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وزارة الصحة
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TRAINING CURRICULUM

FOR HANDBOOK OF QUALITY STANDARDS
AND OPERATIONAL GUIDELINES FOR
CLINICAL SERVICES DELIVERY
IN PRIMARY HEALTH CARE CENTERS IN IRAQ

DISCLAIMER

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Table of Contents

| | |
|--|-----|
| Acronyms | 2 |
| Introduction | 3 |
| Part I: Trainer’s Guide,..... | 4 |
| Part Two: | 38 |
| Training Modules | 38 |
| Module One: Clinical Care Guidelines | 39 |
| Session 1: Management of Trauma and Instrument Sterilization..... | 40 |
| Session 2: Non Communicable Diseases | 47 |
| Session 3: Obesity and Nutrition..... | 60 |
| Session 4: Women`s Health (breast Cancer and premarital counseling)..... | 67 |
| Module Two: Community Partnership in PHC | 79 |
| Module Three: Supportive Supervision for Quality Improvement..... | 86 |
| Session 1: What is Supportive Supervision & Role of Supervisors? | 88 |
| Session 2: Supervision Checklists & The use of results of supervision | 96 |
| Session 3: Quality Services and Quality Improvement & Quality Improvement Process..... | 100 |
| Session 4: Quality Improvement Teams & Tools and Motivation for QI | 104 |
| Module Four: Referral System | 115 |
| Session One: Basics of Health System in Iraq | 116 |
| Session Two: Referral System..... | 124 |

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.

Part I: Trainer's Guide^{1,2}

¹ Training Curriculum in Management and Administration of Primary Health Care Centers, USAID/TMPP, 2006.

² InWEnt - Internationale Weiterbildung und Entwicklung GmbH Capacity Building International, Germany 2004

This training curriculum is a guide to assist trainers in improving health care by training health professionals in PHCCs

Materials in this document are designed for training service providers who work at a variety of health facilities in Iraq, but most importantly for those involved in the management of the PHCCs. The modules can be used to train health professionals, physicians, nurses, midwives and other health workers in group training or, with adaptation, as a basis of individualized or self-directed learning.

Trainers implementing this course should be thoroughly familiar with the policies, strategies, guidelines and procedures. Because the PHCCs' functions and procedures are based on this training course along with the skills in the practices described. The trainers need to have a positive attitude about the participants and their training work.

Training may be implemented either off-site or on-site. In off-site training, a group of participants come together from several health facilities and then return home to apply what has been learned. Off-site training may be the most appropriate way to reach individuals from many small sites. On-site training refers to training held in a health facility team where the participants work. Both types of training can be very effective. When training is conducted off-site, it may be more difficult to observe actual clinical settings. On the other hand, when training takes place on-site, there may be interruptions due to participants being called away for other responsibilities.

How to Use the Manual

This manual is designed as a working instrument for trainers and facilitators. It can also be used as a planning tool for PHC and district health managers. The module schedule contains a condensed summary of the contents organized in units and is meant as a check list for the facilitator/s before and during the course. The time indicated for each unit is an average time span based on experience, and can vary according to the composition and dynamics of each respective group.

The manual is divided into two parts. The first part is an introduction to the training course giving an overview over the rationale, objectives, and target groups for the course. It includes the present section on recommendations on how to use the manual, introducing the structure, training methods and course schedule. It also contains information on how to organize a workshop / training course and concludes with some recommendations on the limitations of the document and how to deal with them.

The second part presents the actual training contents, methods, didactic materials and additional literature recommended for each content area, organized/compiled in the different modules of the program. Every training course starts with the introduction of participants and team presenting the course objectives, contents, methods and program and allowing participants to express their expectations and fears. The course content is presented according to five broad content areas (modules),

subdivided into different sessions:

Overall learning objectives: states the objectives to be achieved at the end of the module in terms of knowledge, skills and competence.

Schedule: gives an overview over the time span, methods, materials and recommended content for each session / topic and states the specific objectives of each session.

Sessions: are subdivisions/sessions of the module that follow a logical flow to develop the content of the module.

Specific objectives of the sessions: relate to the content and the expected level of competence to be achieved and can also be used as basis for the development of exam questions.

Background information for the facilitator: includes background information important for the facilitator to develop the content of the module, necessary and recommended definitions, concepts, theory and its applications.

Exercises: describe practical applications of the theory and are meant to facilitate the learning process through experiential approaches: role plays, games, etc. (see list of exercises).

Handouts: are the essential documentation for the participants about the content of the session / module stating the objectives, listing the key words, developing the concept / theory of the content, and giving recommendations for further reading.

References: additionally recommended literature, articles and books, which are related to the content of the module.

Structure of the Training Course

The training course has been planned as a five days course. However, it is also possible to shorten the course due to limited time and / or to select modules according to learning objectives and needs. As well the time can be expanded in order to deal more in depth with the content and allow for more exercises, practical, field work.

The time frame of the training course consists of six working hours per day. These hours are divided into two morning and two afternoon sessions. Each session normally has duration of 2 hours. The number of course trainers/ facilitators can range from one to two per course according to the requirements. Also, for special topics, external resource persons should be asked to lecture and work with the group in their respective areas of expertise. The trainee - facilitator ratio should be 15 to one, a ratio of 20 or 25 to one still being acceptable. The total number of participants should not exceed 25.

The course structure and training methods not only allow for the development of knowledge, skills, competence and change of attitudes of the participants. The course concept is also designed to be put into practice by participants after the training during their supervisory work or by organizing their own training courses. Therefore this manual is not only a facilitator's manual, but also a supervisor's manual.

Approaches to Training and Learning

The training course outlined in this document is based on adult learning principles, competency-based training and performance improvement. Selected elements of the strategies that guided the development of this material and should guide its implementation and use are listed below.

How people learn best

People learn best when the following conditions are met:

- Participants are motivated and not anxious, know what is expected of them and treated with respect
- Information and skills are interesting, exciting, meaningful, and build on what participants already know, encourage problem-solving and reasoning
- Experiences are organized, logical, practical, include a variety of methods, and protocols and procedures are available
- New learning experiences are relevant to work and training needs of participants, and are applied immediately
- Training involves every participant in active practice and participants share responsibility for learning
- Training is a team activity, including trainers and co-trainers, providing participants with a variety of experiences and limiting trainer's biases
- The trainer acts as a facilitator of the learning process rather than a teacher who "spoon feeds" the learner
- The role and responsibilities of the trainers/facilitators and those of the participants/learners are clearly defined with:

- The facilitators responsible for providing the learners with the necessary opportunities to acquire the knowledge and skills necessary to perform the tasks for which they are being trained
- The facilitators responsible for providing the learners with the necessary opportunities to be exposed to the attitudes necessary to implement the acquired skills in a systematic manner and initiate the process of internalizing these attitudes
- The learner remains responsible for her/his learning

The transactional relationships between the learners and the facilitators are at the level of adult to adult characterized by mutual respect and support

- Trainers are knowledgeable and competent in the subject matter and skills, use a variety of training methods, pay attention to individual participants' concerns, and provide motivation through feedback and reinforcement
- Participants must be selected according to specific criteria, such as the relevance of the training content to the job expectations/tasks
- Participants must have the necessary prerequisite level to enable them to benefit from the learning experience
- Feedback is immediate and focused on behavior that the participants can control
- Assessment of learning and skills is based on objectives that the participants understand

Knowledge, skills and attitudes

This course aims to improve health care by changing health workers' knowledge, skills and attitudes.

- Knowledge includes the facts that the participants need to know to perform their jobs.

Tips on increasing **knowledge** through training

- Start with what the participants already know or have experienced
 - Use a variety of educational resources, including participatory activities that require participants to use their knowledge
 - Use learning aids
 - Review and summarize often
 - Assess knowledge to verify learning
- Skills include the specific tasks that participants need to be able to perform.

Tips on increasing *skills* through training

- *Describe the skill*
 - *Provide protocols and procedures*
 - *Demonstrate the skill*
 - *Have participants demonstrate the skill*
 - *Verify that each skill is practiced correctly*
 - *Assess skill by observation using a checklist*
- Attitudes affect behaviors, such as whether learned skills are applied and interactions with clients.

Tips on changing *attitudes and behavior* through training

- *Provide information and examples*
- *Include direct experience*
- *Invite discussion of values, concerns and experience*
- *Use role plays and brainstorming*
- *Model positive attitudes*
- *Assess changes in attitude by observing behavior*

Methods

The training will use a participatory and “hands on” approach where the role of the trainers is to facilitate learning by the participants. The responsibility for learning remains with the participants.

Participants learn more and stay engaged in learning activities when they play an active role in their learning and a variety of training methods are used. The following methods are recommended in the curriculum/modules.

Selected Training Methods

| | | |
|-------------------------|------------------------|--------------------------|
| Brainstorming | Individual assignments | Return demonstration |
| Case study | Individual exercises | Role play |
| Clinical session | Interview | Self-directed activities |
| Demonstration | Mini-lecture | Small group discussion |
| Discussion | Observations | Simulation |
| Field visits | Pairs exercises | Small group exercises |
| Plenary group exercises | Presentation | Summary |
| Group assignments | Questions and answers | Survey |
| | Research | Team building exercises |

In each module or session

This document contains an outline of a training plan for each of the key areas of content.

Each module contains the following sections:

- Front page with a module number, module objectives, module content by session and an estimated duration for the module.
- Session plans covering the various content areas.

Each session contains the following sections:

- **Trainer Preparation:** This section lists the specific preparations that trainers should make for the session. Preparations for every session include:
 - Making sure the room is properly arranged
 - Ensuring that markers and flip chart or a writing board with chalk or markers are available
 - Reviewing the training plan
 - Reviewing steps for the methods used in the training session
 - Ensuring that the resources needed to facilitate the learning process are available including copying materials that participants need
- **Methods and Activities:** This section lists the methods and activities that are used in the module. General instructions for methods that are frequently used are included in this introductory material. Instructions for participatory activities are included in the training plan.
- **Resources:** The relevant reference materials/handouts and other resources needed are listed here.
- **Evaluation/assessment:** Evaluation methods for the knowledge or skills included are listed. Questionnaires and skills checklists are included where needed.
- **Estimated Time:** The time that each session/module will require depends upon the particular group of participants, the amount of time available and other constraints. The module gives a general time range to allow for flexible scheduling.
- **Training Plan:** This section gives the specific learning objectives or purpose of a session, the key **”must know”** content, and the appropriate training methods and activities for each objective. All modules include one or more activities that give participants structured, participatory practice with the content of the module.
- **Handouts:** When specific activities require handouts, these are included after the training plan and should be copied before the session in which they will be used.

- **Questionnaires:** Each session/module includes a questionnaire that is tied to the learning objectives and a key with the correct answers. It is not appropriate to assign a pass or fail designation to the questionnaire. Instead, use the questionnaire as a learning tool. It must be used for **formative evaluation**. If participants are not certain of the answers, they should be encouraged to use the training resources to find the correct answer. Answer key must be given to the participants after finishing the processing of the responses.
- **Skills Checklists:** Each session that includes skills objectives includes a skills assessment checklist. The checklist is used by the trainer to evaluate the participant's skill based on observation of the specific steps included in the skill. The skills checklists are also used by each participant to assess their performance and take charge of their own learning. They can also be used by other participants for peer assessment. It is recommended that these checklists not only be used during training to assess the acquisition of skills, but also for post training evaluation and supervision.

Note: There are various possible formats for modules and sessions. Provided the necessary information is included for the trainer to use, the selection of format will depend on how comfortable the trainers are in using it.

Methods frequently used in this curriculum

Instructions for methods used frequently in this training course are included here. Activities for specific methods are included with the sessions where they are used.

Mini-lecture

Trainer makes a short (5 to 15minutes) presentation using the materials available. Mini-lectures are used to provide information and knowledge. They insure that all participants have an adequate level of information and insure standardization and uniformity of this information. Mini-lectures should be kept short and should be followed by questions and answers for clarification to enable participants to better understand the content of the session/module and clarify issues, and questions and answers for evaluation to ensure comprehension.

Questions and Answers (Q&A)

Questions and answers sessions are used to recall information or elicit participants' knowledge (in introductory sessions in order to assess training needs), for clarification (to ensure that participants understand information/content), presentation of information (to elicit information that participants may already know) and evaluation (to assess acquisition of knowledge and fill gaps in participants' knowledge).

Steps for Questions and Answers for clarification

1. Trainer asks participants if they have questions
2. If a participant has a question, trainer asks another participant to answer
3. If the participant's answer is correct and complete, trainer reinforces
4. If the participant's answer is incorrect and/or incomplete, trainer may ask questions that lead the participant to a more correct answer or ask another participant to answer
5. If the answer is still incorrect and/or incomplete after two or three trials, trainer corrects and/or completes and informs the participants where to find the information
6. If there are no questions, trainer asks questions to verify knowledge and follows the same steps (3, 4, 5)

Steps for Questions and Answers to elicit information from participant (s)

1. Trainer asks participants questions
2. If a participant's answer is correct and complete, trainer reinforces
3. If the participant's answer is incorrect and/or incomplete, trainer may ask questions that lead the participant to a more correct answer or ask another participant to answer
4. If the answer is still incorrect and/or incomplete after two or three trials, trainer corrects and/or completes and informs the participants where to find the information

Steps for Questions and Answers for evaluation

1. Trainer asks participants questions
2. If a participant's answer is correct and complete, trainer reinforces
3. If the participant's answer is incorrect and/or incomplete, trainer may ask questions that lead the participant to a more correct answer or ask another participant to answer
4. If the answer is still incorrect and/or incomplete after two or three trials, trainer corrects and/or completes and informs the participants where to find the information

Brainstorming

Brainstorming is an excellent way to find out what participants already know and gaps in their knowledge. Brainstorming brings participants experience into the classroom and lets the participants know that their experience is valuable.

Brainstorming is also a very effective way for problem solving.

A brainstorming session should always end with a summary.

Steps for brainstorming

1. Trainer asks an open-ended question
2. Participants shout out their answers or ideas:
 - Until no more ideas are generated, or at least every participant has a chance to contribute or time allocated has run out
 - No ideas are discarded criticized or analyzed, but clarifying questions can be asked
3. Trainer records ideas on newsprint or in another format where all can see them
4. Trainer leads a discussion of each of the ideas generated
5. Trainer clearly marks ideas that are agreed upon
6. Trainer summarizes or asks participants to summarize points of agreement
7. Trainer moves to the next question only after finishing discussion of previous question
8. Ideas generated in brainstorming can be used for summarizing, as input to group exercises, and to relate content to participant experience

Case study

A case study is method of training whereas data/information about a case, preferably a real one or based on one, is presented to the participants for review and analysis. It includes specific questions to be answered. Case studies are a very effective way to allow participants to practice using information to solve problem, the highest level of knowledge objective. They are also effective in providing participants opportunities to explore their attitudes and confront/compare them with other participants and trainers' attitudes. Moreover case studies allow for the identification of gaps in knowledge.

Participants, individually or in small groups are asked to study the case and prepare responses to the questions. The responses are then processed. During the processing the trainer must encourage and ensure that all participants get a chance to provide inputs. Processing can be done using questions and answers and/or discussion.

The questions must be answered in an orderly manner in the sense that each question must be answered fully and the inputs summarized before moving to the next question. Answer key must be given to the participants after the processing of the case study.

Case studies can be presented in different format. They can be based on the presentation of a real patient, the files of a patient, a written description of a case, an illustration such as a photograph or slides of a case, or a video.

This method is not used in this curriculum but trainers can develop case studies based on local conditions/data as additional exercises if time permits.

Discussion

Discussion is indicated when the outcome is not predetermined in advance and is “still negotiable”. Therefore using discussion to provide “scientific” knowledge/information or a decision that has already been made and not to be changed can lead to frustration.

Discussion in plenary or in small groups is recommended to explore attitudes, values and opinions. It is also indicated to confront/compare different options of “doing things” ensuring that the “why” is covered.

During the discussion the trainer’s role is to facilitate the process, and ensure that the discussion remains “on track” and that every participant gets a chance to contribute.

When small groups do not have the same assignment/topic to discuss, each group presents their output(s) and discussion follows immediately after the presentation before moving to the next group. Time management is essential to ensure that no group gets “short changed” and has ample time for the presentation and discussion.

If all the groups have the same assignment, all groups present before discussion takes place. Only clarification questions are allowed during the presentation. Processing the output(s) must focus on the points of agreement before moving to the differences.

If time does not allow for all groups to present, one group can present and the other groups complete from their own group’s output before discussion starts.

Every discussion must be followed by a summary.

Demonstration

Demonstration is a very effective way to facilitate learning of a skill or initiation of the development of an attitude. The facilitator should use this method to show the skill(s) and/or the attitude(s) addressing more than one sense at a time. Often a demonstration can effectively replace a presentation provided the facilitator explains as s/he is doing.

A demonstration should always be followed by a Q/A for clarification session before the learners are required to do a return demonstration.

Steps for a demonstration

1. Trainer assembles resources needed for the demonstration
2. Trainer ensures that participants are ready, can hear and see
3. Trainer explains what s/he is going to do
4. Trainer instructs participants on what is expected of them (e.g. to observe closely, to take notes if appropriate, to use the skills checklist when appropriate etc.)
 - To prepare for the Q/A, and
 - Because they are required to do return demonstration(s) for practice

5. Trainer demonstrates while explaining the skill(s)/attitude necessary for each step of the procedure being demonstrated
6. Trainer conducts a Q/A for clarification at the end of the demonstration

Return demonstration

Return demonstrations provide the learners with the opportunity to practice the skills necessary to perform the procedures they are being trained on. The trainer must ensure that each learner/participant has the opportunity to practice **enough times to reach a preset minimum acceptable level of performance.**

Steps for a return demonstration

1. Trainer reminds participants of what is expected of them:
 - To practice the procedure/skills
 - To observe when others are practicing to be able to ask for clarification
 - To observe when others are practicing to be able to provide feedback and peer evaluation
2. Trainer divides participants into small groups, if more than one workstation.
(**Note:** each workstation requires at least one facilitator/trainer).
3. Participants take turns practicing the procedure/skills
4. Trainer ensures that all participants can hear and see
5. While each participant is practicing trainer can provide guidance as necessary provided it does not interfere with the process and confuse the participant
6. After each participant, trainer solicits feedback from other participants
7. After feedback from other participants, trainer reinforces what is correct and corrects and/or completes feedback
8. Each participant needs to practice more than once or until control of the skill, as time permits
9. If participant(s) need more than time permits, trainer arranges for additional practice opportunities

Simulation/simulated practice

A simulated practice is a very effective method to allow participants to practice procedures/skills in an environment that recreates as closely as possible the “real world” without the stress involved in practicing procedures/skills that they do not control yet in the field. It is recommended to have participants practice on models before they do perform the procedure/ use the skill in the work place. During a simulation the participant practices tasks that are part of her/his actual role in the workplace or that s/he will perform in the job s/he is being trained for.

Use the same steps as for a demonstration/return demonstration practice.

Role play

Role plays are a very effective method to practice procedures/skills in the training room. They are especially effective to practice procedures/skills that deal with human interactions such as health education and counseling sessions. They are also very effective when the learning objective deal with attitudes.

In a role play participants “play roles” that are not necessarily their roles in the “real world”. Often they are asked to play the role of someone they would be dealing with. In this case it is called “role reversal” or “reverse role play”. This allows the participants to explore and discover how other perceive/live the interaction.

A role play must always be processed to analyze the lessons learned.

Summary

Every time a training method allows for inputs through exchanges between the trainer(s) and the participants and between the participants themselves, it must be followed by a summary session to “tie up the loose ends” and provide the participants with clear answers. If this does not happen there is the likelihood that the participants will forget the “correct” answers.

A summary can be done by the trainer to ensure that there are “no loose ends”. If time permits, it is recommended to use the summary for evaluation. In this case the trainer can use the Q/A method.

Steps for a summary for evaluation

1. Trainer asks a participant to summarize
2. Trainers reinforces if the summary is correct/complete
3. Trainer asks another participant to correct/complete if the summary is incorrect/incomplete
4. Trainer repeats steps 2 and 3
5. Trainer corrects/completes if after 2 or 3 trials the summary is still Incorrect/incomplete.

Evaluation

Evaluation of learning and training objectives

Evaluation or assessment of learning and of training objectives allows trainers, program managers and participants to know how successful a training program has been. On-going evaluation and assessment allows trainers to identify gaps in learning and to fill those gaps. Evaluation also assists in revising learning experiences for later trainings.

Many strategies can be used to evaluate learning. Some of the most useful methods include:

- Knowledge assessments: Written or oral questions that require participants to recall, analyze, synthesize, organize or apply information to solve a problem. The knowledge component of a skill objective should be assessed prior to beginning skill practice in a training room or clinical session.
- Questionnaires: Written exercises that assist trainers and participants to identify and fill gaps in knowledge. Questionnaires can be administered as self-assessments. In some situations, it may be reasonable to have participants use course materials or to work together on questionnaires.
- Skill checklists: Observation of a participant performing a skill and assessment of the performance using a checklist. Simulated practice (using real items or models in a situation that is similar to actual practice) should ideally be assessed prior to beginning clinical practice with clients. Checklists should be used by the trainer and other participants to observe simulated (training room) performance and actual practice and provide feedback to help improve the performance. The checklists can also be used by the participant for self-assessment. During the training participants should be trained on how to use the checklists and encouraged to use them after the training to continue assessing their own performance and improving it.

Additional techniques for evaluation include: projects, reports, daily reflection, on-site observation, field performance, and discussion.

Each training module includes assessment of learning methods and tools:

- Questions and Answers should be used to frequently identify gaps in knowledge and fill them.
- Questionnaires are included with every module and can be used for self-assessment. To use them as self-assessment, participants fill out the questionnaire and then use any course materials to check their own answers. Trainers should work with participants filling out the questionnaires to make sure that all gaps in knowledge are filled before practicing and evaluating skills. When time permits, process responses in plenary to address any issues and fill the gaps in knowledge. At the end of this activity the answer key needs to be distributed to the participants.
- Skills Checklists are included for each of the skills that are included in this training curriculum. Participants can use the Skills Checklists as learning guides during practice sessions in training room or clinical sessions. To evaluate skills, trainers should generally observe participants three times with coaching as needed to ensure the skills are learned.

Evaluation of the participants

The evaluation of the learning by participants will be done through questions and answers, synthesis of sessions done by selected participants, self-assessment following the micro-sessions, peer assessment through feedback provided by other participants following the micro-sessions and assessment of performance by facilitators.

Each participant will practice more than once, preferably three times” the use of the curriculum to plan, organize, conduct and evaluate the training through simulated micro-sessions. A checklist will be used both by participants for self and peer assessment, and by the facilitators.

Videotaping the micro sessions or at least significant segments of the micro sessions and reviewing the taped segments after each session will enable the participants to assess their own progress in terms of acquisition of training/facilitation skills. This approach to evaluation although time consuming is very effective in helping participants assess their own performance and stabilize feedback received from their peers and from the trainers/facilitators.

Post training evaluation of the learners must be conducted within three (3) to six (6) months after the end of the training. Further post training evaluation and follow-up can be integrated into routine supervision. It is highly recommended to use the skills checklists used during the training for post training evaluation and follow-up.

Evaluation of the training

The “End of Training” evaluation can be done through a questionnaire (form 1) whereby the participants are asked to respond and express their opinions about various aspects of the workshop, such as organization, the process, the facilitation, and a general assessment.

The “End of module” evaluation can be done through a questionnaire (form 2) whereby the participants are asked to respond and express their opinions about various aspects of the module, such as the relevance of the module objective to the course ones, the relevance of the content to the objectives, the adequacy of the content, the presentation of the content, the effectiveness of the methodology, the facilitation and the sequencing of the content.

A confidence/satisfaction index can be calculated to determine how confident the learners feel that they acquired the knowledge and skills necessary to perform the tasks they have been trained for, and how committed they feel to using those skills to ensure the quality of the services they are to provide. The confidence index applies to the training objectives and acquisition of skills and knowledge and to the degree to which the participants feel that they are able to apply what they have learned during the training. The satisfaction index applies to the organization and implementation of the training.

The items are labeled in the form of statements followed by a scale 5 (Strongly Agree), 4 (Agree), 2 (Disagree), and 1 (Strongly Disagree), where 5 represents the highest level of

satisfaction/confidence (agreement with the statement) and 1 represents the lowest. The participants are asked to select the level that expressed their opinion best. A space for comments is provided after each statement.

The confidence and satisfaction indices are calculated by multiplying the number of respondents by the correspondent coefficient in the scale, then adding the total. The total is multiplied by 100. The product is divided by the total number of respondents to the statement multiplied by 5. 60% represents the minimal acceptable level and 80% a very satisfactory level of performance.

For example, if the total number of respondents is 19 and 7 of them selected 5 on the scale, 6 selected 4, 4 selected 2, and 2 selected 1, then the index will be $(5 \times 7) + (4 \times 6) + (2 \times 4) + (1 \times 2)$ multiplied by 100, divided by (5×19) . A 100% index would if the total number of respondents selected 5. In this case it would be 95. In this example the index is 72.63%.

The training content and process are evaluated on a continuing basis through daily evaluations using methods such as “things liked the best” and “things liked the least” and/or “quick feedback” forms. The facilitators will use the results of this evaluation during their daily meeting to integrate the feedback and adapt the training to the participants needs.

“Where Are We?” sessions will be conducted with the participants to assess the progress in content coverage and process towards reaching the training goals and learning objectives.

Comments are analyzed and categorized. Only significant comments, those mentioned more than once and/or by more than one participant, are retained. The facilitators need to use the results of this evaluation during their daily meeting to integrate the feedback and adapt the training to the participants needs. Feedback and assessment of training experiences allows trainers and program managers to adapt training to better meet participants’ needs. Trainers can also assess their own performance in facilitating the learning experience of participants using a standardized “facilitation skills” checklist (form 4).

Form 1: END OF COURSE EVALUATION QUESTIONNAIRE

TRAINING CENTER

DATE

COURSE TITLE:

INSTRUCTIONS

This evaluation will help adapt the course to your needs and to those of future participants.

It is anonymous. Please respond freely and sincerely to each item. The items are labeled in the form of statements followed by a scale where:

- 5 = **strong** agree
- 4 = agree

- 2 = disagree
- 1 = **strongly** disagree

Please circle the number that expresses your opinion; the difference between **strongly** agree and agree, and between **strongly** disagree and disagree are a matter of intensity.

Add your comments in a specific and concise manner, in the space provided after each statement. If that is not sufficient feel free to use extra paper. If you select 2 or 1, make sure to suggest how to make the situation better, practical, and offer solutions.

N.B: Course goals objectives and duration will vary based on the type of training conducted. Adapt the form to each specific course by including in it the relevant course items.

COURSE GOALS

The Course Achieved Its Goals

1. To provide the participants with the opportunities to acquire/update the knowledge and skills necessary to:

| | |
|--|---------|
| 1.1 Play an effective role as a member of the PHC Center team to improve the quality of care and services | 5-4-2-1 |
| Comments: | |
| 1.2 Use the team approach to solve problems at the PHC center level | 5-4-2-1 |
| Comments: | |
| 2. Provide the participants with opportunities to be exposed to and initiate the development of attitudes favorable to the systematic use of the knowledge and skills acquired in team building and problem solving to improve the quality of care and services | 5-4-2-1 |
| Comments: | |

COURSE OBJECTIVES

1. The course helped me reach the stated objectives:

| | |
|--|---------|
| 1.1 Apply the team approach principles to play an effective role as a member of the Model PHC Center service delivery team | 5-4-2-1 |
| Comments: | |
| 1.2 Use the team approach to implement the problem solving cycle to solve service delivery and management problems at the PHC Center level | 5-4-2-1 |
| Comments: | |
| 1.3 Explain the importance of being an effective team member of the Model PHC Center to improve the quality of care and services | 5-4-2-1 |
| Comments: | |
| 1.4 Explain the importance of using the team approach to implement the problem solving cycle to solve service delivery and management problems at the Model PHC center | 5-4-2-1 |
| Comments: | |

2. The course objectives are relevant to my job description / task I perform in my job

5-4-2-1

Comments:

3. There is a logical sequence to the units that facilitates learning

5-4-2-1

Comments:

ORGANIZATION AND CONDUCT OF THE COURSE

1. Time of notification was adequate to prepare for the course 5-4-2-1

Comments:

2. Information provided about the course before arriving was adequate 5-4-2-1

Comments:

3. Transportation arrangements during the course were adequate (if applicable) 5-4-2-1

Comments:

4. Training site (Training Center) was adequate 5-4-2-1

Comments:

5. The educational materials (including reference material) used were adequate both in terms and quantity and quality in relation to the training objectives and content 5-4-2-1

Comments:

6. The methodology and technique used to conduct the training were effective in assisting you to reach the course objectives 5-4-2-1

Comments:

7. Clinic/ practice site, as applicable, was adequate 5-4-2-1

Comments:

8. Relationships between participants and course managers and support staff were satisfactory 5-4-2-1

Comments:

9. Relationships between participants and trainers were satisfactory and beneficial to learning 5-4-2-1

Comments:

10. Relationships between participants were satisfactory 5-4-2-1

Comments:

11. The organization of the course was adequate (Time, breaks, supplies, resource materials) 5-4-2-1

Comments:

Additional comments:

GENERAL ASSESSMENT

1. I can replicate this training in my future work 5-4-2-1

Comments:

2. I would recommend this training course to others 5-4-2-1

Why or Why Not?

3. The duration of the course (10 days) was adequate to reach all objectives and cover all necessary topics 5-4-2-1

Comments:

General comments and suggestions to improve the course (Please be specific)

Form 2: END OF MODULE EVALUATION QUESTIONNAIRE

COURSE: DATE:

MODULE NUMBER & TITLE:

INSTRUCTIONS

This evaluation is intended to solicit your opinions about the modules. Your feedback will help adapt the course to your needs and to those of future participants.

It is anonymous. Please respond freely and sincerely to each item. The items are labeled in the form of statements followed by a scale where:

- 5 = **strongly** agree
- 4 = agree
- 2 = disagree
- 1 = **strongly** disagree

Please circle the number that best expresses your opinion; the differences between **strongly** agree and agree, and between **strongly** disagree and disagree are a matter of intensity.

Add your comments in a specific and concise manner in the space provided after each statement. If that space is not sufficient feel to use extra paper. If you select 2 or 1, make sure to write specific comments on how to improve the module.

EVALUATION ITEMS

| | |
|---|------------|
| 1. The module objectives are relevant to the course objectives Comments: | 5- 4- 2- 1 |
| 2. The content / topics covered in the unit are relevant to the objectives Comments: | 5- 4- 2- 1 |

| | |
|--|------------|
| | |
| 3. The content / topics were adequate to help me achieve the objectives Comments: | 5- 4- 2- 1 |
| 4. The content / topics were clear and well-presented Comments: | 5- 4- 2- 1 |
| 5. The training methods and activities were effective in facilitating learning Comments: | 5- 4- 2- 1 |
| 6. The training methods and activities were conducted adequately to facilitate learning Comments: | 5- 4- 2- 1 |
| 7. These are important topics that will enable me to better perform my job Comments: (specify these points) | 5- 4- 2- 1 |
| 8. There is a logical sequence to the sessions and topics that facilitates learning Comments: | 5-4- 2- 1 |

| | |
|--|------------|
| | |
| <p>9. There are certain topics that need further clarification</p> <p>Comments: (specify these points)</p> | 5- 4- 2- 1 |
| <p>10. The training materials and resources provided were adequate</p> <p>Comments:</p> | 5- 4- 2- 1 |
| <p>11. Training materials and resources were provided on time to facilitate learning</p> <p>Comments:</p> | 5- 4- 2- 1 |
| <p>1. The training materials and resources used were adequate to facilitate my learning</p> <p>Comments:</p> | 5-4-2-1 |
| <p>14. The training site was adequate</p> <p>Comments:</p> | 5- 4- 2- 1 |

| | |
|--|------------|
| 5. The clinic/ practice site was adequate (if applicable) Comments: | 5- 4- 2- 1 |
|--|------------|

General comments (if any not covered):

Form 3: QUICK FEEDBACK FORM

TRAINING COURSE: DATE:

LOCATION:

MODULE NUMBER AND TITLE:

SESSION NUMBER AND TITLE:

INSTRUCTIONS

This evaluation is anonymous. Please respond freely and sincerely to each item. The items are labeled in the form of statements followed by a scale where:

5 = **strongly** agree

4 = agree

2 = disagree

1 = **strongly** disagree

Please circle the description that expresses your opinion best; the difference between strongly agree and agree, and between strongly disagree and disagree are a matter of intensity.

Add your comments in a specific and concise manner, if you have any, in the space provided after each statement. If that space is not sufficient feel free to use extra paper. If you selected 2 or 1 please make sure to give comments (e.g. why? Solutions?)

1. The session objectives are relevant to the tasks in the job description

5- 4- 2- 1

COMMENTS

2. The methods/learning activities were adapted to the objectives 5- 4- 2- 1

COMMENTS

3. The materials provided were adequate to cover all of the content 5- 4- 2- 1

COMMENTS

4. The time allocated to the session was adequate to cover all the topics 5- 4- 2- 1

COMMENTS

5. The facilitation (conduct of the session) helped reach the session objectives 5- 4- 2- 1

COMMENTS

6. The content of the training was clearly presented 5- 4- 2- 1

COMMENTS

7. The materials/resources were used in a way that helped me learn 5- 4- 2- 1

COMMENTS

8. There are points of content that need further clarifications
(Specify what specific content areas)

Other comments:

Form 4: TRAINING SKILLS CHECKLIST

This checklist is used with the relevant curriculum to give feedback on the trainer's performance.

The checklist contains a list of items to be observed:

- If they are observed a check mark (√) is entered in the column observed under **adequate** or **inadequate** depending on the performance.
- Comments are entered in the appropriate column to clarify/specify what is observed or not observed.
- Is not observed a check mark (√) and comments are entered in the appropriate columns.

The finding and comments are analyzed and discussed with the trainers supervised. Any immediate corrective action(s) taken and further action(s) needed must be entered in the spaces provided.

The trainers supervised must be given an opportunity to comment and the comments must be entered in the appropriate space. The form must be dated and signed by the trainer and the supervisor. It is then filed in the trainer's file for future follow-up and reference.

Legend: A = Adequate NA = NOT adequate NO = NOT observed

| Items | Observed | | NO | Comments |
|---|----------|----|----|----------|
| | A | NA | | |
| 1. <u>Planning of the session</u> <ul style="list-style-type: none"> • Relevant sessions plan selected from curriculum • Organization conduct and evaluation of training in conformity with curriculum (based on observation during the session) | | | | |
| 2. <u>Organizing the session</u> <ul style="list-style-type: none"> • Arrive before beginning of session • Ensure that all training resources are in place • Ensure that equipment is in working condition • Ensure that training site is set up in accordance with the requirements of the training objective (s) and methodology | | | | |

| <ul style="list-style-type: none"> • Prepared/rehearsed for the training (based on observation of mastery in conducting activities and using resources during training) | | | | |
|---|----------|----|----|----------|
| Items | Observed | | NO | Comments |
| | A | NA | | |
| <p>3. <u>Conducting the session</u></p> <p>3.1 <u>Introduction</u></p> <ul style="list-style-type: none"> • Introduce oneself <ul style="list-style-type: none"> - Name - Job - Experience relevant to topic • Introduce/let team members introduce themselves • Module: <ul style="list-style-type: none"> - Introduce topic - Present objective - Clarify topic and objectives - List sessions - Establish linkage with job/task • Session <ul style="list-style-type: none"> - Introduce topic - Present objectives - Clarify topics and objectives - Establish linkage with module - Establish linkage with preceding session(s) - Explain methodology • Present evaluation methodology • State estimated duration <p>3.2 <u>Facilitation skills</u></p> <p>➤ <u>Clarifying</u></p> <ul style="list-style-type: none"> • Make sure participants are ready before starting on any content item • Make sure participants can hear: <ul style="list-style-type: none"> - Trainer - Other participants • Make sure participants can see: <ul style="list-style-type: none"> - Writing - Illustrations/ educational aids | | | | |

| <ul style="list-style-type: none"> - Trainer - Each other • Make sure s/he look at participants • Make sure s/he can hear participants • Use appropriate educational material • Summarize after each content topic item before moving to next topic • Use examples relevant to objectives, content, and participants learning | | | | |
|--|----------|----|----|----------|
| Items | Observed | | NO | Comments |
| | A | NA | | |
| <ul style="list-style-type: none"> ➤ <u>Ensuring Active Participation</u> • Ask participants questions • Allow participants to ask questions • Allow participants to question/discuss/make contributions • Ensure that all participants contribute • Provide participants with opportunities to practice • Adapt to participants' learning capability (speed, learning activities, use of educational material) • Encourage participants through: <ul style="list-style-type: none"> - Listening - Letting participants complete their interventions - Not being judgmental - Maintaining cordial relationships with participants ➤ <u>Mastering Training</u> • Conduct the learning activities as per session plan • Use the training resources/ materials as per plan • Cover content adequately (relevant, clear, concise, complete, concrete, credible, consistent and correct) • Follow curriculum for learning/training activities • Use content as per curriculum <p><u>1. Evaluating learning/training</u></p> | | | | |

| | | | | |
|---|--|--|--|--|
| <p><u>process</u></p> <ul style="list-style-type: none"> • Check that participants understand • Check that participants learn skills • Provide supportive feedback by: <ul style="list-style-type: none"> - Reinforcing the positive learning - Correcting any errors - Correcting any incomplete learning • Listen to participants comment about one's performance (without making it personal) • Adapt one's performance based on feedback from participants • Allow participants to answer questions asked by the group | | | | |
|---|--|--|--|--|

Additional comments or observations

Analysis of findings

Action (s) taken

Further action (s) needed

Trainer's comments

Date:

Trainer's name & signature

Supervisor's name & signature

Part Two:

Training Modules

Module One: Clinical Care Guidelines

Module objectives:

- 1- Understand steps for management of trauma
- 2- Understand the process of sterilization and disinfection
- 3- Explain key points for early detection of the non-communicable diseases (Asthma, Hypertension and diabetes) the their management
- 4- Illustrate importance of primary and secondary survey in the management of traumatized patient
- 5- Explain the triple assessment pathway for managing breast lump

Module sessions:

- **Session 1:** Management of Trauma and Instrument Sterilization
- **Session 2:** Non Communicable Diseases
- **Session 3:** Obesity and Nutrition
- **Session 4:** Women`s Health (breast Cancer and premarital counseling)

Evaluation/ Assessment

Questions and answers, participants' summaries, trainer's evaluation

Estimated Training Time

10 hours

Session 1: Management of Trauma and Instrument Sterilization

Specific objectives of the session

At the end of the session the participants will be able to:

- Explain elements of primary survey (BLS)
- Explain elements of secondary survey
- Illustrate steps of instrument sterilization and HLD

Trainer preparation

- Review the reading material and the session plan.
- Prepare the presentation as appropriate and as recommended in the method column of the session plan, or write the information on a flipchart or board where all participants can see it.
- Prepare copies of the reference materials/handouts and exercises.
- Arrange the training room.

Methods and activities

Mini-lecture, demonstration and

Resources

- Reference material/handouts
- Other: MoH documents, markers, masking LCD projector

Evaluation/assessment

Questions and answers, trainer's observation

Trainer

Have knowledge in emergency management

Estimated training time

75 minutes

Session Plan

| Objectives | Content | Methodology |
|---|--|---|
| 1.1.1 explain elements of basic life support (primary survey) | <ul style="list-style-type: none"> ➤ Primary Survey include ➤ Airway Maintenance and Cervical Spine Protection ➤ Breathing ➤ Circulation and Hemorrhage Control ➤ Disability ➤ Exposure and Environmental Control | <ul style="list-style-type: none"> - Mini lecture (20 minutes) - Questions and answers (10 minutes) |
| 1.2.2 Explain elements of secondary survey | <ul style="list-style-type: none"> ➤ 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 | <ul style="list-style-type: none"> - Demonstration and re – demonstration - (30 minutes) |
| 1.2.3 Illustrate stages for instruments sterilization and HLD | <ul style="list-style-type: none"> ➤ There are four main steps for instruments sterilization: ➤ Stage 1: Soak in water or soapy water ➤ Stage 2: Scrub clean ➤ Stage 3: Instruments must be fully dry ➤ Stage 4: Pack ➤ Stage 5: Sterilization ➤ For HLD the stages are followed but the without the usage of autoclave, instead boil it for 20 minutes. | Mini lecture (15 minutes) |

1.1.1 Elements of basic life support (primary survey)

Primary Survey include

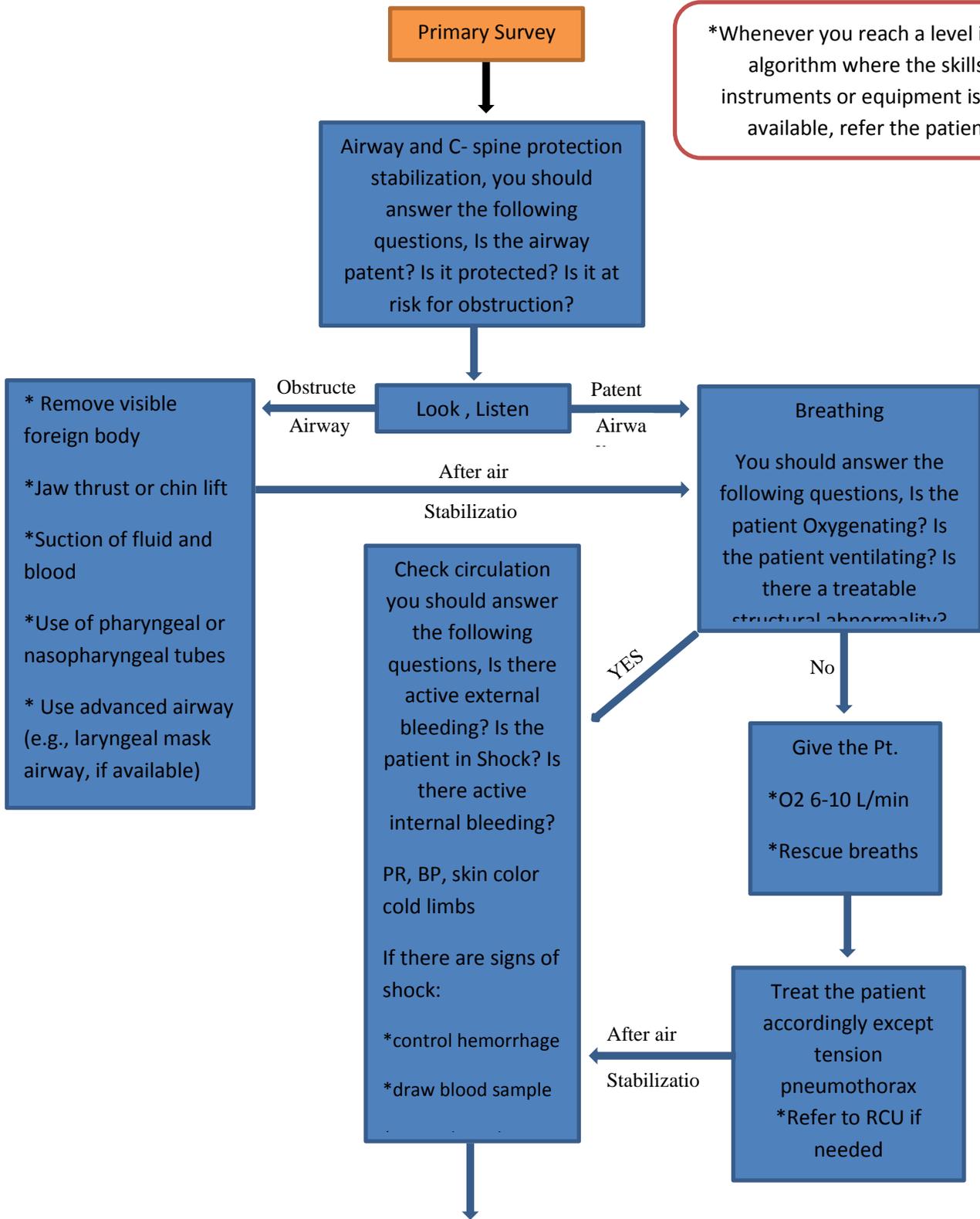
- Airway Maintenance and Cervical Spine Protection
- Breathing
- Circulation and Hemorrhage Control
- Disability
- Exposure and Environmental Control

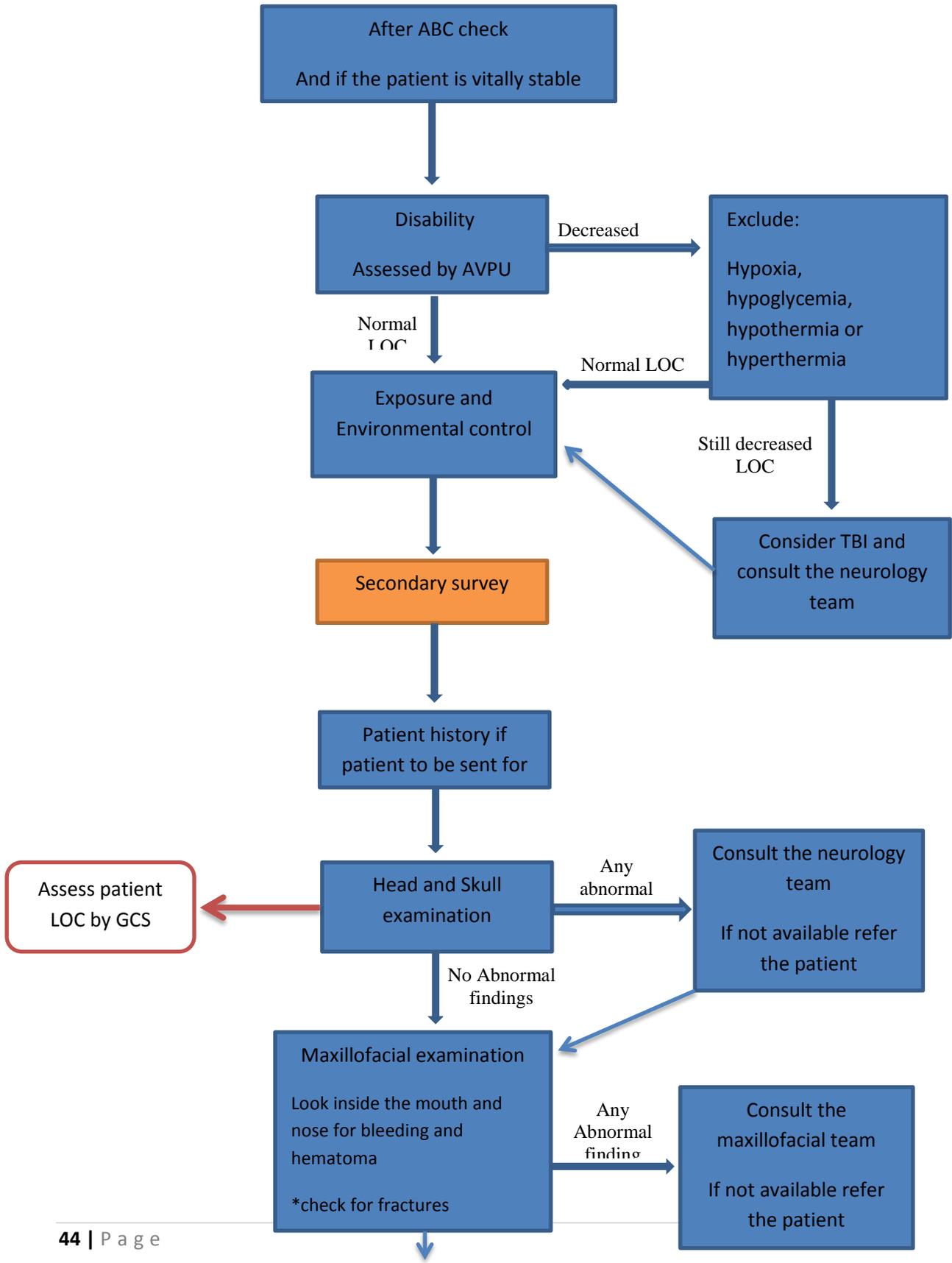
1.2.2 Elements of secondary survey

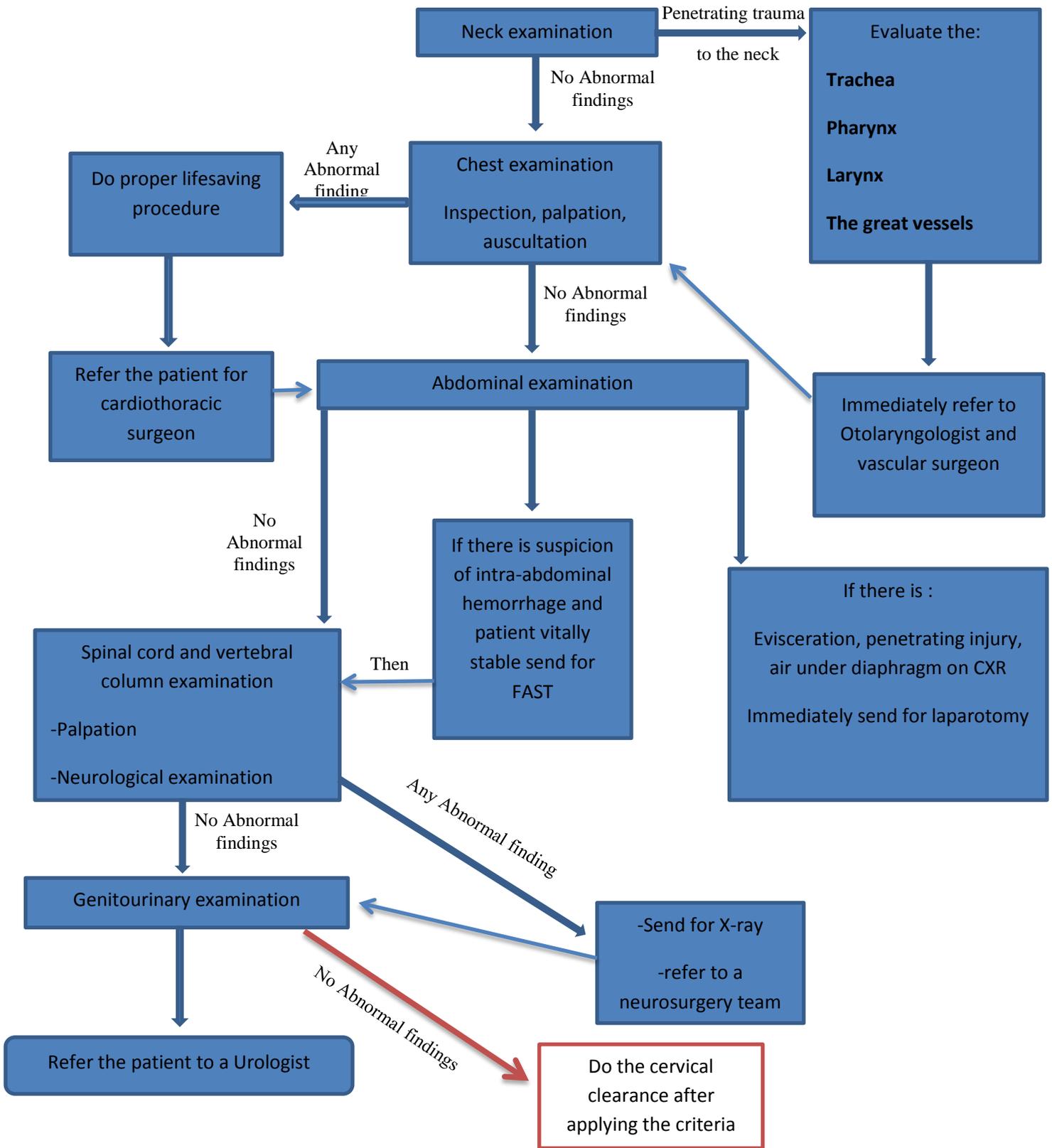
Secondary Survey include

- 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

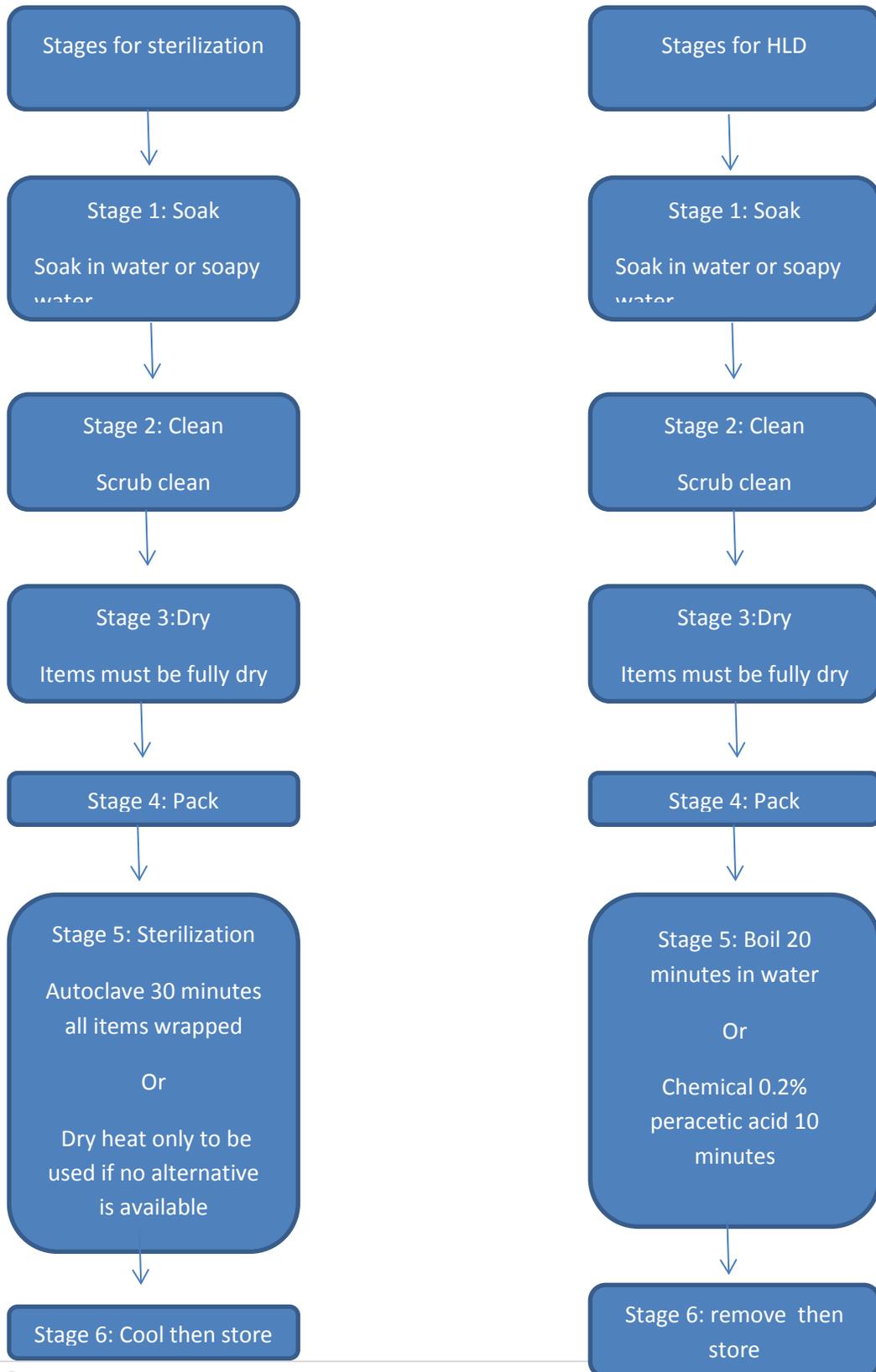
*Whenever you reach a level in the algorithm where the skills, instruments or equipment is not available, refer the patient







1.2.3 Illustrate stages for instruments sterilization and HLD



Session 2: Non Communicable Diseases

Specific objectives of the session

At the end of the session the participants will be able to:

- Classify clinical types of diabetes
- Explain diagnostic features of diabetes
- Identify lines of treatment and follow up in patients with diabetes
- Define asthma and its triad
- Classify Asthma according to severity
- Enumerate goals of asthma management
- Explain medication used for the treatment of different stages of asthma for each degree of asthma
- Define Hypertension
- Enumerate six risk factors for cardiovascular diseases
- Explain clinical assessment of patients with hypertension

Trainer preparation

- Review the reading material and the session plan.
- Prepare the presentation as appropriate and as recommended in the method column of the session plan, or write the information on a flipchart or board where all participants can see it.
- Prepare copies of the reference materials/handouts and exercises.
- Arrange the training room.

Methods and activities

Mini-lecture, demonstration and re-demonstration, mini lecture and brain storming

Resources

- Reference material/handouts
- Other: MoH documents, markers, masking LCD projector

Evaluation/assessment

Questions and answers, trainer's observation

Trainer

Have knowledge in emergency management

| Objectives | Content | Methodology |
|---|--|-----------------------------|
| 1.2.1 Classify clinical types of diabetes | Diabetes can be classified to: <ul style="list-style-type: none"> ➤ Type one: found mainly in children It is characterized primarily by almost total deficiency of insulin ➤ Type two: this is characterized by relative resistance of cells to insulin and found mostly in elderly ➤ Gestational diabetes: This is characterized by a relative glucose intolerance with hyperglycemia during pregnancy | Brain storming (15 minutes) |
| 1.2.2 Explain diagnostic features of diabetes | The following symptoms are suggestive of diabetes: <ul style="list-style-type: none"> ➤ Polyuria ➤ Polydipsia ➤ Weight loss ➤ Intermittent blurred vision And in investigations will find: <ul style="list-style-type: none"> ➤ Fasting plasma glucose ≥ 126 mg/dl (7.0 Mmol/L) ➤ 2 hour postprandial (ideally 75 mg. glucose in water) plasma glucose ≥ 200 mg/dl (11.1 Mmol/L) HbA1c measurement $\geq 6.5\%$ using a standardized method of testing | Mini lecture (25 minutes) |

| | | |
|---|--|--|
| 1.2.3 Identify lines of treatment and follow up in patients with diabetes | <p>Lines of treatment for diabetic patients:</p> <ul style="list-style-type: none"> ➤ Life style modifications ➤ Oral hypoglycemic agents ➤ Follow up with patients monthly, every six months and yearly | <p>Mini lecture (20 minutes) Questions and answers (15 minutes)</p> |
| 1.2.4 Define asthma and explain its triad | <p>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.</p> <p>Asthma triad: Asthma is characterized by episodic attacks of breathlessness, cough, and wheezing</p> | <p>Questions and answers (25 minutes)</p> |
| 1.2.5 Classify Asthma according to severity | <p>Asthma can be classified to:</p> <ul style="list-style-type: none"> ➤ Mild ➤ Intermittent ➤ Mild persistent ➤ Moderate persistent ➤ Severe persistent | <p>Brain storming (25 minutes)</p> |
| 1.2.6 Enumerate goals of asthma management | <p>The goals of asthma management are:</p> <ul style="list-style-type: none"> ➤ Prevent chronic asthma symptoms and asthma exacerbations ➤ Maintain normal or near-normal activity throughout the day ➤ Achieve normal or near-normal lung function as measured by spirometer or peak flow ➤ Minimal use of the short acting β_2 agonist inhaler(salbutamol) for acute asthma symptoms ➤ Tolerable or no side effects from medications | <p>Discussion (20 minutes)</p> |

| | | |
|---|--|--|
| | used for control | |
| 1.2.7 Explain medication used for the treatment of different stages of asthma for each degree of asthma | <ul style="list-style-type: none"> • Mild asthma: Use short acting inhaled β_2 agonist as needed • Mild persistent asthma: One daily CONTROLLER medication OR Sustained-release theophylline to serum concentration of 5-15 mg/dl. (not preferred therapy) • Moderate persistent asthma: One daily CONTROLLER medication OR Two daily medications: Low-to-medium dose inhaled corticosteroid AND Long-acting bronchodilator especially for night time symptoms | Mini lecture (25 minutes) Discussion (10 minutes) |
| 1.2.8 Define Hypertension | <p>Definition of Hypertension:</p> <ul style="list-style-type: none"> • Systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg on the average of two or more readings taken at each of two or more visits after initial screening. | Brain storming (15 minutes) |
| 1.2.9 Enumerate six risk factors for cardiovascular diseases | <p>Cardiovascular Risk Factors:</p> <ul style="list-style-type: none"> • Hypertension BP $\geq 140/90$ • Age men >55 years; women >65 years • Cigarette smoking • Overweight or Obesity • Physical inactivity • Dyslipidemia | Brain storming (20 minutes) Discussion (10 minutes) |

| | | |
|---|---|--|
| <p>1.2.10 Explain clinical assessment of patients with hypertension</p> | <p>For patient presented with hypertension, consider the following:</p> <ul style="list-style-type: none"> • History: like previous elevated blood pressure, diabetes, dyslipidemia, family history of hypertension. • Examination: look for risk factor like central obesity and xanthomas and complete systemic examination. • Investigations: like urine analysis for blood and protein, complete • Advise for lifestyle modification and start pharmacological treatment aiming to achieve blood pressure less than 140/90 and less than 130/80 in diabetic patients. • Follow up continuously | <p>Role play (30 minutes) Questions and answers (10 minutes)</p> |
|---|---|--|

1.2.1 Clinical types of diabetes

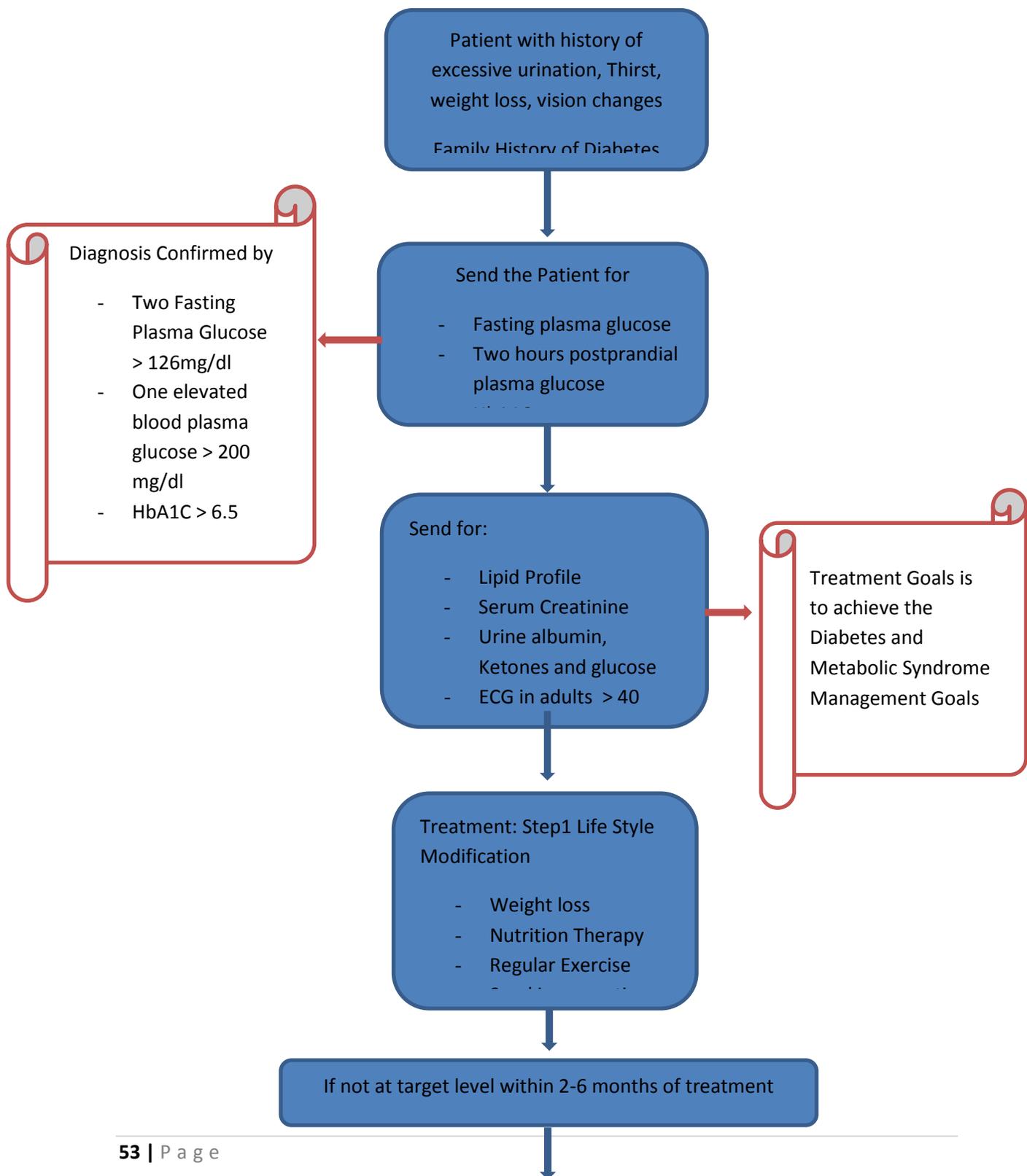
Diabetes can be classified into four clinical categories, which include:

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

1.2.2 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 ≥ 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 ≥ 200 mg/dl (11.1 Mmol/L)
 - Casual (without regard to the time since the last meal) plasma glucose ≥ 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

1.2.3 Identify lines of treatment and follow up in patients with diabetes



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

1.2.4 Definition of asthma and its trait

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”).

1.1.5 Classification of Asthma severity: Clinical features before treatment

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

1.1.6 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 β_2 agonist inhaler(salbutamol) for acute asthma symptoms
 - Less than one usage per day
 - Less than one β_2 agonist inhaler container used per month
- Tolerable or no side effects from medications used for control

1.2.7 Medication Management by Classification of Asthma Severity

| Level of Severity of Asthma | Medication Protocol |
|---|---|
| Step 1: Mild intermittent asthma (<2 symptomatic episodes/week) | No daily medication needed Use short acting inhaled β_2 agonist (salbutamol or albuterol) as needed (1-3 puffs every 4 hours) |
| Step 2: Mild persistent asthma (3-6 symptomatic episodes/week) | One daily CONTROLLER medication, which could be ONE of the following: <ul style="list-style-type: none"> • Low-dose inhaled corticosteroid (50 μgm. 1-4 puffs/day) • Cromolyn (Intal) or nedocromil (Tilade) inhaler • Zafirlukast (Accolate) or Montelukast (Singulair) <p style="text-align: center;">OR</p> Sustained –release theophylline to serum concentration of 5-15 mg/dl. (not preferred therapy) |
| Step 3: Moderate persistent asthma (Daily symptoms) | One daily CONTROLLER medication : Medium-dose inhaled corticosteroid. (50 μ gm. 2-4 puffs twice daily) <p style="text-align: center;">OR</p> Two daily medications: Low-to-medium dose inhaled corticosteroid <p style="text-align: center;">AND</p> Long-acting bronchodilator especially for night time symptoms - sustained-release theophylline or long-acting β_2 agonist (Salmeterol inhaler). |
| Step 4: Severe persistent asthma (continual symptoms) | Three daily CONTROLLER medications: High-dose inhaled corticosteroid (250 μ gm. 1-2 puffs twice daily) <p style="text-align: center;">AND</p> Long-acting bronchodilator (Salmeterol or sustained-release theophylline). <p style="text-align: center;">AND</p> Oral corticosteroid in dosage of 0.25 – 1 mg per Kg per day with the dose generally not exceeding 60 mg/day |

1.2.8 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 ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg on the average of two or more readings taken at each of two or more visits after initial screening.

Classification of hypertension

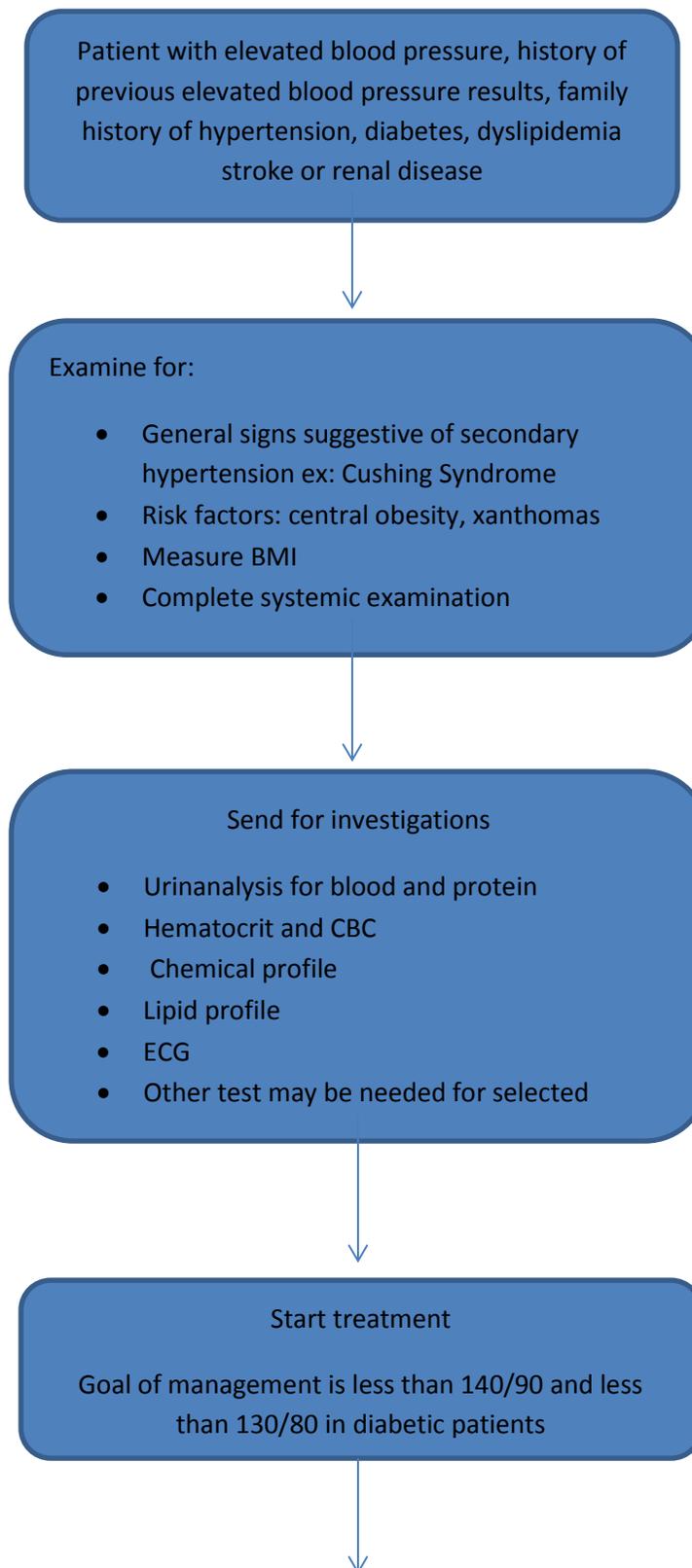
| Blood pressure class | Systolic blood pressure (mmHg) | Diastolic blood pressure (mmHg) |
|-----------------------------|---------------------------------------|--|
| Normal | <120 | And <80 |
| Prehypertension | 120 – 139 | Or 80 – 89 |
| Stage 1 hypertension | 140 – 159 | Or 90 – 99 |
| Stage 2 hypertension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

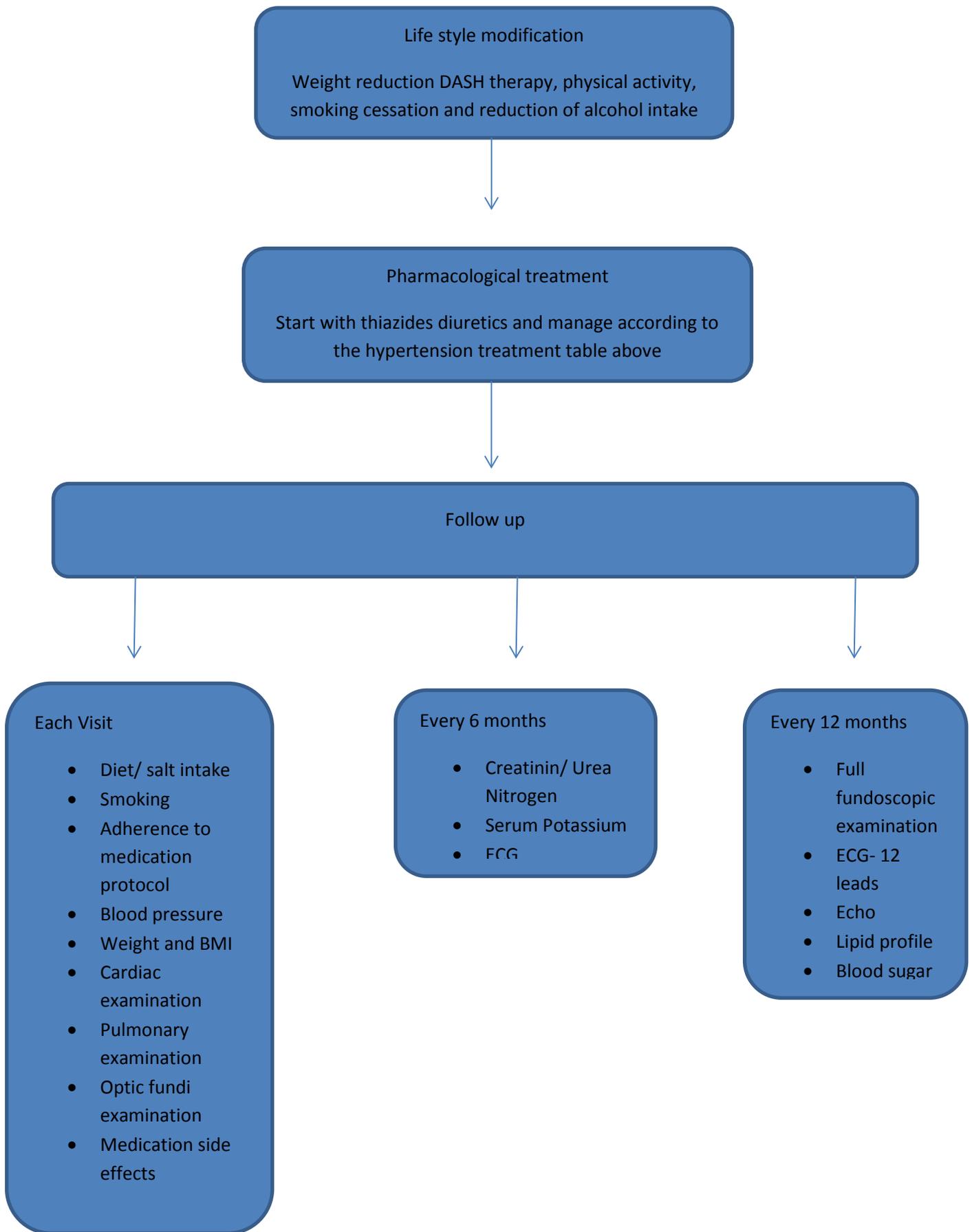
1.2.9 Cardiovascular Risk Factors

- Hypertension BP $\geq 140/90$
- Age men >55 years; women >65 years
- Cigarette smoking
- Overweight or Obesity
 - Body mass index ≥ 25 Kg/M²
 - 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

1.2.10 clinical assessment of patients with hypertension





Session 3: Obesity and Nutrition

Specific objectives of the session

At the end of the session the participants will be able to:

- Explain steps for management of obesity
- Illustrate indications of referral in obesity
- Explain elements of care for antenatal breast feeding education
- Explain nutritional assessment for pregnant women

Trainer preparation

- Review the reading material and the session plan.
- Prepare the presentation as appropriate and as recommended in the method column of the session plan, or write the information on a flipchart or board where all participants can see it.
- Prepare copies of the reference materials/handouts and exercises.
- Arrange the training room.

Methods and activities

Mini-lecture, questions and answers, brain storming

Resources

- Reference material/handouts
- Other: MoH documents, markers, masking LCD projector

Evaluation/assessment

Questions and answers, trainer's observation

Trainer

Have knowledge in obesity and maternal and child nutrition

Estimated training time

115 minutes

Session Plan

| Objectives | Content | Methodology |
|---|---|---|
| 1.3.1 Explain steps for management of obesity | <p>The main steps for the management of Obesity can be summarized as:</p> <ul style="list-style-type: none"> ➤ 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 | Demonstration and re-demonstration (35 minutes) |
| 1.3.2 Illustrate indications of referral in obesity | <p>Indications for referral to a specialized center are:</p> <ul style="list-style-type: none"> ➤ Presence of underlying clinical condition ➤ Previous attempts of weight loss, evidence of having participated in at least 6 different weight interventions, each for at least 3 months. | Brain storming (20 minutes) |
| 1.3.3 Explain elements of care for antenatal breast feeding education | <p>For educating women about breast feeding focus on:</p> <ul style="list-style-type: none"> ➤ Assess where the woman is in relation | Questions and answers (25 minutes) |

| | | |
|--|--|---|
| | <p>to breastfeeding including past experience</p> <ul style="list-style-type: none"> ➤ Ask the woman if she is planning to breastfeed and ➤ Screen women who have decided to breastfeed for any medical or physical conditions that could impair breastfeeding ➤ Provide educational materials ➤ follow up ➤ Record the appropriate information in the appropriate record | |
| <p>1.3.4 Explain nutritional assessment for pregnant women</p> | <p>To assess nutritional status of the mother do the following:</p> <ul style="list-style-type: none"> ➤ Review the mother`s nutritional checklist ➤ Look for signs of anemia ➤ Ask the mother about her past obstetrical history and history of anemia during pregnancy ➤ Ask about additional nutritional energy uptake ➤ Determine any problem that prevent proper feeding | <p>Mini lecture (20 minutes) Questions and answers (15 minutes)</p> |

1.3.1 Explain steps for management of obesity

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

1.3.2 Illustrate indications of referral in obesity

- 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.).

Previous attempts of weight loss, evidence of having participated in at least 6 different weight interventions, each for at least 3 months

1.3.3 Explain elements of care for antenatal breast feeding education

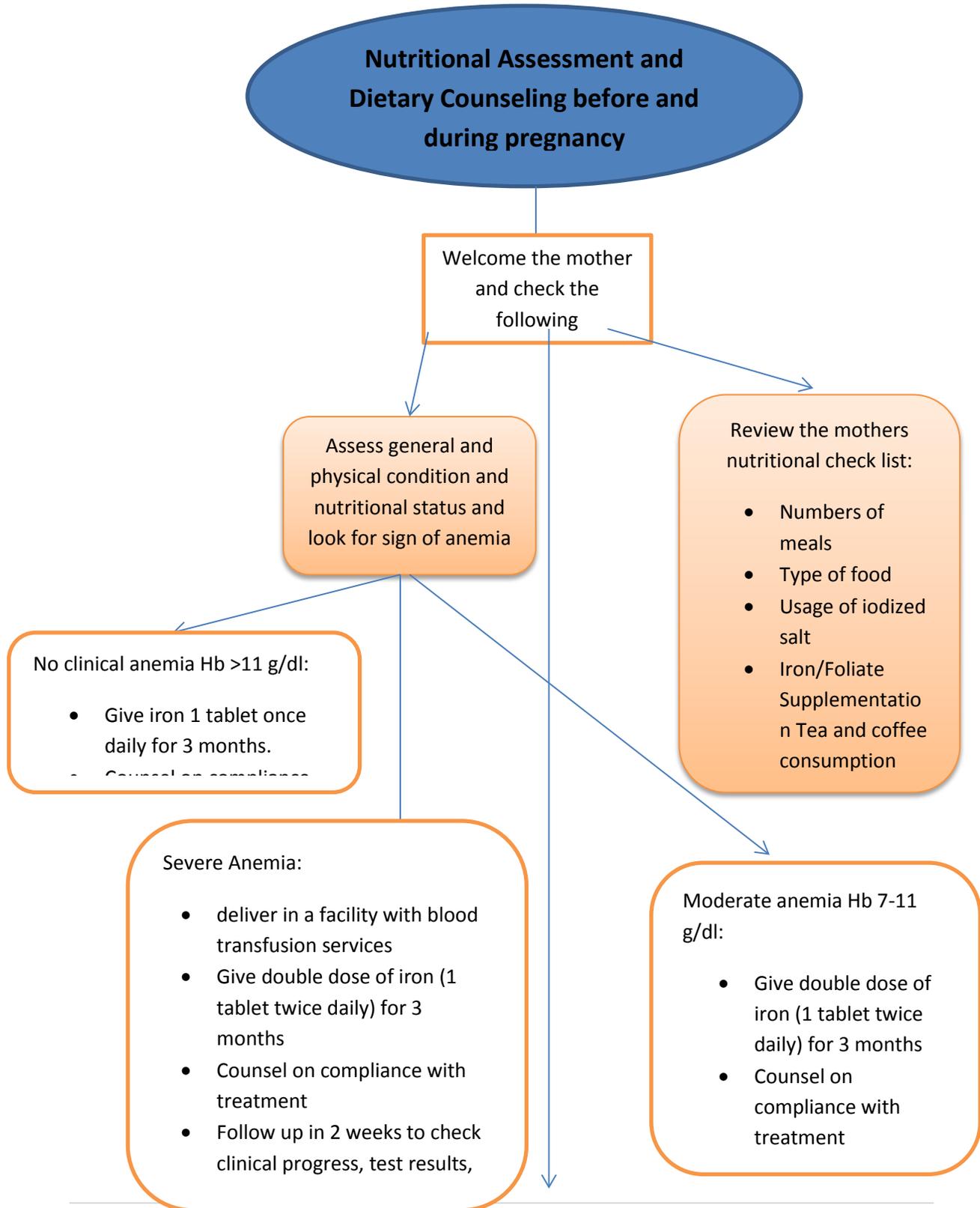
Elements of Care

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.

1.3.4 Explain nutritional assessment for pregnant women



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

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

Session 4: Women`s Health (breast Cancer and premarital counseling)

Specific objectives of the session

At the end of the session the participants will be able to:

- Enumerate components of breast cancer screening program
- Explain Triple Assessment Pathway
- Describe management of breast mass and breast pain
- Describe management of nipple discharge
- Define premarital counseling and enumerate five of its objectives
- Summary the points to be covered during premarital counseling visit

Trainer preparation

- Review the reading material and the session plan.
- Prepare the presentation as appropriate and as recommended in the method column of the session plan, or write the information on a flipchart or board where all participants can see it.
- Prepare copies of the reference materials/handouts and exercises.
- Arrange the training room.

Methods and activities

Mini-lecture, questions and answers

Resources

- Reference material/handouts: Basics of Management and the manager? What are the functions of the management? Role and responsibilities of the manager
- Other: MoH documents, markers, masking LCD projector

Evaluation/assessment

Questions and answers, trainer`s observation and brain storming

Trainer

Have knowledge in breast cancer and premarital counseling

Estimated training time

156 minutes

Session Plan

| Objectives | Content | Methodology |
|---|---|---|
| 1.4.1 Enumerate components of breast cancer screening program | Breast screening program consist of: <ul style="list-style-type: none"> ➤ Breast self – examination ➤ Clinical breast examination ➤ Screening mammography ➤ Other investigations | Questions and answers (25 minutes) |
| 1.4.2 Explain Triple Assessment Pathway | Triple assessment pathway <ul style="list-style-type: none"> ➤ Clinical ➤ Imaging ➤ Pathology | Mini lecture (15 minutes) Discussion (15 minutes) |
| 1.4.3 Describe management of breast mass and breast pain | For patients with breast mass assess the following: <ul style="list-style-type: none"> ➤ Whether the mass is solid and discrete or not ➤ For patients with breast pain assess the following: <ul style="list-style-type: none"> ➤ Whether it is cyclic or non-cyclic ➤ With mass or without ➤ Screen for contributing factors | Mini lecture (20 minutes) Questions and answers (15 minutes) |
| 1.4.4 Describe management of nipple discharge | For patients with nipple discharge assess the following: <ul style="list-style-type: none"> ➤ Whether it is unilateral or bilateral ➤ Whether it is spontaneous or not, persistent or not ➤ Its type: bloody, milky or others ➤ Pregnancy test positive or negative | Mini lecture (20 minutes) Questions and answer (10 minutes) |

| | | |
|--|---|---|
| <p>1.4.5 Define premarital counseling and enumerate five of its objectives</p> | <p>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.</p> <ul style="list-style-type: none"> ➤ Important objectives: ➤ Reduce the incidence of common haemoglobinopathies. ➤ Reduce other hereditary disorders. ➤ Counseling regarding high-risk behaviors, ➤ Early detection and treatment of some sexually transmitted diseases. ➤ Promote awareness regarding reproductive health | <p>Brain storming (20 minutes)</p> |
| <p>1.4.6 Summary the points to be covered during premarital counseling visit</p> | <p>For premarital visits the following points need to be covered:</p> <ul style="list-style-type: none"> ➤ Collect basic information about the couples; such as basic data, family history of diseases, degree of consanguinity, and fill assessment risk form ➤ Give premarital educational booklet to the couple and discuss it with them ➤ Perform physical examination and review lab reports, ➤ Issue certificate of premarital counseling (in case of any abnormal findings act accordingly) | <p>Questions and answers (25 minutes)</p> |

1.4.1 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.

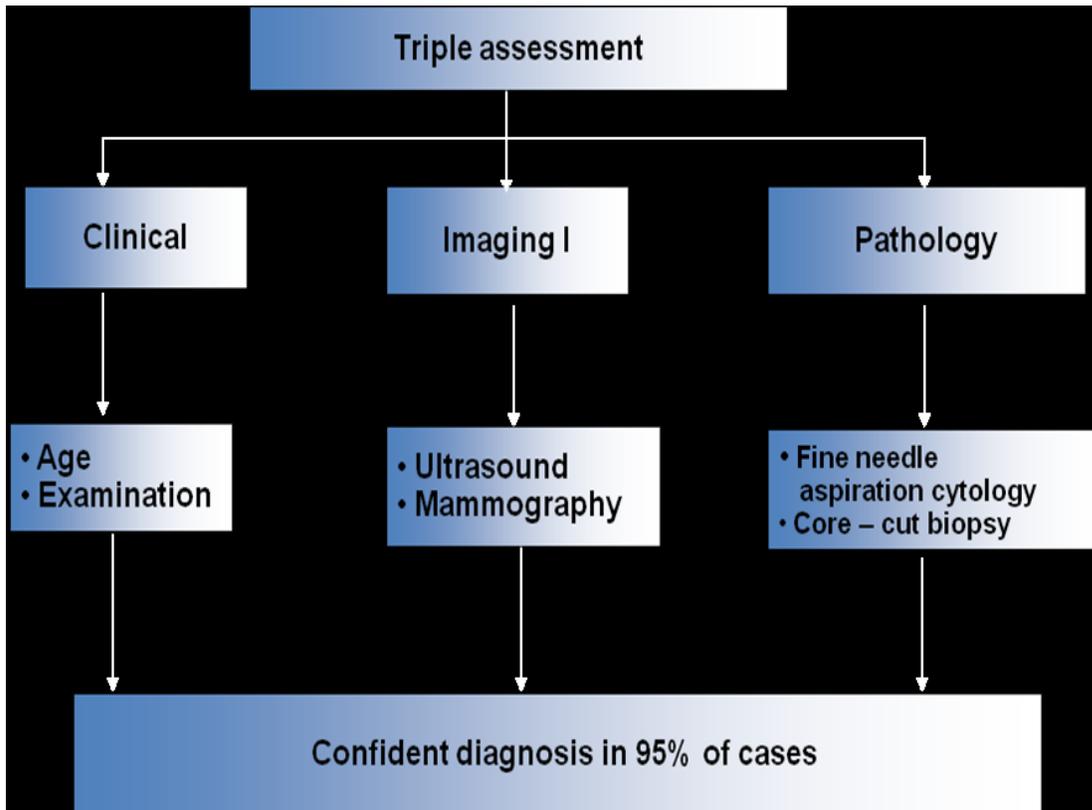
B. Cytology:

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:

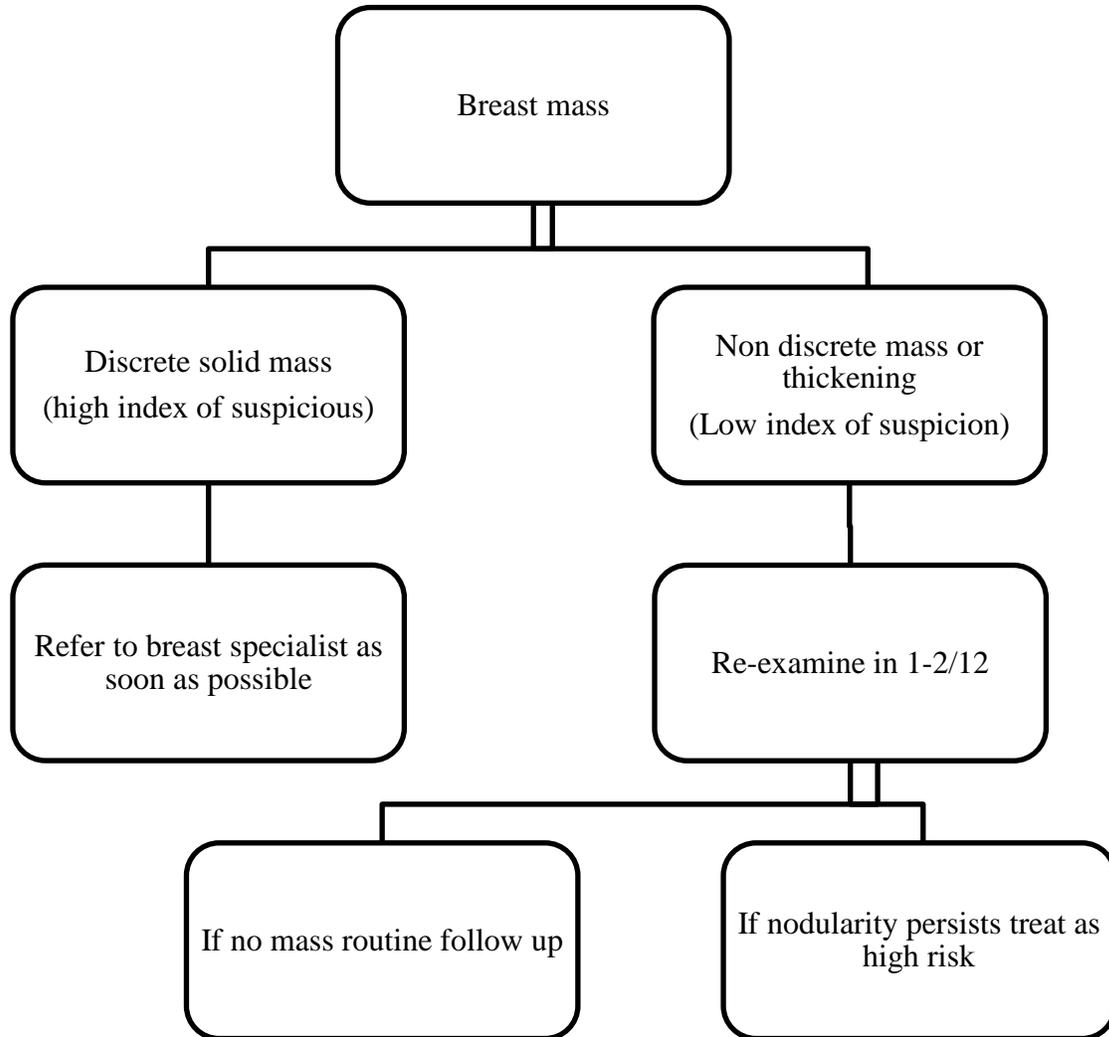
This means is becoming more widely applied in combination with either visual inspection methods or cytology because means of detecting HPV in cervical specimen are becoming increasingly available and take shorter time for results to appear making it suitable to increase the specificity of other tests.

1.4.2 Triple Assessment Pathway

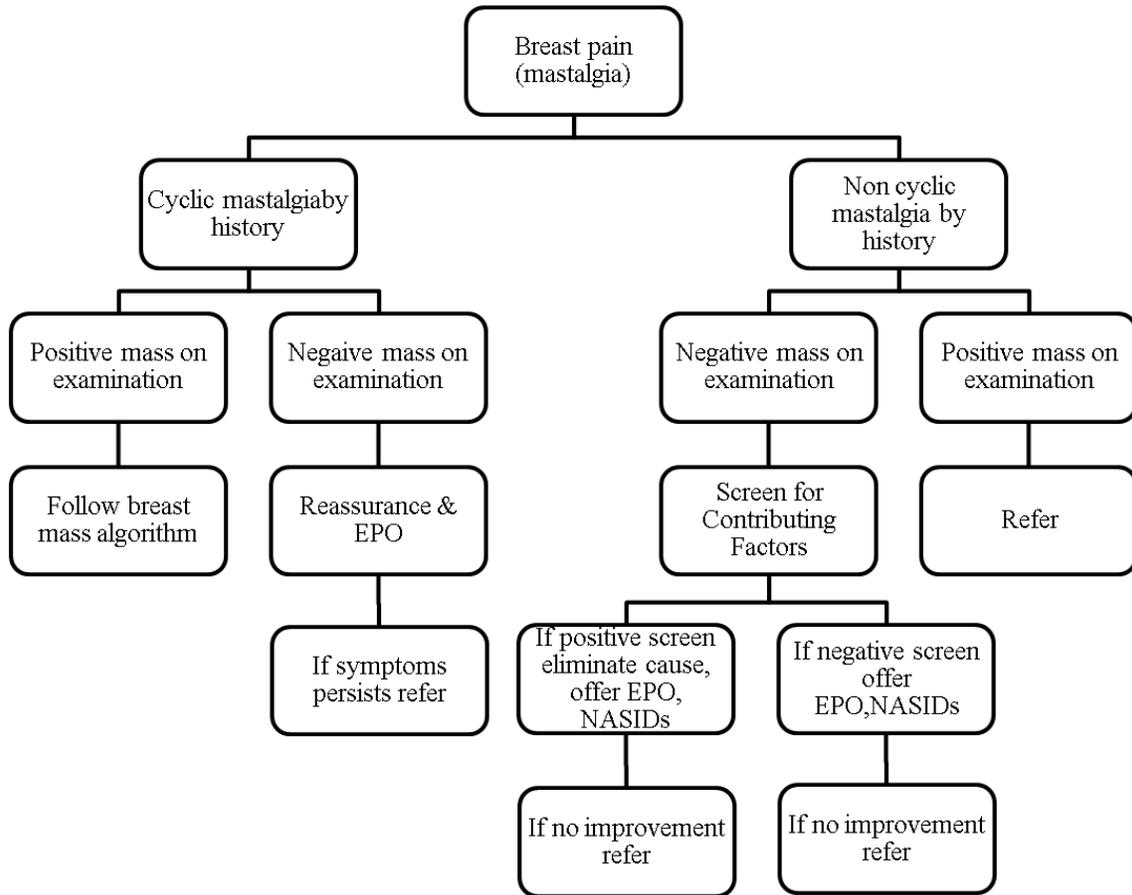


1.4.3 Management of breast mass and breast pain

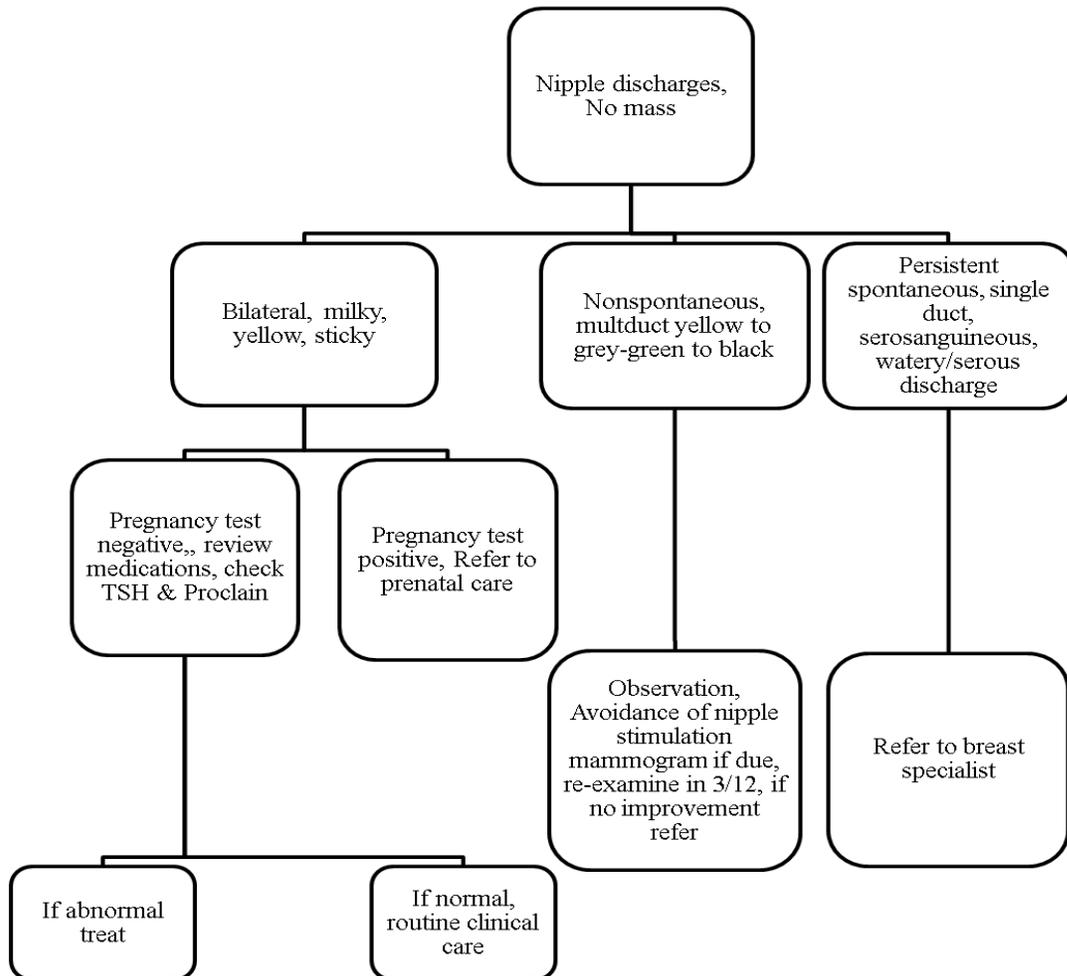
A. for breast mass



B. for breast mass



1.4.4 Management of nipple discharge



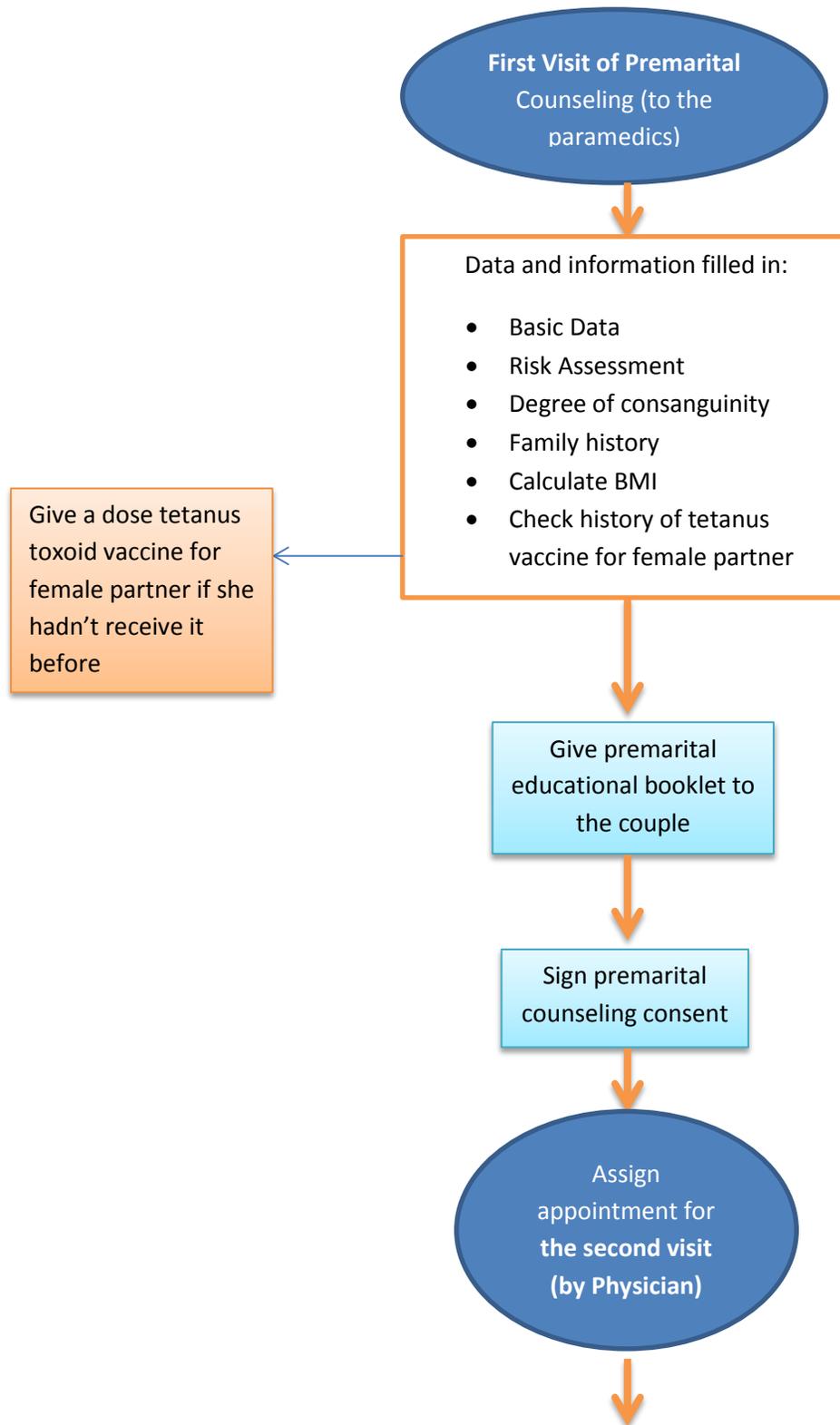
1.4.5 Definition of premarital counseling and its objectives

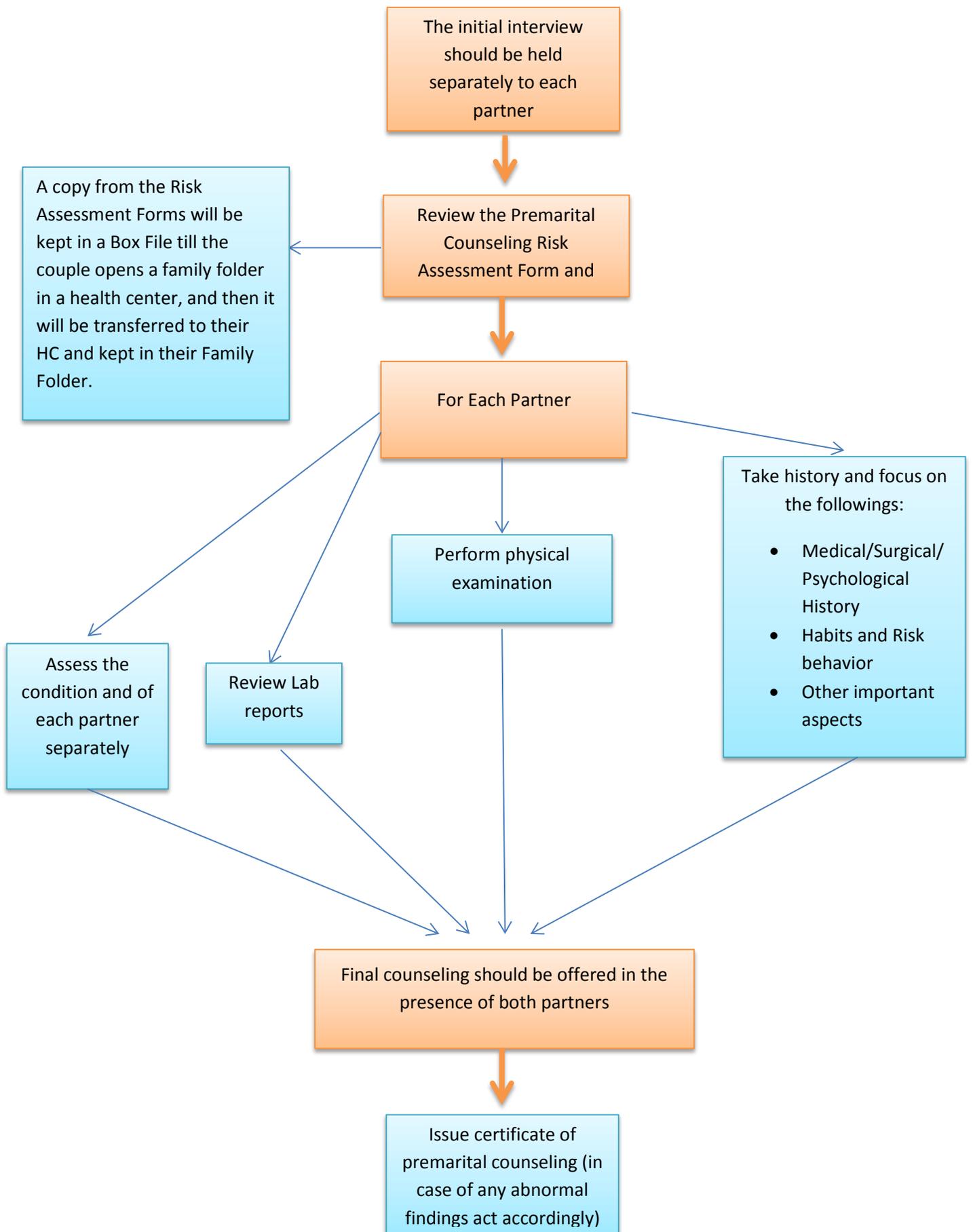
Premarital counseling (PC) is a method of advice and guidance for those intending to marry to enhance their understanding and selection and to improve their quality of life.

Objectives

1. To reduce the incidence of common haemoglobinopathies in Iraq, e.g. thalassemias 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.

1.4.6 Points to be covered during premarital counseling visit





Module Two: Community Partnership in PHC

Session 1:

Specific objectives of this session

At the end of this session participants will be able to:

- List six activities suggested for LHC
- Explain key points for proper facilitation
- Describe effective qualities for CHP facilitation
- Explain steps for conducting successful group talk

Trainer preparation

- Review the reading material and the session plan.
- Prepare the presentation as appropriate and as recommended in the method column of the session plan, or write the information on a flipchart or board where all participants can see it.
- Prepare copies of the reference materials/handouts and exercises.
- Arrange the training room.

Methods and activities

Brain storming, questions and answers and role play

Resources

- Reference material/handouts: Visualization rules, Questions and answers
- Other: newsprint on easel, markers, masking tape, LCD projector

Evaluation/assessment

Questions and answers, trainer's observation

Trainer

Experienced with management of primary health care in Iraq

Estimated training time

100 minutes

Session Plan

| Objectives | Content | Methodology |
|--|--|---|
| 2.1.1 List six activities suggested for LHC | <p>Suggested Activities for Local Health Committees</p> <ul style="list-style-type: none"> • Refuse disposal • Water chlorination and supply • Environmental sanitation • Family and personal hygiene • Provision of WC at family level • Food safety | <p>Brain storming (20 minutes) Question and answers (10 minutes)</p> |
| 2.1.2 Explain key points for proper facilitation | <p>In order to work in a group and be a good facilitator the following key points should focus on:</p> <ul style="list-style-type: none"> • Knowledge of the Subject Matter • Monitors Group Work: • Monitors Group Dynamics | <p>Role Play (25 minutes)</p> |
| 2.1.3 Describe effective qualities for CHP facilitation | <p>Effective qualities of CHP facilitation include:</p> <ul style="list-style-type: none"> • Efficient • Good listener • Key observer • Creative • Analytical • Tactful • Knowledgeable • Open • Sense of humor • Coordinator • Objective • Flexible | <p>Brain storming (20 minutes) Questions and answers (10 minutes)</p> |
| 2.1.4 Explain steps for conducting successful group talk | <ul style="list-style-type: none"> • Prepare notes for the presentation • Think about the words you will use • Control time • Write a list of questions to stimulate discussion | <p>Discussion (15 minutes)</p> |

2.1.1 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

2.1.2 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?

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.

2.1.3 Effective qualities of CHP facilitation

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

Module Three: Supportive Supervision for Quality Improvement

Overall Learning Objectives:

1. Define supportive supervision and its advantages over the traditional supervision approach.
2. Explain the role of the supervisor in the context of supportive supervision.
3. Discuss the methods of collecting information for supportive supervision.
4. Discuss the value of using checklists for supervision.
5. Explain how the results of supervision can be used.
6. Define Quality Improvement.
7. Explain the process of Quality Improvement in primary health care.
8. Discuss the role of Quality Improvement Teams.
9. Discuss the tools that can help the Quality Improvement Teams.
10. Discuss the value of shared learning and motivation of improvement.

Training Approaches:

- Role play: Particularly to highlight the difference between supportive supervision and traditional supervision.
- Case study: To stimulate supervisors to think in a problem-solving mode when confronted with weakness in the performance of staff or clinic.
- Small group exercise: To invite participants to discuss challenges of supportive supervision and processes of quality improvement. Small group exercises will be also used to guide participants to develop a work plan for the next steps and actions to be taken in their Province/District to advance supportive supervision and quality improvement.
- Large group discussion: Particularly in the form of questions by the trainers who invites answers and discussion from participants.

Materials:

- Flip chart to record participants' answers.
- Presentations including summary of main take-home points related to different topics discussed in each session.
- Handouts of documents to be used, such as copies of supervision checklists and instructions.
- Session evaluation forms and course evaluation forms.
- Calculators

References:

- Clinical Guidelines for different topics.
- Handbook of Quality and Clinical Standards.
- Basic Health Services Package.

Course Evaluation:

- Session evaluation forms: To be filled by each participant immediately after each session. It contains participants' assessment of the session and the trainer's competency.
- Course evaluation form: This is to be filled by each participant at the end of the course to provide an overall assessment of the effectiveness of the course in achieving its objectives and getting feedback on how to improve the course in the future.

Estimated Training Time

10 hours

Session 1: What is Supportive Supervision & Role of Supervisors?

| Objective | Content | Method |
|--|---|---|
| 3.1.1. Define and explain supportive supervision. | <ul style="list-style-type: none"> - Define supportive supervision. - Explain the main features of supportive supervision. - Compare the features of supportive supervision and traditional supervision. | <ul style="list-style-type: none"> - Questions to participants and writing answers on a flip chart. (25 minutes) - Role play to compare supportive supervision with traditional supervision (30 minutes) - Summary of main points (10 minutes) |
| 3.1.2 Explain the difference between supportive supervision and traditional supervision | <ul style="list-style-type: none"> - Explain the role of the supervisor before, during, and after a supervisory visit. - Explain the different roles of external and internal supervisors. - Discuss the methods of collecting information for supportive supervision. | <ul style="list-style-type: none"> - Questions to participants and writing answers on a flip chart (20 minutes) - Summary of main points.(15 minutes) |
| 3.1.3 Define and explain the role of the supervisor in the context of supportive supervision | <ul style="list-style-type: none"> - Explain the role of the supervisor before, during, and after a supervisory visit. - Explain the different roles of external and internal supervisors. - Discuss the methods of collecting information for supportive supervision. | <ul style="list-style-type: none"> - Questions to participants and writing answers on a flip chart.(25 minutes) - Summary of main points (20 minutes) |

1. Ask: When you here the term supportive supervision” what comes to your mind?

Write answers on a flip chart.

2. Present and discuss the definition of Supportive Supervision:

Supportive supervision can be defined simply as: The process of objectively assessing the performance of the technical and managerial functions of a health facility and providing support to improve them.

3. Ask: So, what is the goal of Supportive Supervision? Write answers on a flip chart

4. Present the goal of Supportive Supervision:

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.

5. Role Play: Ask participants to observe and take notes about the role play displaying 2 different scenarios, one for traditional supervision and the other is for supportive supervision.

Role Play: Supportive Supervision versus Traditional Supervision

Scenario 1: Traditional Supervision

The supervisor visited the PHC clinic without an appointment, went immediately to the lab room without introducing himself to the lab staff.

Supervisor: How many persons working in the lab?

Lab tech: 5 persons,

Supervisor: Why 2 are not present?

Lab tech: Because they went to the Tb. Lab.

Supervisor: Show me the lab records.

Lab tech: This is a new record for this week,

Supervisor: Have you been trained to fill this record?

Lab tech: Yes, last month.

Supervisor: All the results are wrong and the filling is not complete. You are supposed to know all this.

Lab tech: Please, I would like to know the defects.

Supervisor: (Shouting). Do you want me to train you again and now?

Then the supervisor wrote the remarks in a nervous way he will send a punishment to all

the lab staff.

Scenario2: Supportive Supervision

Supervisor visited the PHC clinic with a previous appointment, he went to the director of the clinic and introduced himself to all the staff and clarified the purpose of the visit. Supervisor visited the lab room. He introduced himself to the lab staff.

Supervisor: How many persons are working in the lab?
Lab tech: 5 persons.
Supervisor: 2 are not present?
Lab tech: They went to TB lab.
Supervisor: Good, can I see the new records please.
Lab tech: This is the new records for this week.
Supervisor: Have you been trained to fill these records?
Lab tech: Yes, the last month.
Supervisor: I found some results are wrong and the filling are not so correct, so I want all of you to come to see the right way for filling this record, do you have any other problems in order to help you to solve them?
Lab tech: No, thank you.
Supervisor: Thank you for your efforts, good bye.

Then the supervisor went to the director office to share the visit's finding in a constructive way, starting with the positive findings. Then the supervisor states that he will visit the clinic again next month and will stay in touch by telephone.

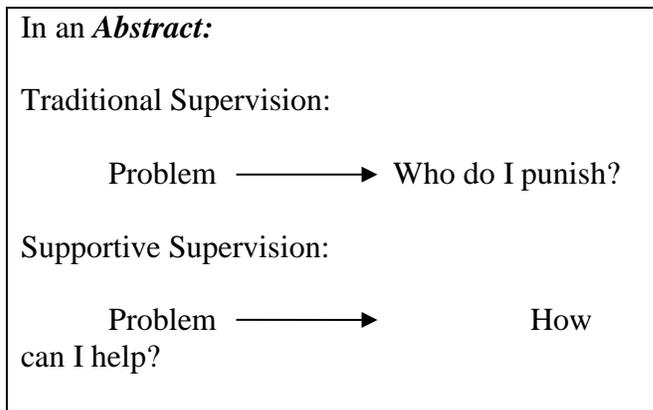
6. Write down the participants' remarks on the role play using a flip chart.

Discuss: Should the supervisor inform the clinic about the date of the visit? Debate on why, or why not.

7. Present a summary of the main difference between Supportive and Traditional Supervision.

| 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. | <p>Review of clinic statistical reports.</p> <p>Review of previous supervisory findings and follow up points.</p> <p>Preparing Supervisory Checklists & other documents (e.g. Guidelines).</p> <p>Inform the clinic about the date of the visit.</p> |
| What happens during supervision | <p>Inspection of the facility, review of records and supplies.</p> <p>.</p> | <p>Observation of performance and comparison with standards.</p> <p>Provision of constructive feedback.</p> <p>On site guidance, training, and problem solving.</p> |
| What happens after supervision | <p>Little feedback mainly focuses on negative findings.</p> <p>No or irregular follow-up between supervisory visits.</p> | <p>The main findings of the visit are summarized including the positive findings.</p> <p>Encouragement of staff to continue the good work.</p> <p>Discussion of the negative findings with constructive guidance for improvement.</p> <p>Agreeing with clinic staff on action needed for improvement and time frame.</p> |



8. Ask: Can you share some of your experiences as a supervisor, or a supervisee? Discuss styles of supervision and effect.
9. Ask: So, based on our understanding of Supportive Supervision, what should be the role of the District/ Provincial supervisor? Write responses on a flip chart.
10. Explain and discuss the role of the District/ Provincial Supervisor (External Supervisor)

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.

11. Ask: Is it important for the supervisor to establish a comfortable environment during supervision? Why? Write responses on the flipchart.
12. Ask: How can a supervisor set comfortable environment for supervision? Write responses on the flipchart.
13. Summarize and discuss ways of setting comfortable environment for supervision.

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.

14. Ask: what is the supervisory role of the clinic's in-charge/manger (Internal Supervisor)? Write responses on flip chart.
15. Summarize and discuss the supervisory role of the clinic's 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.

16. Ask: What are the methods of collecting information for Supportive Supervision? Write responses on a flip chart.
17. Summarize and discuss the important methods for 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.

18. Get any participants’ comments on the session as a whole.

19. Distribute and ask participants to fill out the session evaluation form.

Session 2: Supervision Checklists & The use of results of supervision

| Objective | Content | Method |
|--|---|--|
| 3.2.1 Appreciate the value of Checklists in supervision. | <ul style="list-style-type: none"> ➤ Explain the value of checklists in general. ➤ Explain the use of checklists in health. ➤ Discuss the Basic Primary Health Clinic Supervision Checklist as an example. | Questions to participants and writing answers on a flip chart. (45 minutes) |
| 3.2.2 Identify the stakeholders for supervision results | <ul style="list-style-type: none"> ➤ Listing of all stakeholders who should be interested in the use of the supervision results. | Small group discussion of the Basic Primary Health Clinic Supervision Checklist and its Instructions (45 minutes) |
| 3.2.3 Highlight the actions to be taken by each stakeholder. | <ul style="list-style-type: none"> ➤ Discuss the potential actions to be taken by each stakeholder based on the results of supervision. | Questions to participants and writing answers on a flip chart. (45 minutes) |
| 3.2.4 Explain the Red Flag concept. | <ul style="list-style-type: none"> ➤ Discussion on the potential benefit of the Red Flag concept. | Questions and answers (40 minutes) |

1. Ask: have you ever used a checklist in your personal life? Why? Write responses on a flip chart.
2. Ask: So, what is the use of checklists in health? Write responses on a flip chart.
3. Discuss the use of checklist in health. Mention the recent evidence of reduction in surgical mortality based on the use of checklist models from the aviation industry (Atul Gawande et al).
4. Divide participants into small groups. Distribute copies of the Basic Primary Health Clinic Supervision Checklist and its Instructions.

5. Explain the Checklist briefly (its purpose, its structure, its sections).
6. Ask each group to review the Checklist and refer to the Instructions as needed, select a person to summarize the group's main findings, and be prepared to discuss the following points:
 - Is the Checklist clear in general?
 - Are the components of the Checklist adequate?
 - How useful is the Checklist to supervisors?
 - Will the Checklist help identify actions for quality improvement?
7. Ask a representative from each group to present the group's main findings.
8. Facilitate a discussion on the results of the small groups' findings.
9. Discuss the other documents/references that can help the supervisors during supervisory visits.
10. Ask, whether the supervisor uses a checklist or not, who should care about the results of any supervisor visit? Write the responses on a flip chart.
11. Facilitate a discussion on: Why should each stakeholder (person/position/institution) listed above be interested in the results of a supervisory visit?
12. Ask: Ok, so what are the potential actions that can be taken by each stakeholder identified above based on the results of supervision? Write responses on a flip chart.
13. Explain and discuss the main stakeholders and their potential action based on the results of supervision.

Who uses the results of supervision?

As the purpose of supportive supervision is quality improvement, 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.

14. Ask participants: Can you share your experience regarding any actions you have taken as a supervisor, or action taken by the supervisors of your clinic? Write responses on a flip chart.

15. Facilitate a discussion on how helpful were the actions listed above in improving the quality of care. Discuss how some of the non-helpful actions could have been more helpful.

16. Explain the Red Flag concept in supervision.

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.

17. Discuss how the Red Flag Concept can help in quality improvement.
18. Get any participants’ comments on the session as a whole.
19. Distribute and ask participants to fill out the session evaluation form.

Session 3: Quality Services and Quality Improvement & Quality Improvement Process

| Objective | Content | Method |
|---|---|--|
| 3.3.1 Identify the features of quality health care. | ➤ WHO definition of quality health care. | Questions to participants and writing answers on a flip chart.(35 minutes) |
| 3.3.2 Define Quality Improvement. | ➤ Discuss the definition of quality improvement. | Small group exercise to develop an example of QI process.(45 minutes) |
| 3.3.3. Explain the process of quality improvement. | ➤ Explain the main steps and features of a successful quality improvement effort. | Questions and answers .(45 minutes) |

1. Ask: What comes to your mind when you here the term “quality care”? Write responses on a flip chart.
2. Present and discuss WHO definition of 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.
3. Ask: Then, What is Quality Improvement (QI)? Write responses on a flip chart.
 4. Present and discuss the definition of 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.
5. Present and discuss the main steps of QI process

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

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.

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:

Outcome indicators: Indicators that are related directly to the aim of the collaborative.

Process indicators: Indicators that monitor change in the process of delivering services that will affect the service outcome.

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.

6. Small group exercise: Divide participants in small groups and ask them to:
 1. Select an improvement aim (objective).
 2. Select indicators to measure progress to improvement.
 3. Suggest a limited list of interventions to achieve the desired improvement.

Each group is to select a representative to summarize the group's results using a flip chart.

Other groups can comment on the clarity of the improvement process presented by each group.

7. Get any participants' comments on the session as a whole.
8. Distribute and ask participants to fill out the session evaluation form.

Session 4: Quality Improvement Teams & Tools and Motivation for QI

| Objective | Content | Method |
|---|---|---|
| 3.4.1 Explain the composition of QI Teams. | ➤ Discuss the concept of QI teams and who should be included. | Questions to participants and writing answers on a flip chart. (30 minutes) |
| 3.4.2 Explain the role of QI Teams. | ➤ Discuss the role of QI teams in primary care clinics. | Questions to participants and writing answers on a flip chart (30 minutes) |
| 3.4.3 Explain the role of supervisors in supporting QI teams. | ➤ Discuss the role of the supervisor in supporting QI teams (Quality Improvement Coach). | Questions to participants and writing answers on a flip chart (30 minutes) |
| 3.4.4 Familiarize participants with common QI tools | ➤ Present and discuss common QI tools such as: Root Cause Analysis; Patient Flow Chart; Run Chart; Brain Storming | Present samples of QI tools. (25 minutes) and Small group exercise on using QI tools (25 minutes) |
| 3.4.5 Discuss ways of motivating QI efforts. | ➤ Discuss innovative and sustainable ways to motivate QI teams | Discussion on methods of motivation of QI teams.(35 minutes) |

1. Ask: Who should be a member of a quality improvement team at the primary health care clinic? Write responses on the flip chart.
2. Present and discuss the composition of QI teams:

- 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.
3. Ask: Based on our understanding of the composition of the QI team at primary health clinics, what should be its role? Write responses on the flip chart.
 4. Present and discuss the role of QI teams:
 - 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.
 5. Ask: How can the supervisor support QI teams? Write responses on a flip chart.
 6. Present and discuss the role of the supervisor as a Coach to the QI team:

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.

7. Explain and discuss the value of shared learning between QI teams in different clinics:

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.

8. Ask: How can we motivate QI teams? Write responses on a flip chart.

9. Discuss ways of motivating QI teams:

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.

10. Present and explain the Root Cause Analysis method using an example.

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 treat common cold.

11. Divide participants into small groups and ask each group to:

1. Select a problem facing primary care clinics).
2. Write the problem clearly.
3. Identify the direct causes of the problem.
4. Identify the root caused for two of the direct causes.

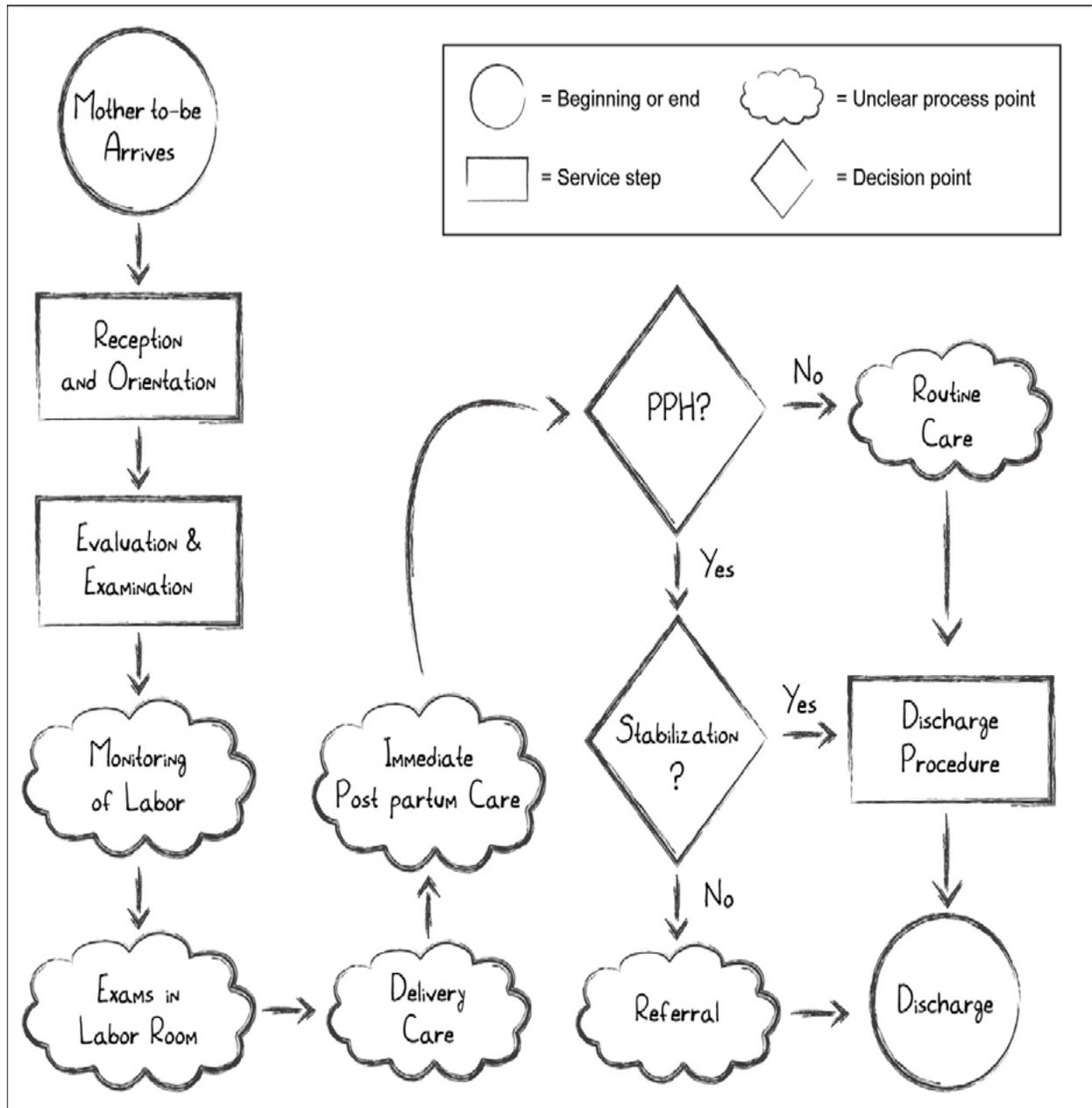
Each group is to select a representative to summarize the group's results using a flip chart.

Other groups can comment/ ask questions.

12. Present and explain the Patient Flow Chart using an example.

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 a flow chart in maternity clinic:



13. Ask: How can the Patient Flow Chart be helpful in the primary clinics in your district/province? Write responses on a flip chart.

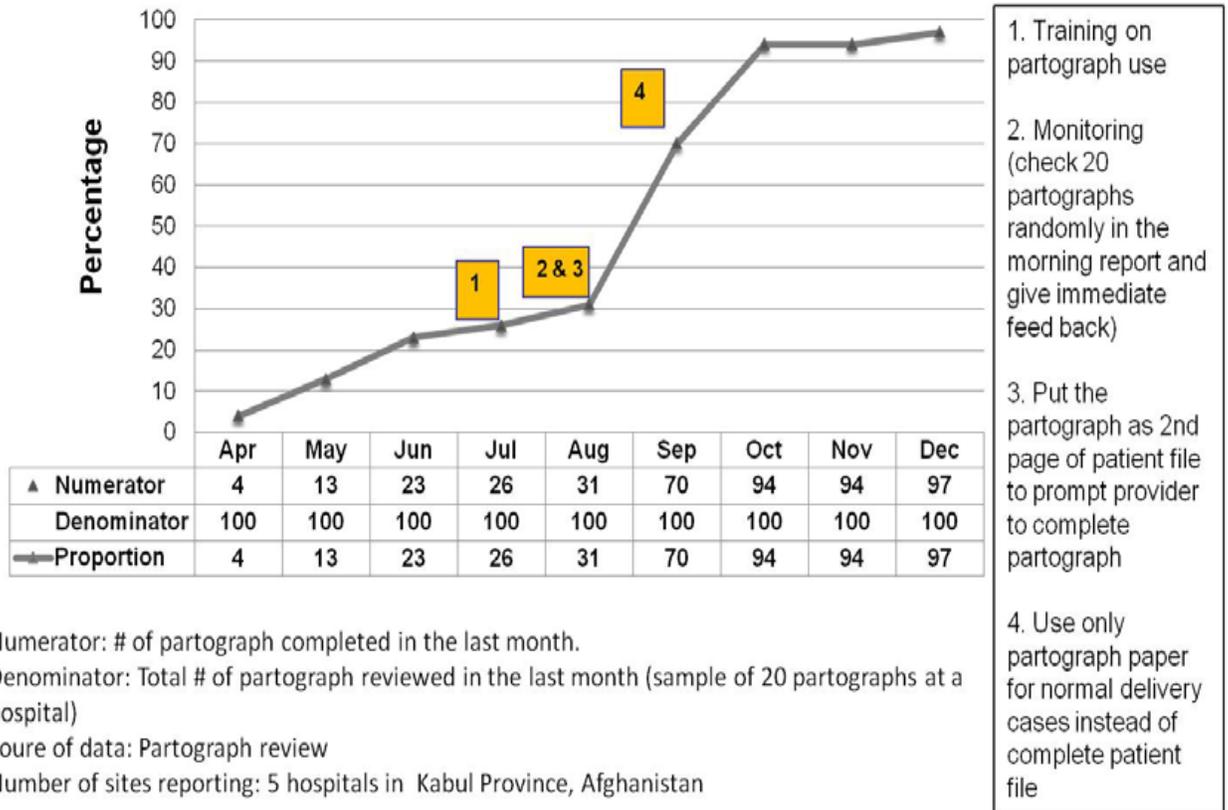
14. Present and explain the Run Chart using an example.

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



Numerator: # of partograph completed in the last month.

Denominator: Total # of partograph reviewed in the last month (sample of 20 partographs at a hospital)

Soure of data: Partograph review

Number of sites reporting: 5 hospitals in Kabul Province, Afghanistan

15. Divide participants into small groups and ask each group to:

1. Use a flip chart to draw a Run Chart using the data below.
2. Discuss the meaning of the data.
3. Discuss the practical implications of the presented results (what decisions can be made accordingly to improve quality of care)

Each group is to select a representative to summarize the group’s results using a flip chart.

Other groups can comment/ ask questions.

Data Exercise for Run Chart:

The QI team applied interventions to increase compliance with the first follow up visit for patients diagnosed with hypertension

Numerator (Num.) = The number of patients diagnosed with hypertension who came back for the first follow up visit.

Denominator (Den.) = The number of patients diagnosed with hypertension in the month.

% = Percent compliance (Num./Den. X 100)

Group1

| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 |
|----------------------|---------|---------|-------------------------------|---------|---------|---------|----------------|---------|---------|
| Num. | 20 | 26 | 16 | 20 | 30 | 34 | 35 | 90 | 85 |
| Den. | 120 | 130 | 90 | 85 | 110 | 105 | 95 | 120 | 110 |
| % | | | | | | | | | |
| Intervention Started | | | Health Education at Reception | | | | Reminder calls | | |

Group2

| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 |
|----------------------|---------|---------|---------|----------------------------|---------|---------|---------|---------|---------|
| Num. | 20 | 24 | 15 | 10 | 40 | 42 | 35 | 52 | 40 |
| Den. | 120 | 130 | 90 | 85 | 110 | 105 | 95 | 120 | 110 |
| % | | | | | | | | | |
| Intervention Started | | | | Special Patient counseling | | | | | |

Group3

| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 |
|------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
| Num. | 20 | 24 | 15 | 40 | 70 | 80 | 75 | 90 | 85 |
| Den. | 120 | 130 | 90 | 85 | 110 | 105 | 95 | 120 | 110 |

| | | | | | | | | | |
|----------------------|--|--|-----------------------|--|--|--|--|--|--|
| % | | | | | | | | | |
| Intervention Started | | | Text message reminder | | | | | | |

Group4

| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 |
|----------------------|---------|--------------------------|---------|---------|---------|---------|---------|---------|---------|
| Num. | 20 | 24 | 15 | 10 | 20 | 19 | 15 | 25 | 28 |
| Den. | 120 | 130 | 90 | 85 | 110 | 105 | 95 | 120 | 110 |
| % | | | | | | | | | |
| Intervention Started | | Patient group discussion | | | | | | | |

Group5

| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 |
|----------------------|---------|-------------------------------|---------|---------|---------|---------|---------|---------|---------|
| Num. | 20 | 24 | 50 | 55 | 80 | 85 | 85 | 105 | 100 |
| Den. | 120 | 130 | 90 | 85 | 110 | 105 | 95 | 120 | 110 |
| % | | | | | | | | | |
| Intervention Started | | Text message & call reminders | | | | | | | |

16. Lead a general discussion about lessons learned as a supervisor.

17. Ask: Can you see a potential value of shared learning between QI teams?
How? Write responses on a flip chart.

18. Present and discuss a summary of the value of shared learning

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.

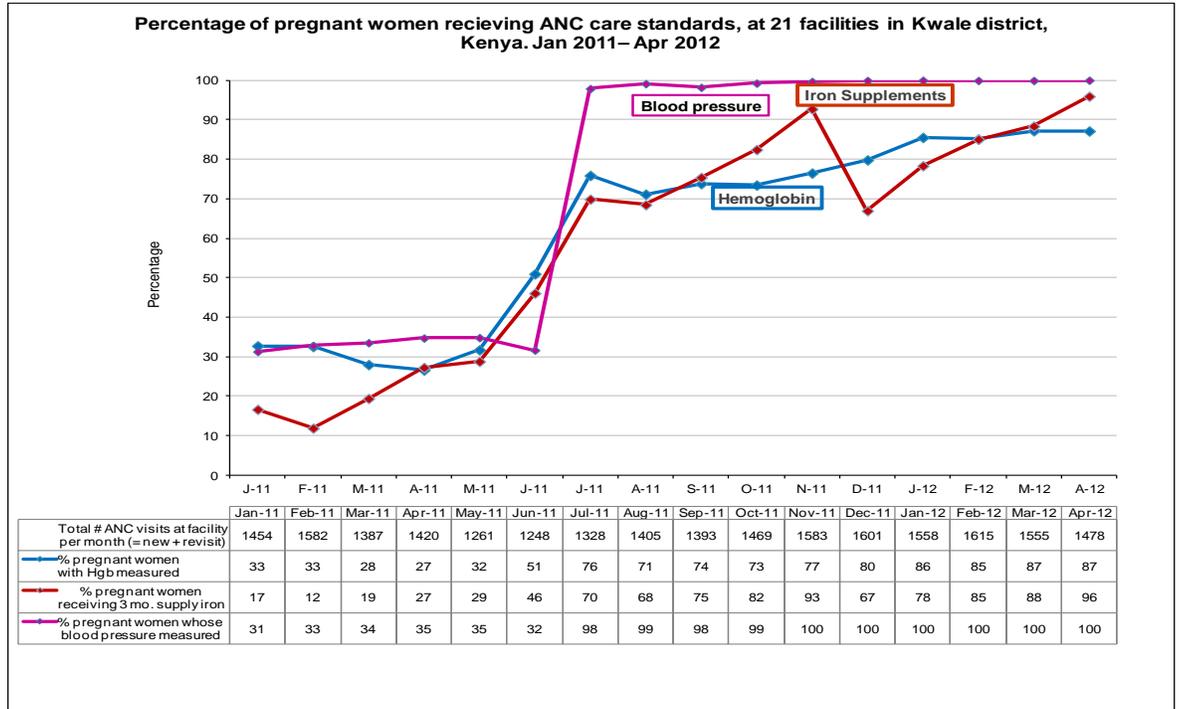
The supportive supervisor should take opportunities to get QI teams together to share their data and improvement experiences.

19. Present and explain the brain storming technique for encouraging innovation. The rules for conducting brain storming 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

20. Ask: How to motivate QI teams? Write responses on a flip chart

21. Present and discuss the importance and ways of motivating QI teams

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.

22. Get any participants' comments on the session as a whole.

23. Distribute and ask participants to fill out the session evaluation form.

Conclusion: Way Forward: Participants Planning and Presentations (4 hours)

1. Give a brief introduction: The value of the training is mainly in the action that will follow to improve quality of primary care. Participants are to develop a plan of action for what they will do based on the content discussed in the training.
2. Divide participants who share common geographic or administrative coverage areas into groups (For example, by province, district, or health clinic depending on the scope of the training). For example, each group could be formed of 2 supervisors working in the same district.
3. Ask each group to work together to answer the following questions:
 1. What will be their plan to form QI teams in health clinics under their supervision? (Specific health facilities and specific time frame).
 2. What will be the supervision schedule for each clinic under their supervision? (Specific supervision schedule).
 3. What tools will they use in supervision?
 4. How they will use the results of supervision?
 5. What will be their plan to provide on job mentoring/guidance and training to each QI team?
4. Give every team a chance to briefly present their plan

Course Evaluation and Closing:

1. Distribute and ask participants to fill out the course evaluation form.
2. Thank participants for their active participation, wish them success, and distribute certificates of participation as appropriate.

Module Four: Referral System

Module Objectives

- Understand health system in Iraq
- Explain concept of referral system

Module sessions:

Session 1: Basics of Health System

Session 2: Referral System

Evaluation/ Assessment

Questions and answers, participants' summaries, trainer's evaluation

Estimated Training Time

200 minutes

Session One: Basics of Health System in Iraq and Referral System

Session objectives:

At the end of the session, participants will be able to:

1. Define health system
2. Demonstrate the levels of health care in Iraq
3. Describe patient's flow inside each facility

Trainer's preparation

- Review the reading material and the session plan
- Prepare, as appropriate and recommended in the method column of the session plan, slides, or write the information on a flipchart or board where all participants can see them
- Prepare copies of the reference material/handouts and exercises
- Arrange training room.

Training methods:

Micro-session, brain storming, and view the presentation once and again

Resources

- Reference material/handouts
- Other: flipchart papers, markers, masking tape, and LCD monitor

Evaluation

Questions and answers, trainer's notes and participants' summaries.

Trainer:

Trainer experienced in referral system's protocols

Estimated training time

100 minutes

Session plan:

| Objectives | Contents | Training methods |
|---|---|--|
| 4.1.1 Define health system | It is the total of organizations, institutions and resources essentially aiming to improve health. There is an urging need to provide services with fairly costs and treat people properly at the same time. | Mini lecture (15 minutes) Questions and answers (10 minutes) |
| 4.1.2 Demonstrate the levels of health care in Iraq | <ul style="list-style-type: none"> ➤ Level one- Primary Health Care PHC (It is of two types: main and sub) ➤ Level two- Hospitals They are categorized, according to the kind of service they provide, to: teaching hospitals, special hospitals and general hospitals ➤ Level three- Specialized Centers They are categorized depending on the kind of service they provide | Mini lectures (25 minutes) |
| 4.1.3 Describe patient's flow in each level of health care levels | Determine the sequence of patient enrollment in PHCCs, Hospitals and Specialized Centers. In addition to the role of each of their units | Demonstration and re-demonstration (35 minutes) Discussion (15 minutes) |

4.1.1 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.

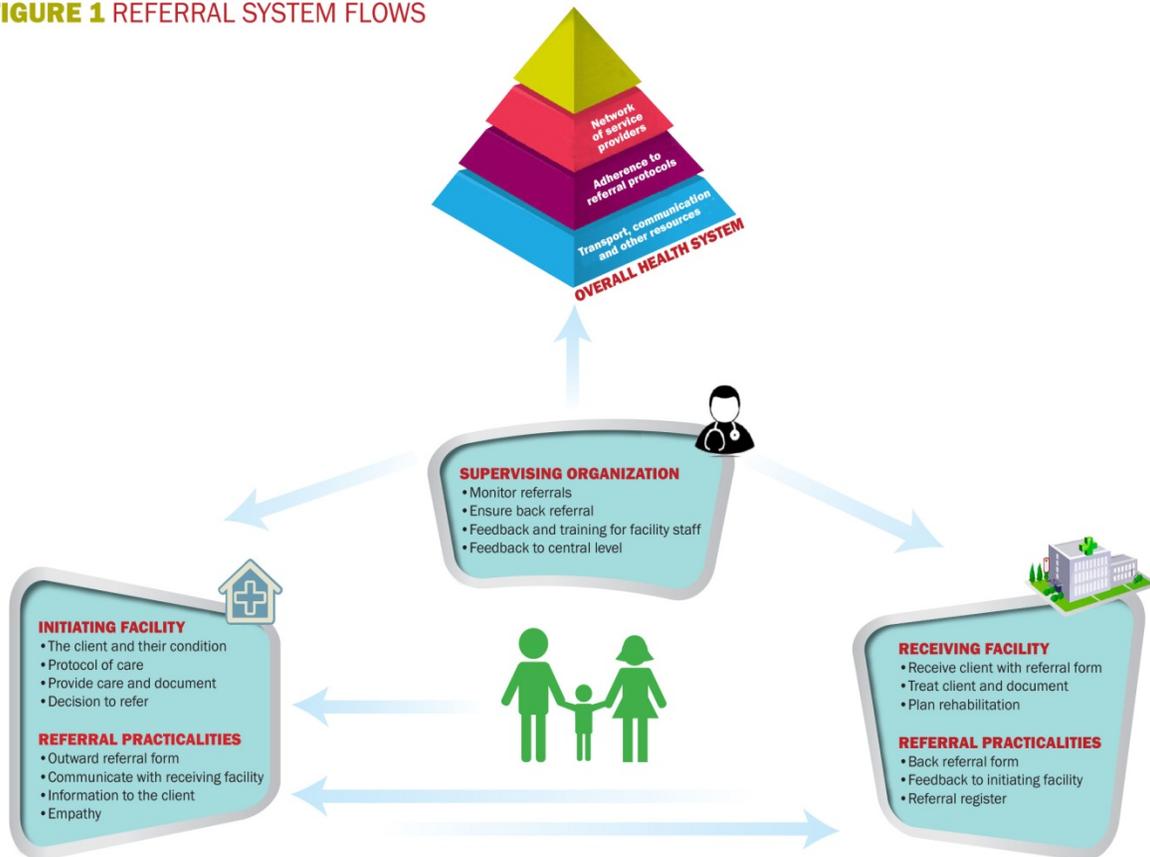
Health care are categorized into the following three levels:

Level one: Primary Health care

Level two: Secondary Health care

Level three: tertiary health care

FIGURE 1 REFERRAL SYSTEM FLOWS



4.1.2 Demonstration of the 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

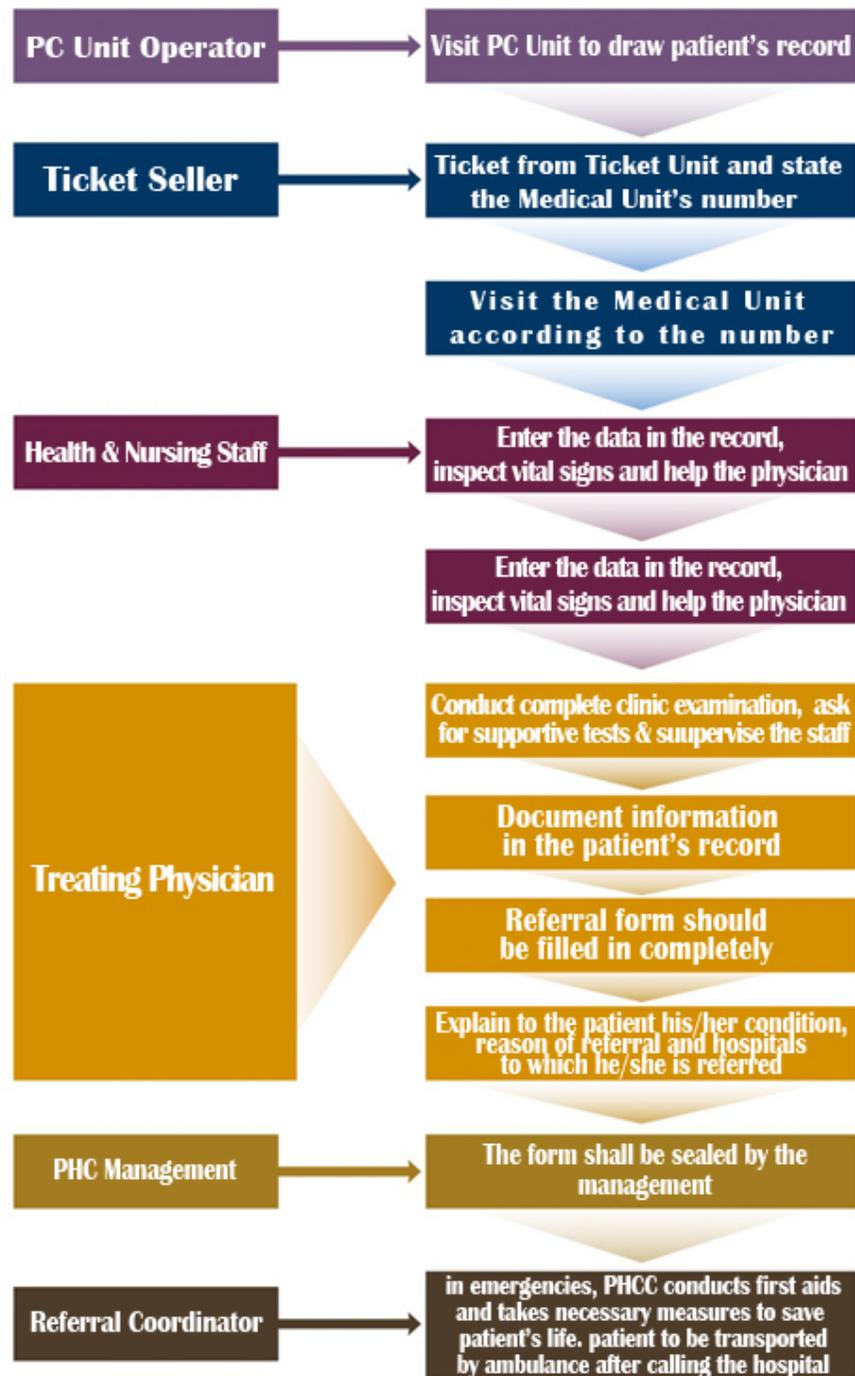
3- Third level (Specialized Centers)

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

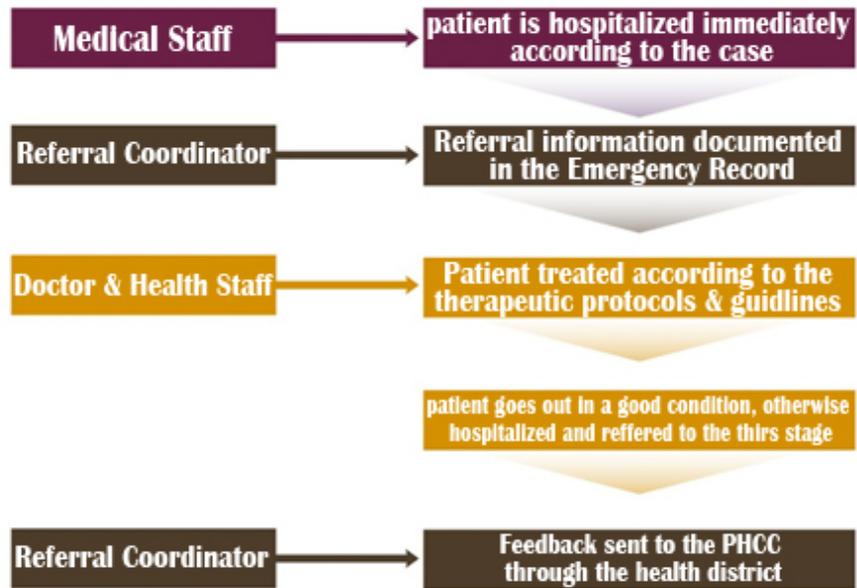
- Cardiac and Vascular surgery
- Sterility and In Vitro Fertilization (IVF)
- Endocrine Glands and Diabetes
- Kidney transplantation
- Bone marrow transplantation
- Blood diseases
- Artificial limbs
- Medical rehabilitation and physiotherapy

4.1.3 Diagram of patient flow inside each of PHC levels

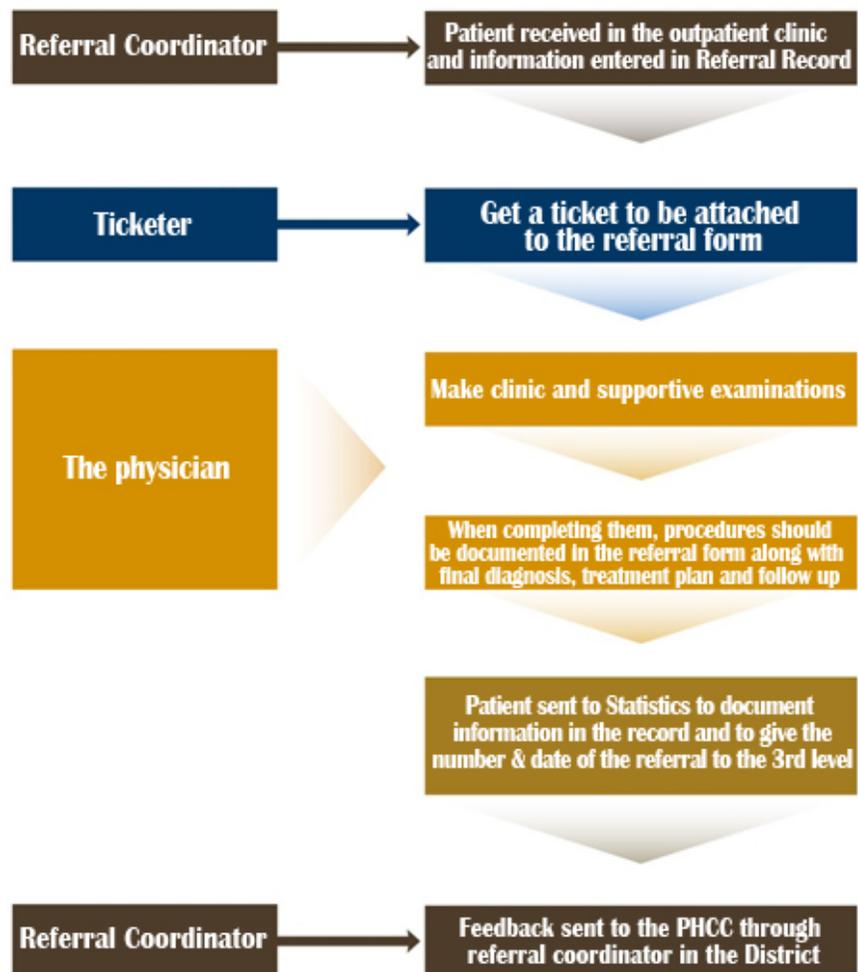
Patient Flow Inside the PHC Clinic



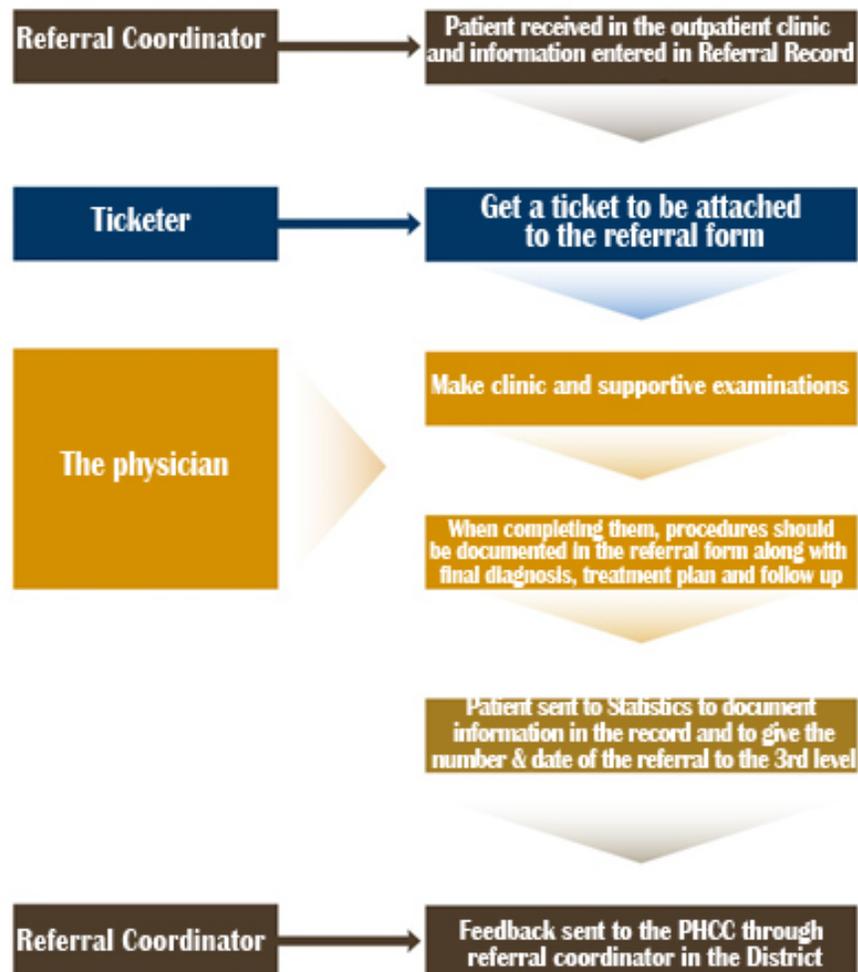
Patient Flow Inside the Hospital



Patient Movement in the Hospital



Patient Movement in the Specialized Clinic



Session Two: Referral System

Specific objectives of the session:

At the end of the session, participants will be able to:

1. Define Referral system
2. Define Referral and refer back
3. Describe Referral types
4. Demonstrate how to fill in referral form

Trainer's preparation

- Review the reading material and the session plan
- Prepare, as appropriate and recommended in the method column of the session plan, slides, or write the information on a flipchart or board where all participants can see them
- Prepare copies of the reference material/handouts and exercises
- Arrange training room.

Training methods:

Micro-session, brain storming, and playing roles

Resources

- Flipchart papers, markers and LCD monitor

Evaluation

Questions and answers, trainer's notes and participants' summaries.

Trainer:

Trainer experienced in referral system

Estimated training time

100 minutes

Session plan:

| Objectives | Contents | Training methods |
|--|--|--|
| 4.2.1 Define referral system | The system that provides high-level care, reduces the need of advanced medical interventions, allows segregation of duties between general physician and specialist, reserves time for specialists to develop their information, and rationalizes the cost of medical care. | Mini lecture (15minutes) Questions and answers (10 minutes) |
| 4.2.2 Define Referral and re-referral | <u>Referral</u> : is the process where the physician at the first or second level of health services, who does not have the specialized skills and diagnostic capabilities, asks for the help of the more specialized and equipped physicians that have capabilities to treat these cases <u>Refer back</u> : is the process of sending back the referred patient to the first unit of referral after dealing with referral causes in the second or third institution. | Brain storming (20 minutes) |
| 4.3.3 Describe referral types | <ol style="list-style-type: none"> 1. Immediate referral 2. Routine referral 3. Specialist consult | Brain storming (20 minutes) |
| 4.3.4 Demonstrate how to fill in referral form | <ol style="list-style-type: none"> 1. Referral form was designed to ensure that the same required information are received to both the sending and receiving institutions 2. The form is divided into three sections <ul style="list-style-type: none"> • First section: concerning the patient • Second section: referral facts • Third section: referral report 3. First and second sections are filled in by health center | Role Play (25 minutes) Questions and answers (10 minutes) |

| | | |
|--|--|--|
| | <p>physician or his second in the center's medical staff</p> <p>4. The physician at hospital or specialized center fills in the third section in order to record the exams and procedures done by the concerned party</p> <p>5. Each case is registered in the Register form existed in the three levels</p> | |
|--|--|--|

4.2.1 Definition of referral system

Referral system

The system that provides high-level care, reduces the need of advanced medical interventions, allows segregation of duties between general physicians and specialists, reserves time for specialists to develop their information, and rationalizes the cost of medical care.

4.2.2 Definition of referral and refer back:

Referral: is the process where the physician at the first or second level of health services, who does not have the specialized skills and diagnostic capabilities (with high costs) to treat these cases in the health centers, asks for the help of the more specialized and equipped physicians that have capabilities to treat these cases.

- Why the referral from first level to second level is made?

Because without that, the patient burdens himself and the service provider leading to squander resources on all levels, leave the health center physician out of the picture, and lack the continuity of care and the follow up.

Family medical records which were entered in all sophisticated international systems, act as mean of ensuring continuous and total health care. This requires recording all the information related to the family so these information can be used in health centers and hospitals in order to achieve the utmost gain for the person and family. Thus referral system is going to be of mutual interest for the patient, physician at HC and specialist at hospital.

Re-referral

It is the process of sending back the referred patient to the first unit of referral after dealing with referral causes in the second or third institution.

4.2.2 Referral types

Referral types:

1. **Immediate referral:** this procedure is taken in emergency cases that can't be treated in HCs. Let the patient receives first aids then refer him to the appropriate hospital according to the attached Emergency Cases Guide, as soon as possible.
2. **Routine referral:** it is made for the following purposes:
 - Specialist consultation
 - For the patient to enter the hospital and treated there.
 - The access of laboratory researches and more complicated and costly exams.

4.2.4 Demonstration of how to fill in 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

جمهورية العراق

وزارة الصحة

استمارة الاحالة

N:- 0000108

العدد/
التاريخ

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رقم

العمر

الجنس :

مركز الرعاية الصحية الاولى/

اسم المريض:

العائلة:

الجهة المحال اليها:

القسم,

Referring Summary

ملخص الحالة

Indications for referring:

Second opinion-----وجهة نظر طبية

Diagnosis-----التشخيص

Management-----العلاج

سبب الاحالة

-Chief complaint-----

-Relevant examination findings: BP: -----Pulse: -----Temp: -----RR: -----

-General examination-----

-Local Examination-----

-investigations:

Lab. Results:

Rad. Results:

-Initial diagnosis:

التشخيص الاولي

-Intervention:

-Name and sign of referring physician.

Referral report

تقرير الاحالة

-Date:

التاريخ:

-Clinical findings:-----

-Investigations:

Lab. Results:

Rad. Results:

Others:

-Final diagnosis:

التشخيص النهائي

-Interventions: Medication (type/dose):

المعالجة

Admission (Ward):

Surgical intervention (type):

Others (type):

Recommendations:

Refer to:

Revisit Date:

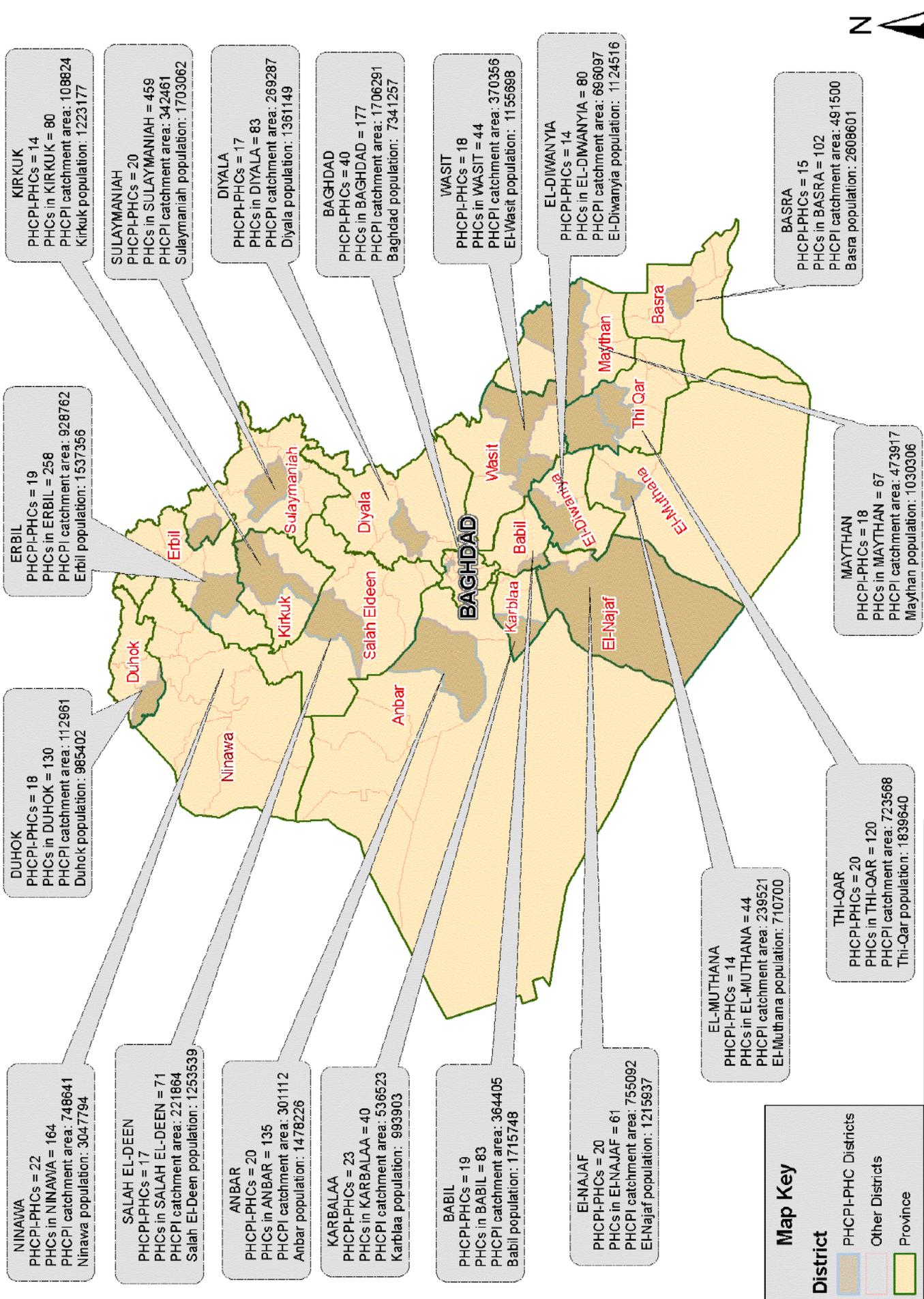
Others:

Name and sign. of specialist:

References

- 1- Communicable Diseases Control Guideline
- 2- Non Communicable Diseases Guideline
- 3- Infection Prevention and Waste Management Control
- 4- Early management and life support of trauma in PHC centers guideline
- 5- Early Detection of Breast and Cervical Cancer Guideline
- 6- Management of overweight/obesity in PHCC guideline
- 7- Premarital counseling guideline
- 8- Maternal and Child Nutrition guideline
- 9- Referral System Orientation Guide

PHCPI-PHCs population mapped to IRAQ population



Map Key

District

- PHCPI-PHC Districts
- Other Districts
- Province

U.S. Agency for International Development
Primary Health Care Project In Iraq
<http://phciraq.org/>
www.usaid.gov