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TRAINING CURRICULUM

ON SUPPORTIVE SUPERVISION

FOR PRIMARY HEALTH CARE CENTERS IN IRAQ

DISCLAIMER
This guideline has made possible through support provided by the U.S. Agency for International Development (USAID) under Primary Health Care Project in Iraq (PHCPI) implemented by University Research Co,. LLC. This guideline has been developed in Iraq in close collaboration with the Ministry of Health (MoH) in February, 2012

Contents

Foreword

Supervision is the critical action of watching, directing, and supporting a course of action.[1] It is recognized as critical part of human resource management for the delivery of quality health care services. [2]In order to ensure a quality PHC system, there must be a means for 'watching, directing and supporting' a correct course of action. Thus, supervision serves as a means of ensuring that PHC services and systems are delivered in a safe and quality manner. Supervisors assess current performance of PHC systems and services; identify gaps in performance, report findings and support improvements in performance based on improvement plans and standards of practice. To assist with these efforts, the Primary Health Care Project in Iraq (PHCPI) funded by the United States Agency for International Development (USAID) in collaboration with the Iraqi Ministry of Health (MOH) The USAID/PHCPI developed Guidelines for Health Centre Supervision: A Resource Manual as well as a comprehensive training curriculum which will therefore serve as a resource to supervisors when considering how to address the supervisory needs and ensure delivery of standardized PHC services tailored to meet the priority health issues faced by the majority of the population.

Quality Supervision can guide the development of curricula for In-Service, Pre-Service, and Continuing Medical Education (CME) Training Programs to improve PHC services/systems performance. This training manual will simply assist supervisors to strengthen the quality improvement (QI) supervisory process within PHC clinics including reviews, problem solving, and improvement planning. It provides tools for strengthening supervisor's information management and communication processes. It also will aid to determine appropriate checklists and mentoring materials for assessing, identifying and supporting improvements in PHC systems and service delivery.

PHCPI team are happy to join hands with all Iraqi health stakeholders to improve the PHC system and services compliance with standards, thus, facilitating better health outcomes for Iraqis.

[1] Merriam-Webster Dictionary: http://www.merriam-webster.com/dictionary/supervision, Accessed August, 17,
2 A Manual For Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services, 2010

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
ANC	Ante-Natal Care
BHSP	Basic Health Service Package
BP	Blood Pressure
CBO	Community Based Organization
CD	Communicable Disease
CHC	PHC facility Health Committee
CHW	Community Health Worker
CPR	Cardio Pulmonary Resuscitation
CS	PHC Clinic Supervisor
CSM	PHC facility Supervision manual
CVD	Cardio Vascular Disease
DG	Director General
DHIS	District Health Information System
DM	District Manager
DOTS	Directly Observed Treatment Short Course
RTH	Road to Health Card
EDL	Essential Medicine List
EHO	Environmental Health Officer
EPI	Expanded Program on Immunization
FEFO	First Expiry, First Out
FP	Family Planning
GOI	Government of Iraq
HBP	High Blood Pressure
HIV	Human Immunodeficiency Virus
ICMMS	Iraq Child and Maternal Mortality Survey
IEC	Information Education and Communication
IFHS	Iraq Family Health Survey
IMCI	Integrated Management of Childhood Illnesses
IPC	Infection Prevention and Control
IUCDs	Intra Uterine Contraceptive Devices
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NCD	Non Communicable Diseases
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PHCPI	Primary Health Care Project in Iraq
QA	Quality Assurance
QAP	Quality Assurance Project
QI	Quality Improvement
QS	Quality supervision
Rx	Treatment
SBA	Skilled Birth Attendant
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
STGs	Standard Treatment Guidelines
TB	Tuberculosis
TT	Tetanus Toxoid

Definitions and Terms used in This Manual

Checklist	A printable document used to examine the accuracy, quality, or condition of a health care activity. It has blank spaces for information to be inserted.
Facility manager	A person appointed, delegated or assigned to manage the overall PHC activities and personnel in one local PHC facility.
PHC	A set of prescribed services, defined in the Iraq Basic Health Service Package (BHSP).
Supervisee	A provider appointed, delegated, assigned to provide the actual health care to the patients, community and public at any PHC facility.
Supervision	The actual activity or duty that the supervisor and any other manager or coordinator, performed at the PHC facility during official visits or on a daily basis, as depicted in this manual.
Supervisor	A health officer that is appointed / assigned / delegated to observe and direct the execution of the work of the PHC personnel, including that of a facility manager, in one or more PHC facilities.
Red flags	Critical assessment elements that depict a warning of danger. The elements identified as such require immediate attention.

Part I About the training course

Introduction:

Well-conducted supervision provides critical support to health care workers who deliver services. Of the five factors in the performance improvement model, three of them (clear job expectations, performance feedback, and motivation) relate directly to the role of the supervisor. When that role is carried out with commitment to meeting service providers' needs, it helps close the gap between actual and ideal performance.

The concept of Supportive supervision is based on widely accepted quality management principles. It is an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between a supervisor and those being supervised.1 Evidence demonstrates that continuous implementation of facilitative, or supportive, supervision generates sustained performance improvement Rationale

Reviews of intervention studies other countries suggest that the simple dissemination of written guidelines is often ineffective, that formal and informal training, supervision and audit with feedback is generally effective, and that multifaceted interventions might be more effective than single interventions although few interventions have been evaluated with rigorous cost-effectiveness trials. For decades it was assumed that poor performance was simply due to lack of knowledge and skills. As a result, most interventions concentrated on training, which has had mixed and sometimes disappointing long-term results. We need to go beyond the old paradigm that most performance problems can be solved by training alone.

Supervision as an intervention deserves special attention due to the following reasons: 1) It can improve performance, at least in the short term; 2) If correctly done, it could be a mechanism for providing professional development, improving health workers' job satisfaction, and increasing motivation; 3) Although often dysfunctional, supervision systems are ubiquitous; 4) With decentralization, district supervisors are increasingly the only human contact between health workers in remote villages and the rest of the formal health system; 5) Most policymakers and managers already think supportive supervision is valuable (Rome A.K. et al., 2005). The main challenges for supervision are improving quality, increasing the time supervisors actually spend with health workers, and measuring its cost effectiveness.

The goal of this training course is to build supervisors' knowledge, skills, and attitudes, to enable you to apply a supportive approach to supervision to improve providers' performance and the quality of health care services.

Purpose of this manual

All PHC staff are supervisors in one way or another and thus need to understand basic tenets of supervision. This manual serves as a resource for supervisors to know what about quality supervision (QS). QS enables systems and services to run more efficiently and be more effective.

Thus, this manual will support the PHC staff in their role of improving the quality of PHC in PHC facilities by providing a set of flexible, adaptable tools and guidelines to reference. This manual may be used as a key resource during pre-service and in-service training for PHC staff regarding supervisor roles and responsibilities. By utilizing ideas and information from this manual, PHC trainers will better be able to devise and facilitate comprehensive training curriculum concerning QS. The purpose of this manual is to standardize the approach to supportive supervision and mentoring process and activities in PHC services. This manual will complement the National Supportive Supervision Guidelines for Quality Health Care Services developed by USAID/PHCPI in 2011,

BHSP developed by WHO in 2009 and Quality of Care Monitoring and Supervision System Handbook USAID-funded Training Model Primary Providers (TMPP) project in 2006.

This manual aims at training and professional development: thereby ensuring supervisory skills to improve delivery of care through engaging the PHC providers and users. The illustrative information system examples that are included could be used to create systems to measure quality and therefore form a base for continuous self-monitoring, evaluation and improvement including where applicable, accreditation of some programs.

Learning Objectives

Upon completion of the course, participants will be able to:

- Understand the difference between traditional supervision and Quality Supervision
- Summarize the Quality Improvement methodology
- Explain the Supportive approach to supervision
- Understand the roles and functions of facilitative supervisors within the supervisory system to ensure the fundamentals of care
- Review the elements of a primary health care facility's norms and standards
- Identify the application of checklists in practice
- Demonstrate strengths in assessing a primary health care facility's monthly reports.
- Provide a standardized definition of supportive supervision and mentoring;

Target Audience of the Manual

The target audience of this manual includes:

- Programme managers, administrators from PHC and districts of health in Iraq;
- Supervisors and who are responsible for PHC services at national, provincial, district and health facility levels; and
- Trainers who provide in-service and pre-service training to health care workers.

How to Use the Manual

This training curriculum is a guide to assist trainers in improving health care by training health professionals in the Supportive Supervision for Primary Health Care Centers (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 supervision 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.

The module schedule contains a condensed summary of the contents organized in sessions The time indicated for each session is an average time span based on experience, and can vary according to the composition and dynamics of each respective group.

The course content is presented according to three broad content areas (modules), subdivided into twelve sessions which present 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.

This training curriculum is designed to be used in tandem with the Supportive Supervision Manual and the Leadership and Management Training Curriculum. Participants are encouraged to use these materials as references when completing this training course. Reference page numbers are provided throughout this document.

Structure of the Training Course

The training course has been planned as a three days course. However, it is also possible to expand the time 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 different duration according to the material included. The number of course trainers/ facilitators can range from one to two per course according to the requirements. 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.

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.
End of course evaluation forms presented at the end of this manual.

Proposed Training Schedule

	Activities	**Time**
DAY 1	Session 1: Introduction to Quality Improvement	90 minutes
	Session 2: Quality Improvement Methodology	90 minutes
	Lunch	30 minutes
	Session 3: Quality Supervision	90 minutes
	Session 4: Supervisory Checklists	90 minutes
DAY 2	Session 5: Building Leadership Skills	90 minutes
	Session 6: Effective Team Building and Communication	90 minutes
	Lunch	30 minutes
	Session 7: Staff Development and Coaching for Success	90 minutes
	Session 8: How to Conduct Effective Supervisory Visits	90 minutes
DAY 3	Session 9: National Norms and Standards for PHC Centres	90 minutes
	Session 10: Problem Solving at the PHC Facility and District Levels	90 minutes
	Lunch	30 minutes
	Session 11: In-Depth Program Reviews	90 minutes
	Session 12: PHC Information Systems Guidelines	90 minutes
	Course Evaluations	30 minutes

Part II: Training Modules[3] [4] [5]

[3] Adapted from USAID/PHCPI Supportive Supervision Guidelines, Leadership and Management Handbook 2011
[4] USAID/AQUIRE project Facilitative Supervision for Quality Improvement –Trainer's Manual 2008.
[5] From Facilitative Supervision Handbook© 2001 EngenderHealth

Module I: Basics of Quality Improvement and Quality Supervision

Session 1: Introduction to Quality Improvement

Welcome: 15 minutes

Duration of session: 90 minutes

Materials needed: Guidelines for Health Center Supervision: A Resource Manual, pens or pencils, markers, flipchart.

Training Methods: Minilecture, Brainstorming and working in plenary

Learning Objectives: By the end of the session, participants will be able to:

- Define Quality Improvement
- List 5 elements of a QI model

Suggested Reading: Guidelines for Health Center Supervision: A Resource Manual, pp. 11-36

Welcome:

Welcome participants and introduce yourself

- Explain that Resource Manual has details of the key points and that it is a useful tool for reviewing this module after the session
- Allow participants to introduce themselves

1.1 Purpose for implementing QI in Iraq

In Iraq, the reconstruction of basic health services became a priority after 2003 when access and utilization of these services became a major problem compounded by the poor infrastructure and ongoing security issues. Currently, the Primary Health Care Project in Iraq (PHCPI) has started a QI process which addresses those factors which are amenable to change in the short- to medium term. In this way, PHCPI mobilizes Quality Improvement teams at Primary Health Care centers and will eventually lead to local health care reform.

The purpose of implementation of primary health care programs is:

- To overcome the serious deficiencies in the distribution of health resources
- To improve the availability and accessibility of essential health care services
- To improve health status indicators
- To support the development of a system that can take on a wider range of responsibilities. Countries worldwide are beginning to introduce the concept of quality into their health care systems because focusing on access alone has not demonstrated satisfactory results.

1.2 Definitions of Quality and Quality Improvement

Numerous definitions of quality exist.

For the purpose of this course, ***Quality of Care is defined as the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and is consistent with current professional knowledge.***

From the perspective of the health care provider: ***Quality means doing the right thing or taking the correct action, using appropriate evidence-based medicine that is implemented in a timely manner and communicated respectfully to the client.***

Dimensions of quality from the provider's perspective therefore typically include:

- decision-making;
- implementation;
- Communication

From the perspective of the patient: Quality means focusing on

- Patient satisfaction;
- Access to health facility and provider;
- Information and education;
- Communication, respect and caring; and
- Coordination and continuity of care

From the perspective of the MoH: ***Quality means focusing on accountability, efficiency and cost-effectiveness of services provided.***

1.3 Elements of the QI Model

QI facilitates dialogue and coordination among partners, donors, and stakeholders.

The elements of a QI model are:

- **Standards**: reference points adapted from international or national guidelines for a particular set of health services.
- **Organizational drivers**: This may be persons, teams, and/or organizations that facilitate and support the QI process.
- **Situation analysis**: An initial assessment performed to identify deficiencies, deviations, or gaps between the standards and actual practices.

- **Specific aims**: that provide a rationale and targets for what the QI effort is trying to accomplish. Specific indicators are identified to help track progress toward reaching the overall goal.
- **Identification and selection of interventions**: Various tools are used to identify and select interventions to narrow performance gaps.
- **Implementation of interventions**: a deliberate set of steps, which are used to close the gap between standards and actual practices documented during the situation analysis.
- **Monitoring and documentation of results**: Tools for monitoring and documenting QI results include repeated self-assessments, external audits, and run charts.
- **Community involvement**: in activities such as advocacy, awareness-raising, and active participation in the QI process.
- **Incentives and motivation**: these are financial or non-financial rewards to inspire providers to change and sustain behaviors and practices according to standards.
- **Scale-up plan**: devised to spread the interventions.
- **Sustainability plan**: to ensure that health care providers continue to perform according to standards over the long term.

Organizations implementing QI programs need to be flexible in their approach to QI. Stakeholders implementing QI approaches must place special emphasis on monitoring the impact of QI interventions.

Measurement of process and outcome indicators over time provides evidence for evaluating whether the QI interventions result in the anticipated change; and will guide efforts to modify and improve the interventions.

Summary

- In order to guarantee high quality services, there needs to be ***careful planning***.
- A Committee for Quality Management will need to know the current situation, human resources, material resources and prevalent health conditions.
- Managers must articulate a clear future vision; draft a mission statement with goals and strategies to achieve these goals.
- In order that improvements may happen within a system, it must be changed to yield better results
- Changes must address individual components of a system as well as the links between them.

Session 2: Quality Improvement Methodology

Duration of session: 90 minutes

Materials needed: Guidelines for Health Center Supervision: A Resource Manual, pens or pencils, markers, flipchart.

Training Methods: Minilecture, Discussion and Questions and Answers

Learning Objectives: By the end of the session, participants will be able to:

- Define the steps to QI
- Understand the Quality Cycle
- List the approaches to QI

Suggested Reading: Guidelines for Health Center Supervision: A Resource Manual, pp. 11-36

Suggested Reading: USAID/PHCPI - Quality Improvement Model

2.1 Steps to Quality Improvement

- In order to guarantee high quality services, there needs to be ***careful planning***.
- A Committee for Quality Management will need to know the current situation, human resources, material resources and prevalent health conditions.
- Managers must articulate a clear future vision; draft a mission statement with goals and strategies to achieve these goals.

There are **4 steps** to Quality Improvement namely Identify, Analyze, Develop, Implement. The act of implementing changes, and monitoring their effect is called a "quality cycle." ***Its components are "Plan, Do, Study, Act."***

Step 1: Identify - common problems and the dimensions of quality they affect

Problem	Effect on Quality
Drugs are not available at the health facility	Effectiveness, access and continuity of care are interrupted
Lab reports are lost	Efficiency and continuity of care are interrupted
Over-prescription/incorrect prescription	Poor performance, impaired effectiveness and efficiency of care

Activity: Ask participants to identify four problems at their own facilities

Case Example:

- A QI team has noted a shortage of drugs for respiratory infections among children ages 0- 5 years old.

How do we know that this is a problem?

- Drugs run out by the end of the second week of every month

How frequently does this occur?

- This has occurred every month for the past seven months

How has this affected quality of care at this facility?

- Pediatric patients develop complications
- There is an increased number of referrals to a higher level facility

How will we know when the problem has been resolved?

- When drugs will last until the end of the month

Step 2: Analyze – data, data, data

- Clarify the problem through flowcharts or cause and effect analysis
- Review existing data
- Collect additional data

Data helps to document the problem and identify possible solutions and provides credible evidence to pursue the need for improvement

Step 3: Develop hypotheses

At this stage, an educated guess is made about what changes would solve an existing problem but no testing is done.

- Individual Problem solving approach involves few individuals, less time and planning and brings about minor change in the system. It does not require teams or experts.
- Other approaches to problem solving at this stage may include Rapid Team Problem Solving where small changes are made; Systematic Problem Solving where larger changes are proposed; and Process Improvement where permanent monitoring is carried out over time.

Therefore, as the complexity of QI increases, the approach to problem solving will vary and the magnitude of the desired change will increase.

Step 4: Test and Implement

This is the stage for the Quality Cycle. It applies to each of the 4 approaches to QI and is illustrated below.

PLAN	▪ **Develop a plan for change** ▪ **Collect baseline data** ▪ **Educate and communicate**
DO	▪ Test the change ▪ Change must be tested according to plan ▪ Collect data and check for completion ▪ Document any change that was not included in the original plan
STUDY	▪ Verify that change is tested according to plan ▪ Collect data and check for completion and accuracy ▪ Compare data with baseline assessment to see whether an improvement took place ▪ Compare actual results with predicted results
ACT	▪ Summarize and communicate ▪ If no change is observed, modify or abandon the plan and repeat PDSA cycle ▪ If change is successful, then implement as standard procedure ▪ Monitor the change to check for improvement or problems ▪ Consider implementing throughout the system

2.2 Methods and Tools for Quality Management

There are many methods and tools for quality management, most are based on general management. Some important methods are:

- Accreditation
- Benchmarking
- Supervision internal/external
- Quality or Clinical 'Audit'
- Critical incidents
- Evidence based medicine
- Standards
- Practice Guidelines
- Quality Circles
- Indicators

Summary:

QI process:

- Identify: determine what needs to be improved
- Analyze: understand what must be known about the nature of the problem
- Develop hypotheses: from the information collected in the previous steps to determine what changes will lead to improvements in the system.
- Test and implement: Check to verify whether the proposed intervention led to the anticipated improvement

Session 3: Quality Supervision

Duration of session: 90 minutes

Materials needed: Guidelines for Health Center Supervision: A Resource Manual, pens or pencils, markers, flipchart.

Training Methods: Minilecture, Discussion and Questions and Answers

Learning Objectives: By the end of the session, participants will be able to:

- Define the concepts related to Quality supervision
- Describe the elements of an effective supervisory visit
- List at least two ways in which Traditional supervision differs from Quality Supervision
- Identify the responsibilities of the QI team
- Identify the processes that are important in health facility supervision

Suggested Reading: Guidelines for Health Center Supervision: A Resource Manual, pp. 11-36

Suggested Reading: USAID/PHCPI Quality Improvement Program Model

3.1 Concept of Supervision

By definition, supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, optimizing the allocation of resources, promoting high standards, team work and better two-way communication (Marquez and Kean 2002). The international supportive supervision guidelines similarly describe supportive supervision as a "process which promotes quality outcomes by strengthening communication, identifying and solving problem, facilitating team work, and providing leadership and support to empower health providers to monitor and improve their own performance." Supportive supervision involves directing and supporting health care workers in order to enhance their skills, knowledge and abilities with the goal of improving health outcomes for the patients they manage. It is an ongoing relationship between health care workers and their supervisors.

Some of the benefits of supportive supervision include: helping service providers to achieve work objectives by improving their performance, ensuring uniformity to set standards, identifying problems and solving them in a timely manner, making a follow-up on decisions reached during previous supervision visit, identifying staff needs and providing opportunities for personal development and reinforcing administrative and technical link between high and lower levels.[6]

PHC supervision can be thought of as analogous to car maintenance. Safe and high quality cars comply with international standards. In this way, cars become valuable and pose no risk to the owner and the public. A schedule of visits will determine whether all parts are in

[6] A Manual For Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services, 2010

working condition. The driver of the car must know how to operate the vehicle, and the supply of fuel must be adequate for travel.
Likewise, supervision of PHC facilities requires that the manager:

- Facilitate good teamwork and effective working relations at all levels of the PHC system.
- Ensure regular monitoring of information systems, communication strategies, health worker trainings, mentoring opportunities, performance appraisals and compliance with standards.

Activity:

Are You an Encouraging Leader? A Self-Assessment
Rate each of the statements in terms of your own leadership style, as follows:

A = This statement is definitely (strongly) characteristic of me.
B = This statement is somewhat characteristic of me.
C = This statement is probably not characteristic of me.
D = This statement is definitely not characteristic of me.

Rating	Points		
_____	_____	1.	I spend a great deal of time listening to my people.
_____	_____	2.	I have been spending more time fixing what my people do incorrectly.
_____	_____	3.	My people rarely have new ideas.
_____	_____	4.	My people trust me.
_____	_____	5.	I only recognize jobs well done.
_____	_____	6.	I have a talent scout's ability to see hidden assets and resources in my people.
_____	_____	7.	I take on too much; including what should be other people's responsibilities.
_____	_____	8.	I have created an atmosphere in which people can laugh at mistakes.
_____	_____	9.	My people see me as a perfectionist.
_____	_____	10.	I am a team player, and everyone has his or her responsibilities.

Calculate your score as follows:

For items 1, 4, 6, 8, and 10:	For items 2, 3, 5, 7, and 9:
• A = 4 points	• A = 1 point
• B = 3 points	• B = 2 points
• C = 2 points	• C = 3 points
• D = 1 point	• D = 4 points

Total your points: _____

- 30-40 = A highly encouraging leader
- 20-29 = An above-average encouraging leader
- 19-below = A discouraging leader

Key Points

The Language of Encouragement

When commenting about people's efforts, encouraging leaders don't place value judgments on what they have done. When we attempt to "praise" others, we often express our values and opinions rather than helping others believe in themselves.

Substitute words of praise, such as "good," "great," and "excellent," with words of encouragement.

Phrases that specifically recognize effort and improvement

- It looks as if you really worked hard on that.
- It looks as if you spent a lot of time thinking that through.
- Look at the progress you've made in ….
- You're improving in ….
- You may not feel you've reached your goal, but look how far you've come!

3.2 Traditional versus Quality Supervision

Refer to Table 1, Page 13

Although the traditional approach to doing supervisory visits is effective to some extent, it also has several shortcomings. For example, in the past the supervisors have leaned more towards facility inspection rather than guidance for problem-solving to improve performance. Supportive supervision promotes sustainable and efficient programme management through interactive communication, as well as performance planning and monitoring.

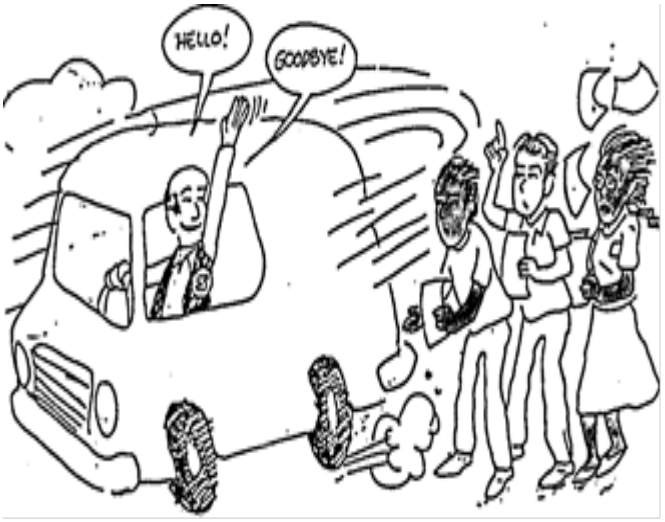
Traditional Supervision is done by external supervisors during periodic visits. The period between supervisions varies and no follow up is done following the visit. During the visit, a supervisor may inspect facilities, review records and supplies, makes decisions and usually does not discuss any findings related to the visit. The tools used during supervision are often designed by the supervisor who has identified a specific need.

Quality supervision is based on a self assessment by the health center staff and QI team, includes regular feedback from community groups and stakeholders and periodic visits from external supervisors. In addition it is characterized by the existence of a Technical Advisory Group which provides CME credits. It is a continuous process that occurs during routine work and through online mentoring.

Review of health facility's progress toward annual expected results and previous supervisory findings are integrated in an individualized development plan. During supervision, compliance with standards is observed, feedback and follow-up is provided, mentoring and training are ensured. After supervision, these findings are shared with a Quality Council and achievements are recognized. Online mentoring is continually available throughout the process. The tools used for supervision are standardized checklists, guidelines and accredited CME assessments.

3.3 Weaknesses of Traditional Supervision[7]

The traditional supervision does not deliver the desired results because of the following weaknesses:



- **It is superficial**.
  The supervisor isn't able to spend enough time at the site to become familiar with its problems or helpful in solving them. We call this "hello supervision"-supervision in which the supervisor arrives, collects statistics, and then rushes off to visit another site.
- **It is often punitive, fault-finding, and critical**.
  Traditional supervisors often come and go without any staff interaction. Because they don't have enough time or the supportive tools, supervisors often can only look for deficiencies, point them out to staff, and report them to headquarters.
- **It focuses on individuals rather than on processes**. Supervisors look at why an individual hasn't done a good job, rather than considering that the workings of the overall *system* or the process may be preventing staff members from performing well.
- **It emphasizes the past rather than the future.** Because the focus is on individual performance, the result is a report on what happened rather than a plan to improve things for the future.
- **It is not continuous**. Too often, supervision is sporadic and does not build on past experience.

3.4 Supportive Supervision

Supportive supervision is a system of management whereby supervisors at all levels in an institution focus on the needs of the staff they oversee. Supervisors who use the supportive approach consider staff as their customers. The most important part of the supportive supervisor's role is to enable staff-to manage the quality-improvement process, to meet the needs of their clients, and to implement institutional goals. This approach emphasizes mentoring, joint

[7] From Facilitative Supervision Handbook © 2001 EngenderHealth

problem solving, and two-way communication between the supervisor and those being supervised.

Supportive supervision casts the supervisor in the role of "middleman"- one who serves as a liaison between the staff and sources of external support. The supportive supervisor realizes that staff cannot provide quality services unless their needs are met.

Supportive supervision is different from traditional supervision because it:

- Focuses on helping staff solve problems through the use of quality-improvement tools
- Focuses on processes rather than on individuals
- Assists staff in planning for future quality-improvement goals
- Is continuous and builds on past gains while setting higher quality improvement goals

3.5 Benefits of Supportive Supervision

Supportive supervision may seem like a lot more work than traditional supervision. While this approach does require an initial investment of extra time, after using supportive supervision techniques, you will find that these techniques may end up actually freeing up time that can then be devoted to more appropriate responsibilities.

As staff learns to solve their own problems, you will have fewer routine, low-level problems to solve by yourself.

As other supervisors under your authority learn to supervise in a facilitative manner, you will need to provide them with less technical assistance.

- You will gain a reputation as a leader, an effective supervisor, and an enabler.
- You will be more welcome at sites because you help staff solve their problems, rather than criticize them for their faults.
- You will have the satisfaction of working as a team member, watching staff learn and grow and watching quality improve.
- Your job will become more fulfilling as your staff's motivation and commitment increase.
- Thus, supportive supervision is just as good for you, the supervisor, as it is for the people you supervise. In addition, the impact of supportive supervision is much stronger than that of traditional supervision.

3.6 Supportive Supervision and Quality Improvement

We have defined the supportive supervisor's main responsibility as implementing the quality-improvement process. Next we need to define what we mean by quality and quality improvement in the primary health care setting.

3.7 Responsibilities of a Supervisor/Coach

What is a coach?

- In the context of QI, coaches are mentors who model how to conduct QI. They support the team leader and the rest of the team when they have difficulties working together, get stuck or confused about what to do next, or need to learn new skills: for example, data skills, interpersonal skills and clinical skills (if they don't have the expertise themselves, they provide access to an expert who does). They help the leader and the team to become self-sufficient in the use of appropriate tools and procedures to function and solve problems by themselves. An effective coach has developed an understanding of how people work together in a team and how to improve the effectiveness of work within the team.

- Coaches help team leaders plan, conduct, and evaluate team meetings; observe team meetings to see how well the team is working; check data for accuracy; impart knowledge and build skills among individual team members and with the team as a whole.

- A QI coach may be from a district or regional health management team, such as a district health officer, who is appointed to support a number of teams in his or her geographical area. The organization that is conducting the collaborative can select and train appropriate members of their staff or local experts with a strong interest in QI to perform this function. A person who is selected to be coach should be a "champion" of QI and knowledgeable (or trained) in QI and coaching skills. Even if the new coach already has QI skills, he or she will need training in coaching skills and mostly likely additional QI training.

- A QI coach is someone who has QI skills (PDSA, data, working in teams, etc.) that will be used to provide support to QI teams in the various locations, or sites, who actually carry out the work of a collaborative.

- It is critical that the coach and the team leader have a good working relationship. They should have a mutual understanding regarding the roles and responsibilities of both the coach and team leader and their shared responsibilities.

- They help the teams to learn how to work together as a team using QI tools and methods, such as conducting meetings; collecting, displaying, and interpreting data; conducting PDSA cycles; and documenting changes.
- Periodic visits from coaches are critical to the well-functioning of teams.
- The goal of the coach is that the leader and the team will become self-sufficient in the use of appropriate tools and procedures.
- Coaches mentor team leaders, helping the team leader plan, conduct, and evaluate meetings, observing group processes and giving both supportive and constructive feedback.
- Coaches model how to "do" QI for teams, sharing their knowledge and abilities with them

Duties and Responsibilities of Supervisors for Site Visits

- Evaluate whether site QI teams are functional;
    - Review of the team composition and assist the site appropriately.
    - Team members have roles and responsibilities.
    - Number of meetings held, review minutes.
    - Level of completion of the action plans developed at the end of the QI training
    - Documentation of changes /Quality improvement efforts by use of the documentation journal.
- To assist teams in ensuring continuous data collection;
    - Ensure that QI teams understand the information needed for the indicators monitoring performance.
    - Review staff plans on data collection and assist accordingly to ensure that data is collected regularly.
    - Review data collected and changes implemented to improve care.
    - Identify and discuss challenges with data collection.
    - Ensure MOH tools (registers) are properly completed and regularly updated
- To facilitate site teams to start improving care:
    - Ensure that sites have collected information from the registers to establish gaps in their service delivery.
    - Facilitate sites in problem identification, analysis and solutions to the problems.
    - Review the documentation journal and assist site teams in linking changes to performance.

Proposed method of work by the Supervisors:

- Meet the facility administration/ in charge and give a brief on reason for the visit.
- Meet with site QI team members and discuss the above points.

- Demonstrate how to collect data on the different indicators.
- Verify information gathered (data, team members, team functionality).
- Assess all care providers for resuscitation skills.

3.8 Objectives of Quality Supervision

Refer to page 24 in the Resource Manual.

The objectives of QS are to ensure that inputs, processes, and outcomes (IPO) are in compliance with quality norms and standards.

- Inputs are those resources which are available to provide service
- Processes are those actions which are necessary for compliance with norms and standards
- Outcomes are defined as those targets, outputs, coverage, effects and service standards that need to be met by different clinical areas within PHC facilities.

3.9 Assessment and Facilitation

Refer to page 25 in the Resource Manual.

Assessment involves case management and resource management. Facilitation involves feedback and problem solving plus planning and monitoring. Assessment and facilitation are integrated through supportive feedback. Monitoring is done through review of previous plans and identifying activities for the next period. Supervision checklists, questionnaires and surveys are used for the purpose of assessing inputs and outputs. Data is displayed in the form of graphs and followed up at district and sub-district levels.

3.10 Monitoring [8]

Refer to page 33 in the Resource Manual: Figures 18 and 19.

Mentoring describes a process conducted by a mentor to a mentee in order to help the mentee to do a job more effectively. Mentoring can be conducted to all interventions but when applied in the clinical setting it is referred to as "clinical" mentoring. According to the WHO, mentoring is a "system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. Mentors need to be experienced, practicing clinicians in their own right, with strong teaching skills" (WHO, 2006).

The WHO further lists the objectives of mentoring as:

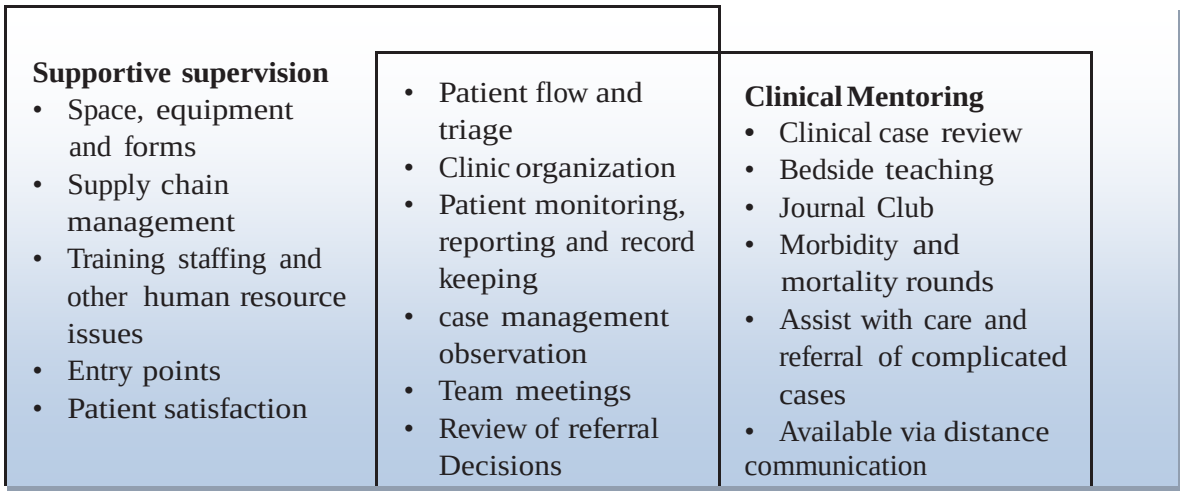
- Supporting decentralized delivery with high-quality care at all levels;
- Supporting the application of classroom learning to clinical care;
- Maintaining and progressively improving the quality of clinical care;

[8] From Facilitative Supervision Handbook© 2001 EngenderHealth

- Building the capacity of first-level health care workers (health centre staff) and second level health care workers (district hospital staff) to manage unfamiliar or complicated cases when appropriate; and
- Improving the motivation of health care workers by providing effective technical support.
- Data is usually presented as run charts or bar graphs to show change over time. It can be used to assess service use at health facilities. Combined with tables, it becomes an effective way to monitor quality of services without threatening the workers whose performance is being assessed.

How Supportive Supervision and Mentoring Overlap

Although supportive supervision and mentoring are two very different approaches, there are areas In which they overlap as indicated in the figure below.



Source: *Adapted from: WHO Recommendations for Clinical Mentoring to Support Scale-Up of HIV Care, Antiretroviral Therapy and Prevention in Resource-Constrained Settings*

While mentoring and supportive supervision have several areas of overlap, each requires different skills and should be undertaken by different, but complementary teams. Whereas mentoring mostly targets individual clinicians or small groups supportive supervision provides an excellent opportunity for follow-up training, to improve overall performance and solve other systemic problems that contribute to poor service delivery. Mentors need to be very experienced and practicing individuals while supportive supervisors can be trained management staff. At the clinic level, effective patient care requires that both mentors and supervisors monitor clinic activities such as patient flow and triage, clinic organization, patient monitoring, record-keeping, case management, team meetings, and review of referral decisions. As such it is important for these two systems to work together to maximize the effectiveness of each and to avoid duplication of efforts.

3.11 Resources Needed for Supportive Supervision

The main resources required are:

- Reliable transport;
- Adequate time for preparation, travel, field visit, reporting and follow-up activities ;
- Travelling allowances;
- Supportive supervision tools and stationery;
- Supportive supervision manual and the latest HIV intervention guidelines and SOPs;
- Monitoring and Evaluation tools; and
- Support for periodic review meetings.

Session 4: Supervisory Check list

(Afternoon session)

Duration 90 minutes

Training Methods: Working in groups

Learning Objectives: By the end of the session, participants will be able to:

- Describe the elements of an effective supervisory visit

This session will be a simulation of a basic in-person supervisory process. *Refer to page 21*.

- ✓ This lab will be a simulation of a basic in-person supervisory process. *Refer to page 21*.
- ✓ Participants are divided into 5 groups. Each team will choose one person to represent a supervisor and the other team members will act as staff.

- Appendix 1: Quality of Care Checklists
- Appendix 2: Material Resources Checklists
- Appendix 3: PHC Center Director Skills Checklists
- Appendix 4: Provider Skills Checklists
- Appendix 5: Women's Health Checklists
- Appendix 6: Integrated Management of Childhood Illnesses (IMCI) Checklists
- Appendix 7: Trainer Skills Checklists

Each team will choose one person to represent a supervisor and the other team members will act as staff.

Module II: Important Supervisory Skills

Session 5: Leadership Skills

Duration of session: 90 minutes

Materials needed: pens or pencils, markers, flipchart.
Leadership and Management for District and Primary Health Care Managers: Participant's Guide

Training Methods: Minilecture, Discussion and Questions and Answers

Learning Objectives: By the end of the session, participants will be able to:

- Describe concepts related to leadership and management
- Distinguish between leaders and managers
- List 2 characteristics of an effective leader

Suggested Reading: USAID/PHCPI Leadership and Management for District and Primary Health Care Managers: Participant's Guide 2011

5.1 Manager versus Leader

Manager: the person who has the responsibility of achieving certain outcomes having been given the authority to utilize the resources of the organization.

Leader: a person who manages people by creating high involvement and shared commitment that stimulates people to overcome obstacles in the way of achieving maximum results.

Potentially anyone could be a leader. Leadership requires personal qualities more than technical skills.

A good leader is characterized by

- social and communicative competence
- intuition and emotional intelligence
- ability to cope with given socio-cultural settings
- ability to cope with interpersonal relationships and unpredictable or irrational behavior

Effective leaders empower people. In doing so, leaders can adopt different roles. They may become:

- Teachers and coaches
- Facilitators of others who do the work
- Resource providers
- Communicators of the vision
- Climate setters

5.2 Basic concepts of effective leadership

Effective leadership deals mainly with communicative tasks and abilities, with different people involved in different roles and functions.

Leadership styles are classified into 4 groups.

The Autocrat: This leader takes all decisions and assigns all responsibility to himself. This is a top-down approach to achieve a singular objective. Team members are not asked about their opinion, and there is no common planning. This results in passive resistance from the team members and requires continuous pressure and direction in order to get things done. It spoils the resources of a team and leads to low performance.

The Paternalist: "You do what I say; I know what is best for you." This approach is friendlier within the team, but leaves team members out of any decision making. Sometimes the leader listens to their opinions but will not take them seriously into account, believing that he is the only expert. Although large resistance may not develop, yet the team's competence will not be used to achieve the objective.

The Democrat: The leader is a catalyst for group decision making and shared responsibility, but still maintains control of the group and the crucial responsibility for the task. The group may be allowed to choose a task; decide who will perform it and how it will be tackled.

The Laissez-faire manager: This leader leaves all decisions and responsibilities to the group. This approach may prove to be dangerous when a team is not well motivated and is not very clear about the task to be achieved. It works perfectly well when leading a team of highly motivated and skilled people who have produced excellent work in the past. By handing over ownership in this setting, a leader can empower the group to achieve their goals.

Ultimately leadership styles should be adaptive, so that an experienced leader is able to choose a style that depends on the problem at hand and the qualities of his collaborators. In settings where team members are not very competent, a leader may demonstrate directive behavior, in order to get the task completed. In settings where team members have low motivation, a leader may demonstrate supportive behavior, in order to encourage team members to perform in compliance with standards.

Therefore success factors for effective leadership are:

- Excellent interpersonal skills
- Ability to learn on the job
- Hard work and working smarter
- Ability and commitment to motivate people
- Linking strategic planning to implementation
- Facilitating teamwork
- Organizational development

5.3 Tips for Leading Staff

How can you lead staff and colleagues toward the goal of quality improvement? The following tips will help you guide staff in group decision making and foster commitment.

- *Share the vision of high-quality services.*

One of the best ways to motivate people is to share an inspiring vision. If you are excited about what the future could be for the site, if you are optimistic about the staff's ability to achieve that future, and if you are able to articulate it, you will inspire them to follow you toward that goal. A staff that is excited about the goal will be more willing to go through a process of change in order to achieve it. A leader could enable staff to envision what their service would be like if it were a model that every one came to see and learn from. Or, if infection prevention is deficient, a leader can conjure up for the staff a vision of high-quality infection prevention: sparkling tables, floors, and instruments; all staff cooperating in the effort to keep the site clean and disinfected; and an infection rate that plummets over time.

> The deepest need in all human beings is the need to be appreciated."
>
> **William James**

- *Build commitment and confidence.*

Emphasize the importance of quality improvement. Use recognition, praise, and positive reinforcement to build confidence. At the outset, guide the group toward solving small problems in order to build the confidence and expertise to tackle larger problems.

- *Be well informed and prepared.*

You can't expect people to follow you if you're not sure where you're going or what you're doing. Become expert in the skills, quality-improvement tools, and problem-solving methodologies that you will be transferring to your colleagues. Always be prepared for meetings and interventions.

- *Use facilitation skills.*

Show leadership in group meetings by using facilitation skills to keep the group on track and manage interpersonal and power related conflict.

5.4 Strategic versus operational change

Strategic change is defined in terms of vision and scope for the entire organization

Operational change is related to producing immediate effects on specific parts of the organization through systems, procedures, or technology.

5.5 Traditional Management versus Leadership for Change

In order for change management to occur, organizations need effective leadership which allows active participation of all team members with a clear sense of purpose and mutual support.

In such an organization, team members will gain experience and qualify themselves for promotion and advancement.

Refer to page 16 of the Participant Manual: Table comparing Traditional Management vs. Leadership.

Four conditions must be met in order to facilitate good leadership and management in any organization. These are:

- Ensuring adequate numbers of managers

- Ensuring managers have appropriate competencies
- Creating better critical management support systems
- Creating an enabling working environment

Summary

- Effective Leadership is one of several commonly identified principles in the health sector that lead to sustainable quality improvement worldwide
- Change is inevitable and is of two kinds: strategic change and operational change
- In an effective organization, team members will gain experience and qualify themselves for promotion and advancement.
- When leaders adopt coaching behaviors their team members are motivated to perform according to standards. *Refer to graph on page 12.*

Session 6: Effective Team Work and Communication

Duration of session: 90 minutes

Materials needed: pens or pencils, markers, flipchart.

Training Methods: Minilecture, Questions and Answers, Role Play and working in plenary

Learning Objectives: By the end of the session, participants will be able to:

- Demonstrate understanding of leadership styles
- Demonstrate an understanding of team work
- Explain important role of feedback in communication and know basic rules for feedback

Source: USAID/PHCPI Leadership and Management training program: Participant's Guide 2011

6.1 Team work

Effective teamwork is essential in today's world, but as you'll know from the teams you have led or belonged to, you can't expect a new team to perform exceptionally from the very outset.

Good team relationship is an attitude of respect for its members, and confidence in one another.

Working in teams means that there is a significant opportunity to increase performance and to improve performance impact.

For team building to be effective, leaders must first identify the issues their group is facing. Keep competition out of the exercises, and aim to make team building part of the daily culture.

A cross-functional team is simply a team made up of individuals from different functions or departments within an organization. Teams like this are useful when you need to bring people with different expertise together to solve a problem, or when you want to explore a potential solution.

As the manager, you'll probably be "leading equals," as you won't have direct authority over many of your team members. So, you'll need to use a more persuasive leadership style, rather than a controlling approach, to help them set their priorities. Often, this involves functioning as a coach, helping people make their own decisions and solve their own problems, rather than as a traditional manager who issues orders and distributes tasks.

6.2 Stages of Team Formation

"**Forming" stage:**
Members are positive and polite and the leader plays a dominant role at this stage. There may be discussions about how the team will work, which can be frustrating for some members who simply want to get on with the team task.

"Storming" phase:
Your authority may be challenged; and you must be aware that some members may feel overwhelmed. This is the stage when many teams fail.

"**Norming" stage**:
Team members come to respect your authority as a leader, and others show leadership in specific areas. The team develops a stronger commitment to the team goal, and you start to see good progress towards it.

"Performing" stage:
Hard work leads directly to progress towards the shared vision of goals, supported by the structures and processes that have been set up.

Individual team members may join or leave the team without affecting the performing culture.

Key Points

Teams are formed because they can achieve far more than their individual members can on their own, and while being part of a high-performing team can be fun, it can take patience and professionalism to get to that stage.
Effective health managers can accelerate that process and reduce the difficulties that team members experience by understanding what they need to do as their team moves through the stages from forming to storming, norming and, finally, performing.

6.3 Effective Communication

The trainer refers to Interpersonal communication Module in the leadership and Management Training program and uses the exercises illustrated in the course.

Few people know how to provide effective feedback.

Feedback is a good tool to also look into the relationship part of communication. It means having the opportunity to know and learn how we are perceived by others as well as being able to openly express what we think and feel about others.

It can reduce uncertainty, solve problems, build trust, strengthen relationships and thus improve work quality.

So feedback is:

☐ A piece of information for another person.
☐ Means having contact with another person in a regulated way
☐ An opportunity to know and learn
☐ An opportunity to openly express thoughts and feelings

Key Points:

- Understanding and being understood are not only matters of content as sometimes assumed, but involve all levels/parts of communication.

- A listener needs to be more sensitive to the possibilities of misunderstanding and of being misunderstood in a larger group. We often assume that our own thinking is also that of the other person. This is definitely not the case.

Supervisors:	
Who are your customers?	Site staff
What is your role?	To learn and use the new approach to supervision.
Supervisors of supervisors:	
Who are your customers?	Supervisors
What is your role?	To learn and use the new approach to supervision and to train other

6.4 Constructive Feedback[9]

As a supervisor, you are called upon to evaluate the performance of staff and the quality of the services they provide. As part of this evaluation, you need to discuss your findings with the staff. This is called *feedback.* Feedback can be:

- Negative-overly critical, causing hurt feelings
- Positive-supportive, causing good feelings
- Punitive-focusing on assigning blame
- Constructive-focusing on the solutions to the problem

When performance is good and the quality of services is high, the supportive

[9] From Facilitative Supervision Handbook© 2001 EngenderHealth

supervisor never fails to acknowledge and praise. Congratulations on a job well done are *always* in order.

However, there will be circumstances when performance and quality need to be improved. Supportive supervisors keep in mind that the people they supervise are their customers and must always be treated with respect. Therefore, supportive supervisors always give positive feedback. In addition, supportive supervisors understand that their job is to help their customers solve problems. Therefore, supportive supervisors always give constructive feedback and ensure two-way communication.

6.5 Group Dynamics: Working Effectively with Groups

As a supportive supervisor, your goal is to help your customers, whether they are other supervisors or PHC centre staff, solve their quality-related problems by themselves. In order to improve quality, site staff will have to work as a group or team to address their problems. Most staff has little experience in working effectively in groups, and even less experience in groups comprising different levels of staff. Consequently, your job as a supportive supervisor is to learn how to work effectively with groups and coach other supervisors or clinic managers in these skills.

Working with groups may seem difficult to you. But the proverb "many hands make light work" applies here. Eventually, as the site staff learns to work effectively as a team, their collective wisdom and experience will enable them to solve their own problems, thus lessening the burden on you.

In order to work effectively with groups, you will need to know how to

- Foster a nonthreatening environment
- Encourage different levels of staff to work together
- Encourage different types of people and personalities to work together
- Manage and resolve conflict
- Transfer these skills to your customers (other supervisors or clinic staff) through coaching

6.6 Fostering a Nonthreatening Environment[10]

Why should you foster a nonthreatening environment? Because a threatening environment will militate against problem solving, since staff will not contribute their insights and ideas if they don't feel comfortable.

Consider the following components to ensuring a nonthreatening environment.

Respect

All members of the group must feel valued and appreciated. No member should be treated with disrespect. As a supportive supervisor, your role is to model respectful treatment of all the members, regardless of their rank, seniority, or position. The following behaviors will help foster a respectful environment.

[10] From Facilitative Supervision Handbook© 2001 EngenderHealth

- Use good communication skills with everyone. This will show that the per- son's opinion is valued regardless of his or her position in the organization's hierarchy.
- Set ground rules at the outset (e.g., that interrupting people, attacking people rather than ideas, sarcasm and the like are not acceptable behaviors in the group).
- Deflect or neutralize aggressive behavior.

Confidentiality

If staff is to feel free to voice their opinions in group meetings, it is important to establish ground rules at the beginning. For example:

- The group may agree that all discussions will be held in strict confidence.
- This rule should be adopted at the outset and restated after each meeting.
- Confidentiality does not necessarily have to apply to all of the group's deliberations, but may pertain only to certain topics or kinds of interactions. Members should agree at the beginning of the discussion whether to keep it confidential, if necessary.
- A member may request that his or her statements in a given situation be kept confidential. Members must honor such a request.
- If it is learned that any member has broken confidentiality, the supervisor Should approach the member, remind him or her of the rule, and explain the negative impact of the breach. Breaches of confidentiality leave group members feeling vulnerable and cause them to participate less frequently and less honestly. As a supportive supervisor, your responsibility is to deal with such breaches and instruct other supervisors to do so as well. (Harrington-Mackin 1994.)

Physical environment

If you have a choice of venue for group meetings, select one with the appropriate physical environment. Group members need to feel comfortable in order to participate fully in meetings. If they are uncomfortable, they will not pay attention, will try to leave early, and will refuse to interact. In choosing a meeting place, pay attention to the physical elements:

- Temperature (not too hot, not too cold)
- Lighting (not too dark, not too bright)
- Noise (choose a place without distractions)
- Seating (make sure there are enough chairs-no one should be standing-
- and that the chairs are as comfortable as possible)
- Ventilation (choose a place with air conditioning or windows that can be opened so that the room doesn't get too stuffy)

Last, pick a location and setting where all members of the group should feel at ease (e.g., low-level staff might feel uncomfortable in a meeting held in the director's office). Choose a meeting space that most people are familiar with, if it meets the other requirements.

Session 7: Staff Development and Coaching for Success

Duration of session: 90 minutes

Materials needed: pens or pencils, markers, flipchart.

Learning Objectives: By the end of the session, participants will be able to:

- Demonstrate understanding of human resource development and QI
- Describe the role of performance interviews
- List at least 3 steps of coaching

7.1 Health Facility Staff Development

Managing performance is one of the most important components of any human resource development (HRD) system. It involves:

- Written job descriptions
- Defined supervisory relationships
- Regular work planning meetings
- Performance review
- Opportunities for training and staff development.

Some basic rules for managers (superiors, team leaders) are to avoid defining targets or standards which are:

- not measurable, exaggerated, too general or vague,
- focused on activities without a clear purpose,
- over-optimistic or pessimistic,
- too numerous, lengthily and indeterminate in terms of time,
- unethical or illegal.

Performance interview is a summary of earlier meetings, with a major portion of the interview time devoted to a discussion of future performance and career development planning.

7.2 Coaching

Coaching involves interaction in which someone helps someone else to learn to do something new, to solve problems and issues, to achieve goals and attain success.

It is regarded as a process of continuous human resource development and quality improvement. Most people occasionally get stuck with a problem that they can't solve. It is sometimes considered a sign of weakness to not be able to solve a problem without outside help.

A coach mainly listens, promotes reflection, gives feedback, may offer stimulus, and encourages new ideas and experimentation.

Coaching can be a useful tool in handling changes in routine work, but also after the introduction of new performance standards and objectives and other processes.

The coach can be a superior, as well as a colleague or an expert. Experts may be fairly directive, and usually non-experts may be supportive facilitators (non-directive).

> Coaching is a training approach that seeks to achieve continuous improvement in performance through motivation, modeling, practice, constructive feedback, and gradual transfer of skills.
> Adapted from **Landsberg 1997.**

In the district health system, coaching could be a useful tool in the development of human resources. Especially the development of new and/or young staff to competent members of the health workers community in the district can be supported through a coaching system.

Steps involved in coaching [11]

In modern supervision the situation between supervisor and supervisee is described as a coaching situation. The steps of coaching can be followed in supervision as well as in specific coaching situations.

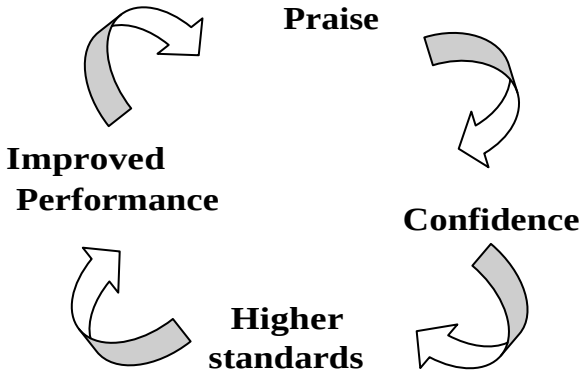
- questions to open up
- questions to penetrate
- offering information on resources
- be an active listener. Use listening to inform the exploration of the "problem"
- summarize – offer reflective descriptions of what was said, the stage you have reached, what has been agreed

7.3 Motivation

An understanding of the drawbacks of traditional supervision will help motivate your customers (site staff or other supervisors you are coaching) to learn the supportive supervision approach. For example, in explaining supportive supervision, you may want to choose an existing supervision problem and discuss why traditional supervision has not been successful in solving it. Or you may choose a problem that someone else at

[11] From Facilitative Supervision Handbook© 2001 EngenderHealth

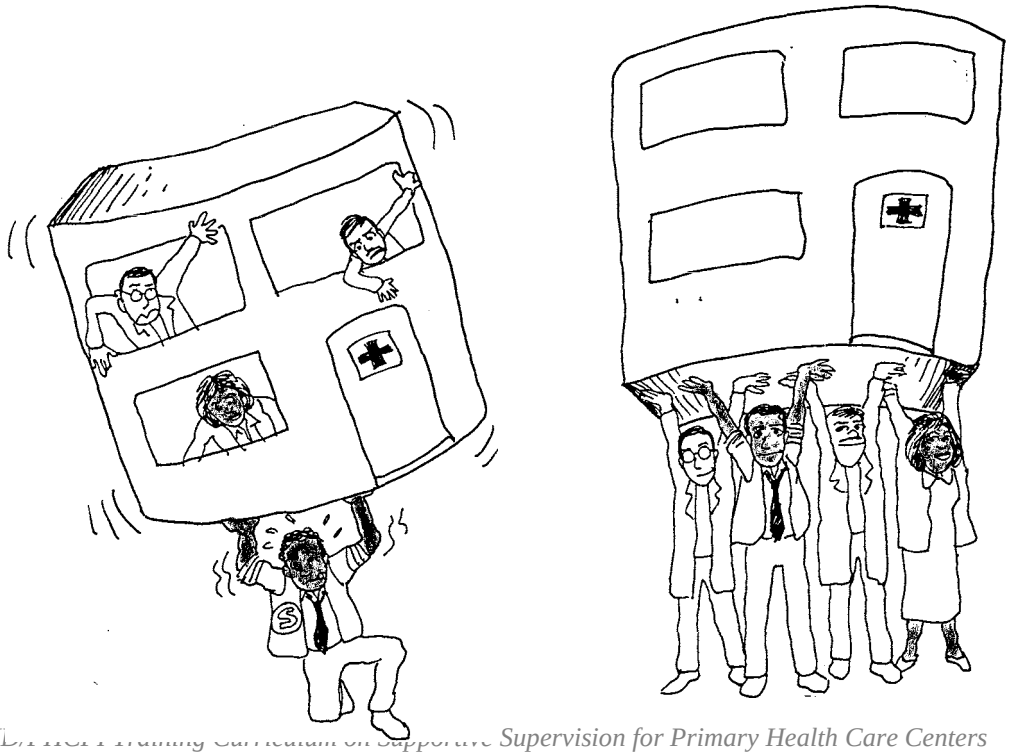
another site is having (without naming the person or the site) as an example of the failure of traditional super- vision. Explain how supportive supervision could solve this problem. You can also give supportive supervision success stories from other sites. Express your firm belief that the person you are coaching will be able to learn and apply the new approach. Praise this person for the good work done as a supervisor to date and explain that the new approach will allow an even better job.



Modeling/Demonstration

As you coach staff, do so in a supportive manner using the communication skills described in this chapter. If you supervise site supervisors, travel with them to their sites and help demonstrate how supportive supervision works in practice.

You can model the facilitation skills described in this manual, demonstrate the use of the quality improvement processes and tools recommended, and serve as a role model in your respect for clients' rights and health care staff's needs.



7.3 Training and continuing education

Organizations are dynamic. Organizational change requires new professionals and continuous learning for the existing staff.

Trainings needs are identified by comparison of task analysis and the existing staff in an organization. Training and continuing education contribute to high quality services and standards.

Because adults have many practical experiences and often only need to put these experiences in systems, the trainer acts more as a facilitator than a lecturer. Adults start their learning process from the identification of problems.

7.4 Managing People and Conflict Resolution

Encouraging people to work together

- When attending group meetings, a facilitator supervisor must convey the message that "We are all in this together, and everyone has a valuable role to play"
- Engage lower level staff in the meeting, assuring them that here is no penalty for pointing out problems, smiling and making eye contact
- Adopt a respectful attitude toward all staff
- Encourage staff by using both verbal and non-verbal cues
- Provide positive feedback and constructive feedback. Both are significant ways to encourage people

Managing difficult situations and different personalities

- Aggression inhibits team members from working toward a common goal. A facilitative supervisor has to control aggressive behaviors in order to improve the group dynamics.
- When someone is trying to impose an idea on the entire group, try to involve each group member in discussing the positive and negative aspects of that idea.
- Remind the group that personal attacks are not acceptable. Separate judgment from facts.
- When team members exhibit insulting behaviors, call for short breaks and help them to calm down.
- Use team building strategies such as reminding them about their responsibilities, their value to the group and advocating for the goals of the group. Acknowledge each person's contribution to the work and respond to their concerns with honesty.

- Acknowledge the anger, ask for reasons related to the outburst and provide a caring, specific response

Steps in conflict resolution

Definition: A conflict is the result of a difference between several points of view.
Hence, in order to maintain motivation within the team, a supervisor needs to deal with conflicts in a constructive manner.

- **Analyze the problem**: do not jump to a conclusion without a complete analysis
- **Examine the facts**: the situation, the context, people involved, stakeholders involved, individual points of view
- **Define the conflict**: speak to individual team members to analyze their point of view, decide where is the contradiction between them
- **Diagnose the conflict**: what preceded the conflict, what are the individual interests involved, what advantages are available to each party, what power issues are involved
- **When there is a misunderstanding:** explain the situation explicitly
- **When different points of view cannot be changed:** accept them
- **Implement solution:** which is chosen by all
- **Evaluate solution**: if there is no resolution, begin the process again

Two qualities need to be understood before discussing the Thomas-Kilmann Conflict Mode Instrument. *Refer to page 109*

Assertiveness: the extent to which a member satisfies his or her own interests
Cooperativeness: the extent to which a member satisfies the concerns of other people

There are 5 options for dealing with a conflict.

- ➢ Competing—a power-oriented mode
- ➢ Accommodating—the opposite of competing (You neglect your own concerns to satisfy those of the other person.)
- ➢ Avoiding—choosing not to address the conflict by postponing, sidestepping, etc. (You do not pursue your goals or those of the other person.)
- ➢ Collaborating—the opposite of avoiding (By collaborating, you attempt to involve the other person in finding a solution to the issue at hand. It means digging into the issues to find an appealing alternative.)
- ➢ Compromising—trying to find a mutually acceptable solution that is at least somewhat satisfactory to both parties

The basic point of the model is to make you aware of the choices and of people's tendency to use one mode more often than another. Supervisors need to remember that the best option is collaborating.

Facilitation of a group is done by involving everyone, keeping on track with objectives, managing conflict, reaching an agreement, dealing with difficult behaviors, providing feedback, maintaining good communication, creating a non-threatening work environment, and fostering leadership skills in others

Activity

Choose a historical figure, movie star, sports figure, or anyone about whom your table group knows a lot.

- List some of the negative traits and characteristics of this person.
- List some of the positive traits and characteristics of this person.
- Discuss how this exercise can help you to change your perception of this person.

Session 8: How to Conduct Effective Supervisory Visits

Duration of session: 90 minutes

Materials needed: Guidelines for Health Center Supervision: A Resource Manual, pens or pencils, markers, flipchart.

Training Methods: Discussion and working in groups

Learning Objectives: By the end of the session, participants will be able to:

- Describe the elements of an effective supervisory visit
- Understand key elements of supervisory visits
- Demonstrate an understanding of patients' rights

Note to Trainer:

This is a continuation of day one afternoon (session 4). Participants who have not finished reviews of previous checklists may use this time to look over them before proceeding to the checklists for this lab.

- ✓ This session will be a simulation of a basic in-person supervisory process. *Refer to page 21*.
- ✓ Participants are divided into 5 groups. Each team will choose one person to represent a supervisor and the other team members will act as staff.
- ✓ Participants will review *pages 78 to 89 of the Resource Manual* along with checklists in *Appendix 8*.

Good supervisors promote compliance amongst all facets (management, clinical care, and community involvement) of the PHC system. In order to ensure quality in Iraq's PHC system and services, staff must be aware of how to support continuous monitoring and maintenance of performance improvements. Supervisors must monitor and support improvements in performance with prescribed management, clinical and community engagement standards, guidelines, and targeted health outcomes. The PHC facility supervisor creates a vital link between service management and service delivery within PHC facilities. In order to sustain this linkage, the supervision needs to focus on a number of key areas during an on-site PHC facility visit.

In-depth Program Review: During the course of the year the Supervisory team will conduct in-depth reviews of all functions of PHC centres. The correct application of standard guidelines is of great importance to ensure high quality care. The Supervisory team will concentrate on the correct use of SOPs by PHC personnel in order to ensure that PHC facility personnel are conducting and maintaining quality health systems and services, thus reinforcing correct practices and ensuring adherence to established standards.

Problem solving: Solving problems related to all aspects of the PHC facility is an integral part of the supervisory process. The supervisory team should engage with PHC facility personnel around problems, which are being experienced. Many problems can be dealt with on the spot at the PHC facility whilst others will have to be taken to the district or addressed by e-training or other mentoring options. A note will be made of problems requiring

solutions at a higher level and actions taken will be reviewed at the subsequent supervisory visit.

Information System Review: A functioning PHC information system is essential for the effective management of PHC Services. The supervisory team plays a very important role in ensuring the accuracy and validity of the information system. The supervisory team concentrates on ensuring the proper use of the PHC facility registers, the correct completion of the monthly PHC report, the correct documenting and graphing of patient, medicine and equipment data and the use of data for health service planning and monitoring accomplishments at the PHC facility level.

Referral System Review: Dealing with referral problems is an important element of the supervisory visit. Any problems with referrals, in terms of patient movement as well as communication between PHC facilities and higher levels will be investigated and facilitated.

Training: The supervisory team is responsible for ensuring that PHC facility health care personnel are updated, trained and appropriately mentored in weak performance areas. Thus, the team will support the facilitation and/or connecting of staff with educational/mentoring sessions during each visit designed to address specific needs of the PHC facility health care personnel, covering elements of PHC facility service provision (updating and implementing program changes), health care personnel management (new rules and regulations related to government service) and PHC facility administration.

PHC facility Administration Review: The supervisory team should review certain administrative aspects related to the PHC facility. This would include health care personnel matters, financial matters, infrastructural aspects such as building, water supplies, electricity, grounds, equipment, supplies as well as regulatory and legal issues i.e. Infection Prevention and Control (IPC) collection of vital statistics, etc.

Community Involvement Review: The supervisory team will enquire about issues related to community involvement during each visit. Regularity and participation of PHC facility health care personnel in PHC facility and community committee meetings will be assured. Concerns of the PHC committee will be brought to the attention of the District Management and any community problems that need urgent attention (disease outbreaks such as cholera in internally displaced communities (IDPs), etc) will be noted. The CS will also encourage PHC facility personnel to plan and conduct specific community outreach activities on a regular basis to elicit community feedback on PHC services.

Other: PHC facility staff often has personal issues/problems that need to be addressed. The supervisory team should be available to sympathetically listen to these issues and support and assist health care personnel as far as he/she can in dealing with personal problems/issues, so that their work quality is maintained.

Specific tools have been developed to support each set of activities, which should receive attention during the visit. These tools include checklists (program review lists, community participation assessment checklists, etc), guidelines (information system) and information, which may support certain activities (problem solving diagrams, flow charts, graphs, etc).

8.1 General Supervisory Process during visit to PHC facility

The basic in-person supervisory process consists of five steps:

1. Regular review of PHC facility performance - this includes the completion of the red flag checklist and monthly checklist. This step will cover and integrate the review of PHC facility administration, the information system, referral system, PHC facility services and community participation activities. This step should last between 60 – 90 minutes. These checklists are very important as they allow systematic and standardized assessment of important elements of service provision. The checklists also allow similar review processes to be conducted at different PHC facilities.

2. In depth program review - during this step individual clinical program reviews are done and should take about 45 minutes.

3. Problem solving discussion - Duration 30 minutes.

4. Training - the focus of this step is to do in-service training. Duration about 30 minutes.

5. Review of previous actions taken during last month and new actions for forthcoming month - an essential step in the supervisory process is to reflect on progress made since the last supervisory visit and identify activities, which should be completed by the next supervisory visit. The monthly checklist provides an opportunity to document progress and the number of planned activities for the next period. Duration 30 minutes.

The duration of the visit should be between three to four hours. All steps should be completed at least once per month.

8.2 Tips for Supervisory Team

Supervisors need to be trusted and respected in order to properly support QI in the management of the PHC system and its services. To facilitate a strong and positive relationship between the supervisory team and PHC centre staff, the team should focus on the following supervisory tips.

- ***Be Friendly***: Spend some time reacquainting yourself with the PHC staff by exchanging some pleasantries about what has happened in their lives since the last visit.

- ***Start with the Positive***: Initiative discussion about supervisory visit findings with positive feedback.

- ***Relate Finding to Guidelines***: Focus on facts and findings related to work guidelines, not on supervisor's feelings.

- ***Assess the Situation Together***: Where there is a problem, analyze the problem with the supervisee to gain a good understanding of what has been causing the problem; otherwise you could propose the wrong solution.

- ***Be Constructive***: Once you believe you know the causes of problems/poor compliance, try to get the supervisee to suggest possible solutions, since a person is more likely to accept ideas that they have come up with themselves.

- ***Support Follow-Up***: Provide hard copy materials, e-resources, and on-the-spot mentoring regarding identified performance gaps. Create an action plan (including immediate and long-term corrective actions) with the supervisee on how to improve observed weaknesses.

Exercise: Role Playing a Supervisory Visit

Participants should break into small groups and act out the in-person supervisory process. After one participant pretends to the supervisor, the other participants give feedback on how well they followed the tips mentioned above. Then, the participant playing the supervisee discusses how s/he felt about the feedback s/he received and how it was communicated.

Module III: Guides for Quality Supervision

Session 9: National Norms and Standards for PHC

Duration of session: 90 minutes

Materials needed: pens or pencils, markers, flipchart.

Training Methods: Minilecture and Questions and Answers

Learning Objectives: By the end of the session, participants will be able to:

- Understand the norms and standards
- List the key standards for PHC facility

Suggested Reading: USAID/PHCPI Supportive Supervision Guideline Manual 2011

Norms and standards are important in to ensure quality of services and continuity of care across different levels of the health care system. They guide policymakers, planners, and managers with regard to the expectations, rights and obligations of each role player. It would be impossible to institute quality improvement without a basic and uniform understanding of what constitutes quality. Norms and standards should be developed as part of a consultative process among all stakeholders, and adapted to meet the various needs of different regions, communities, and facilities. This section provides examples of standards and norms for the PHC system, noted by the MOH and the PHCPI. Additional norms and standards should be determined and agreed upon based on the basic service health package (BHSP) and Technical Advisory Group consultative meetings.

9.1 Norms for PHC

- The PHC facility renders comprehensive integrated PHC services using a family medicine approach for at least 8 hours a day, five days a week.
- Main PHC facilities provide a BHSP that covers: maternal and newborn health; child health and immunization; communicable disease treatment and control; immunization; non-communicable diseases; mental health; emergency care; dental services; laboratory services; and essential medicines.
- Access, as measured by the proportion of people living within 5km of a PHC facility, to quality health care is improved.
- There is an updated system for patient records including treatment management plans and referrals as well as supply chain management.
- The PHC facility receives a supportive monitoring visit at least once a month by PHC centre managers to support personnel, monitor the quality of services and identify needs and priorities.
- The PHC facility has at least one clinical provider who has completed training in Handbook of Quality Standards and Operational Guidelines of Clinical Service Delivery.
- PHC facility managers received copy of Quality Standards and Operational Guidelines for Management of Primary Care Clinics and leadership and management training.

- There is an annual evaluation of the provision of the PHC services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the PHC facility. In addition, an annual plan is made, based on this evaluation.
- The PHC facility has a mechanism for monitoring services and quality assurance and at least one annual service audit.
- Health promotion activities within the community are undertaken by the PHC facility, at least once a quarter.
- Community members are engaged in improving PHC services by being involved in local health committees and training in community partnerships handbook.

9.2 Standards for PHC

References, Prints, and Educational Materials

1. 20 standard clinical protocols and the essential medicine list (EDL) are included in Handbook of Quality Standards and Operational Guidelines for Clinical Service Delivery.
2. All relevant national and provincial health related circulars, PHC policy documents, and protocols included in the Handbook of Quality Standards and Operational Guidelines for Management of Primary Care Clinics.
3. Copies of the Patients Rights and Responsibilities Charter as well as Operational Guidance for Community Partnerships available.
4. Supplies of appropriate health learning materials in Arabic and Kurdish.

Competence of Health Care Personnel

Organizing the PHC facility

1. Map the PHC facility catchment area and draw specific and achievable PHC objectives set using district, national and provincial goals and objectives as a framework.
2. Organize outreach services for the PHC facility catchment area.
3. Organize the PHC facility to reduce waiting times to a minimum and initiate an appointment system when necessary.
4. Train community health care promoters to educate caretakers and facilitate community action.
5. Plan and implement a district focused and community based activities, where health workers are familiar with their catchment area population profile, health problems and needs and use data collected at PHC facility level for this purpose.

Caring for Patients

1. Health care personnel are able to follow the disease management protocols and standard treatment guidelines, while providing quality care that is sensitive to culture and the social circumstances of patients.
2. Health care personnel are positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome.
3. Patients are treated with courtesy in a client-oriented manner to reduce the emotional barriers to access of health facilities and prevent the breakdown in communication between patients and health care personnel.
4. The rights of patients are observed.

Running the PHC facility

1. A clear system for patient management including referrals and feedback on referrals is in place.
2. A clear system for supply chain management regarding pharmaceuticals and medical supplies is in place.
3. A list of employees and management procedures including job descriptions is understood.
4. All personnel wear uniforms and insignia in accordance with the Iraq Professional Councils' specifications.
5. The PHC facility has a strong communication link with the community, civic organizations, schools and workplaces in the catchment area.
6. The PHC facility is clean, organized and convenient and accommodates the needs of patients' confidentiality and easy access for older persons and people with disability.
7. Every PHC facility has a house keeping system to ensure regular removal and safe disposal of medical waste, dirt and refuse and cleaning of furnishings and linens.
8. Every PHC facility provides comprehensive security services to protect property and ensure safety of all people at all times.
9. The PHC facility equipment is kept at optimal functioning ability through proper use and preventative maintenance.
10. The PHC facility has an operating physical infrastructure including a supply of electricity, running water and proper sanitation.
11. The PHC facility has a written infection control policy, which is followed and monitored, on protective clothing, handling of sharps, incineration, cleaning, hand hygiene, wound care, patient isolation and infection control data.

Patient Education

1. Health care personnel are able to approach the health problems of the catchment area hand in hand with the PHC facility health committee and community civic organizations to identify needs, maintain surveillance of cases, reduce common risk factors and give appropriate education to improve health awareness.
2. Culturally appropriate patients' educational pamphlets in Arabic and Kurdish are available on different health issues for free distribution.
3. Appropriate educational posters are posted on the wall for information and education of patients in Arabic and Kurdish
4. The Patient Rights Charter is displayed at all PHC facilities.
5. Confidential patient feedback systems are present at all PHC facilities.
6. Consent forms are used to ensure patients understanding and consent to medical exams and procedures.
7. Educational videos in those PHC facilities with audio-visual equipment are on show while patients are waiting for services.

Records

1. The PHC facility utilizes an integrated standard health information system that enables and assists in collecting and using data for patient and facility management.
2. The PHC facility has daily service registers, road to health charts, patient treatment cards, notification forms, and all needed laboratory request and transfer forms.
3. All information on cases seen and discharged or referred is correctly recorded on the registers.
4. All notifiable medical conditions are reported according to protocol. Confidentiality is maintained where necessary.
5. All registers and monthly reports are kept up to date.
6. The PHC facility has a patient carry card or filing system that allows continuity of health care.

Community Activity

1. There is a functioning community health committee in the PHC facility catchment area.
2. The PHC facility has links with the community health committee, civic organizations, schools, and workplaces in the catchment area.
3. The PHC facility has been sensitized, and receives support from, the community health committee.
4. PHC facilities are linked to appropriate community based organizations within the catchment area which conduct regular home visits with appropriate reporting and referral mechanisms.

Referral

1. All patients are referred to the next level of care when their needs fall beyond the scope of PHC facility health care personnel competence.
2. Patients with a need for additional health or social services are referred as appropriate.
3. Every PHC facility is able to arrange transport for an emergency within one hour.
4. Referrals within and outside the PHC facility are recorded appropriately in the registers.
5. Feedback from facilities that patients are referred to is received at original facility that patient was seen to mark in patient records.
6. Merits of referrals are assessed and discussed amongst technical advisory groups, as part of the continuing education of the referring health professional, to improve outcomes of referrals.

Collaboration

1. PHC facility health care personnel collaborate with social welfare for social assistance and with other health related public sectors as appropriate.
2. PHC facility health care personnel collaborate with health orientated civic organizations and workplaces in the catchment area to enhance the promotion of health.

Management Norms and Standards

Leadership and Planning

1. Each PHC facility has the 20 management guidelines posted in the PHC facility.
2. The Handbook of Quality Standards and Operational Guidelines are developed with PHC facility input and copies are kept at all facilities.
3. An operational plan or business plan is updated each year based on the previous year.
4. District personnel policies on recruitment, reporting structure, grievance and disciplinary procedures are available in the PHC facility for health care personnel to refer to.
5. The health care personnel roles and responsibilities for all categories are known and vacancies discussed with the supervisor. New PHC facility health care personnel are oriented.
6. Job descriptions for each health care personnel category are in the PHC facility file.
7. There is a performance plan/agreement, training plan and supervision schedule made and a performance appraisal carried out for each member of health care personnel each year.
8. The on-call roster and the PHC facility task list with appropriate rotation of tasks are posted.
9. An attendance register is in use and reported to the district MOH.
10. There are regular health care personnel meetings, with the TAG, and in-service training takes place on a regular basis.
11. Services and tasks not carried out due to lack of skills are identified and new training sought.
12. Disciplinary problems are documented and copied to supervisor.

Finance

1. The PHC facility, as a cost centre, has a budget divided into main categories based on medical units within PHC centre.
2. The monthly expenditure of each main category is known and reported.
3. Under and over spending is identified and dealt with including requests for the transfer of funds between line items, where permitted and appropriate.

Transport and Communication

1. A weekly or monthly transport plan is submitted to the supervisor or transport co-ordinator.
2. The telephone or radio, which enables communication amongst facilities, is working.
3. The ambulance can be contacted for urgent patient transport to be available within two hours.

Visits to PHC Facility by Unit Supervisor

1. There is a schedule of monthly visits stating date and time of supervisory support visits.
2. There is a written record kept of results of visits.

Community

The community is involved in helping with PHC facility needs. A community health committee is in place and meets monthly.

Facilities and Equipment

1. There is an up-to-date inventory of PHC facility equipment and a list of broken equipment.
2. There is a list of required repairs (doors, windows, water) and these have been discussed with the supervisor and PHC facility committee.
3. There is a log book containing a report of all repair work done at the PHC facility.

Medicines and Supplies

1. Stocks are secure with stock cards used and up-to-date.
2. Orders are placed regularly and on time and checked when received against the order.
3. Stocks are kept orderly, with FEFO (first expiry, first out) followed and no expired stock.
4. The medicines ordered follow EDL principles.

Information and Documentation

5. New patient cards and medico-legal forms are available.
6. The laboratory specimen register is kept updated and missing results are followed up.
7. Births and deaths are reported on time and on the correct form.
8. The monthly PHC statistics report is accurate, done on time and filed/ sent.
9. Monthly and annual data are checked, graphed, displayed and discussed with health care personnel and the health committee.
10. There is a catchment area map showing the important features, location of mobile PHC facility stops, CHWs and other outreach activities.

Session 10: Problem Solving at the PHC Facility and District Levels

Duration of session: 90 minutes

Materials needed: pens or pencils, markers, flipchart.

Training Methods: Minilecture, Discussion and Questions and Answers

Learning Objectives: By the end of the session, participants will be able to:

- Understand the health problems and how to use the indicators/measurement
- Understand the problems at the PHC and district levels

Suggested Reading: USAID/PHCPI Supportive Supervision Guideline Manual 2011 and USAID/PHCPI Leadership and Management training program 2011

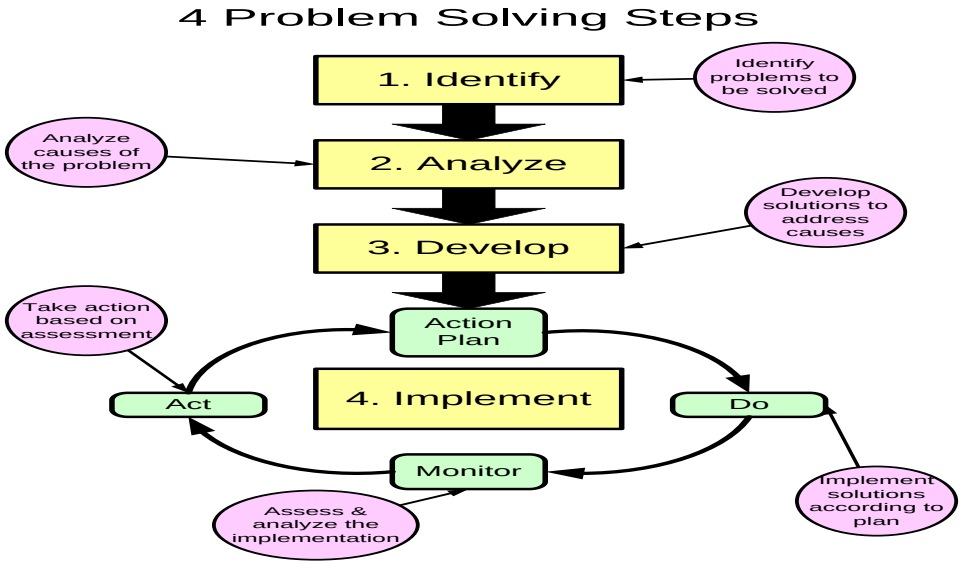
Introduction to Health Problems

We move within a complex system when we work at the district, depending on upper levels and interests as well as being challenged by local needs and pressures.

Changing one thing changes the whole system. Working with scarce resources obliges us to use these resources in an economic/efficient way trying to achieve the best results and be effective.

10.1 Problem Solving at PHC facilities

Problem solving is used to address problems that cannot be improved by direct feedback and require additional review by the supervisor and PHC facility health care personnel. It is a 4-step method to identify and analyse problems, develop solutions and test interventions to address problems.



Within the PHC facility, it is important to include all PHC facility health care personnel directly involved with providing health services as well as the PHC centre manager in order to enhance the process of problem solving and address common issues that affect the entire PHC facility and its health care personnel, as well as improve reporting, communication and accountability.

To begin the process, the supervisor should convene a debriefing and problem solving session with health care personnel. Using information collected from the assessment, the supervisor should start with a discussion of the strengths and good practices seen. Together with the health care personnel, the supervisor identifies and prioritizes the main "problem" areas in the implementation of the service, which are then dealt with appropriately.

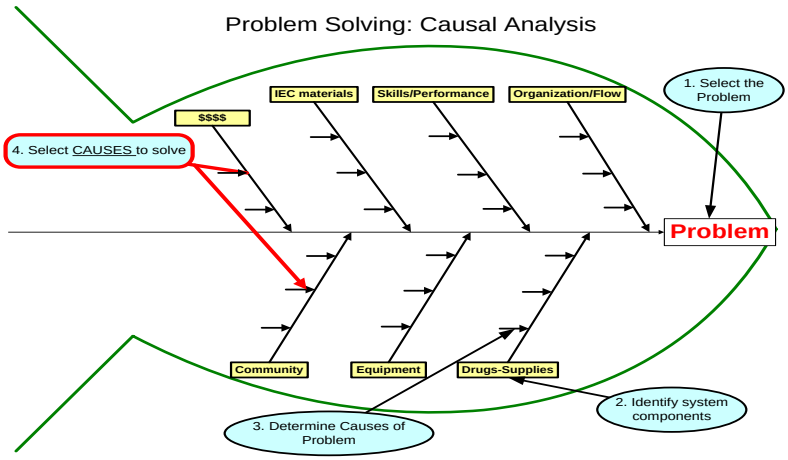
The following figure illustrates a system model for communicable disease treatment. A similar model can be used by supervisors to look for problems (using assessment tools) then trace back in the system to determine the cause(s). If a problem is found with medicines, then the supervisors can apply a more detailed fishbone or flow chart of the medicine management sub-system. This is a generic tool that can be adapted and used for all PHC services.

Problem solving may be at two levels:

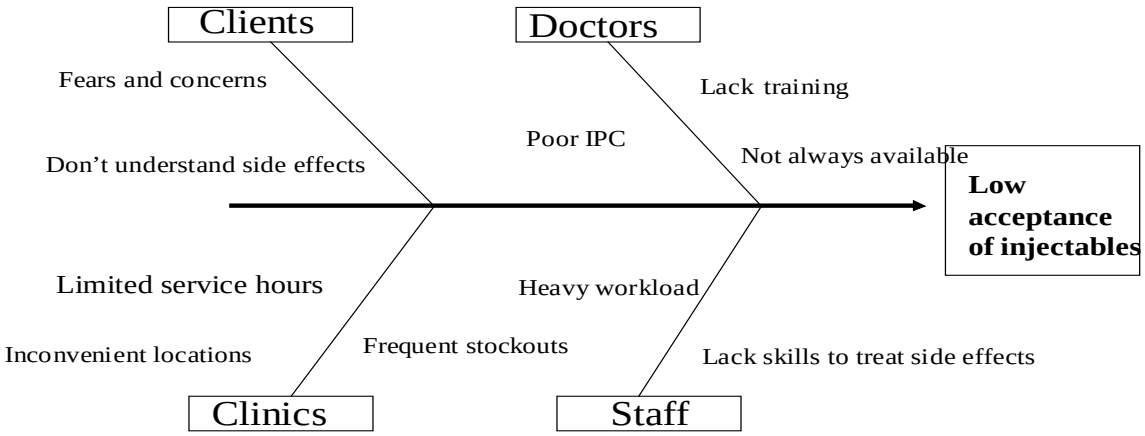
Level 1 – Rapid problem solving
This is often used to address causes and solutions that are obvious to the PHC facility health care personnel and supervisor. Brainstorming is a common method for rapidly identifying possible causes and solutions.

Level 2 - Detailed causal analysis and solution development
This is used when the causes or solutions to problems are not obvious and requires a more systematic analysis of the causes of problems and related solutions. The process of problem solving is commenced with a QI tool such as the fishbone or flowchart to identify system components (such as equipment, health care personnel skills, financial resources, guidelines, etc) and possible causes.

Fishbone diagrams can be used by supervisor to diagrammatically indicate technical areas that may be related to the problem at hand.



Fishbone diagram



Example Fishbone Diagram: Analysis of low injectable contraception use among reproductive age women

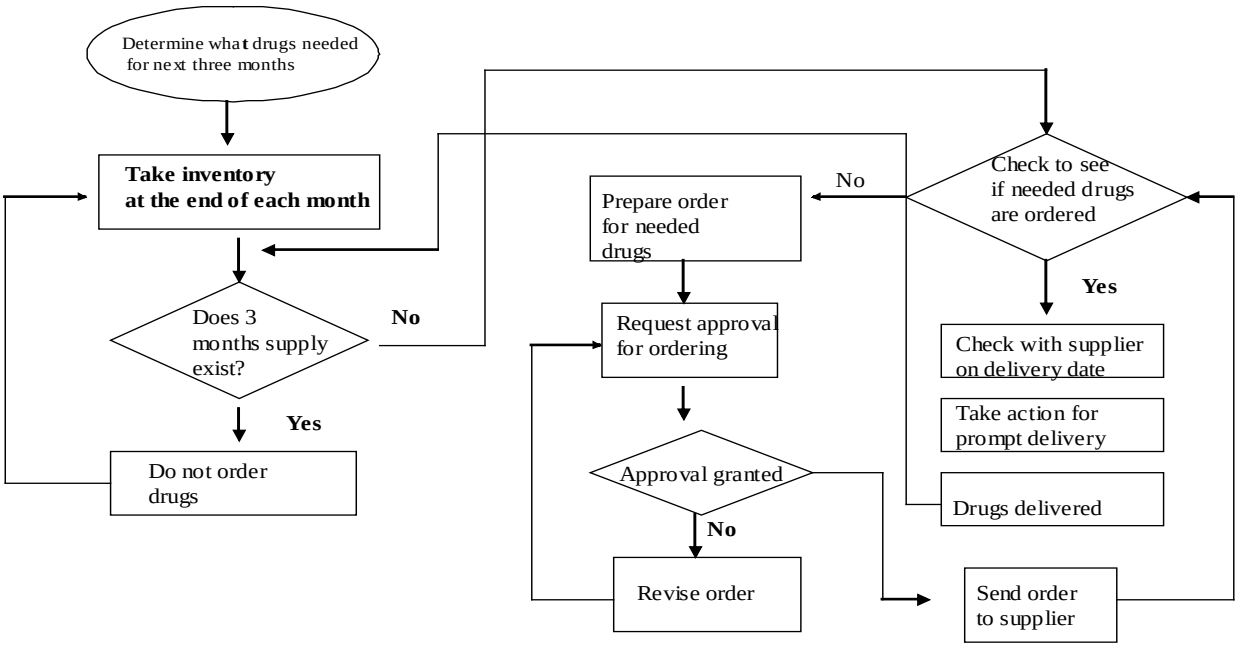
Flow charts help supervisor clarify with staff the actual steps in a process (procedure or technical protocol) so that the supervisor and PHC facility health care personnel can graphically view the process and begin to identify specific problems and causes.

They are utilized during problem solving to:

- Describe the actual process
- Involve the people that work in the process and know it
- Provide a shared understanding of the process
- Uncover problems and bottlenecks in the continuum of care
- Uncover the sub-steps that are required for each major step in the continuum of care
- Guide discussion to identify problems, causes and solutions
- Facilitates action planning by helping to determine where to start

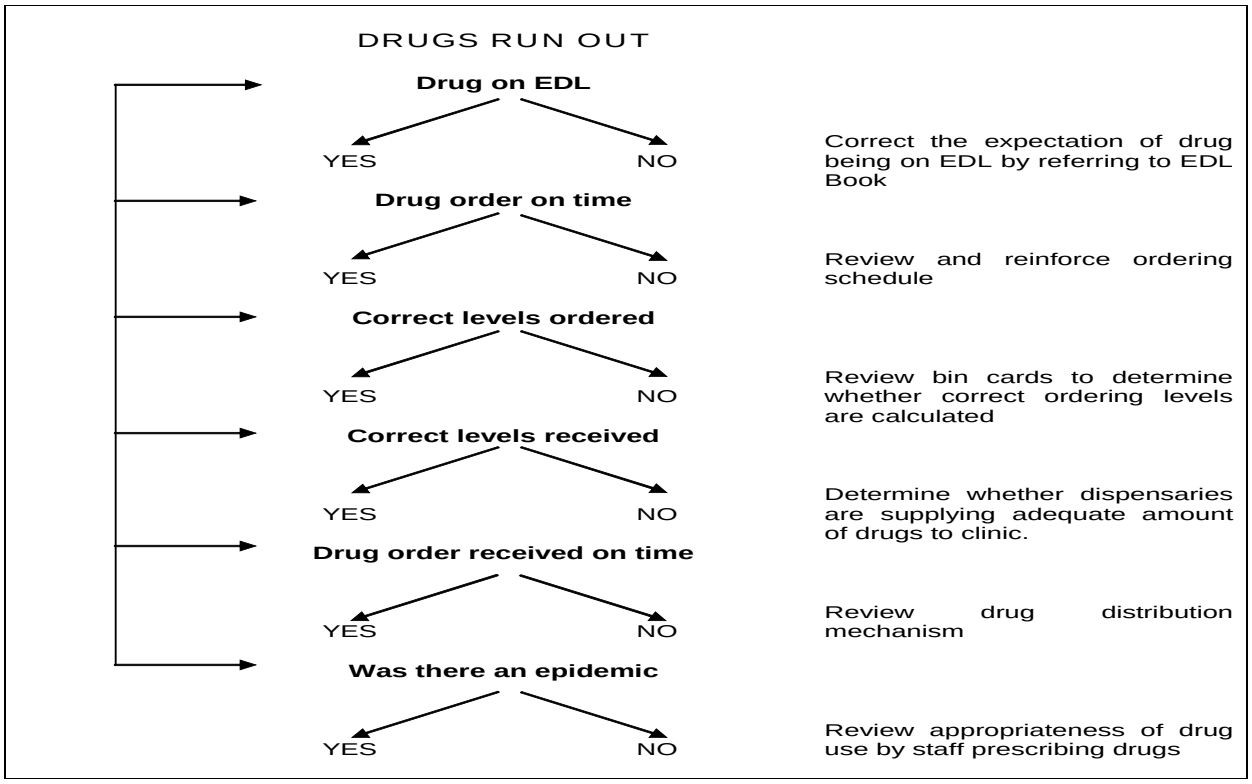
Flow charts are based on technical and procedural norms and the actual flow within clinic of district. By flow-charting the actual process and comparing with the desired norm or standard, the problems, the causes and perhaps even the solutions become apparent. Similar flow charts can be developed and applied for technical standards dealing with integrated management of childhood illness (IMCI), ante-natal care (ANC), cardiovascular disease, etc.

Flow Chart - Ordering drugs



Example Flow Chart: Ordering medicines

Where there are a limited number of causes for a problem, a step-by-step flow chart is useful.



Step-by-step flowchart

Where problem solving job aids are available, the process of problem solving is performed faster, resulting in appropriate action plans. When the team has completed problem solving, the problem(s), causes and solutions should be recorded on the Action Plan form.

In summary, solutions that are not obvious and require additional causal analysis and solution development require the use of QA/QI tools such as the fishbone diagram and flowcharts. Some problems can be addressed at the facility level while others require interventions at the district. Problems and solutions that are common and / or need to be addressed at higher levels (district and provincial levels) often require additional problem solving with supervisors or managers at the district and provincial levels.

10.2 Problem Solving at the District/Provincial Level

Some problems identified at the PHC facility level or district level can only be analyzed and solved at the district and provincial levels (i.e. the cause is located at these levels). Thus QS problem solving tools can also be used at the district and provincial levels to address problems.

The forums for this level of problem solving are, could be as follows:

- Monthly meetings of provincial supervisors and technical advisory groups
- Special meetings with supervisors designed to address common problems or problems requiring intervention at a higher level.

At these high level problem-solving meetings, the following should be addressed:

- Problems related to the supervision process itself (e.g. transport, time, preparation, communication);
- Problems and solutions emanating from PHC facility visits that should be shared among the group; and
- Problems that need to be addressed by the district/provincial managers

Action Plan

During the Problem Solving process, the supervisor should ensure that the problems, possible causes and solutions are clearly identified. The next tasks involve translating the solutions into specific activities, responsibilities (internal and external to the PHC facility), and specific timelines (beginning and end dates). All these should be documented on an Action Planning form, with meticulous follow up.

No.	Problem	Causes	Solutions	Activities	Dates	Person Responsible	Comments
1							
2							
3							
4							
5							

Use the SMART approach to check your action plan:

SMART Method:

Operational Plans must be SMART:

S	–	Specific	– What action will be done? By whom?
M	–	Measurable	– How will we know when it has been done?
A	–	Attainable	– Is that something we will be likely to achieve?
R	–	Realistic	– What is feasible? This overlaps with attainable, but includes identifying the resources that will be needed. Are the necessary materials, finances and personnel available? Local conditions will influence what is attainable and/or realistic.
T	–	Timeframe	– By when will this be done i.e. action completed? Do some of the plans need interim time frames?

Monitoring of quality improvements

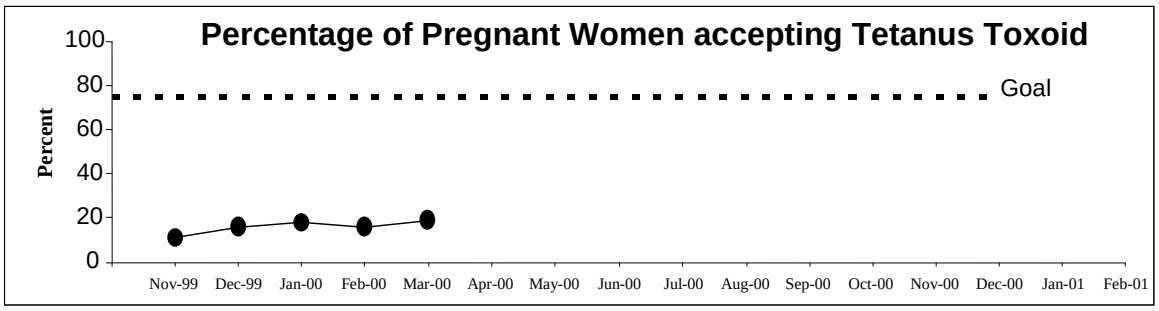
A monitoring system consists of a process for regular collection and analysis of a core set of indicators. The system provides data that can be used for assessing problems, making decisions to improve the situation, and monitoring progress. An effective monitoring system should meet the following criteria:

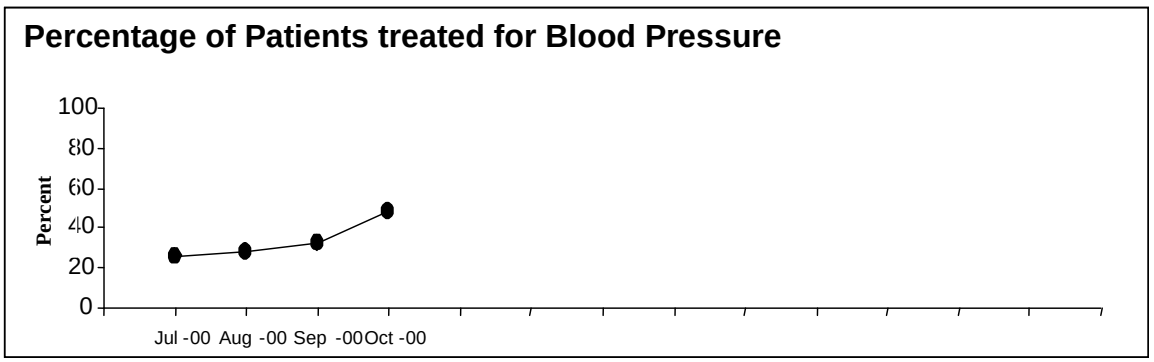
- Data is collected to monitor the trend of indicators over time
- Data is used to identify the presence and causes of problems
- Data is used to guide management decisions, planning and QI activities.

A system that monitors quality not only collects information on inputs (i.e. resources) and outcomes (outputs, coverage/effects, and impact), but also focuses on processes to determine if services meet defined standards (technical, communication, procedures). Therefore, in order to ensure quality, monitoring systems should include SOPs.

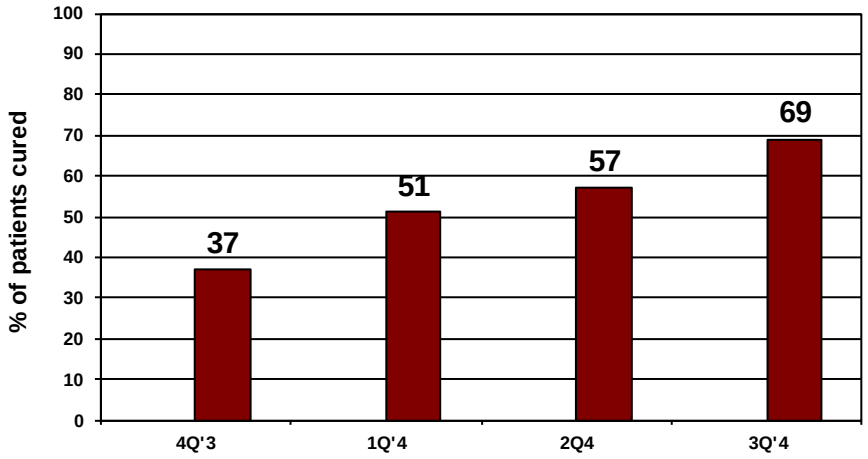
Presentation of data: Data is most commonly presented in tabular form. However, the impact of this data may be significantly improved if presented along with a run chart or graph showing changes over time (against a target or standard).

The graphs below show how improvements in health care are tracked over time, as a result of the assessment and facilitation processes. Run or bar charts may be utilized to detect trends over time & to determine whether there's a change in the process or not. They may also be used for presentation of data to PHC facility health care personnel, to show service utilization improvements.





The following figure also shows how monitoring results are presented with a bar graph, particularly when you want to combine several different types of indicators or geographic locations on a single graph. The limitation of bar charts is that when many points of time are required, the chart becomes more difficult to interpret and a run chart is preferred.



As noted, data shows what has been achieved and what has not been achieved. Data also displays (after analysis) what needs to be addressed through QS. Monitoring data reminds PHC facility health care personnel about where they are and where they need to go and serves as a point of entry for problem solving (since these data often tracks outcome and process measures).

Improving quality can be a unifying goal — one that can unite healthcare providers and supervisors. Utilizing tools such as the QS assessment checklist and the QS monitoring graphs provide the documentation needed to justify the decisions made for QI. Information is used with the objective of improving performance and quality within the health system without threatening the people whose performance is being assessed.

Strategic Action

The following steps will be helpful in clarifying areas that need attention, breaking issues or problems into manageable pieces and addressing them in a systematic way.

Vision	Using a vision as starting point maintains focus on direction and values that are important to the team. Use an overall vision for the PHC facility as a whole, but use a more specific vision when planning or problem solving for a service or program.
Analyze situation	Carry out a "contextual analysis" or "situation analysis" using a tool or approach that provides a consistent and organized picture of the kinds of issues you are investigating.
Select problem	From the situation analysis, identify areas that need attention. From them, determine what most seriously needs attention, what is feasible to work on with the available skills and financial resources. Often a good choice is an area that the team is motivated and enthusiastic about addressing.
Clarify and define problem	Using a systematic approach, identify various components and roots of the problem. Try not to define the problem as the absence of an assumed solution (e.g. transport, separating health care personnel from hospitals), but rather in terms of what is needed or what ought to be. This allows for more creativity in identifying optional strategies.

Measure baseline of problem	Once the problem is more clearly defined, establish the starting point, or baseline. The more objectively the starting point can be expressed, the more effectively progress can be measured.
Choose strategy to fix problem	Explore different approaches to dealing with the problem. Also explore who should be involved as a resource or who must be co-opted to ensure successful implementation. Choose an approach that seems effective, feasible and appropriate in the setting.
Set specific objectives and milestones	For each strategy, specific objectives that describe what will be accomplished should be established. Where possible, objectives or milestones should be expressed in terms of numbers of an accomplishment (e.g. 3 nurses trained or a manual written) and describe the phases of progress to be made. Time frames are essential.
Plan specific actions	To reach each milestone, describe the specific steps that will be followed. Include who will be responsible for ensuring that each step is taken.
Implement plans	Get busy to carry out the above plan!
Monitor progress of implementation	Follow the progress in carrying out the actions described. If constraints or obstacles impede progress, make and implement a plan to deal with the obstacle, or modify the strategy to be more realistic. Ensure that all responsible parties are fulfilling their obligations.
Evaluate: measure achievements	Using the same technique as when establishing the baseline, assess progress made. Is there an improvement in the situation? If not, why not? If yes, is progress sufficient? What other related gains were made?
Reconsider strategies	If more progress is needed, what is needed next? Is a change in strategy needed to make more progress?
Redefine problem	Follow the steps above to again clarify and define the problem as it is now, establish new baselines, etc. Follow the cycle through again.

Session 11: In-Depth Program Interviews

Duration of session: 90 minutes

Materials needed: pens or pencils, markers, flipchart.

Training Methods: Minilecture and Questions and Answers

Learning Objectives: By the end of the session, participants will be able to:

- Understand the national norms and standards
- List the key standards for PHC facility

Suggested Reading: USAID/PHCPI Supportive Supervision Guideline Manual 2011

**Note to the trainer: This section might be very long so you can take sample reviews and have the participants do some homework.*

This section includes essential program services, determined by the Iraq MoH, as listed in the BHSP. The tables included in this section should be considered along with the resource checklists from the TMPP and other international PHC programs, included in the appendix, when determining appropriate supervisory checklists to implement at the various PHC centre facilities.

11.1 Maternal and Newborn Health

Norms

- Reduce maternal mortality by three-fourths (Millennium Development Goal- 5A-Maternal health).
- Support achievement of universal access to reproductive care (Millennium Development Goal-5B-Maternal health).
- Increase the percentage of pregnant women receiving antenatal care (ANC) from the existing level to at least 70%.
- Increase the deliveries in institutions by trained birth attendants from the existing level to at least 75%.
- Reduce the proportion of pre-term deliveries and low birth weight babies by at least 20%.
- Reduce the proportion of births in women below 16-18 years from the existing level.

Standards

References, prints and educational materials

1. BHSP services listed
2. TMPP checklists
3. Emergency Obstetric Care protocols
4. Ante-natal and Post-natal care protocols
5. Contraception protocols
6. Family Planning Compliance Plan
7. All policy guidelines regarding women's health issues
8. A library of suitable references and learning material on women's health issues, updated by the TAG on a regular basis

Competence of health care personnel

- Doctors and nurses receive training in antenatal care, emergency obstetric care, and post-natal care.
- Health care personnel are able to take a history and perform a physical examination and tests according to protocols and guidelines.
- Health care personnel provide routine management, observations and service according to the
- ANC protocol at each step of the pregnancy including at least three visits during pregnancy.
- Health care personnel provide education and counselling to each pregnant woman and partner on monitoring signs of problems (e.g. bleeding, dizziness, vomiting, early contractions, lack of foetal moment), nutrition, child feeding and weaning, basics of what to expect in delivery, potential delivery complications, newborn and child care, advanced maternal age, family planning and child spacing.

At least one member of health care personnel is able to:

- Deliver uncomplicated pregnancies.
- Make routine observations according to the pre-natal and postnatal care protocol.
- Make usual routine observations and select and prescribe appropriate family planning methods according to national protocol.
- Conduct breast cancer and cervical screening for women older than 35 years as per protocols.
- Provide appropriate health education and counselling.

Patient education

- Information is given to mothers on pre-natal care for themselves, stages of labour and delivery, baby safety care including education about child feeding.
- Further information is given to mothers on the care of breasts, vaginal bleeding and scars, signs of hypertension, diabetes, anaemia, return to usual physical efforts, labour rights, rights of the child and advice on family planning.
- Patients are given group education.
- Patients' relatives and the community receive continuous, appropriate high quality information on the importance of antenatal care, institutional deliveries, post-natal care, baby care and family support.

Records

- All information on cases and outcome of deliveries are correctly recorded on the register.
- All registers and monthly reports are kept up to date.
-

Community & home based activity

- The PHC facility is sensitized, and receives support from, the community health committee about the positive encouragement of attendance at PHC facility of all pregnant women.
- Health care personnel, as necessary, conduct regular home visits using a home visit checklist.

Referral

- All referrals within and outside the PHC facility are motivated and indications for referral written clearly on the referral form.
- Patients with need for additional health or social services are referred according to protocols.
- Referrals from traditional birth attendants (TBA) should be encouraged and associated with the training of the TBA and follow up of the training.

Collaboration

- PHC facility health care personnel collaborate with social welfare for social assistance and other role players.

- PHC facility health care personnel collaborate with PHC facility health committee, the civic organizations and workplaces in the catchment area to enhance health promotion.

11.2 Child Health, Immunization Services and Nutritional Status

Service Description

Promotive, preventative (monitoring and promoting growth, immunizations, home care counselling, de- worming and promoting breast feeding), curative (assessing, classifying and treating) and rehabilitative services are given in accordance with integrated management of childhood illness (IMCI) protocols at all times that the PHC facility is open.

Norms

- Reduce the infant and under-5 mortality rate by two-thirds (Millennium Development Goal, Number 4-Child Health).
- Reduce under 5 mortality to less than 46 per 1000 live births (Millennium Development Goal, Number 4-Child Health).
- Reduce mortality due to diarrhea, cholera, measles and acute respiratory infections in children by 50% (Millennium Development Goal, Number 4-Child Health).
- Increase full immunization coverage among children of one year of age against diphtheria, pertussis, Hib, tetanus, measles, poliomyelitis, hepatitis and tuberculosis to at least 60% (Millennium Development Goal, Number 4-Child Health).
- Increase regular growth monitoring to reach 75% of children < 2 years.
- Increase the proportion of mothers who breast-feed their babies exclusively for 12 months.
- Reduce the prevalence of underweight-for-age among children < 5 years to 10%.
- Reduce the prevalence of severe malnutrition among children < 5 years to 1%.
- Eliminate micro nutrient deficiency disorders.
- All children treated at the PHC facility are treated according to IMCI Guidelines.
- Every PHC facility has at least two health care personnel members, who have had the locally adapted IMCI training with the Handbook of Quality Standards and Operational Guidelines for Clinical Service Delivery, based on the WHO/UNICEF Guidelines.
- Every PHC facility has a rehydration corner with oral rehydration therapy available to all children.

Standards
References, prints and educational materials

1. IMCI wall charts and booklets.
2. A copy of the IMCI Standard Treatment Guidelines included in the Handbook of Quality
3. Standards and Operational Guidelines for Clinical Service Delivery.
4. Child Health Charts to supply to new-borns and children without charts.
5. Copies of the National Essential Medicines List and Standard Treatment Guidelines including information from Helping Babies Breathe.
6. Posters on Kangaroo Care and immunizations.
7. Tick charts stuck to the desk as a reminder.

Competence of health care personnel

- Every PHC facility has a doctor or nurse able to treat clients in accordance with the IMCI guidelines.
- District Supervisor makes regular mentoring/supervision visits, initially 6 weeks after training, thereafter every 3 months.
- Each PHC facility has an annual review of quality of care by Supervisor.
- At least one member of health care personnel takes overall responsibility for the assessment and management of the child.
- Health care personnel are able to establish trust and credibility through respect, courtesy, responsiveness, confidentiality and empathy, approaching consultations in a patient -centred way.
- Health care personnel are able to organize and implement an effective triage system for clients attending the PHC facility based on the IMCI protocol.

Referral

Children with danger signs and/or severe disease are referred as described in the IMCI protocol.

Patient education

- The mother or caregiver is counselled in accordance with the IMCI counselling guidelines.
- Key family/household practices to improve child health are promoted as described in the IMCI community component.

Records

An adequate patient record system is in place, using the child-health chart as the basic tool.

Community and home based activity

- This takes place in line with the IMCI Guidelines for the Community Component.
- The PHC facility works in close co-operation with community-based health programs like CHW schemes or care-groups to link children with food fortification/supplementation resources and community outreach regarding growth monitoring and vaccinations.

Collaboration

PHC facility health care personnel collaborate with CHWs, NGOs, CBOs, and other sectors to improve child health.

11.3 Diseases Prevented by Immunization

Service Description

Immunization is an essential service that is available when the PHC facility is open and based on an uninterrupted and monitored cold chain of constantly available vaccines.

Norms

- All PHC facilities provide immunizations at least for five days a week and if the community desires additional periods specifically for child health promotion and prevention.
- Every PHC facility has a visit from the District MoH every three months to review the expanded program on immunization (EPI) coverage, practices, vaccine supply, cold chain and help solve problems and provide information and skills when necessary.
- Every PHC facility has a senior member of health care personnel trained in EPI who acts as a focal point for EPI programs.

Standards

References prints and educational materials

1. Copies of the Handbook of Quality Standards and Operational Guidelines for Clinical Service Delivery, with sections on immunization protocols.
2. Copies of the Technical guidelines on immunization in Iraq.
3. Patient and community information pamphlets in Arabic and Kurdish.
4. Copies of the EPI Posters and other EPI disease and schedule promotional materials.

Competence of health care personnel

Health care personnel are able to:

- Routinely perform correct immunization practices according to protocol. Vaccines are checked periodically to ensure no frozen DPT, HBV, TT, HIB and none out of date or indicators showing expiry.
- Provide mothers with correct knowledge of what is needed during pregnancy in order for children to be healthy.
- Provide mothers with correct knowledge of what vaccine is given when and possible side effect.
- Provide group education for mothers and antenatal care attendants.
- Follow up suspected cases of measles at home to determine the extent of a possible outbreak.
- Implement correct disposal of sharps.
- Ensure all reported and notified measles cases are reported to and followed up within 48 hours by district investigation team of which the nurse in PHC facility is a co-opted member.
- Organize immunization service as a daily component of comprehensive PHC and to minimize waiting/queuing times.

- Community health committees are given the lay case definitions of acute flaccid paralysis (AFP), measles and neonatal tetanus (NNT) and urged to report suspected cases immediately.
- The PHC facility has a good relationship with the district office for assistance in outbreaks investigations.
- Ensure that appropriate laboratory specimens are taken for the investigation of all AFP, NNT, measles and AEFI investigations are taken or else referred to the nearest hospital where specimens can be taken.
- A 24 hour toll free number for notification - is on the PHC facility wall.
- PHC facilities arrange mass immunization in their communities as required by the District Manager.
- Remote villages have mobile outreach sessions to provide routine services and to improve coverage where necessary.
- Reduce missed opportunities and ensure that ill children and women in the childbearing age are immunized as appropriate.

Referrals

Children with signs and symptoms of the EPI priority diseases (AFP, measles, NNT and AEFI) are referred as in the IMCI protocols.

Patient education

All clients attending PHC facilities for immunization services receive the appropriate health education, information and support.

Records

- Patient records and patient notification forms.
- Monthly immunization statistics.
- Case investigation forms for flaccid paralysis.
- Case investigation forms for measles.
- Case investigation forms for NNT.
- Case investigation forms for adverse events following immunization.
- Supply of child road to health charts for clients to keep and bring at every appointment.

Community based services

- Communities participate in campaigns and national health days.
- PHC facility health care personnel follow up suspected cases of measles at home to determine extent of outbreak.

Collaboration

Health care personnel collaborate with other departments like education and other sectors to promote immunization and improve coverage.

11.4 Tuberculosis Norms and Standards

Description of Services

Early diagnosis and treatment of active TB is essential in controlling TB and its transmission. Following national protocols, the PHC facility health care personnel diagnose TB on PHC facility suspicion using sputum smear microscopy, provide information education communications (IEC) and active screening of families of patients with TB, treat, dispense and follow-up using directly observed treatment short course (DOT) and complete the TB register.

Norms

- Halve TB prevalence (Stop TB partnership)
- Halve TB mortality rate (Stop TB partnership)
- Achieve a minimum of 85% cure rate of new sputum positive TB cases
- Achieve a minimum of 85% smear conversion rate of new sputum positive cases and 80% smear conversion rate for re-treatment cases
- Achieve a smear positive rate of <10% amongst all TB suspects tested
- Every PHC facility has at least one health care personnel member who has been trained in TB management
- Receive a six monthly assessment of quality of care of the TB service by the District

Standards

To address three categories of activities i.e. Diagnosis, Treatment and Public Health responsibilities

References, prints and educational material

1. The Handbook of Quality Standards and Operational Guidelines on Clinical Service Delivery, which includes TB training modules for PHC personnel
2. The Community Partnership Handbook, which includes directions for community based directly observed treatment short courses (DOTS)
3. TB posters on walls, leaflets and pamphlets in Arabic and Kurdish for distribution

Competence of health facility health care personnel

Health care personnel are able to:

- Suspect and identify TB by early symptoms such as cough, loss of weight and tiredness.
- Initiate and follow up treatment of patient using the latest recommended TB management regimens and protocols.
- Educate the community and patients with the emphasis on correcting misinformation and seeking to prevent the spread of disease.
- Start DOTS supported by PHC personnel or through identified community structures/volunteers chosen and accepted by the patient.
- Enter all patient information and sputum results on the TB Suspect Register, TB Register, the
- Patient PHC facility Card, the Patient Treatment Card and Patient Transfer Form.

Referral

- Before being transferred to another health facility the patient receives a completed transfer form and a sufficient supply of medication and when possible the facility to which he/she is transferred is notified by telephone or in writing.
- Appropriate referrals to a PHC facility/hospital linked to the TB program should be made e.g. very ill patients, severe complications of TB, adverse medicine reactions, MDR-TB, children with extensive TB or gross lymph-adenopathy, or not improving on treatment.

Patient education

- Patients, relatives and communities receive high quality information on TB.
- Supporting information is available in the form of leaflet, pamphlet or poster, in Arabic and
- Kurdish and is given to the patient to reinforce the main messages
- Patients are educated about HIV/AIDS/STIs in addition to TB so that they can recognize predisposing conditions and prevent them. Counselling and testing for HIV should be promoted.

Records and statistics

- All confirmed TB cases to be notified using the standardized reporting tools.
- All registers, recording and reporting forms, monthly and quarterly reports are kept up to date and readily available when needed.

Community and home based activities

- The PHC facility has good communication skills and knowledge of available community resources in the PHC facility catchment area.
- The PHC facility has an agreement with resulting support from the PHC facility Committee about the use of community-based DOT.
- DOT is arranged in the most convenient way possible for the patient.
- The quality of DOT management within the PHC facility and the community-based supporters are monitored and evaluated monthly and quarterly.

Collaboration

The PHC facility refers patients to the Department of Social Development / Social Welfare when necessary.
Health care personnel collaborate with NGO's, schools, private practitioners and workplaces in their catchment area to enhance the promotion of TB prevention and care.

11.5 Sexually Transmitted Diseases (STD)

Service Description

The prevention and management of sexually transmitted infection (STI) is a service available daily at a

PHC facility and is a component of services for communicable disease control.

Norms

- Every PHC facility has a review of quality of care once a year by a supervisor.
- Every PHC facility has at least one member of health care personnel trained in the management of STI using the Handbook of Quality Standards and Operation Guidelines for Clinical Service Delivery.

Standards

References prints and educational materials

1. Handbook of Quality Standards and Operation Guidelines for Clinical Service Delivery including Standard Treatment Guidelines for Syndromic Case Management of STIs and Essential Medicine List, latest edition.
2. Supplies of patient information pamphlets on STI in Arabic and Kurdish.
3. Posters on STI in Arabic and Kurdish and condoms.

Competence of health care personnel

- PHC facility health care personnel provide STI management daily and have extended hours, or on call weekend time, if in an urban or peri-urban area.
- PHC facility health care personnel are adolescent friendly with friendly communication so as to be accessible and acceptable to all patients. Referral to adolescent friendly sites should be carried out where necessary
- Consultation for all patients takes place in private consultation rooms, to ensure confidentiality.
- Health care personnel are able to accurately diagnose and treat STI according to the latest guidelines with relevant partner tracing.
- The history is taken correctly and partner change inquired about (the gender of partners is not presumed).
- Syphilis serology is done on all patients with STI - and during in pregnancy.
- All PHC facility health care personnel should receive annual STI updates.
- Pap smears are done on women over 18 years or with a history of vulvae warts.
- Patients are counselled on safe sex and HIV/AIDS is explained to them.
- Treatment is according to the protocol for each syndrome.
- Condom use is demonstrated and condoms provided.
- Contact cards in the correct language are given and reasons explained so that at least 60% result in the contact coming for treatment.

Referrals

- All patients are referred to the next level of care when their needs fall beyond the scope of competence.
- Conjunctivitis in the newborn is referred after initial treatment.
- The patient is referred if pregnant mother has herpes in the last trimester.
- Pelvic inflammatory disease is referred if patient is sick, has pyrexia and tachycardia, or severe tenderness, or is pregnant.
- A painful unilateral scrotal swelling age under 18 is referred immediately for a surgical opinion regarding a possible torsion.

Patient education

- All patients receive health education on asymptomatic STI, misconceptions, rationale of treatment, compliance and return visit.
- All patients are treated with respect and given the option to decide the gender of the provider they feel most comfortable.
- Time is given during counselling and discussion after treatment about the need for contacts to be treated.
- If pregnant then implications for the baby are discussed (congenital syphilis, ophthalmia neonatorum, HIV, chlamydia).
- The importance of condom use (male and female) is stressed.
- All female clients receive information about the female condom.
- All patients should receive safe sex counselling.

Records

- Patient's records are maintained confidentially, according to protocol.
- Laboratory registers with return time for laboratory specimens not greater than three days.
- A register is kept of contact cards issued and returned.
- Anonymous partner notification cards are in Arabic and Kurdish.

Community based services

Health care personnel liaise with men's groups and religious organizations about the signs, symptoms, prevention, referral and care of STI.

Collaboration

Health care personnel collaborate with different departments such as schools, mosques, and community organizations implementing health promotion activities leading to the prevention of STI.

11.6 Non-communicable Diseases

Norms and standards

Referrals

- All patients are referred to the next level of care when their diagnosis and needs fall beyond the scope of competence as recommended by national protocols.
- Health care personnel are aware of resource personnel / facilities that are contactable for advice.
- Doctors keep detailed information on the frequency of follow-up visits 1 - 3 monthly and yearly for detailed examination.
- Patients suspected of having Diabetes Mellitus are referred to hospital for diagnosis.

Patient education

- All patients and caretakers are supported and their capacity developed regarding self-care, self- monitoring, compliance, prevention of complications and management of the disease.
- Education activities are sensitive to the cultural and economic realities of the patient and home.

Records

- Patient register of chronic conditions and treatment record.
- Patient carried cards.
- Home-based care records.

Community based services

- Health care personnel works with any district NGO and CBO dealing with chronic conditions.
- After analysis of the chronic disease, register attempts are made to provide education in the community on modifiable risk factors, early recognition of symptoms and periodic check-ups.
- Educational activities are culturally and linguistically appropriate.
- PHC personnel approach the catchment area population through community health committees, NGOs, CBOs, youth groups and mosques to reduce common risk factors operating in the community.

11.7 Mental Health

Service description

Mental health can be greatly affected by the social environment/stressors, including but not limited to civil unrest and war. Mental health service seeks to improve mental health and social wellbeing of individuals and communities. Promotion of community mental health is included in PHC facility and community based IEC. Preventive measures for mental disability are included in all services such as antenatal, infant, child, reproductive health and curative care.

Norms

- In every PHC facility there are personnel trained in mental health assessment and management of post traumatic stress disorder.
- In every PHC facility there are personnel with education in community aspects of mental health (including community aspects) in the last year.
- In every PHC facility there is at least one person trained in counselling and the management of victims of violence (rape, psychological abuse, and physical and mental torture).

Standards

References, Prints, and Educational Materials

1. Mental health policy document for all communities exposed to civil unrest and internal displacement.
2. Mental health assessment guidelines included in Handbook of Quality Standards and Operation Guidelines for Clinical Service Delivery.
3. Psycho-social rehabilitation checklist for community work included in Community Handbook.
4. Emergency medication protocol included in Handbook of Quality Standards and Operation
5. Guidelines for Clinical Service Delivery.
6. Essential drug list for PHC.
7. 24 Hour access to telephone or radio to district hospital.
8. Posters and pamphlets on mental health, severe psychiatric conditions, post-traumatic stress disorder, available services and user rights.

Recognizing Mental Illness

- PHC facility personnel consider risk factors for mental health within their catchment area: civil unrest, poverty, unemployment, ill health, physical and mental abuse, homelessness, etc.
- Personnel identify and provide appropriate interventions for patients suffering from depression, anxiety, post traumatic stress disorder (PSTD), physical and mental abuse, substance abuse and special needs of women (childbearing, abortion, sterilization, disability, malignancy, etc.)
- PHC personnel recognize the signs of emotional distress and mental illness early (especially in young patients or in relapse of a psychiatric condition).
- PHC personnel participate in the promotion of healthy life style in PHC facility attendees and the community.

Organizing Services

Personnel organize the PHC facility to have periods of the day set aside for mental health assessments.
Personnel provide prompt help from or at the PHC facility if a patient's condition in the community deteriorates.
Personnel ensure time is allocated for home visits to patients who have returned from hospital with mental illness.
Personnel ensure there is no segregation or stigmatization, at the PHC facility or the community, of people who have to use mental health services.
Personnel arrange access to a consistent member of personnel for each consultation.

Managing Care

Specially trained personnel are able to:

- Maintain relationships with patients that are just, caring, and based on the principles of human rights.
- Perform an adequate medical examination which:

- Identifies the general mental state e.g. psychotic or depressed.
- Identifies the severity and level of crisis.
- Rules out systematic illness.
- Records temperature and blood glucose level.
- Take a history that includes previous service use such as admission to hospital.
- Take a family history and evaluate support.
- Develop a sustained therapeutic relationship with patients and their families.
- Know and implement standard treatment guidelines especially the section on delirium with acute confusion and aggression, acute psychosis and depression.

PHC Nurses/Doctors are able to:

- Detect and provide services for severe psychiatric conditions as a component of comprehensive PHC.
- Provide follow-up of all cases returned to community after hospitalization and upkeep to register.
- Make appropriate and informed referrals to other levels of care.
- Provide basic psychiatric care and assess urgency and severity of symptoms.
- Provide individual community maintenance and care for stable long-term patients who have severe psychiatric conditions and have been discharged from hospital.
- Cope with disturbed, intoxicated, aggressive suicidal behaviour without resorting to violence, abuse of undue physical restraint.
- PHC facility personnel conduct consultations in privacy and in a confidential way and informed consent is obtained for communication to others.
- Provide each stable long-term user with individualized comprehensive care which includes:
- An ongoing assessment of mental state, functional ability, and social circumstances.
- Familiarity with the internationally recognized diagnostic system.
- An ability to detect and monitor distress and relapse.
- An ability to provide basic counselling and support to patient and family.
- A basic knowledge, criteria and pathways for referral for disability.
- Knowledge of community referral and support organizations.
- An ability to use records to facilitate continuity of care, such that:
- The condition of patients in the community is monitored including issues surrounding: poor compliance, functional deterioration, substance abuse, family conflict, and community ridicule are identified.
- The onset of mental deterioration in PTSD, and/or terminally ill patients is recognized.
- The prescription of sedation for aggressive of violent patients is appropriate when other measures fail.

Referral

Referral pathways to other levels or types of care are known and expedited.

Patient Education

- Patients, relatives and the community receive high quality information on mental health and mental illness.
- Patients and their supporters are given individualized education when their situation is reviewed.

- Patients and their supporters are educated on how to recognize predisposing factors and conditions to prevent relapse.
- PHC personnel use education in the family and community to address ignorance, fear, and
- Prejudice regarding patients with severe psychiatric conditions attending the PHC facility.

Records

- Records are kept according to protocol with emphasis on confidentiality and accuracy.
- A register of psychiatric patients in the community is maintained.
- Personnel analyze indicators and develop appropriate action.
- Personnel record mental health indicators on:
- The number and mix of cases
- The frequency of contact

Community and Home-based Activity

- Personnel participate in community awareness programs for mental health according to the national and international calendar.
- Personnel participate in the training of family and carers of patients to plan an active role in their rehabilitation.
- Personnel encourage patient and caregiver support groups in community.
- Personnel keep the addresses and phone numbers of people assisting with mental health and social problems.

Collaboration

- Personnel collaborate with all community services e.g. crisis counselling and mental health groups especially those for youth.
- Personnel collaborate with the hospital for planning discharges to the community.

11.8 School Health Services

Basic Considerations

The Schools are expected to provide health promoting services, making use of the skills and capacity in different sectors of society, including the community, the learners themselves, educators and NGOs.

Standards set for the School Health Service need to take into account the diverse situation of schools and school health services at present and the changing philosophy introduced by the education sector, including outcomes based education and inclusive education. The introduction of the philosophy of inclusive education means that children with barriers to learning will be included in ordinary schools and that these schools and communities will have to be developed to provide acceptable services for these children. Teachers generally do not have the capacity to deal with these children and the school health services can play a role in enabling teachers to identify and integrate these children into the classroom. School Health personnel may not have the capacity to implement their new role so a transformation-

training program is required. New resources for school health promotion need to be developed and funded. The School Health Teams are becoming an integral part of the primary health team and intrasectoral (i.e. they work with other sections of the Health Department).

Service Description

The school health service is a health promotive service dealing with the individual in the context of the family and community and with the school environment. The service encourages the school to seek to develop and implement school policies that promote and sustain health, improve the physical and social environment within which children learn and develop and improve children's capacity to become and stay healthy.

Norms:

- Each district has a minimum of one School Health Promoting Team.
- Every PHC facility will be able to access a nurse on school health within the district
- District School Health Promoting Teams are supported from provincial level with an appropriate, effective transformation training program, and the development of standardized resource packs and the training occurs during those times of the year when schools are closed.
- Screening Programs are provided to give adequate coverage to identify all children at risk of barriers to learning and are not limited to certain age groups.
- The School Health Promoting Service creates a positive learning environment, by identifying barriers to learning, and developing ways to remove these barriers in a community inclusive way.
- School Health Promotion Programs promote acceptance and celebration of diversity among individuals through a learner centred approach.
- An accessible, healthy physical and social environment in which children can learn is promoted.

Standards

References prints and Educational Material

1. A standardized questionnaire for use by teachers to screen for the presence of factors causing barriers to learning in the individual.
2. A standardized questionnaire for use by school health promoting teams to assist them in detecting barriers to learning in the environment of the learner.
3. A resource register for the district for use by School Health Promotive Teams and Educators, by which available health services can be identified, and how they can be accessed, to be compiled by each district and regularly updated.
4. Health promoting educational materials in Arabic and Kurdish and accessible to people with disabilities, including films, videos, posters, booklets, visual aids and audiotapes.

Competencies

The School Health Promoting Team is able to:

- Function as an effective and efficient team.
- Promote the whole person and life-style skills development of pupils and educators.
- Identify resource people and involve them to promote the transformation.
- Promote community participation and the participation of all stakeholders in programs e.g. Participatory Learning and Action (PLA) skills.
- Plan and implement health promoting programs.
- Apply and interpret the screening questionnaires for individuals and schools and transfer these skills to the teachers.
- Identify gaps in the service and barriers to learning.
- Promote healthy nutrition, mental health and reproductive health.
- Counsel for substance abuse and victims of violence including rape.
- Identify and seek to reduce stress.

Referral

Refer to nearest PHC facility service, the students that require more intense PHC facility assessment and management.

Records

An information system at all levels of the service, which informs the different sectors to make effective use of existing services, identifies gaps in the service and monitors the progress toward the development of Health Promoting Schools.

Community based activities

Promote the development of child–to–child programs as an important resource.
Work with school boards to promote activities in the community such as libraries and sport activities.

Collaboration

PHC facility personnel collaborate with and involve officials from health, welfare, education, agriculture sectors, educators, learners, parents, community leaders CBOs and NGOs, School Health Promoting Teams are intra- and intersectoral.

11.9 Victims of Abuse and Violence

Service Description

The service, requires co-operation between the health sector, the police and the Department of Justice, provides counselling and referral of victims, STD prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence.

Norms

- Every PHC facility has established working relationships with the nearest police officer and social welfare service by having visits from them at least twice a year.
- Personnel of every PHC facility have received training in the identification and management of mental, physical, and gender related violence. The training includes gender sensitivity and counselling.

Standards

References prints and educational materials

1. All relevant guidelines / protocols related to women health issues.
2. A suitable library of references and journals on sexual offences, domestic and gender violence.
3. The PHC facility has a list of names, addresses and telephone numbers of the nearest accredited health care practitioners, police and social workers who would be involved in dealing with these cases.
4. The PHC facility has a list of names and addresses of NGOs or other organizations (e.g. CBO), which undertake appropriate counselling for violence, child abuse and sexual offences.

11.10 Rehabilitation Services

Basic considerations

Rehabilitation services are an integral part of the services provided at the primary level. This constitutes a reorientation of rehabilitation from mainly institution-based services to community oriented and community based services. Communities and particularly people with disabilities should be involved in designing, implementing and monitoring services for people with disabilities. This precludes a disability service from being seen narrowly as a therapy service provided only by a certain category of staff. All health personnel in co-operation with all other sectors and the communities/people themselves are responsible for making society inclusive of all people including people with disabilities.

The PHC facility is the first point where people with disabilities, their family members or caregivers meet health staff. PHC facilities need to become creative in their approach to the problems experienced by these patients.

Service Description

The purpose of rehabilitation at PHC facility level is to provide a service to prevent disabling conditions, to detect disabilities early so to prevent complications and the worsening of the effects of a disability on a person's functional ability, to treat disabling and potentially disabling conditions and to provide access to rehabilitative services for people with disabilities, making them appropriate and acceptable.

All PHC staff are important in providing access to treatment of potentially disabling conditions, which would otherwise be difficult for people to access on a regular affordable basis.

Specific rehabilitative services include a basic assessment of people with disabilities e.g. stroke, spinal injury, cerebral palsy, developmental delay, blindness, communication problems, arthritis, amputations, backache, followed by an appropriate treatment program, in consultation with the disabled person and his family. Consumable assistive devices e.g. continence devices, rubber ferrules and other aids to daily living are prescribed provided and people trained in their use. Management of continence problems of patients with spinal cord injury, spina bifida, mental retardation, traumatic conditions and the elderly includes the supply of continence devices and devising continence programs.

Norms

- Improve access to comprehensive health services for the disabled.
- Have a responsive and area-specific disability information system in place, which will feed into the general information system of the district and PHC facility.
- Institute a functional referral system between the community-PHC facility-district hospital, as well as other relevant sectors.
- Institute a system of obtaining, repairing and maintaining essential assistive devices for rehabilitation at PHC facility level.

Standards

References, Prints and Educational Materials:

A register of all local, regional, provincial and national resources for referral for rehabilitation, education and training.

Competence of Health Staff

PHC facility staff are able to:

- Use of standardized questionnaire for the detection of hearing loss.
- Identify and refer patients requiring rehabilitation.
- Teach prevention of pressure sores and pressure sore care.
- Identify and implement techniques in a walking re-education program.
- Construct simple aids for daily living from locally available materials and teach the patient how to make and use them.
- Teach mobility and daily living skills to a blind person.
- Identify articulation, language and fluency disorders.
- Plan, implement and monitor language stimulation programs.
- Use augmentative and alternative communication methods with appropriate patients, construction of simple communication boards, and teach the family how to use them.
- Plan, implement and monitor basic programs for the rehabilitation of people with neurogenic disorders of communication.
- Counsel the family and teachers of a person with hearing impairment on simple measures to improve communication.
- Have knowledge of available resources for rehabilitation.
- Construct and instruct in the making of corner chairs with table, standing frames and walkers out of Appropriate Paper Technology.

- Construct and instruct in the making of toys out of locally available waste materials and plan, implement and monitor play and stimulation activities to facilitate development.
- Teach basic maintenance of wheelchairs, hearing aids, callipers and crutches.
- Teach an exercise program for the prevention and treatment of backache.
- Instruct on back care and joint protection principles to decrease pain and maintain the range of movement in the treatment of back pain and other conditions involving joints.
- Design treatment/rehabilitation programs for people with stroke, spinal injury, spina bifida, cerebral palsy, barriers to learning, sports injuries, backache, arthritis, amputations, blindness, to be implemented by the therapy assistant or family members of the person with a disability.
- Assess people with disabilities for the need for Specialized Assistive Devices, and prescribe and order these from the District, Regional or Tertiary Hospital.
- Assess patients with burn scar tissue, and prescribe and order pressure garments.
- Assess scholars with barriers to learning
- Design and direct needs driven awareness raising, education and prevention programs.
- Assess the need for surgical release of contractures and other corrective procedures.
- Supervise and arrange the continuing education of community therapy assistants.
- Assess continence problems, and advise suitable continence management.
- Manage spasms related to spinal injury with drug treatment and/or detection and treatment of stress factors.
- Diagnose disabilities as early as possible, and develop a system of referral.
- PHC facilities are accessible to wheelchairs and trolleys and have toilet facilities for people on wheelchairs.
- People with disabilities are given preference when queuing for services and, where feasible, appointments are given to patients to reduce waiting times.

Referral

From district hospital to PHC facility:

- All patients with newly acquired disabilities, who have completed the acute phase of their rehabilitation for follow up by the therapy assistant.
- All newly detected patients with disabilities, who have been assessed by a therapist, doctor or specialist, for follow up and rehabilitation at the nearest PHC facility.

In the PHC facility to the rehabilitation service:

- All children detected with a developmental delay for assessment.
- Patients with healed burns that cover a joint surface for the prevention of contractures and treatment of scarring.
- Patients with disabilities for alleviation programs and rehabilitation.
- All patients with chronic deforming arthritis.

Referral of patients to doctor or multidisciplinary team:

- Patients with spinal cord injury with troublesome spasms.
- Patients with continence problems for institution of an adequate continence program.

From PHC facility for specialist assessment or treatment:

- Patients with physical disabilities amenable to corrective surgery, assuming that a therapy follow- up service is available.
- Patients with chronic disabling rheumatoid arthritis for assessment and monitoring.

From PHC facility to hospital:

- Patients requiring intensive daily rehabilitative therapy.
- Patients with extensive bedsores.
- Patients in need of more assistive devices not available at district level.
- Complicated burns (facial, perinea, burns involving a joint or over 10% of body surface).
- Patients with spinal injury and sudden increase in spasms, temperature and high blood pressure. From PHC facility to other sectors:
- Children with sensory loss to schools.
- Patients with disabilities who are capable of working, to department of labour for employment opportunities
- Patients with disabilities for training in suitable occupational skills.
- Patients with disabilities that are not suitable for the open labour market, to community groups for disabled people, self-help groups, or protected workshops.
- Any other sectors which are deemed useful for the development of social and economic independence of the disabled person e.g. training centres for the blind.
- Peer support groups.
- Patients with disability who are not acceptably cared for in the community to the welfare department
- Severely disabled children, who are not accepted at schools to community day care centres

Patient education

Prevention of bedsores in debilitated patients and patients with sensory loss.

Records

- Data collected at PHC facilities to be used for development of a district data base on disability for use for program planning
- Initial assessment and follow up forms standardized for the district, and kept in the chronic file of the patient at the PHC facility.
- A summary note of the diagnosis, referral and treatment is in the patient held record.
- The visiting therapist ensures that data and information, and records are accurately and consistently maintained.
- Data fields for clients referred for rehabilitation are included in the PHC facility register.

Community & Home Based Activity

- Refer patients to community monitoring programs, mobilize community support, where indicated by the patients' social circumstances to ensure compliance with treatment.

- Needs analysis for rehabilitation in the community, to plan appropriate and effective intervention programs.
- Home visits on patients to gain insight into their social situation.
- Devise home based rehabilitation programs for people requiring extended rehabilitation, in collaboration with the disabled person, his family, and/or community.
- Maintain contact with clients through follow up visits.
- Identify and mobilize community resources for groups and peer support, skills training and income generation.
- Supervise, advise and assist community therapy assistants.
- Recommend and assist with implementation of adaptations to client's homes, communities, work areas, or schools.

Collaboration

Develop a responsive disability information system and database in consultation with Disabled People's Organizations and Community. The information system provides the "brains" for PHC to track services provided and guide managerial decisions. The quality of data provided from the PHC facilities is the most critical factor in assessing the validity of the information system. If the monthly reports from the PHC facilities are incorrect the entire system is misled. A standard data form for PHC monthly data has been agreed to for each province, although individual districts can add additional information to this form if they desire. It is important that workers in the PHC facility understand the definitions of each data element and record it correctly. One of the most frequent errors is a misunderstanding of the definition of the data item. It is the supervisor's job to understand the definitions and to scrutinize the monthly report each month to see that the information submitted is correct and valid.

Session 12: PHC Information Systems Guidelines

Duration of session: 90 minutes

Materials needed: pens or pencils, markers, flipchart.

Learning Objectives: By the end of the session, participants will be able to:

- Demonstrate understanding of Information System Guidelines
- Understand PHC reports

Source: USAID/PHCPI Leadership and Management training program: Participant's Guide 2011

The District Health Information System - DHIS is the computer software that analyses this data. It provides not only for the validation of entry figures (detecting numbers which lie outside of a normal range described as the minimum and maximum of each data field and also does validity checks on certain figures to be sure that they are within the range of possibility). The computer automatically produces reports of the data for any desired period and calculates a whole set of indicators, many of which are described in this information section.

It is important for people in the PHC facility to understand their own data and to use it for self analysis and decision making. For this reason PHC personnel are encouraged to graph the data from their monthly reports. Supervisors are expected to assist and oversee in this graphing process. Each month the latest addition to the graphs should be discussed to decide whether or not progress is as expected. Some items such as immunization coverage and family planning are best graphed in a cumulative graph. This shows the number for the month as well as the total numbers receiving the service since the beginning of the year to show the progress towards an annual objective. Other data is best graphed month by month to show differences according to season, such as cases of diarrhoea or acute respiratory illness. Sometimes data can be shown or traced on a locally drawn map. New cases of cholera will cluster in a particular geographic area and will give hints on control options. New cases of tuberculosis may show communities in particular need of intensive case finding and control of spread.

The monthly review of the routine statistics is an important supervision activity and contributes to improved quality of both health services and management.

12.1 Guide for Reviewing the Monthly PHC Report

The PHC facility Supervisor is responsible for reviewing the monthly report, verifying the data, making suggestions to the PHC facility and signing the report to signify the data have been checked and found correct, before it is submitted to the district office. This guide provides pointers for the supervisor in this important task.

Notice that there is a space for comments next to each data box. Here is where any observations on the data, especially validating unusual data, should be recorded. Data, which falls substantially out of line from past months, should be questioned and if verified as true, a comment should be made explaining why it is outside normal. Any unusual circumstances may also be noted in this space.

Management

- Headcount under five and over five record of the number of visits made to the PHC facility throughout the month.
- PHC personnel days worked cannot be any higher than the total working days in the month times the number of personnel in the PHC facility. Any personnel providing services regardless of their actual rank or title (doctors of nurses) is included in "health care personnel days worked". If absences are high, look into the reasons.
- Supplies or medicines available all month are recorded from the list, which is also appended and sent in. The list of tracer medicines and supplies should be kept in the PHC facility medicine storage area and if any item is found out during the month tick [✓] to indicate that a stock-out occurred. It is not necessary to record how many days the item is out but just a single tick is adequate to say at some point it was out of stock. The number of items with a tick is filled in this box and represents the number of items out of those traced (if the PHC facility has certain items which are never stocked, the number of expected items is less than the full list). Find out <u>why</u> any item has gone out of stock and try to suggest remedial measures.

Ante-natal visits

- First antenatal visits - is the number of pregnant women who were newly booked this month. Some provinces record whether this first visit occurred before or after 13

weeks (first trimester) or before or after 20 weeks. Subsequent ante-natal visits is all other ante-natal, which is usually more than the first ante-natal.

- Pregnant women receiving tetanus toxoid number two (previously only the third dose was recorded), or a booster if tetanus toxoid was given previously, is recorded here. This will probably occur during a subsequent antenatal visit. The number who receive tetanus toxoid number 2 should be the same number as first ante-natal visits when summed over the year but will not be the same month to month as two or more doses are required, requiring more visits.

Deliveries

- Note that live births that were delivered in this reporting facility are the only ones that should be recorded. Make sure that only those born in the facility, not outside of the facility are recorded. Those born in the facility weighing less than 2.5 kilograms assumes that all others born in the facility weighed more than 2.5 kilograms.
- Deliveries to women age less than eighteen is women up through age seventeen and provides a measure of what is called teenage pregnancies delivering in this facility.
- Stillbirths are those who are not alive at birth, made no breath or cry.

Contraceptive protection

- Please note it is not numbers of people but oral pill cycles that are recorded. Injections are usually one per person. IUDs are no longer reported from PHC as they are unusual at this level.
- Condoms dispensed are the number of condoms, which were given out plus those taken from the public dispensing box in the waiting area.

Child Health

- Diarrhoea in children is generally defined as greater than three loose stools, although even a massive watery stool is technically diarrhoea. Here one would look for unusual increases in numbers representing a local epidemic. Check that each child received oral rehydration solution (ORS).
- Lower respiratory infection is diagnosed by counting respirations. (Greater than 60/minute in infants under 2 months old, > 50/minute in infants, > 40/minute in children over age one according to the IMCI protocol). Other children with cough and cold should not be recorded here.
- Children under five years weighed should be recorded in this box. If any child is weighed more than once in a month it may be recorded on the RTH card but is recorded here only once in the month. Note that every child under age five coming to the PHC facility should be weighed whether he is coming for nutritional services or not. Of those who are weighed how many did not gain weight since the last time they were weighed? This is an important indicator of faltering growth and should be monitored carefully by PHC personnel to be sure those not gaining weight have received advice and follow-up. They are not necessary malnourished but simply not growing as expected and some action should be taken, usually advice for more frequent feeding at home. This is not necessarily an indicator to provide nutritional supplements but follow-up of each child is indicated to assure growth recovers.
- Severe malnutrition these are only the cases newly diagnosed this month. Any case severely malnourished will surely remain so for several months.

Immunizations

- Doses are recorded as they are given.
- Note that when a child has received all of the primary immunizations before one year he is recorded once and only once in the box "new cases fully immunized before age one year". It is very unusual for this number to be higher than the number of measles (nine month) or the number of third DPT or third Polio or third HBV.
- You should check the number of doses to be sure they make sense.
- Vitamin A supplementation is provided as part of the immunization program. Newly delivered mothers should receive a dose before their baby reaches 4 weeks of age, preferably given to the mother in the hospital before she is discharged. Check each postpartum mother to be sure that she received this dose – if not give it in the PHC facility. Only doses given in the PHC facility should be recorded.
- A dose of 100,000 units is given to the child at 6 months (or any time up to 11 months)
- A dose of 200,000 is given to older children (at 12, 18, and 24 months in E. Cape, six monthly in other provinces).
- Check to see that the doses of vitamin A given are equal to the comparable doses of vaccines at the same ages (e.g. BCG at birth, 9 month measles and 18 month measles). You may want to graph these together.

Tuberculosis

- Suspect TB cases are the number of cases from whom sputum was taken and sent to the laboratory are counted as suspect TB cases. The PHC facility should be regularly suspecting TB in any adult with chronic cough. Normally, one would expect at least 1-2% of the adult head count to require a sputum exam. If fewer sputa are sent, the PHC facility is not adequately seeking new TB patients.
- New TB cases are those diagnosed this reporting month
- All new cases of TB should be urged to have a HIV test. Up to 50% of TB cases also have HIV infection and it is important to treat both conditions.
- TB cases under treatment are those who are carried on the TB register for treatment during the reporting month. This means any case, even if they have been irregular, is recorded here. Do not report those who are cured, died, transferred out or abandoned treatment.
- TB cases under DOTS care was previously recorded, but is no longer collected – all patients with TB should be on DOTS care either in the PHC facility (desirable) or if not possible, in the community with a DOTS supporter.

STI

- New cases treated as STI are any new case treated according to the STI protocol, whether it is truly diagnosed, as STI should be recorded here.
- All new cases of STI should be urged to have an HIV test. HIV is just one form of STI
- Contact slips should be issued to each patient treated as STI and contact slips issued are probably close to the same number as new cases.
- PMTCT data fields enable you to track the positive rate in pregnant women, and the proportion of them who accept Nevirapine treatment for themselves and their babies. A high rate of acceptance of testing and of Nevirapine use by positives is desired.
- Babies of HIV positive mothers should receive either exclusive breastfeeding or exclusive bottle feeding – mixed feeding is dangerous to these infants

- Infants are tested at one year to see if they are infected – if positive, they should be tested again at 18 months as a few could be false positives at 12 months. When HIV positive mothers have received Nevirapine and given a dose to the baby, then HIV positive at one year should be less than 10% if bottle-fed, less than 15% if breast fed.

Mental health cases are now divided into:

- Cases of violence against women. Any complaint of violence, physical or mental, would be recorded here.
- Cases of psychiatric illness are those with psychiatric diagnosis being treated or having been discharged from a facility, are coming back for re-treatment of established illness.
- All other mental health cases are marked, as before, as those cases requiring counselling of some type but are not a psychiatric diagnosis

Chronic cases are comprised of: Diabetes mellitus, Hypertension, Epilepsy Arthritis, Asthma, HIV positive, etc.

Other things to consider

- Referred to doctor are all cases that the nurses refer to the doctor whether the doctor is in the same establishment, the same building or visiting occasionally, or the patient is sent out of the facility to the doctor. It is assumed that patients see the nurse first and are sent by her to the doctor.
- You should discuss any unusual findings, making suggestions to the nurse as how to improve performance or response to any of these reported services.
- In cases where numbers look clearly wrong, inspect the register or source of data directly and make concrete suggestions for improvement.
- For each facility data should be monitored in a graphic form on the wall of the PHC facility. The supervisor can help to set up these graphs and transfer the data to the graphs each month, eventually passing this responsibility on to the PHC personnel. Feedback on earlier reports from the district office should also be discussed with the PHC personnel. And plans made to take action to improve the performance such as immunization coverage, ante-natal coverage, STI contact tracing or better TB outcomes. Monitor the results of these actions each month as you review the data returns.

12.2 Informed Consent

Activity: Inventory of supervisory style

This is a tool for self-improvement, which is designed to help you reflect on areas in which you need to strengthen your supervisory capability. Respond honestly to the questions below. Count the total score for each column.

Stateme	Yes	No
Job Expectations		
1. I always discuss work expectations with each staff member I supervise.		
2. I discuss job description(s) periodically with the staff members I		

3. I always ensure that health staff has access to current reference books, norms, guidelines, and regulations in all areas and procedures of		
4. I always encourage and help the staff I supervise to do self-assessment and to develop an action plan to improve their performance and the		
Performance Feedback		
5. I always provide staff with **constructive** feedback on their performance in a timely manner, focus on solutions to problems, and offer help (but not in front of others.		
6. I believe in empowerment rather than criticism.		
7. I work with the staff to ensure that they have ways to receive feedback from clients and the community.		
8. I always practice active listening and other communication skills when supervising and providing feedback.		
Motivation		
9. I often ask staff what motivates them and what does not, and I use this information to motivate staff effectively.		
10. I always recognize good staff performance by telling them personally and in front of their colleagues that they have done well.		
11. I always make the effort to ensure that there is a transparent and fair system of motivation and incentives.		
12. I always treat staff at all levels with respect, and I encourage staff to treat each other respectfully.		
Physical Environment and Tools		
13. I always make sure that the staff I supervise have the necessary equipment and supplies to do their job (including supplies for infection prevention) and to meet clients' and community needs and provide		
14. I always make sure that staff has the educational aids and informational materials they need to provide clients with information and to conduct counseling and educational activities.		
15. I make sure that the staff I supervise have adequate working conditions.		

All of the actions described in the questionnaire represent variety of behaviors and tasks while supervising staff. If you answered "no" to two or more of the questions, you may be ready to try a different approach to supervision. Share this tool with other supervisors at your work- place and encourage them to use it to reflect on their supervisory style.

Informed consent

The purpose of informed consent is to involve the patient in the decision-making process involving his or her treatment and care. Informed consent not only protects providers from liability, but also ensures that both the provider and patient are on the same page regarding the course of treatment.

Characteristics of Meaningful Informed Consent:

Decision-making capacity: For patients to play a role in treatment decisions, they must possess a minimum level of decision-making capacity or **competency**. That capacity includes 1) the ability to receive, process, and understand information, 2) deliberate, and 3) articulate

their choices. Patients are presumed to be competent unless proven otherwise. If a patient is ruled incompetent, then consent may be obtained from a surrogate.

Absence of manipulation or coercion: Primary care providers must present patients with complete, unbiased information. They must present alternatives in a balanced fashion so as not to manipulate the patient. A provider may not withhold treatment if a patient chooses an alternative to the one the provider has recommended.

Adequate information: Patients must be provided with all the information they need in order to be an informed participant in the decision.

Adequate understanding: Patients must demonstrate an understanding of the nature of the decision and its consequences.

Opportunity to express a preference: Patients must be given an explicit opportunity to voice their preferences.

Key Points

In order for meaningful informed consent to occur: service options must be available, decision making process must be voluntary, patients must have appropriate information, counseling should be available to ensure improved patient-provider interaction, patients' rights must be clearly understood.

These rights include access to certain information, fair treatment, and control over treatment decisions.

Access. Everyone has the right of access to health care services that include:

Use of quality diagnostic and treatment methods;

- Emergency care;
- Provision for special needs e.g. newborn infants, children, pregnant women, the elderly, disabled persons;
- Counseling without discrimination, coercion or violence e.g. reproductive health and STDs
- Health information, in the language understood by the patient, that includes the availability of health services and how best to use such services;
- Referral, if necessary, to another health facility;
- Quality of patient-provider interactions e.g. courtesy, human dignity, patience, empathy and tolerance.

Consent. Everyone has the right to participate in decision-making including 1) the provider they choose to see; 2) the facilities they utilize; and 3) the services they accept.

Confidentiality. Related to 1) health service procedures; and 2) exam and testing results.

Environmental Safety. Related to 1) Adequate water supply; 2) Proper Sanitation; and 3) Infection Control Procedures.

Equity. Everyone has the right to receive quality health services regardless of their sex, gender, race, sexual orientation or religion.

End of Course Evaluation Forms[12]

Form 1: END OF COURSE EVALUATION

QUESTIONNAIRETRAINING 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.

[12] These forms adapted from previous USAID training curricula developed for MoH

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

Comment

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 5-4-2-1

   adequate (if applicable)

   Comments:

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

   Comments:

5. The educational materials (including reference material) 5-4-2-1

   used were adequate both in terms and quantity and quality in relation to the training objectives and content

   Comments:

6. The methodology and technique used to conduct the training 5-4-2-1

   were effective in assisting you to reach the course objectives

   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:

4. 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 5- 4- 2- 1

   Comments:

2. The content / topics covered in the unit are relevant to the objectives 5- 4- 2- 1

   Comments:

3. The content / topics were adequate to help me achieve the objectives 5- 4- 2- 1

Comments:

4. The content / topics were clear and well-presented 5- 4- 2- 1

Comments:

5. The training methods and activities were effective in facilitating learning 5- 4- 2- 1

Comments:

6. The training methods and activities were conducted adequately to facilitate learning 5- 4- 2- 1

Comments:

7. These are important topics that will enable me to better perform my job 5- 4- 2- 1

Comments: (specify these points)

8. There is a logical sequence to the sessions and topics that facilitates learning 5- 4- 2- 1

Comments:

9. There are certain topics that need further clarification 5- 4- 2- 1

Comments: (specify these points)

10. The training materials and resources provided were adequate 5- 4- 2- 1

Comments:

11. The training materials and resources were provided on time to facilitate learning 5- 4- 2- 1

Comments:

12. The training materials and resources used were adequate to facilitate my learning 5- 4- 2- 1

Comments:

13. The training site was adequate 5- 4- 2- 1

Comments:

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

Comments:

General comments (if any not covered):

Form 3: QUICK FEEDBACK FORM

TRANING 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. Planning of the session • Relevant sessions plan selected from curriculum • Organization conduct and evaluation of training in conformity with curriculum (based on observation during the session)				
2.Organizing the session • 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 • Prepared/rehearsed for the training (based on observation of mastery in conducting activities and using resources during training)				

Items	Observed		NO	Comments
	A	NA		
3. <u>Conducting the session</u> **3.1 <u>Introduction</u>** • Introduce oneself - Name - Job - Experience relevant to topic • Introduce/let team members introduce themselves • Module: - Introduce topic - Present objective - Clarify topic and objectives - List sessions - Establish linkage with job/task • Session - 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 **3.2 <u>Facilitation skills</u>** ➢ **<u>Clarifying</u>** • Make sure participants are ready before starting on any content item • Make sure participants can hear: - Trainer - Other participants • Make sure participants can see: - Writing - Illustrations/ educational aids - 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**		
➢ **<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: - Listening - Letting participants complete their interventions - Not being judgmental - Maintaining cordial relationships with participants ➢ **Mastering Training** • 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 **Evaluating learning/training process** • Check that participants understand • Check that participants learn skills • Provide supportive feedback by:				

- 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

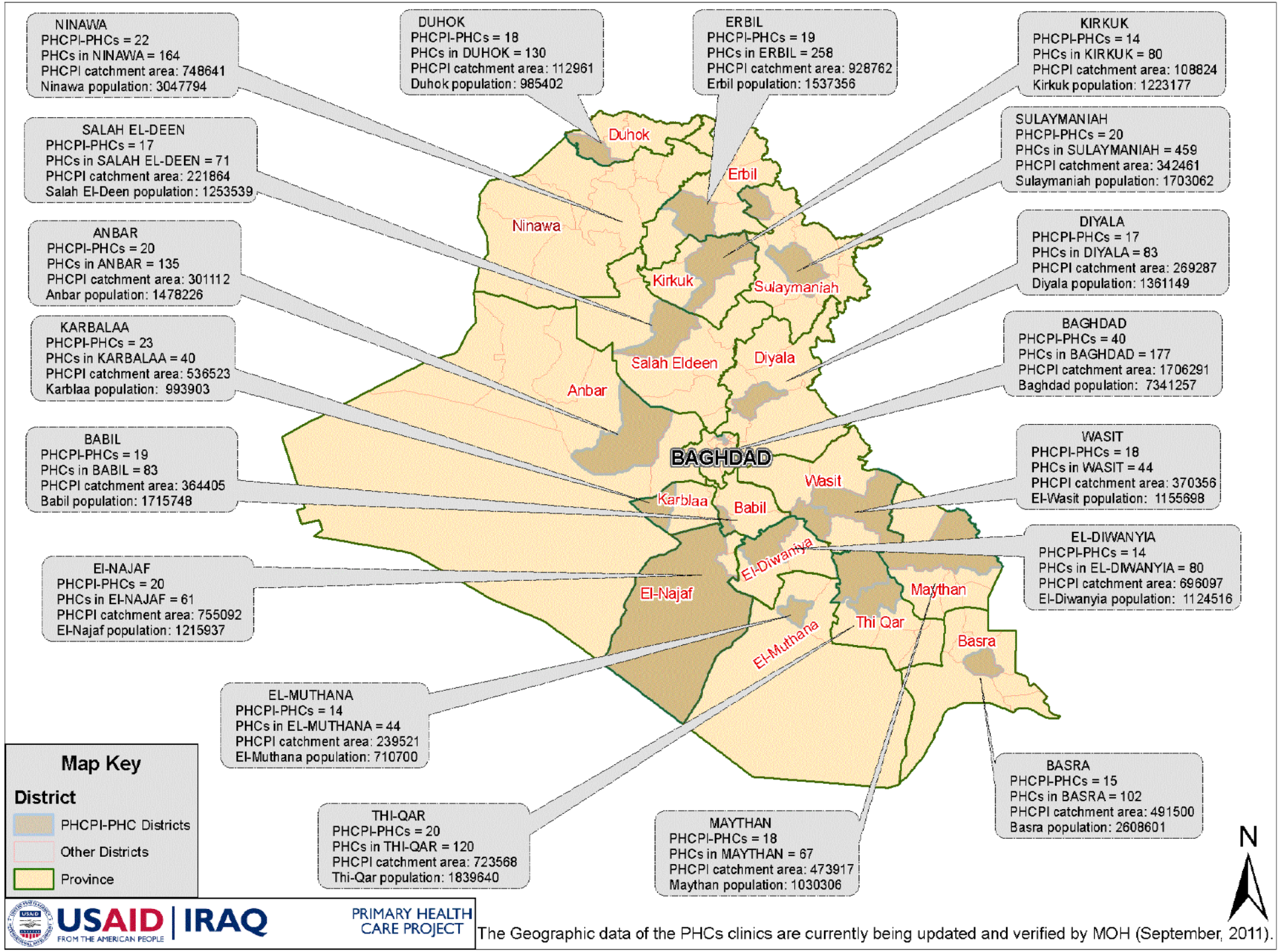
Further action (s) needed

Trainer's comments

Date:

Trainer's name & signature **Supervisor's name & signature**

PHCPI-PHCs population mapped to IRAQ population



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PRIMARY HEALTH CARE PROJECT

The Geographic data of the PHCs clinics are currently being updated and verified by MOH (September, 2011).

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