

WHO-EM/HCD/120/E

Report on the

Expert consultation on improving the quality of care at primary health care level through the implementation of quality indicators and standards

Cairo, Egypt
11–12 May 2015



World Health
Organization

Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The World Health Organization (WHO) Regional Office for the Eastern Mediterranean has launched an initiative to develop a quality tool for primary health care that includes a list of core quality indicators and standards for service provision.

A quality tool for the assessment of quality of care at the primary health care level was developed through desk and literature reviews. The tool identified a broad list of potential indicators covering the six quality domains throughout the care continuum, from prevention to diagnosis and treatment. Subsequently a Delphi study along with several field tests enabled the selection of 24 core quality indicators that cover the different domains of quality. In addition, the quality tool includes a list of standards related to the core indicators.

A consultation on this initiative was organized in Cairo, Egypt, from 11 to 12 May 2015 with the participation of experts in the area of service delivery and quality and safety from across the world. This consultation reviewed the key quality indicators developed by WHO and drew up a number of key lessons which are of value both to WHO in the Eastern Mediterranean Region in furthering their own initiatives, and also to other regional offices or countries which are considering similar initiatives.

The programme and the list of participants are attached in Annexes 1 and 2. A copy of the draft core equity indicators is attached in Annex 3.

The objectives of the consultation were to:

- present an overview of the situation relating to quality of care at the primary health care level in countries of the Eastern Mediterranean Region;
- present a framework/tool for the assessment of quality of care at the primary care level;
- develop consensus on the adopted quality indicators and standards, the methodology and the recommended approach for implementation at the operational level;
- share regional experiences on quality improvement/accreditation programmes for primary care;
- share experiences on the integration of patient safety outcomes to promote improvement at the primary care level.

In his opening remarks, Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean Region, highlighted WHO efforts and guidance in promoting quality and patient safety in the Region and the need for a regional roadmap and a framework for national action plans for the implementation of quality standards at primary care. Dr Alwan also made reference to the importance of reviewing and finalizing the proposed tool for assessing quality of care at primary care level, for which this experts' meeting was convened with the overall aim of improving health care delivery based on defined indicators and standards related to the main functions of primary health care facilities to move towards universal health coverage as an ultimate goal.

2. APPROACHES TO QUALITY IMPROVEMENT IN PRIMARY CARE: GLOBAL AND REGIONAL EXPERIENCES

Key messages from the technical sessions highlighted the overall objective of the consultation: to improve health care delivery at primary health care facilities. This will have a substantial impact on strengthening health systems in the Region and moving towards achieving universal health coverage.

In regard to approaches for tackling quality at the primary health care level, there is a need to differentiate between quality improvement (the use of various methodologies to facilitate improved quality of health care provision and outcomes) and quality indicators (measures of performance which can detect weaknesses and serve to identify opportunities for quality improvement). Quality indicators are not, in themselves, an improvement initiative and should not be framed as such. However, the need for quality indicators should be contextualised within overall quality improvement efforts at the policy level. Those tasked with the development and implementation of indicators should therefore be clear about current efforts and future goals, and the role (and limitations) of indicators in seeking to achieve those goals should be well understood.

The developers of quality indicators and those tasked with the interpretation and analysis of data emerging from those indicators should be aware that health systems are complex adaptive systems. The system or service which is being assessed should be viewed as a complex living entity and the indicators and their analysis should reflect the fact that health care provision comprises a multitude of intertwined processes which themselves may not be perfect.

This complexity means that while developing the quality indicators, it should be clear what and who are being assessed. When considering quality at the primary health care level, for example, the focus could be solely on the 'micro-level', that is, on elements of practice which are under an individual facility's direct control (e.g. percentage of children with height and weight monitored at a given age or over a particular time frame). Alternatively, the focus might be on 'meso-level' factors, including the allocation of resources for quality improvement initiatives, or on 'macro-level' considerations, including accountability and regulatory mechanisms. In order to develop indicators which provide the knowledge required, it is therefore important that the levels of focus are determined in advance, with the indicators developed accordingly.

There are a variety of frameworks and categorizations upon which a set of quality indicators might be developed. These include Donabedian's structure, process and outcomes and the six key dimensions of health care described by the Institute of Medicine in their 2001 report Crossing the quality chasm. In addition, the development of quality indicators could focus on a current area of interest, for example noncommunicable diseases or maternal and child health. Regardless of which approach or combination of approaches is used, these frameworks should serve as guidance only and there is no requirement to adhere strictly to any one method. Ultimately, quality indicators have to be useful to those who will be tasked with their adoption and to whom they are addressed – they must inform practice on the ground. At the primary health care micro-level, for example, quality indicators should serve

to inform those working in the facility about their level of practice and should therefore be linked with the actual quality of care which is being provided within that facility.

Where possible, pre-existing indicators which have been validated elsewhere and which have been demonstrably linked with quality of care should be incorporated into the package of indicators which is developed. Where the development of new indicators is required to reflect local or contextual factors or health priorities, these should be extensively piloted to ensure their relevance to the community they are supposed to serve.

The development of quality indicators should not require extensive additional resources, and the collection of relevant information should not be overly burdensome. Therefore, it is important to understand the extent to which existing data and data collection mechanisms can be incorporated into the process, thus avoiding a situation in which only what can (rather than what should) be measured is measured.

The quality initiative will target the health care facility as the priority level, then the health system level. After measuring and collecting the indicators, data should be interpreted and reported to the policy-makers for evidence decision-making. It is essential to consider how this initiative will work and how it can affect the resistance faced by the staff at primary health care facilities. It is also important to define the measurement methods; the most difficult is clinical audit.

3. DEVELOPMENT OF QUALITY INDICATORS AND ASSESSMENT TOOLS FOR PRIMARY CARE IN THE REGION

The importance of information in improving the safety and quality of patient care was highlighted. The use of indicators would promote accountability among all stakeholders, including the public, service users, clinicians and government by facilitating informed decision-making and safe, high quality reliable care through monitoring, analysing and communicating the degree to which health care organizations meet key goals.

The quality tool was proposed and the participants discussed the results of testing in countries. Country experiences, along with the pilot testing in Egypt and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), helped to inform the development of a draft quality tool for the WHO Eastern Mediterranean Region.

The experts gave feedback on the approach and the process of getting consensus on the quality tool. It was agreed that universal health coverage should be the underpinning principle for the initiative, with a focus on access to and improvement in the quality and safety of the care delivered at the primary health care level. The tool may represent a response to the lack of data on the quality of care at the primary care level that would allow the identification of quality priorities at the facility level. However, to address the gaps in quality and patient safety, it is important to develop an instrument that is appropriate to all the countries in the Region, to assess quality at different levels (facility, district, national), and to focus on how to implement it and how to help countries improve quality of care and patient safety.

When developing a set of quality indicators for implementation in a region with such diversity, it is necessary to accept that it may not be feasible to collect some of the indicators, nor indeed appropriate for a particular health service at a given point in its development. It should, however, be possible to develop a set of core indicators which are applicable to all countries, with additional indicators included for those countries which are at a later stage in their development of services at the primary health care level. However, even the core set of indicators must be capable of providing a comprehensive view of the services under review, otherwise they may encourage organizations to focus on the activity being measured – to the detriment of the service as a whole, leading to a “what gets measured gets done” situation.

It was clear that if quality indicators are to be implemented successfully and sustainably, they need to be valued by those working at the facility level. While achievement of the measures described above will contribute to ensuring this sense of value, there are a number of additional actions which can reinforce this. The need for quality indicators and their purpose should be explained to those on the front line, and extensive piloting in different countries and types of facility should be undertaken to ensure local applicability. In particular, this should seek to identify and minimize unintended consequences. There is a need for buy-in from health services leadership; the indicators should form part of a quality movement and should be deployed as part of a wider change in management strategy rather than being framed as a stand-alone solution for the problems in primary care.

The existing draft quality tool covers both the public and the private sectors, however governmental linkage is very important for implementation, and linking the financing of services with the performance of the facility is essential.

Another issue raised during the consultation meeting was on specifying whether the tool was intended for external assessment supervision, performance feedback benchmarking, or clinical governance in terms of accountability, peer review, clinical indicators, incident reporting and clinical audit. Participants also debated specifying how the tool would be used in the internal system. Meanwhile, the reviews of the situation in Egypt, Jordan and Saudi Arabia underscored the need for expanding accreditation programmes targeting primary health care facilities.

Three working groups were established based on the number of indicators proposed in the tool. The working groups discussed the core set of indicators. The groups had differing perspectives regarding the proposed indicators in regard to their domains. Some indicators were perceived as being especially relevant and important, while others were considered not feasible and very hard to collect and measure data for, although all three working groups acknowledged their importance. Overall, the experts agreed on the importance of most of the proposed indicators with a general consideration that the main role should be given to primary health care in terms of responsibility to patients in regard to health promotion, prevention, diagnosis and treatment.

4. ALIGNMENT OF THE QUALITY TOOL WITH PRIORITY PROGRAMMES IN THE REGION

The group work and subsequent discussions allowed for sharing information and exploring obstacles to effective implementation of this initiative. Indicators are based on the Donabedian – input/process/output – model and also cover the six Institute of Medicine quality domains, although there has to be a balance among the quality dimensions. Thus, the alignment of the quality indicators with the other perspectives from all relevant stakeholders, e.g. physicians, nurses, administrative staff, is very important to consider in the process.

It is important to build on any indicators already existing in the country and/or facility. The workforce should be connected to the quality culture within the facility. Thus, adding the staff satisfaction rate to the list of indicators was recommended.

The broad list of indicators shortlisted was included in the Delphi exercise and the feedback from the field test. However, there are still some indicators that need to be added, for instance, those related to mental health and communicable diseases. Life cycle-approach indicators, e.g. children, should get more consideration along with indicators for safety, e.g. medication safety, and those related to tracers, e.g. management issues, organizational structure, continuity of care and environmental safety, etc.

Indicators that are related to the essential package of services at primary health care facilities, and used as measures for effectiveness at primary care, e.g. noncommunicable diseases, mental health, maternal and child health and other priority programmes in the Region should also be included. It might be beneficial to focus on chronic heart diseases and their risks for noncommunicable disease indicators.

The discussion covered patient centeredness as an emerging domain that needs to be tackled in any quality improvement initiative: to what extent patient satisfaction rate can be relied on for improvement and whether it is about perceived quality of care by the patients and patient expectations, e.g. access to the emergency room and the cost of the service.

The groups discussed the proposed standards and how closely they are related to the core indicators developed, though this is not a comprehensive set of standards, rather it is a set of core indicators and standards to assess and define quality at the facility level. The incremental process is more appropriate for primary health care facilities, where the standards can be divided into critical, core and stretch. The small package can be used to push the quality culture inside the facility, not for accreditation purposes. Then, the facility would move to the second set and so on until it becomes an accredited facility. Standards have to be benchmarked and compared with other available sets.

In regard to the regional situation on quality and safety, the shared experiences from three selected countries (Egypt, Jordan and Saudi Arabia) highlighted the progress in this area of work. It is important to determine whether the accreditation system is a national programme or not, and what the aim of accreditation is in primary health care (e.g. assessing the capacity of the public sector, universal health coverage, monitoring the delivery of services, organization

development or improving quality). Most countries from Group 1 are using accreditation as a tool to improve quality at the facility level. Only three countries in the Region have national agencies for accreditation of health care facilities, accredited by the International Society for Quality in Health Care (ISQua). In addition, three main international accreditation agencies are operating in the Region, mainly in Gulf Cooperation Council countries. The discussion highlighted the issue of advocating for compulsory or voluntary accreditation. This needs to be carefully considered as it is important to make sure that the accreditation bodies have the capacity and resources to cover all health care facilities. Furthermore, where there is non-compliance, what action will be taken if the facility is the only one available to the local population? Should the facility be shut down or should monetary sanctions be applied? And what is the connection between accreditation and health insurance?

The discussion also encompassed the main challenges to accreditation, such as sustainability, linkage to the health system, business plan, and whether or not it should be compulsory. It was suggested that ISQua should have a role in regulating accreditation and in raising the performance of the accreditation system. Other methods that should be considered to improve quality of care include clinical governance, performance indicators, balanced scorecards, etc.

One approach to the introduction of external quality assessment and accreditation that might better suit most countries of the Region would be the gradual approach following a stepwise method. The first step would be compliance with standards that are critical for the quality of care based on evidence: health care facilities should comply with 100% of these standards. After the assessment, technical assistance should be guaranteed for these facilities to achieve this goal as a top priority in the short term. After achieving compliance with the critical standards, the health care facilities should pursue the quality improvement process to achieve the remaining core and stretch standards.

5. OPERATIONAL INTEGRATION OF QUALITY

Operational integration of quality within the health care delivery system was discussed, and the issue of incorporating quality improvement at the policy level was raised. There should be a legislative framework supporting the principles of quality, safety and performance by enabling information exchange and cooperation. Clinical guidelines/protocols and clinical practice have to conform with international standards as well. In addition, the information systems should be integrated and shared among managers, clinicians, financing bodies and supervision. For example, the United Kingdom's operational approach to quality improvement in primary care was proposed along with some good practices on quality assessment and improvement suggested by ISQua.

Finally, participants were briefed on the elements to consider for the quality framework and agreed on how to fill some of the gaps in the proposed tool. After extensive discussion, and taking into account the experts' feedback, the draft set of core indicators for the Eastern Mediterranean Region (Annex 3) was adopted. It was announced that the next step for the countries of the Region will be a workshop on capacity building of patient safety and health care quality from assessment to improvement, 14–16 June 2015, in Tunisia.

6. KEY CHALLENGES

The consultation highlighted the main challenges to improvement in the quality of service delivery. These can be summarized as follows.

- Quality of care is particularly challenging in the fragmented health systems often seen in many countries in the Region that result in an increasing preference for the private sector as a source of care, overtaking primary health care as a frontline to secondary level care without a referral channel.
- The lack of a common understanding for quality improvement terminologies among providers, policy-makers and the public, with their different perspectives, is an obstacle to implementing quality of care.
- The health systems are not designed to meet patients' needs due to their verticality and the poor integration of the vertical programmes and activities within the health system. Additionally, poor health sector planning, which is resource-based rather than results-based, leads to lack of comprehensive operational plans.
- Lack of political commitment is another hindrance; where it does exist, it does not necessarily translate into action, e.g. ineffective implementation and application of existing laws, inadequate funding and shortages of trained and motivated human resources.
- The participation of civil society is ineffective and there is a need for promoting quality and patient safety through awareness campaigns to involve patients and the community.
- Lack of sustainability and resistance to change, along with poor linkages to the health systems, are serious issues for the accreditation process.

7. THE WAY FORWARD

High performing primary health care facilities in the area of service provision are central to the goal of achieving universal health coverage in high, low and middle income countries. WHO has taken the initiative in seeking to develop a set of quality indicators which can assist improving service provision across this diverse and challenging region. In doing so it has sought to place quality at the forefront of the health care agenda. While quality indicators alone will not improve quality, their identification and implementation should serve to maintain quality as a priority and should lead to better outcomes for patients. The following activities were identified as important for the developing programmes within existing health systems for the countries of the Region.

For the draft quality framework itself

- The selected quality indicators should be further refined. The layout should follow the structure/process/output approach and the indicators selected should relate to the priorities identified for the Region.
- The amended list of indicators should also refer to the collected inputs from the different programmes and focus on core indicators that are adaptable for the Region.
- A minimum data set should be developed for the refined list of indicators; this should include the definition of the indicator, the calculation, the source of information, the inclusion criteria, the target and the interpretation of the indicator.

- The revised version of the quality indicators and the relevant framework should be presented to the forthcoming WHO meeting on quality and patient safety scheduled for 14 to 16 June 2015 in Tunisia. This will give the end-users (quality and primary care representatives from Member States) an opportunity to discuss it based on their operational experiences and to get feedback on the perceived importance, scientific soundness and feasibility based on the environment of practice at the primary health care level in each country. After the endorsement of the framework, it should be pilot-tested in a sample of primary health care facilities in three countries of the Region.

For the required interventions to promote quality and patient safety at primary care level in the Region

- At the macro level (policy context)
 - There is a need for political commitment to move towards universal health coverage with promoting access to quality health care.
 - There should be a policy to promote quality as a cornerstone for better health for all, along with a clear vision for quality improvement and promoting primary care services.
 - Strengthening accountability and regulatory mechanisms will help in implementing quality programmes and accreditation, along with the introduction of incentives for better performance and sustainability.
 - Involvement of the ministries of health as quality focal points is very important for better ownership of the initiative and to be able to collect meaningful data from the operational level to support policy-making.
- At the meso level (i.e. where policy begins to take shape as a specific programme)
 - The institutionalization of quality at the operational level is an area of concern especially since each country in the Region has to deal with a different approach.
 - Avoiding complexity in quality improvement terms and definitions will lead to better implementation of quality indicators.
 - Patient- and community-centredness should be a priority.
 - Efficient allocation of resources will improve quality improvement activities.
 - Partnership with civil society and the community should be considered as this can improve the quality and safety of health care services.
- At the micro level (operational level)
 - Building capacities among health care professionals on quality concepts, patient safety and improvement activities is very important. This can be achieved through continuous training on implementing quality indicators, standards and guidelines.
 - The rewards system and motivation are very important for sustainability.
 - Learning from successful experiences will support the delivery of efficient health care services through the use of community health workers and outreach teams to promote health care quality.

Annex 1**PROGRAMME****Monday, 11 May 2015***Opening session*

08:00–08:30 Registration

08:30–08:45 Opening remarks

*Dr Ala Alwan, Regional
Director, WHO/EMRO*

08:45–08:55 Objectives and method of work

*Dr Mondher Letaief*08:55–09:10 The quality of care at the primary care in countries of the
Region: current situation and challenges*Dr Mondher Letaief*

09:10–10:00 Discussion

*Session 1: Approaches and experiences of quality improvement in primary care: global and regional experiences**Moderator: Dr Sameen Siddiqi, Director, Health Systems Development*10:30–11:30 Global experiences on quality improvement at the
primary care level*Dr Rashad Massoud
Dr Aziz Sheikh
Dr Charles Shaw
Dr Ronan Glynn
Dr David Wright*

11:30–12:00 General discussion

Moderator: Dr Rashad Massoud, Director, USAID

12:00–13:00 Panel discussion on quality improvement at the primary
care level in the Region*Dr Salem Al Wahabi
Dr Salma Jaouni
Dr Jamal Al Khanji
Dr Mahi Al Tehewy**Session 2: Process of development of quality indicators/assessment tools for primary care in the Eastern Mediterranean Region**Moderator: Dr Aziz Sheikh, University of Edinburgh*14:00–14:20 Framework for core quality indicators at the primary
health care level*Dr Mondher Letaief*14:20–15:00 Feedback from the experts on the approach and process of
getting consensus on the quality tool*Dr Aziz Sheikh
Dr Rashad Massoud
Dr Mahi Al Tehewy
Dr Safaa Qsoos*

15:00–15:45 Discussion

15:00–16:20 Lessons learned from the field test of the quality tool:
selected primary health care centres in Egypt; selected
primary health care centres in UNRWA*Dr Wesam Mansour
Dr Meriam Saweres
Dr Ali Khader*16:20–17:30 Group work: on the review and comments on the quality
indicators, standards, metadata, challenges

Tuesday, 12 May 2015*Session 3: Alignment of the quality tool with priority programmes in the Region**Moderator: Dr Ezzeddine Mohsni*

08:30–09:30	Group presentations and discussion	
09:30–10:30	Panel discussion on quality of care and perspectives from priority programmes in the Region: Health systems development/integrated service delivery Noncommunicable diseases Maternal and child health Communicable diseases	<i>Dr Ramez Mahaini Dr Wendy Venter Dr Slim Slama</i>

Session 4: Operational integration of quality within the health care delivery system

11:00–11:15	United Kingdom's operational approach to quality improvement in primary care	<i>Dr Aziz Sheikh</i>
11:15–11:30	Good practices on quality assessment and improvement	<i>Dr Ronan Glynn</i>
11:30–11:45	Prerequisites for incorporating quality improvement at the policy level	<i>Dr Charles Shaw</i>
11:45–12:30	Discussion: lessons learnt and how this can be used in the Eastern Mediterranean Region	
13:30–13:45	Summary on the elements to consider for the quality framework	<i>Dr Mondher Letaief</i>
13:45–13:55	Objectives and outline of the programme of the regional workshop "Capacity building on patient safety and health care quality from assessment to improvement," 14–16 June 2015, Tunisia	<i>Dr Mondher Letaief</i>
13:55–14:30	Next step for countries in the Region: messages for the regional workshop "Capacity building on patient safety and health care quality from assessment to improvement" 14–16 June 2015, Tunisia	
14:30–15:00	Closing session and concluding remarks	<i>Dr Sameen Siddiqi</i>

Annex 2

LIST OF PARTICIPANTS

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Dr Slim Slama, Medical Officer, Noncommunicable Disease Management, WHO/EMRO
Ms Ghada Ragab, Programme Assistant, WHO/EMRO

Annex 3

PROPOSED LIST OF QUALITY INDICATORS

Classification	Indicator
Structure	% of individual patient files with unique identifier within the health care facility % of catchment population registered with the facility
Process	% of appropriate (upward) referrals during past 6 months (by specific condition) % of staff who have attended continuing training on quality and patient safety during past year Average waiting time at outpatient clinics % of prescriptions that include antibiotics in outpatient clinics % of hypertension patients with initial laboratory investigations % of registered hypertension patients with BP < 140/90 at last 2 follow up visits % of registered diabetic patients with fasting blood sugar controlled at last 2 follow up visits Number of days of stock-outs per year for 15 identified essential medicines in the available essential drug list in the facility % of the 8 essential cardiovascular disease and diabetes mellitus medicines with no stock out in past 3 months % of safe injections in the health care facility % of health facility staff immunized for hepatitis B (3 doses) % of children screened for anaemia % of registered noncommunicable disease patients with 10-year cardiovascular risk recorded in past 1 year % of registered noncommunicable disease patients with blood pressure recorded twice at last follow-up visit Timely ambulatory follow-up after mental health hospitalization (% of persons hospitalized for primary mental health diagnoses with an ambulatory mental health encounter with a mental health practitioner within 7 and 30 days of discharge)
Outcome	% of patients aware about patients' rights and responsibilities Patient satisfaction rate Number of adverse events reported (immunization/medication) Staff satisfaction rate % of smokers attending smoking cessation counselling % of children under 12/23 months immunized according to the national protocol % of children under 5 who had weight and height measured in past 1 year % of high risk group immunized against influenza % of diabetes patients with HbA1c less than 7% % of diabetes mellitus patients who had fundus eye examination during last 12 months % of pregnant women with first visit at the first trimester % of pregnant women received at least 4 antenatal checks % of pregnant women who received health education (nutritional care, anaemia, sanitation, and high risk pregnancy signs) % of pregnant women fully vaccinated against tetanus Mortality for persons with severe psychiatric disorders (standardized mortality rate for % of persons in total population with specified severe psychiatric disorders)



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