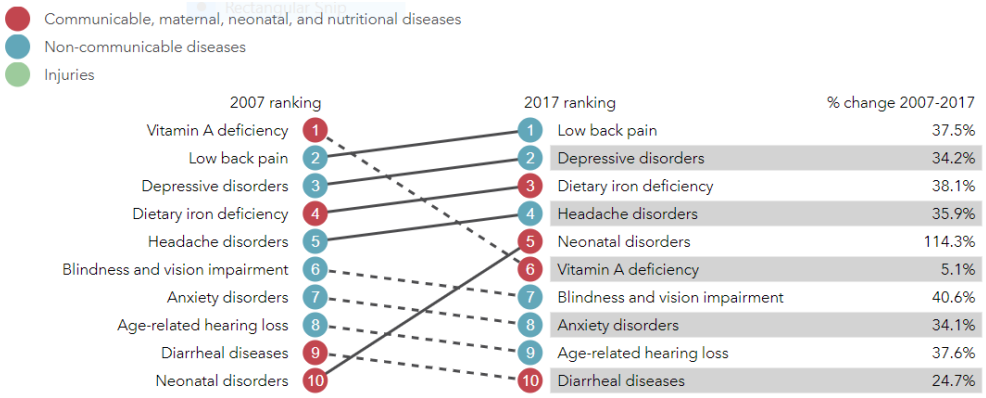
Ethiopian primary health care clinical guideline Implementation Manual

Background about primary health care clinical guideline

Diseases burden of Ethiopia

Ethiopia is now experiencing triple burden of diseases: communicable, reproductive health threats and under nutrition as well as non-communicable diseases and injuries[1]. The epidemiologic transition from infectious to chronic non-infectious diseases is an expected horizon as most countries in the world experienced—this is due to the different life style modification and the urbanization in the country. According to the 2017 Ethiopia diseases burden report, most death occurred due to: neonatal disorders, diarrhoeal diseases, lower respiratory tract infection and tuberculosis. Ischaemic heart diseases and stroke are increasingly becoming the top most common causes of diseases.

The top five common health problems that cause most disability are: low back pain, depressive disorders, dietary iron deficiency, head ache disorders, neonatal disorders[2].



Top 10 causes of years lived with disability (YLDs) in 2017 and percent change, 2007-2017, all ages, number

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5521057/pdf/12963_2017_Article_145.pdf
[2] http://www.healthdata.org/ethiopia

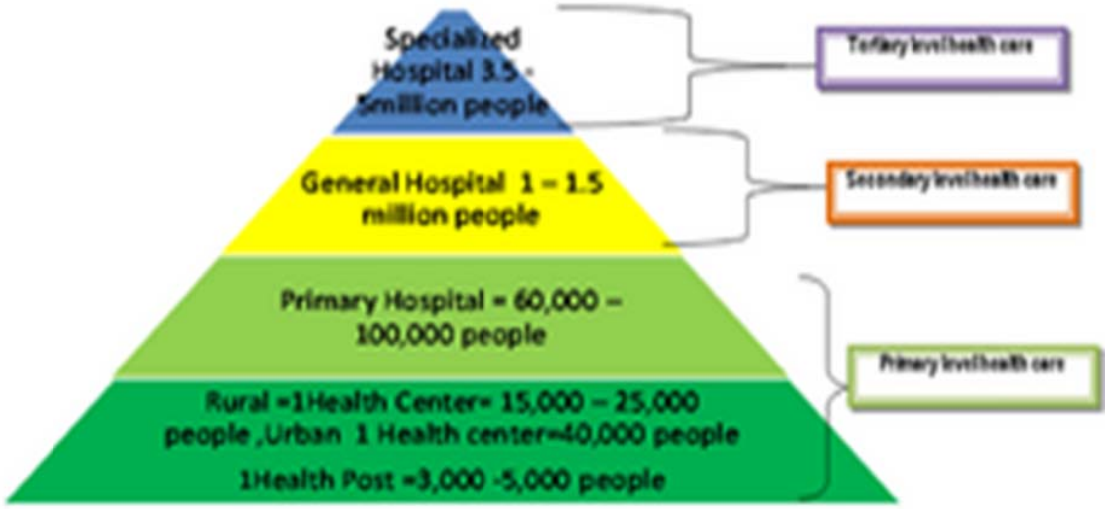
Health care system in Ethiopia

Federal ministry of health has been working on the health service expansions on the past two decades and it was successful in the coverage of the primary health care service in all parts of the country, especially the coverage of Maternal and child health, family planning, malaria intervention, TB and HIV care…. etc has shown great improvement the past two decades.

The life expectancy of the nation has improved very much from bass line of 48.8 for female and 45.6 for male in 1990 to 70.4 for female and 66.7 for male in 2017.

Ethiopia has a decentralized three-tier system of primary, secondary and tertiary care system. The devolution of power to regional governments has largely resulted in shifting decision-making for public service delivery from the central to regional and district levels. To improve the delivery of quality health care services, the sector has invested tremendously on primary health care through its brand new program called health extension package. The primary clinical guideline will be implemented at the lowest tier of health hierarchy—at the health center level. The major users of the guideline will be those who are currently working at the health center: nurses, midwives, and health officers.

Ethiopia Health Tire system



Ethiopian primary health care clinical guideline

Ethiopia has been doing excellent job in expanding access to primary health care and tremendous success has been achieved on child health, mobilizing the community to promote hygiene and sanitation thorough its brand new program called health extension program. Despite its success on primary health care, concern remains on quality of primary health care quality at facility level—at health center.

The health sector transformation plan has envisioned promoting quality, equity and access at all tiers of health care. The major initiatives to cascade this vision are: task shifting at the primary health care level—such as providing comprehensive facility based maternal services by building 400 OR blocks; establishing model health facilities; and promoting evidence-based PHC interventions by competent, compassionate and respectful staff. The Ethiopian primary health care clinical guideline is supposed to be implemented in this context

The primary health care clinical guideline is initially localized from the south Africa PACK (practical approach to care kit) program. The PACK program has a PACK guide—a "carefully designed comprehensive and integrated clinical decision support". It has a link with British Medical Journal evidence synthesis product, Best practice, which is an online clinical decision support tool. The evidence is synthesised and updated yearly. The Ethiopia PHCG has more than 2300 recommendations and aligned to WHO guidance and global evidence[3]. T

The guideline (EPHCG) contains adult and child (5-14 years) pages—33 child pages. The major causes for health problems—as shown by the 2017 diseases burden report of Ethiopia—are included in the guideline. The guideline prompts to: give comprehensive and integrated care; enable to give whole person care; give all service at service delivery point ("one stop shop"); and provide services that are safe and respectful to the user.

Ethiopian primary health care clinical guideline (EPHCG) is a new initiative to be implemented at health centre level throughout the country. The training delivery method is unique in that on-site training is the major modality; that means users of this guideline will get the training while they are on their job —one to hours per week

[3] Using a mentorship model to localise the Practical Approach to Care Kit (PACK): from South Africa to Ethiopia

and totally 8 weeks training. Nationally trainings were first given for master trainers; and in return, master trainers will train at least two facility trainers from each facility. These facility trainers will cascade the on-site trainings to health workers.

Implementation standardsand checklists for EPHCG

To ensure the uniform implementation of Ethiopian primary health care clinical guideline, a standard must be set along with checklists to ensure the implementation of those standards. Any health center management should ensure all these standards are done and regularly monitored and evaluated. Some of the standards are intended to check whether health centers are making themselves ready to start the implementation. The following are the standards for implementation of EPHCG:

1. The health center shall ensure cascading of the onsite training according to the national EPHCG training cascading scheme.
2. The health center shall ensure availability of all necessary resources to cascade the implementation of EPHCG.
3. The health center management shall ensure EPHCG implementation is integrated with the health center core activities.
4. The health center shall ensure the full implementation of EPHCG in the health center.
5. The health center shall advocate the importance of EPHCG for the community.
6. The health center shall ensure continuous mentoring is conducted on EPHCG.

Supportive supervision checklist on PHCG

No	Standards	Verification points	Met	Unmet	Remark
1	The health center shall ensure cascading of the **onsite training according to the national EPHCG** training cascading scheme.	➢ Check onsite trainings are conducted by facility trainers			
		➢ Check the action plan has been developed and signed by the health center manager to cascade the trainings.			
		➢ Observe individual and facility trainer records' completeness.			
		➢ Ask at least **2 health workers listed in facility trainer records** form about: o Norm and the four steps			

		of onsite training steps were posted?			
		o Game board played?			
		o Completed 8 weeks of training and saw at least 12 cases?			
2	The health center shall ensure **availability of all necessary resources** to cascade the implementation of EPHCG	➢ Observe whether the EPHCG guidelines are adequate, distributed and available at all places (OPDs, Emergency, MCH, ART and TB clinics)			
		➢ See intra-facility report and resupply (IFRR) report, BIN card and Stock card and observe essential drug lists and laboratory reagents (**Use Annex I)** (as per EPHCG) are available. ➢ Observe the health center essential laboratory monitoring log sheet and see whether essential laboratory tests (as per EPHCG) are being done.			
3	The health center management shall ensure EPHCG implementation is integrated with the health center core activities.	➢ Check whether EPHCG implementation team is part of the health center quality committee (see their plan, activity report) ➢ Check whether the facility trainers are team members of the HC quality committee (see their assignment letter) ➢ Observe EPHCG implementation plan is included in the health center yearly, semiannually, quarterly, monthly plan. ➢ Check the EPHCG implementation team has done monthly supportive supervision for the first six months, and quarterly afterwards			
4	The health center shall **advocate the importance of EPHCG** for health workers and community	➢ Check EPHCG is integrated with the onsite health education program (see H/E schedule and log books).			
		➢ Check minutes held with public forum whether EPHCG is discussed with the public.			

		➢ See any advocacy efforts made (fliers, banners etc) made by the health center.			
5	The health center shall ensure **continuous mentoring** is conducted on EPHCG.	➢ Check whether mentoring group is officially assigned (see official letter of assignment for establishment of mentoring group).			
		➢ After the 8 weeks onsite training, biweekly(every two weeks) regular clinical forum is conducted (see the minute produced on the regular clinical forum)			
		➢ Check activity reports and minute produced of mentoring groups (one on one mentoring, team meeting, chart review and support provided etc).			
6	The health center shall ensure the full implementation of EPHCG in the health center	➢ Observe **2 HW- patient interactions using a checklist**. ***(use Annex I)*** ➢ Take **three patient charts** (from different departments) and audit according to a checklist prepared for chart abstraction. ***(Use Annex II)*** ➢ Pick randomly **3 referrals (cases) from the referral registry**, see the reason for referral, and compare with the criteria set on the EPHCG. ***(Use Annex III)*** ➢ Pick randomly 5 patients at exit and interview them(use annex IV) ➢ Conduct a **focus group discussion** (FGD) with five health workers and interview them ***(use Annex V)***			

Levels of supportive supervision

Supportive supervision could be conducted at the three levels: at national level by the federal ministry of health; regional level by regional health bureau and/or by zonal health department and at woreda level by woreda health office. Each health facility will conduct supervision (called internal supportive supervision). The information gathered each month during the first six months of the commencement of the implementation and communicated to woreda health office and regions. After the first six months the supportive supervision will be integrated with the normal supportive supervision time of the facility.

Internal supportive supervision

Supportive supervision at a health care facility shall be internal in nature and it shall be conducted by the facility management committee.

- Internal supportive supervision shall be conducted each month by an assigned team —the assignment should be official with management committee of the facility.
- The internal supportive supervision shall be conducted each month for the first six months of the commencement of the PHCG implementation; then integrated with the normal internal supportive supervision time; and reported to the respective bodies.
- The process of internal supportive supervision shall be written well; it includes: the reports generated, who participated with their signature, what action plan produced and acted up on, and improvement observed after the implementation of the action plan etc.
- The team shall use the standards and implementation checklists to supervise the implementation of PHCG.
- The team shall supervise all units implementing PHCG.
- The team shall produce a quarterly activity reports on the internal supervision findings, and send the report to woreda health office and any other relevant stakeholders.

Brief Supportive supervision report

After conducting the supervision using the above standards, the team leader should review all evidence and based on this should prepare a site visit briefing document. This should include:

- Summary of health center performance according to the checklist
- Strengths/successes of the health center
- Areas of possible weakness
- Priority areas for further investigation during the site visit
- Staff members interviewed during site visit along with their contact details.

Table 2: Levels of supportive supervision for the implementation of primary health care clinical guideline

Description	**Levels of supportive supervisions**		
	National level	**Regional/zonal level**	**Woreda office level**
Who leads the supervision?	Federal ministry of health	Regional and/or zonal health department	Woreda health offices
Where the supervision could be done?	At regional, zonal, woerda and health facility level	Woreda , health facility level	Health facility level
Regular schedule of supportive supervision	Twice per year	Twice per year	Quarterly(four times per year
Number of people who visit a facility	at least three people	at least two people	two people
Duration of supportive supervision at health facility(health center) level including the feed back	At least 12 working hours per facility	At least 8 hours per facility	At least 6 hours per facility

N.B: the national and regional level supervision may be synchronized and conducted as a team composed of people from national and regional level.

Mentoringof EPHCG implementation

Training cascading model of primary health care clinical guideline

The primary health care clinical guideline, if implemented well, will standardize medical services at the primary health care unit. Standardization of services is one of the powerful interventions to improve quality of medical care. Regular mentoring and supportive supervision do help to keep the uniform implementation of primary health care clinical guideline across all primary health care units (i.e health centers). As we establish supportive supervision structures for EPHCG guideline implementation, we need to establish the same for mentoring. Mentoring and supportive supervision system should be interdependent and conducted by different teams even if overlap exists.

The mentorship approach is initially instituted in the primary health care clinical guideline. To institute a mentorship system for implementation of EPHCG, we need to understand the EPHCG guide as well as the training approach.

- The Ethiopian primary health care clinical guideline (EPHCG): this is - evidence informed, algorithmic, comprehensive clinical content for primary care use. The prototype HIV/AIDS mentorship program may not be fully adopted, for this guide is an algorithmic and mentorship should focus on consistent use of EPHCG. In fact mentors main responsibility is whether trained health workers are strictly using this guideline: to take history, physical examination, diagnosis, management and counselling of patients. The primary target of mentorship on EPHCG is to encourage health workers at the forefront to discuss cases continuously so that health workers at the forefront will develop knowledge and skills to diagnose and manage common health problems of that community. Mentorship should always target consistent use of EPHCG; prepare different cases based on the framework of EPHCG; and continuously discusses on those cases. EPHCG based continuous case discussion will help health workers to get credit points for continuing professional development. Health facilities, woreda health offices, regional health bureaus must understand the EPHC is a major interface between health workers and patients at the forefront.
- Training program: it uses different approach: EPHCG cascade model.

- The EPHCG national team at the federal ministry of health: with the support of Knowledge Translation Unit (KTU), the national team localised the training package. The national team who adopted the guideline are also part of the mater trainers. This team will be part of the national technical working group who technically support the ministry in implementation of EPHCG
- Master trainers: a pool of master trainers has been created. The main purpose of this pool is to train facility trainers—each implementing facility has been training at least two. One of the purposes of the master trainers is to mentor the facility trainers in addition to delivering the 4 days facility trainers. The facility trainers, after the training, will produce an implementation plan—the main purpose of it to conduct the onsite trainings.
- Facility trainers: at least two heal workers will get this training and cascade the 8-weeks training at the health service level. They equip, train, support and mentor clinicians at the health center level.
- Educational outreach (onsite training): This is 8 week training—each session last 1 to 1.5 hours per week. A total of 12 cases are used to train. After completing the training, clinicians are expected to use and easily navigate the PHCG.

While establishing the mentorship model for PHCG, considerations of the training system as well as the unique nature of the guideline will make the mentoring process very unique.

Purpose and objectives of EPHCG mentorship

Purpose

To provide integrated, comprehensive high quality clinical care at the primary health care unit.

Objectives

- To establish mentorship system for the implementation of EPHCG.
- To improve the use of the EPHCG guideline at the PHCU.
- To provide various services at a service delivery point (“one stop shop”)
- Build the capacity of providers to manage or refer unfamiliar or complicated cases, as appropriate.

- Strengthen problem solving and clinical decision making skills of the health care provider.
- To provide care that is safe and respectful to the users.
- Improve patient clinical outcomes.

WHO ARE EPHCG MENTORS?

An EPHCG mentor is a health worker who can navigate the EPHCG and doesn't necessarily have deep experience on each subject matter. An EPHCG mentor needs to be very conversant about the primary health care clinical guideline and navigate the guideline easily. He/she should take any of the EPHCG training: master, facility trainer, or certified for finishing onsite training and a treating clinician using the EPHCG for at least 6 months. In addition an EPHCG mentor should have effective mentoring and couching skills:

- Ability to utilize effective mentoring techniques and coaching and communication skills to transfer or impart the mentor's knowledge/skills to the mentee.
- Establish an effective learning environment as part of a mentoring visit.
- Ability to communicate clearly and effectively with staff including provision of constructive, timely, and interactive feedback.
- Capacity and desire to motivate the mentee to perform well.
- Ability to gather and analyse information.

Establishing a mentorship system for PHCG

Introduction

Ethiopian Primary health care clinical guideline (EPHCG) needs a very close mentoring at least for the first six months of its implementation and then quarterly. The following mentorship structure is suggested after extensive discussions with the relevant stakeholders.

Organization of the PHCG mentoring system

Mentorship team will be established at health facility level. The main mentorship structure will anchor on the Ethiopian primary health care quality alliance structure at woreda level. Woreda health offices will have the overall responsibility of overseeing mentorship and supportive supervision of EPHCG at the facility levels. One of the

main priority areas of EPAQ (apart from EHCIRIG, KPI, Woreda management standards) will be the Ethiopian primary health care guideline implementation. But, zonal health department, regions and Federal ministry of health will have more a supportive supervision roles.Therefore, through the structure of EPAQ, health centers will interdependently support each other to cascade EPHCG apart from the other main priority areas. Despite the major mentorship structure lies at Woreda/EPAQ structure, Federal ministry of health, Regional health bureaus and Zonal health department main responsibilities will be to create a conducive environment for the facilitation of mentorship program and conduct supportive supervision using the standard implementation checklists. In addition, they mobilize resources and strengthen the EPAQ structure and EPHCG mentorship program. They will make sure woreda health offices uphold EPHCG is one of the priority areas.

The role of hospitals in EPHCG mentoring

Recent experience in the implementation of EPHCG has shown hospitals engagement in the successful implementation of EPHCG is mandatory. As the guideline is unique, there may be a need to disentangle from the previous way of thinking and doing in health care. One area we must do so is referral. Most of the time referral is made based on the judgment of the referring professional and no standard or criteria is clearly know who are going to be referred. Ethiopia primary health care clinical guideline will break that trend and the guide specifically put crystal clear indications to refer a patient. This must be known by hospitals very well. Engagement of hospitals in EPHCG implementation will facilitate such kind of problem. In fact, EPHCG will be a pushing factor for hospitals to have their own protocol for treating their patients.

In fact hospitals could play a very pivotal role in mentoring of EPHCG implementation as well as supervision if they are engaged.

In some regions, some EPAQ alliances are made between hospitals and health centers(example in Harar general and referral hospital is part of the EPAQ structure). Engaging hospitals will benefit the transfer of knowledge transfer from hospitals to health centers. In fact, EPHCG will benefit hospitals as well, as they may gain insights and improve their practice despite the primary purpose of the guideline is meant for health centers; especially primary hospitals could benefit a lot and referral

linkage will be strengthened if hospitals will be involved in EPAQ structure and engage in mentorship program. Primary hospitals may support health centers in strengthening continuous clinical forum.

Approach and tools for EPHCG clinical mentoring

Site visit by mentors

Comprehensive readiness assessment before starting the onsite clinical mentoring is necessary in collaboration with the onsite supportive supervision team. Ethiopian primary health care clinical guideline will introduce new horizons for health workers: increase the capacity of diagnosing new kinds of diseases; enhancing the management capacity of both existing and new kinds. Therefore, before starting the implementation of the guideline, initial readiness assessment must be done and necessary preparation to equip that health center will enhance effectiveness of the guideline.

In a facility that is newly starting PHCG, making frequent site visits—at least each month is mandatory for the first six months.

The major responsibility of doing site visit is that of hospitals which are given the responsibility of mentoring and woreda health offices. The major goals of site visits by the clinical mentor are reinforcing the training and building relationship with the clinical team members. Each visit will take at least one full day. The mentor may use some or all of the following modalities of clinical mentoring. These techniques will be implemented to strengthen learning and gain competencies.

1. One on one case management observation.
2. Review patient records and provider documentation of health care.
3. Team meeting to elicit feedback: identifying potential problem areas and issues and recommendations;
4. Clinical case review (different cases treated by the guideline such as hypertension, diabetes, mental illness etc).

Each mentoring visit activities like who was mentored, for how long, problems identified and discussed, findings, recommendations and lessons learned should be documented (may be preparing formats is needed???).

The onsite mentoring should be monitored and evaluated by the onsite mentoring team who are members of facility quality committee (???).

1. **One on one case management observation**

   Mentor observes the mentee managing a patient and then provides constructive feedback. The approach of giving feedback must be tactfuland productive. There are different kinds of checklists developed for one-on-one mentoring (need to develop checklists to observe patient- health worker interaction). I

   Give constructive feedback

   Giving feedback generally facilitates learning. Feedback should be:

   - Be both formal and informal
   - Encourage self-assessment and emphasize the positive
   - Be specific and constructive, and done at the right time, in the right place

2. **Review patient records and provider documentation of health care**

   Reviewing patient records using a standardized checklist (will be prepared and sent) is critical to see the gap in knowledge and skills of practicing clinicians. Based on the guideline, preparing a standardized checklist on some indicative disease may be important to look through every step necessary treat those indicative diseases (such as hypertension, diabetes, mental illness, PTB, ANC etc)

3. **Team meeting to elicit feedback:**

   Clinical team meetings are opportunities to bring together all members of a clinical site, to discuss issues relating to the use of EPHCG guideline, challenges encountered, patient care, promote continuous quality improvement at the health facility, and for staff to provide support for each other.Clinical team meetings can serve as a forum:

   - For various clinical team members to share what is going well in the clinic;
   - To share what is not going well, and to brainstorm for ways to improve the problem area with input from different members of the team;
   - To provide EPHCG updates that are important for all staff; and
   - To promote continuous quality improvement at the health facility.

4. **Clinical case discussion**

   Health centers are expected to conducted continuous case discussions after onsite trainings. Based on the contents of EPHCG, a health center is expected

to prepare a case discussion (clinical forums). Primary hospitals could help to strengthen such kind of clinical case discussions.

Role and Responsibility

1. **Ministry of health**
   - It will coordinate and manage the overall implementation of EPHCG throughout the country
   - Mobilize necessary resources(technical, financial and material) to implement EPHCG throughout the country
   - Coordinate master trainers training on EPHCG
   - Regularly update the EPHCG guideline
   - Establish a team of professionals/ body to regularly update EPHCG
   - Develop standards, monitoring and evaluation frameworks for the implementation of EPHCG.
   - Help regional and City administration health bureaus to strengthen their capacity on mentorship and supportive supervision of EPHCG implementation
   - Support to generate evidences on the impact of EPHCG.
   - In collaboration with regional and city administration health bureau, support mentoring and supportive supervision on EPHCG.
   - Compile reports coming from regional health bureaus and send feedback to regional health bureaus about EPHCG implementation status.
   - Conduct national review meeting on EPHCG implementation
2. **Regional/City administration health bureaus**
   - Coordinate and manage the overall implementation of EPHCG in their regions.
   - Mobilize necessary resources (technical, financial and material) to implement EPHCG in their regions.
   - Coordinate facility trainer training in their regions.
   - Conduct regional review meetings on EPHCG implementation
   - Help zonal and woreda health officers to strengthen their capacity on mentorship and supportive supervision on EPHCG implementation.
   - Compile reports from each woreda and send reports to Ministry of health

- In collaboration of Woreda health officrs, support health facilities to conduct EPHCG readiness assessment.
- Support equipping health facilities with necessary drugs, laboratory tests and equipment as per EPHCH standard.

3. **Woreda health offices**
   - Coordinate and manage the overall implementation of EPHCG in their regions.
   - In collaboration with zonal and regional health bureaus, facilitate the trainings of facility trainers
   - Coordinate and closely follow the onsite educational trainings.
   - Coordinate mentoring and supportive supervisions on EPHCG in their woredas.
   - Conduct woreda review meetings on EPHCG implementation
   - Allocate resources to effect full implementation of EPHCG
   - Support health facilities to conduct EPHCG readiness assessment.
   - Support equipping health facilities with necessary drugs, laboratory tests and equipment as per EPHCH standard.
   - Compile reports from each facility and send reports to regional/zonal health bureaus
4. **Health facilities**
   - Implement EPHCG according to the standard set on this implementation manual
   - Establish internal supportive supervision and mentoring team to guide the implementation of EPHCG
   - Conduct onsite educational training based on the standard
   - Conduct facility readiness assessment and send report to Woreda health offices
   - Equip the facility with necessary drugs, lab tests and equipment as per EPHCG standard
   - Conduct all activities of EPHCG as per the implementation standard of EPHCG dictated in this implementation manual
   - Allocate necessary resources from the available budget of the health facilities
5. **Development partners**

- At each level of the administration (Federal, regional, zonal, woreda and health facility) support financially and technically to implement EPHCG.
- Engage in mentoring and supportive supervision of EPHCG implementation
- Support evidence generation on EPHCG
- Support experience sharing and best practice activities

International primary health care institute/health colleges

- Engage in evidence generation on the impact of EPHCG
- Engage in updates of EPHCG guideline.

National insurance agency

- Reimburse health facilities according to the compliance of EPHCG
- Conduct clinical audit on EPHCG implementation.
- Help the standardization process of EPHCG necessary inputs.

Monitoring and evaluation of EPHCG implementation

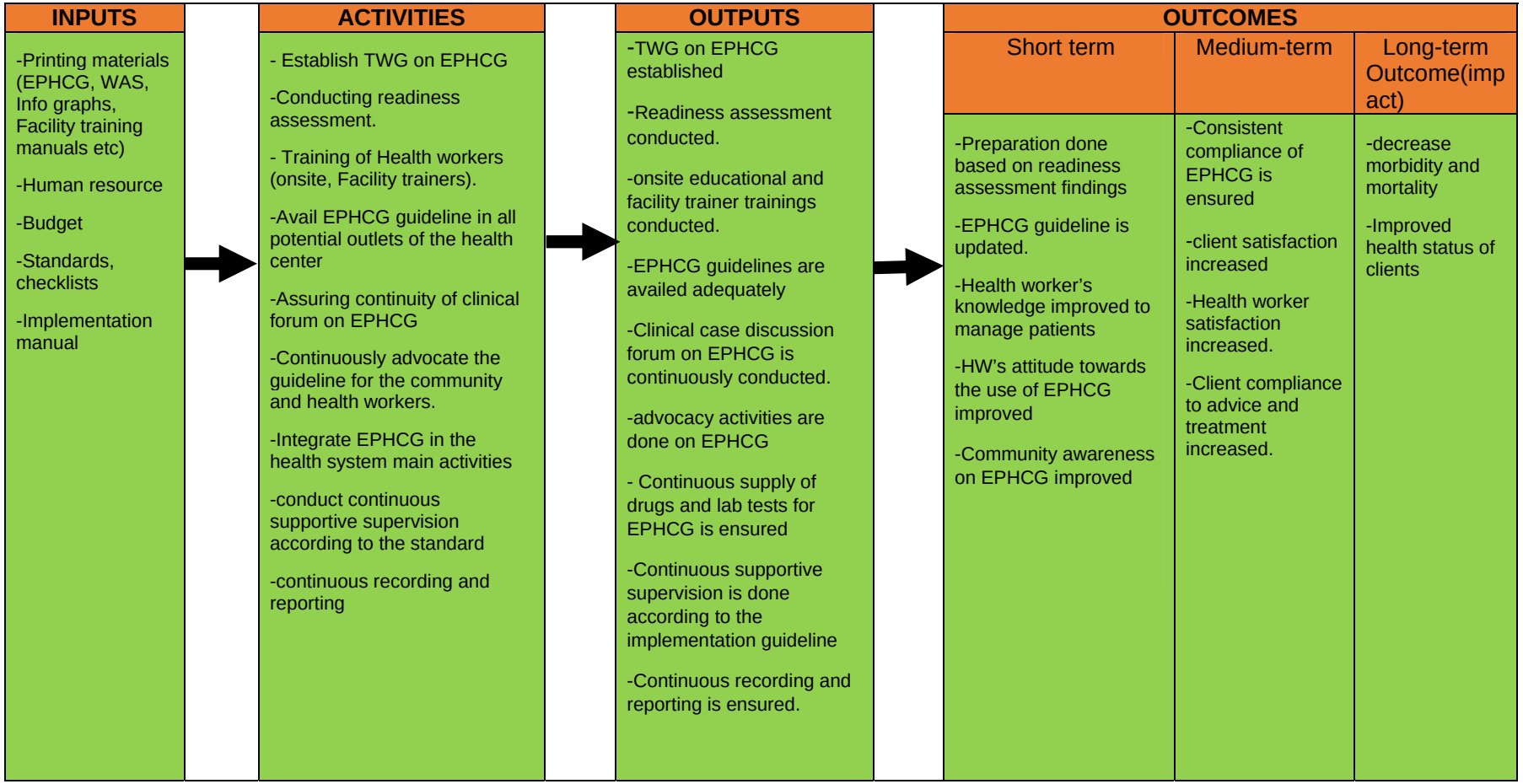
Introduction

Ethiopian primary health care clinical guideline should be regularly followed and evaluatedat all levels. Monitoring of the guideline implementation at the input, process and output level as well as evaluating the outcome (short, intermediate and long term outcomes) and impact of the guideline should be thought at this stage of guideline presentation.

Purpose of the M &E plan

The purpose of the monitoring and evaluation plan is to keep tracking the implementation of Ethiopian primary health care clinical guideline; improve learning and accountability from the implementation.

Ethiopian primary health care clinical guideline logic model



PROCESS EVALUATION				OUTCOME EVALUATION		
-Minute on establishment and activities of TWG -Readiness assessment report -Training reports, attendance sheet(facility record and individual record), -EPHCG on the site at all outlet of HCs -Clinical forum reports -Minutes of community forum; schedule and minutes of health education - see plan whether EPHCG implementation is one of the major activities in health center monthly, quarterly and yearly plan; in individual BSc plan. -mentoring and supportive supervision team establishment letter -Internal supportive supervision reports from the facilities		- # TWG established -Proportion of HCs done readiness assessment -# of facility trainers trained -proportion of HCs which completed 8 weeks onsite trainings within 14 weeks of placement of Facility trainers. -Proportion of HCs which availed the EPHCG on all possible clinical outlets. -Proportion of HCs established biweekly clinical case discussion forum. -# of advocacy activities done on communities. -essential drugs availablity -essential lab tests availability -Proportion of continuous supportive supervision done according to the implementation manual		-Proportion of HC which made preparation based on the conducted readiness assessment. - EPHCG guideline regularly updated (how regular???) -proportion of HWs with minimum acceptable knowledge score on basic areas of EPHCG. -Proportion of HWs with positive attitude towards EPHCG. -Proportion of clients who know the guideline. -	-proportion of HCs having 100% compliance of using EPHCG - % increase in client satisfaction -% increase in health workers satisfaction. -proportion of clients who comply with advice on selected case types. -proportion of clients who comply with treatments on selected case types.	-Indicators on major types of diseases and conditions will be selected latter(infectious, maternal and child health, Non-communicable diseases)

Performance monitoring tracking of Ethiopian primary health care clinical guideline

Implementation standard checklists suggested will be used mainly to track the activities of Ethiopian primary health care clinical guideline implementation. It is clear from the above logic model that the implementation checklist mainly focuses on activity and output level; and may be some of the immediate outcomes will be touched. The major tool to conduct supportive supervision will be these implementation standards. But, further work will continue to track the performance of EPHCG at the intermediate and long term levels. For that indicators must be selected first and other further actions must be pursued before applying those selected indicators.

ANNEX I:Health worker with patient interaction while using PHCG

No	**Standards**	**Verification points**	**Met**	**Unmet**	**Remark**
1	The health centre implements clinical communication skill for Initiating the Consultation (**PRY**:Prepare, **R**elationship Building and Find out wh**Y** the patient has come to the clinic)	➢ Make sure your space is clear			
		➢ Read history of patient if possible			
		➢ Use patient name			
		➢ Make sure patient is comfortable			
		➢ What brings you to the clinic today?			
		➢ Is there anything else you would like to discuss today?			
		➢ Practicing active listening			
2	**Gathering Holistic Information (ICE: Ideas, Concerns and Expectations)**	➢ "What do you think is causing your pain to act up?"			
		➢ "What concerns you the most about not being able to work?"			
		➢ "What do you think will help with your pain?"			
3	The provider should use PHCG to treat the patient	➢ Asking the patient complaint			
		➢ Go to content page ➢ Go to specific page that can address patient complaint			
		➢ Follow the PHCG algorithm			

ANNEX II: CHART ABSTRACTION

Standard	Verification point	Met	Unmet	Remark
Applying symptom-based approach using PHCG	➢ Written c/complaint ➢ Check any clue on the chart whether the provider assessed issues in urgent attention box. ➢ Review whether the provider Managed and referred the patient that need urgent attention. ➢ Check any clues whether the provider followed the algorithmic approach to either a management plan or to consider chronic condition			
Apply Clinical content approach for the patient coming with chronic condition	➢ Check if the provider started from chronic condition ➢ Review if the provider followed the **3-step** approach (**Assess**, Advice and treat) ➢ Review if the provider followed the 3 parts for assessing the patient: **history taking** (what to ask), **examination** (what to look for) and **investigation** (what tests to do) ➢ Check if the provider used the **Diagnosis page** first for new suspect patient for chronic condition and if there is a finding and or for chronic care patient that are in a routine care, go **to routine care page**			

ANNEX III:summary of findings of referrals (cases) from the referral registry

Standard	Verification point	Cases	Symptom page seen	Reason for referral	Met	Unmet	Remark
The reason for referral should be based on PHCG	➢ Compare reason for referral with the criteria set on the EPHCG.	Case 1					
		Case 2					
		Case 3					

ANNEX IV: EPHCG FGD interview Guide

Thank you for taking the time to speak with us today.

My name is _____ and I am working at the FMOH, HEP & PHC Directorate as a health center reform expert. I would like to ask you about your own experiences and opinions regarding the PHCG implementation in your health center.

The interview will take about 15 to 20 minutes. I appreciate you spending this time with us. If you have any questions about this interview, you can ask. Shall we continue? **If yes, start the discussion**.

No	Discussion point	Summary of the discussion
1.	**What are the benefits of PHCG?**	

2.	**What are the main concerns/challenges regarding PHCG implementation?**	
3.	**Tell me about acceptance of PHCG by: -**	
	➢ **Management body**	
	➢ **Health professional**	
	➢ **The community**	

4.	**What things to be improved to implement PHCG effectively?**	

ANNEX V: Levels of the supervision system for EPHCG implementation

Overview of the supportive supervision site visit process

The following supportive supervision site visit process mainly works for supportive supervision conducted by Federal ministry of health and regional health bureaus. Woreda health department may adopt their standard for supportive supervision process or could use this standard. The following steps could be followed, as adopted from the hospital performance monitoring implementation manual (HPMI) for hospitals.

Step 1: Selection of the site visit team

Step 2: Pre-visit preparation

Step 3: The site visit

Step 4: Post-visit report and follow up

A timeline for each of the above steps is presented in Figure 10 followed by detailed descriptions of each step.

steps	Activities	Time line	Remark
1: selection of the site visit team	• Site visit team leader and team members.	6 weeks before the visit	
2:Pre-visit preparation	• Site visit team collates information about the health center performance • Team communicate the health center and request additional necessary information and gives dates of site visit.	4 weeks before the visit	Information should be reviewed: • The most recent site visit report and the health center response & action plan • The most recent and previous health center self-assessment reports
	• Site visit team prepares site visit briefing document	2 weeks before the visit	
	• Site visit briefing document and schedule of the visit will be sent to the health center manager	1week before the visit	
3:Conduct the site visit	• Opening meeting with health center manager and management committee		

	• Evidence gathering • Site visit team collates information and agree on the findings • Closing meeting with the management committee		
4: Post visit follow up	• Site visit report prepared and sent to health center manager	**1 weeks after site visit**	
	• Health center sends health center response and action plan	**3 weeks after the site visit**	
	• Site visit report and health center response and action plan to the relevant stakeholders	**4 weeks after the site visit**	

Supportive supervision for implementation of PHCG

Attributes of supervisor

A supervisor should have the following attributes:

- Familiar with health care system;
- Familiar with the PHCG program(including both the guideline as well as implementation at the health center level;
- Ability to address both administrative and programmatic issues and needs related to implementation of PHCG;
- Committed, responsible and have strong interpersonal skills;
- Ability to train, motivate and support supervisees; and
- Flexible, respectful and hardworking attitude.

Core Competencies of a Supervisor

The supervisor should have attained the following competencies:

- Conceptual skills: ability to listen, probe and analyse situations, problems and formulate solutions;
- Sufficient knowledge and skill to utilize the primary health care clinical guideline;
- Ability to coach, train and convey information to others and learn from them;

- Sufficient knowledge of concept of quality improvement (QI) including supportive supervision and mentoring and the use of national guidelines and SOPs:
- Deep understanding of the roles and responsibilities of both supervisors and mentors and align oneself with mentors; and
- Ability to provide and receive feedbacks after each visit and write reports.

Based on these competencies, the directorate may prepare training manual (one to two days training) for potential supervisors and mentors.

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;
- Support for periodic review meetings.

Supportive supervision process

At the beginning of the supervision on site/ health facility:

- Establish rapport - always start by greeting and introducing yourself and
- the rest of the team to the supervisees;
- Tell the in-charge and supervisees the purpose of the visit. Let the
- supervisees introduce and listen in a relaxed manner but attentive and
- avoid interruption;
- Explain the whole supportive supervision plan e.g. supervisee to be met,
- Time to be spent, feedback session etc.;
- Avoid making promises and be honest; and
- Use communication skills to encourage active participation.

During the supervision

- Show respect and patience throughout the supervisory visit.
- Allow time for staff to complete any consultations underway and for any hand over.
- Review the previous action points and status of implementation.
- Observe and gather information using the checklist.

- Listen to their problems and challenges.
- Address and follow up on problem areas.
- Provide corrective and supportive feedback on performance.
- In case a procedure is performed incorrectly, demonstrate the correct Procedure and ask for return demonstration.
- If there is a need, liaise with mentors.
- Update supervisees on new guidelines and information.
- Give on-the-job training on new techniques and approaches if required.

During immediate feed back

- Once you are done with supervision, find a conducive environment with appropriate privacy to give feedback.
- Use positive feedback, when performance is good; and constructive feedback, when performance needs improvement.
- Start with those areas they are doing well followed by those where there are problems.
- Focus on systems and processes, the performance or action, not on the person.
- Discuss previous action points which were not implemented and include them in the new action plan.
- Outline areas needing improvement and guide them to come up with corrective actions and time line. Link the behaviour to programme.
- Start with those areas they are doing well followed by those where there are problems.
- Focus on systems and processes, the performance or action, not on the person.
- Discuss previous action points which were not implemented and include them in the new action plan.
- Outline areas needing improvement and guide them to come up with corrective actions and time line.
- Listen attentively, with encouragement and open mind believing that everyone has good contributions to make. Give a chance to the supervisee to respond.

During wrap up

- Share new information, such as guidelines and training opportunities;

- Share some observations/findings made such as data recording and
- reporting;
- Summarize the specific aspects that require change or improvement, discuss/review and agree on what needs to be done and how.
- Identify areas of strengths including specific aspects of care going well and commend them appropriately.
- Identify areas that need improvement/strengthening and agree on the action plan using a joint problem solving approach;
- Set aside adequate time for supervisees' questions;
- Identify persons responsible to solve the identified action points and problem areas;
- Share with staff as a group the supervisor's general impressions on what is going well and what needs further improvement based on the supervisor's findings;
- When ready to leave, thank the supervisees and others.

Report writing and follow up actions

- Use the report writing format to document the visit including action and follow up plans.
- Disseminate the report to the relevant levels including the supervision site/ health facility.
- Share the information on the identified gaps with mentors.

Prepare draft site visit briefing document

After gathering the above information, the site visit team leader should review all evidence and based on this should prepare a site visit briefing document. This should include:

- Summary of health center performance
- Strengths/successes of the health center
- Areas of possible weakness
- Priority areas for further investigation during the site visit
- Staff members to be interviewed during site visit.

Levels of supportive supervision

Supportive supervision could be conducted at the three levels: at national level by the federal ministry of health; regional level by regional health bureau and/or by zonal health department and at woreda level by woreda health office. Each health facility will conduct supervision (called internal supportive supervision). The information gathered each month during the first six months of the commencement of the implementation and communicated to woreda health office and regions. After the first six months the supportive supervision will be integrated with the normal supportive supervision time of the facility.

Table 2: Levels of supportive supervision for the implementation of

Description	Levels of supportive supervisions		
	National level	**Regional/zonal level**	**Woreda office level**
Who leads the supervision?	Federal ministry of health	Regional and/or zonal health department	Woreda health offices
Where the supervision could be done?	At regional, zonal, woerda and health facility level	Woreda , health facility level	Health facility level
Regular schedule of supportive supervision	Twice per year	Twice per year	Quarterly(four times per year
Number of people who visit a facility	at least three people	at least two people	two people
Duration of supportive supervision at health facility(health center) level including the feed back	At least 12 working hours per facility	At least 8 hours per facility	At least 6 hours per facility

N.B: the national and regional level supervision may be synchronized and conducted as a team composed of people from national and regional level.