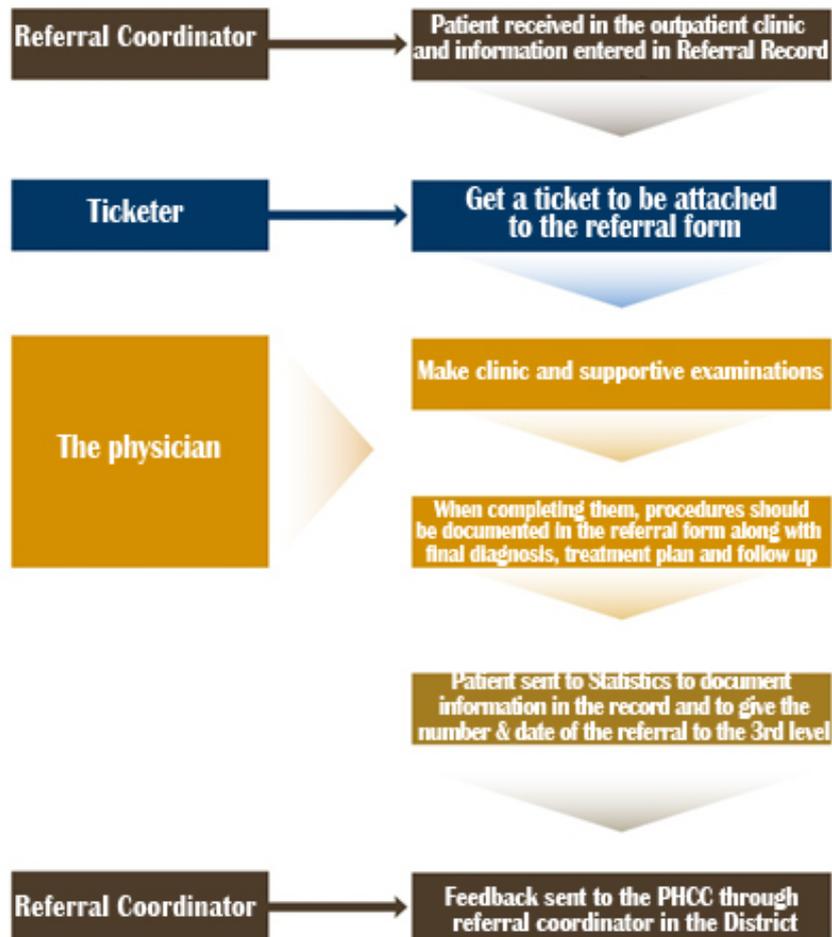
### C. Patient flow in the hospital for cold cases

## Patient Movement in the Hospital



#### D. Patient flow in the specialized clinics

### Patient Movement in the Specialized Clinic



## **Referral Form**

**First section:** this section is about the patient and it is filled with the following information:

- Patient's name
- Family
- Gender
- Age
- Patient's Number
- The referred to institution and department

**Second section:** Referral summary

The following information are filled in referral summary:

- Indication for referral
- Diagnosis
- Main symptoms
- Exam notes
- The taken exams
- Initial diagnosis
- Measures taken
- The name and signature of the referring physician

**Third section:** Referral report

Includes the following columns:

- Date
- Clinical findings
- Tests and exams
  - Laboratory exams
  - Radiographies
  - Others
- Final diagnosis
- Measures taken
- Recommendations
- Name and signature of specialist



## Annex 1: Basic Primary Health Clinic Supervision Checklist

### Primary Health Care Project - Iraq

### Basic Primary Health Clinic Supervision Checklist (DRAFT)

#### Section 1: Location and Date

Province: DoH: District:  
Primary Health Care Facility Name: Clinic Type (see instructions):  
Address:  
Manager's Name: Phone number: Email address:  
Supervisor's Name: Phone number: Email address:  
Date of Supervision visit:  
Time supervision visit started: Time visit ended: Visit's duration:

---

#### Section 2: Introduction and setting comfortable atmosphere (see instructions)

---

#### Section 3: Health Facility Environment and Infrastructure

Observation of land surrounding the facility	Yes	No	Red F.	Comment
Free of any Water leakage?				
Free of any Garbage?				
Free of medical waste?				

Health facility infrastructure				
Good condition of walls and roof?				
Electricity available at time of visit?				
Generator available and functioning?				
Water running from taps?				
Air conditions are available & functioning?				
Is the center wired for internet connectivity?				
Is there internet available?				
Are computers available?				
Are computers functioning?				
Are there functioning UPSs?				
Facility has fire extinguishers?				
if yes, Are fire extinguishers within expiration date?				
<b>Section 4: Reception and Waiting Area</b>	Yes	No	Red F.	Comment
Receptionist available?				
Reception register up to date?				
Sitting places available for patients?				
Waiting area clean?				
Waiting area organized ?				
Waiting area has comfortable temperature?				
No smoking signs displayed and enforced?				
Waiting area has RO (filtered) drinking water?				

Waiting area has access to toilets?				
If yes, are toilets functioning?				
Are toilets clean?				
Do toilets have sink, tap water, soap & hand drying facility?				
Waiting area include Health Education materials?				
<hr/>				
<b>Section 5: Examination Room</b>	Yes	No	Red F.	Comment
Examination room has exam table?				
Examination room has chairs?				
Sphygmomanometer available and functioning?				
Adult weighing scale available and functioning?				
Infant weighing scale available and functioning?				
Stethoscope available and functioning?				
Tongue depressor available?				
Diagnostic set (Ophthalmoscope & Otoscope)?				
Examination room has a sink with tap water?				
Examination room has soap and hand drying facility?				
Examination can be conducting in privacy?				
Examination room has disposable gloves?				
Examination room has comfortable temperature?				
<hr/>				
<b>Section 6: Equipment &amp; Supplies (Available &amp; Functioning?)</b>	Yes	No	Red F.	Comment
<b>Imaging:</b>				
General X ray machine?				

Benchtop semi-auto film processor?				
Supervisor: select additional items to check (see instructions)				
Item 1: _____				
Item 2: _____				
Item 3: _____				
<b>Laboratory:</b>				
Microscope?				
Centrifuge?				
Biochemistry Analyser?				
Haematology Analyser?				
Counter blood cell/WBC differential digits with totaliser?				
Supervisor: select additional items to check (see instructions)				
Item 1: _____				
Item 2: _____				
Item 3: _____				
<b>Dental Unit:</b>				
Dental Treatment Unit?				
Dental X ray?				
Tooth Extraction Instrument Set?				
Supervisor: select additional items to check (see instructions)				
Item 1: _____				
Item 2: _____				



<b>Labour and Delivery Room (if applicable):</b>			
Obstetric delivery bed?			
Gloves?			
Cotton and gauze?			
Disinfectant Solution?			
Oxytocin injection?			
IV fluids?			
Vit K injection?			
Folic catheter?			
Kidney basin?			
Partograph chart?			
Tetracycline eye ointment?			
Emergency Light with Rechargeable Battery?			
Newborn Resuscitation set (Bag, mask, mucus aspirator)?			
<b>Dressing Room/Emergency Room/Operating Room (for minor surgery)</b>			
Access to the room is limited?			
Scrubbing space and facilities?			
Sterile gloves?			
Operating Table?			
Anaesthesia machine minor w ventilator?			
Diathermy machine?			
Infusor Pressure?			
Operating light mobile?			
Laryngoscope set?			

Instrument trolley?				
Oxygen Cylinder?				
Trolley Procedure Hilo?				
Patient trolley transfer?				
Wheelchair?				
Stretcher canvas?				
Stethoscope adult?				
Stethoscope child?				
Diagnostic set (Ophthalmoscope & Otoscope)?				
Laryngoscope set adult?				
Laryngoscope set child?				
Immobilizers, Plints & Cervical collar sets?				
Oxygen Cylinders?				
Ambulance?				
Supervisor: select additional items to check (see instructions)				
Item 1: _____				
Item 2: _____				
Item 3: _____				
<b>Section 7: Essential Drugs (Available?)</b>	Yes	No	<b>Red F.</b>	Comment
List of Essential drugs?				
Lignocaine topical ?				
Acetylsalicylic Acid tablet 100 mg ?				

Paracetamol tablet 500 mg ?			
Diphenhydramine Hcl injection: 10 mg/ml amp?			
Carbamazepine tablet 200 mg (in Main PHC Centers only)?			
Mebendazole tablet 100 mg ?			
Amoxicillin Syrup 125mg/5ml ?			
Procaine penicillin + benzyl penicillin sodium ?			
Isoniazid tablet 100 mg?			
Metronidazole tablet (in Main PHC Centers only)?			
Ferrous Sulfate tablet 200 mg?			
Glyceryl Trinitrate tablet 0.5 mg ?			
Benzyl benzoate 25% application?			
Chlorhexidine solution?			
Oral Rehydration Salts (ORS)?			
Ethinylestradiol + Norethsterone tablet ?			
Insulin neutral injection 100 units/ml (in Main PHC only)?			
Salbutamol inhalation?			
Carry Blair Powder (for stool, Cholera testing)?			
Supervisor: select additional items to check (see instructions)			
Item 1: _____			
Item 2: _____			
Item 3: _____			
Item 4: _____			
Item 5: _____			

**Section 8: Health Workforce**

	No. employed	No. present	No. with written SOW	No. trained	Comment
Physician ( NA for some Sub-centers) ?					
Nurse ?					
Medical Assistant ?					
Lab Assistant ?					
Health technician ?					
Vaccinator?					
Dental Assistant?					
Assistant Pharmacist ?					
Administrative staff?					

<b>Section 9: Clinical Services Knowledge and Skills</b>	Yes	No	Red F.	Comment
<b>Availability of Clinical Standard Guidelines:</b>				
IMCI Guidelines for physicians (in Main PHC)?				
IMCI Guidelines for nurses ?				
Non Communicable Diseases (NCD) ?				
Communicable Disease Control (CDC) ?				
Infection Prevention & Control ?				
Trauma ?				
Supervisor: select additional items to check (see instructions)				

Item 1: \_\_\_\_\_  
 Item 2: \_\_\_\_\_  
 Item 3: \_\_\_\_\_


**Staff Knowledge (see instructions)**

	0	1	2	Red F.	Comment
Management of Hypertension?					
Management of Diabetes?					
Management of Asthma?					
Infection Prevention & Control (IPC) ?					
Management of child Acute Respiratory infection?					
Management of child diarrhea?					
Emergency Maternal Care?					
Emergency Newborn Care?					

Supervisor: select additional items to check (see instructions)

Item 1: \_\_\_\_\_  
 Item 2: \_\_\_\_\_  
 Item 3: \_\_\_\_\_

**Staff Skills (Direct observation or Demonstration)**

Patient treated with respect?					
Patient's privacy respected?					
Provider capable of measuring blood pressure?					
Provider can count respiratory rate of children ?					

Provider can do/demonstrate AMTSL (Main PHC)?				
Provider can do/demonstrate Newborn resuscitation?				
Supervisor: select additional items to check (see instructions)				
Item 1: _____				
Item 2: _____				
Item 3: _____				
<b>Section 10: Infection Prevention and Control (IPC)</b>	Yes	No	Red F.	Comment
Hand washing is practiced when needed?				
Hand washing is practiced correctly?				
Instruments are put in Chlorine Solution after use?				
Instruments are washed and brushed after use?				
Instruments undergo high level disinfection after use ?				
Instruments used in the operating room are sterilized?				
<b>Section 11: Health Management Information System</b>	Yes	No	Red F.	Comment
Is there a medical record for every patient?				
Are patient records complete and accurate?				
Are patient records kept in an organized manner?				
Are statistics from medical records aggregated in reports?				
Are statistical reports submitted to the district on time?				

Do staff at the clinic read or use their own data/statistics?				
Does the clinic have someone who can use computer?				
<b>Section 12: Waste Management</b>	Yes	No	Red F.	Comment
Guidelines for Waste Management Available?				
Medical waste stored in resistant bags?				
if yes, are bags appropriately labeled?				
Procedures for handling used sharp objects followed?				
Covered trash cans available in the building?				
<b>Section 13: Quality Improvement Process</b>	Yes	No	Red F.	Comment
QI team established in the clinic?				
The scope of work for the QI team available & understood?				
QI team met during the last month?				
QI team identified problems with clinic performance?				
QI team identified the causes of the problems?				
QI team identified changes to address the problems?				
QI team identified indicators to test the effect of changes?				
QI team tested the results of the changes?				
<b>Section 14: Referral System</b>	Yes	No	Red F.	Comment

Guidelines for referral available?				
For the last case referred by the clinic:				
- Is there a record kept for the referral?				
If Yes:				
- Patient identification complete?				
- Information on the referring health clinic complete?				
- Reason for referral clearly stated?				
- Receiving clinic/Dr. contacted before referral?				
- Patient information was sent to the referral clinic?				
- Was transport/ambulance arranged by the clinic?				
<b>Section 15: Community Activities</b>	Yes	No	Red F.	Comment
Target population for the clinic well defined?				
Population size known?				
Estimate of number of women in reproductive age known?				
Estimate of number of pregnant women known?				
Estimate of number of children under 5 years old known?				
Estimate of number of infants (less than 12 months) known?				
Local Health Committee established?				
Local Health Committee met during last 4 months?				
Staff can name at least one NGO in catchment area?				
Clinic disseminates health messages to the community?				

Section 16: Patient Satisfaction (Private Exit Interview)	Yes	No	Red F.	Comment
	<b>Patient 1:    adult male?            adult female?            Child?</b>			
Was the waiting duration acceptable to you?				
Was the waiting area comfortable?				
Did the clinic receive patients in an organized manner ?				
Do you think the clinic is clean?				
Did reception staff treat you with respect?				
Did the health provider treat you with respect?				
Provider gave you information about illness or treatment?				
Did you understand the provider's information?				
Did provider give you a chance to ask questions?				
Over all, are you satisfied with the services received?				
<b>Patient 2:    adult male?            adult female?            Child?</b>				
Was the waiting duration acceptable to you?				
Was the waiting area comfortable?				
Did the clinic receive patients in an organized manner ?				
Do you think the clinic is clean?				
Did reception staff treat you with respect?				
Did the health provider treat you with respect?				
Provider gave you information about illness or treatment?				
Did you understand the provider's information?				
Did provider give you a chance to ask questions?				

Over all, are you satisfied with the services received?			
<b>Patient 3:    adult male?            adult female?            Child?</b>			
Was the waiting duration acceptable to you?			
Was the waiting area comfortable?			
Did the clinic receive patients in an organized manner ?			
Do you think the clinic is clean?			
Did reception staff treat you with respect?			
Did the health provider treat you with respect?			
Provider gave you information about illness or treatment?			
Did you understand the provider's information?			
Did provider give you a chance to ask questions?			
Over all, are you satisfied with the services received?			
<b>Patient 4:    adult male?            adult female?            Child?</b>			
Was the waiting duration acceptable to you?			
Was the waiting area comfortable?			
Did the clinic receive patients in an organized manner ?			
Do you think the clinic is clean?			
Did reception staff treat you with respect?			
Did the health provider treat you with respect?			
Provider gave you information about illness or treatment?			
Did you understand the provider's information?			
Did provider give you a chance to ask questions?			
Over all, are you satisfied with the services received?			

<b>Patient 5:</b>	<b>adult male?</b>	<b>adult female?</b>	<b>Child?</b>	
Was the waiting duration acceptable to you?				
Was the waiting area comfortable?				
Did the clinic receive patients in an organized manner ?				
Do you think the clinic is clean?				
Did reception staff treat you with respect?				
Did the health provider treat you with respect?				
Provider gave you information about illness or treatment?				
Did you understand the provider's information?				
Did provider give you a chance to ask questions?				
Over all, are you satisfied with the services received?				

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**Section 17: Summary and Follow up Points (leave a copy with clinic in-charge/manager)**

**Summarize the main positive findings:**

## **Annex 2: Instructions for Supervisors**

The Basic Primary Health Clinic Supervision Checklist is a tool to help supervisors at the provincial, district, and health clinic level conduct a general assessment to all aspects of primary health care services provided by the primary health care clinic for the purpose of quality improvement. The Checklist is not meant to replace other official reports and forms that are required to be filled by the MoH. More in-depth specialized assessments are encouraged for different services offered at the primary care level. The Checklist can be filled by one supervisor, or a team of supervisors who divide the sections among themselves.

### **Section 1: Location and Date**

For Clinic Type: The supervisor is to select a number/letter describing the type of center according to the following classification:

Primary Health Care Center Types are:

- (1) Main
  - (1a) Works with Family Medicine Approach
  - (2a) Contains labor and Emergency rooms
  - (3a) Contains Training Center
  - (4a) Works with Family Medicine Approach and Contains Labour and Emergency room
- (2) Sub-center managed by a Doctor
- (3) Sub-center managed by a paramedic

### **Section 2: Introduction and setting comfortable atmosphere**

It is essential for supportive supervision that the clinic staff are made at ease and are not feeling threatened by the supervisory visit so that they are open to the supervisor about the conditions they are working in and the challenges they face. To put the staff at ease, the supervisor is encouraged to:

- Keep a smiling face and shake hands with staff when appropriate. Exchange brief courteous salutations as appropriate. Introduce him/her self and the purpose of the visit.
- Emphasize that the purpose of the visit is for the supervisor to join effort with the clinic staff so that the services are provided with high quality to the population. Hence, the supervisor is a partner with the clinic staff, and can be considered a member of the clinic staff, not an outsider.
- Explain that the visit is not meant to “find mistakes”, but to see the good work the clinic is doing and congratulate the staff for it. If there are issues or challenges with the work of the clinic, the supervisor will try to work with the clinic team to address them in a joint and constructive way.

### **Section 3: Health Facility Environment and Infrastructure**

This section is to be based on the supervisor’s own observation and through questions to selected clinic staff as necessary.

Across the Checklist, check the appropriate space under “Yes” or “No” according to the question. The “**Red F.**”, for “**Red Flag**”, space can be checked when the supervisor thinks that there is a serious **weakness/problem that needs urgent attention**.

The Supervisor is encouraged to **praise the staff** for items checked “Yes”. For Items checked “No” or “Red F.”, the supervisor is encouraged to give the staff **constructive guidance** on how to improve the item right after checking the item. The supervisor does not have to wait till the end of the supervision checklist to give feedback on what he/she is observing.

#### **Section 4: Reception and Waiting Area**

This section is to be filled based on the supervisor’s own observation and through questions to selected clinic staff as necessary.

#### **Section 5: Examination Room**

This section is to be filled based on the supervisor’s own observation and through questions to selected clinic staff as necessary.

If there are several examination rooms, the supervisor is to select one of them in each supervisory visit.

#### **Section 6: Equipment and Supplies (Available & Functioning)?**

This section is to be filled based on the supervisor’s own observation and through questions to selected clinic staff as necessary. **If time permits** and the supervisor would like to extend the list of equipment to check, the supervisor can select additional items from the list attached at the end of this document under the title “*Equipment PHC Main Center*”.

The supervisor should note that some of the equipment listed in the Checklist should only be available at the Main Primary Health Care Clinics. If the Checklist is being filled for Sub centers, then the supervisor should put “**NA**”, for “**Not Applicable**”, in the Comment line.

#### **Section 7: Essential Drugs (Available?)**

This section is to be filled based on the supervisor’s own observation and through questions to selected clinic staff as necessary. **If time permits** and the supervisor would like to extend the list of essential drugs to check, the supervisor can select additional items from the list attached at the end of this document under the title “*Essential Medicines by Type of Facility*”.

The supervisor should note that some of the drugs listed in the Checklist should only be available at the Main Primary Health Care Clinics. For items that should only be available in Main Clinics, if the Checklist is being filled for Sub centers, then the supervisor should put “**NA**”, for “**Not Applicable**”, in the Comment line.

#### **Section 8: Health Workforce**

For line related to “Physician”, if the supervisory visit is made to one of the sub-centers managed by paramedics, the supervisor should put “**NA**” for “**Not Applicable**”.

The column for “No. employed” = the number of staff registered to work in the clinic.  
The column for “No. present” = the number present at the day of supervision.

The column for “No. trained” = the number of staff attended any training arranged by PHCPI.

## Section 9: Clinical Services Knowledge and Skills

For the “Availability of Clinical Standards Guidelines”, if time permits and the supervisor would like to extend the list of guidelines to check, the supervisor can select additional items from the list attached at the end of this document under the title “*List of Clinical Standard Guidelines*”.

For “Staff Knowledge”, the supervisor can refer to the “*Handbook of Quality Standards and Operations Guidelines for Clinical Service Delivery in Primary Care Clinics*” to ask questions for the purpose of checking the knowledge of the appropriate staff member responsible for examining patients on the content of the clinical standard guidelines. The supervisor is to check the space under:

- “0” if the knowledge is inadequate or incorrect.
- “1” if the knowledge is adequate, correct, but not complete.
- “2” if the knowledge is correct and complete.
- “Red F.” if the knowledge is grossly inadequate and incorrect.

**If time permits** and the supervisor would like to extend the questions about staff knowledge, the supervisor can select additional knowledge related to additional clinical standard guidelines.

For “Staff Skills”, This section should be filled based on direct observation of the staff performing the skill or by asking the staff member to demonstrate the skill. The supervisor can refer to the “*Handbook of Quality Standards and Operations Guidelines for Clinical Service Delivery in Primary Care Clinics*”. The supervisor is to check the space under:

- “0” if the performed skill is incomplete, or with mistakes.
- “1” if the performed skill is correct, but not complete.
- “2” if the performed skill is correct and complete.
- “Red F.” if the performed skill is grossly inadequate and incorrect.

**If time permits** and the supervisor would like to extend the questions about staff skills, the supervisor can select additional skills related to additional clinical standard guidelines.

## Section 10: Infection Prevention and Control (IPC)

This section should be based should be checked based on supervisor’s direct observation of whether staff wash their hands between examining patients and whether the hand washing technique is correct according to the Guidelines for Infection Prevention and Control. Also, the supervisor should observe how the staff handle clinical instruments after use and check the appropriate space. If there is no opportunity for direct observation, then the supervisor can ask the appropriate staff to demonstrate how to wash hands, or handle medical equipment after use.

## Section 11: Health Management Information System

To complete this section, the supervisor is encouraged to ask to see the medical records for patients and the aggregated statistics of the clinic to verify their presence and whether they are complete and up to date.

## Section 12: Waste Management

To complete this section, the supervisor is encouraged to observe directly the waste management procedures. If there is no opportunity to perform direct observation, then the supervisor can ask the appropriate staff to demonstrate the item to be checked.

## Section 13: Quality Improvement Process

If there is no quality improvement (QI) team, then it is in the context of supportive supervision that the supervisor, also acting as a quality improvement coach to the clinic staff, should help the clinic establish a QI team, explain its rationale and scope of work, and provide constructive guidance and on job training to the clinic leader and the QI team members on the process of QI in their own clinic.

## Section 14: Referral System

The supervisor is encouraged to see directly the referral record for the last case referred, as a sample for verifying compliance with referral procedures. However, if time permits, the supervisor may want to ask to see referral procedures for other cases referred previously.

## Section 15: Community Activities

This section is to check on the community component of the clinic's work. Each clinic should have an active community component to learn about the pattern of population in the catchment area, the percent of women in reproductive age, and the percent of children less than 5 years old. The health staff should be working with community to establish a Local Health Committee and activate it to support community health activities in the clinic's catchment area. The clinic should also be aware of NGOs present in the catchment area and try to engage them in health activities as appropriate. The clinic should disseminate health messages to the community as appropriate.

## Section 16: Patient Satisfaction

The supervisor should randomly select 5 patients (depending to the time available, fewer number of patients could be selected) after completing their visit to ask them a few questions related to the experience they had during their visit. The supervisor should **circle the type of patient (adult male, adult female, or child under 5 years old)** before the interview. The supervisor should try to select a variety of patients (adult male, adult female, or child) to get a wider view of the patients' opinion of the services offered by the clinic. If the patient is a child, then the adult person who brought him/her to the clinic should be interviewed. **The interview should be conducted privately.**

## Section 17: Summary and Follow up Points

At the conclusion of the supervisory visit, the supervisor should try to have a meeting with the clinic's leader and QI team to share a summary of the findings and discuss next steps.

The supervisor should **start with positive findings** and praise the staff for their good work.

Emphasis should be given to the Red Flag items. The supervisor should give the QI team constructive guidance on how to address them and summarize the follow up action needed from the QI team as well as the supervisor him/her self, as well as time frame for each action.

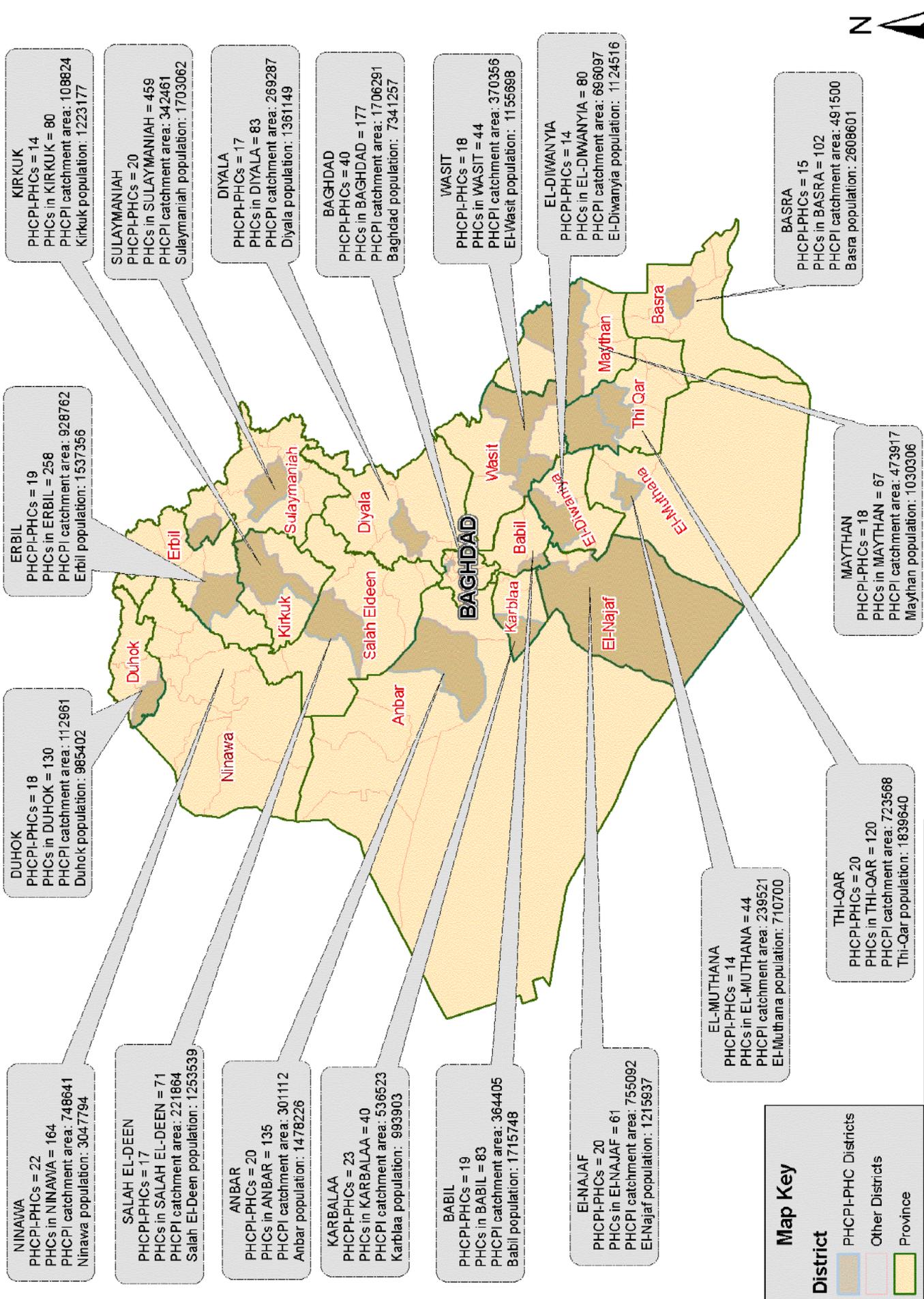
**Attachments:**

1. List of Essential Medicines by Type of Facility
2. List of Equipment PHC Main Center
3. List of Clinical Standard Guidelines

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# PHCPI-PHCs population mapped to IRAQ population



**Map Key**

**District**

- PHCPI-PHC Districts
- Other Districts
- Province

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