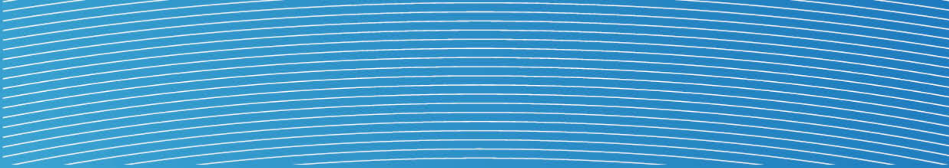
Internationalization of Health Service Delivery in the Iran University of Medical Sciences and Health Services (IUMS)

A joint collaborative project coordinated by the deputies for International Affairs & Public Health - IUMS

International campus
Iran University of Medical Sciences and Health Services



Contents

Preamble 5

Introduction to the Iranian Health System Network based on Primary Health Care 6

Justification and objectives for Internationalization of health service delivery in IUMS 11

Implementation steps 12

The result of service delivery assessment in 21 health care facilities of Shahr Ghods District 18

Developing plan of action to improve service delivery 20

Harmonization Workshops for the Care Providers of the Health Facilities, 10 and 16 October 2023 22

Annexes 24

Annex 1. Assessment questionnaire in line with WHO PHC Framework of Action 24

Annex 2. Plan of Action for strengthening Health System in Ghods District "Pilot district for PHC framework of action" 39

Preamble

Dr.Abdolreza Pazouki

The Iran University of Medical sciences and Health Services (IUMS) for the first time established in 1974 named Iran International Health Center. In 1978 the medical university has been added to this center and after victory of Islamic Revolution and integration of Medical universities with the health system the IUMS has been officially established in 1982 – 1987. The IUMS has been credited as one of the successful universities in Iran with quality and quantity improvement. Currently more than 7000 Iranian students and nearly 2400 foreigner students are studying in the medical, paramedical, nursing and midwifery, public health, rehabilitation, information management, mental health and behavioral science, and health technology. The IUMS has more than 750 members of academia, 10 major teaching hospitals, 7 curative care hospitals and 30 research centers in health sciences.

On the other hand, the IUMS is responsible to deliver Primary Health Care (PHC) services in addition to hospital and ambulatory care to 7 districts namely: Shahryar, Robat Karim, Shahr Ghods, Malard, Baharestan, North West Tehran and West Tehran with a population of more than 6500,000,000.

The deputy for international affairs and president of International Campus is continuously emphasizing on sharing experiences, result of researches in health sciences, major scientific outcomes and challenges with other international medical universities elsewhere in the world as well as sharing it during international congresses and meetings.

On the way towards internationalization of healthcare services in June 2023 under a close collaboration between deputies for public health and international relation it was decided to select Shahr Ghods District as the first model district implementing the WHO PHC Framework of Action recommended by the 2020 World Health Assembly. In this regard, after briefing the experts and managers of public health affairs in Shahr Ghods district a questionnaire has been finalized and all health facilities in the target districts has been assessed in 14 domains. The result of initial assessment has been analyzed by the consultant recruited for this project and shared with the experts and managers of the Shahr Ghods District. The meeting came out with a plan of action to overcome shortcomings and improve quality and quantity of health services, increase community engagement under Health Volunteers intervention and specially clients and care provider's satisfaction. By April 2024 the care delivery will be evaluated and the interventions will be expanded to other 6 districts within IUMS.

The chancellor of university and his deputies are fully committed to support implementation of the PHC framework of action and develop an educational field of service delivery for the internal and foreigners' health experts and managers specially countries of Eastern Mediterranean Region supported by World Health Organization.

We hope this booklet that summarize steps to implement WHO Framework of Action will be a useful guide for all internal and external interested health care managers and experts.

I use this opportunity to appreciate efforts of Dr Moghtadaei the deputy for International Affairs, Dr Tabatabaei deputy for Public Health, Dr Maleki the OIC International Affairs, Dr Ghoshtaei the head of the health education department, Dr Syed Hossain Mirsharifi the head of the Shahr Ghods Health Network System and his colleagues.

Last but not least Dr Ali Nemati the research deputy for International affairs and Dr Mohammad Assai Ardakani the senior consultant and expert for the project with many years national and international experiences in the health system management who both has substantial role in finalizing this document.

Dr Abdolreza Pazooki
Chancellor of Iran University of Medical Sciences
and Health Services

Introduction to the Iranian Health System Network based on Primary Health Care[1]

Following the victory of the Islamic Revolution (more than 4 decades ago), the Ministry of Health attempted to design the health system for a more equitable allocation of health resources based on Primary Health Care (PHC). The basic policies were declared as follows:

- Priority of prevention as a long-term investment to curative care
- Priority of rural and underprivileged areas in resource allocation to urban settings
- Priority of ambulatory care to hospitalization

Based on these policies and the results of the West Azarbaijan Province experience conducted in early 70s, a network of health facilities was designed mainly to deliver PHC services equitably to all those who need them. The first limited experience of hiring indigenous community health workers (Behvarz) for delivering primary health care services was conducted in this province in collaboration with WHO.

The PHC network (figure 1) is an integrated and stratified health care delivery system. A well-defined and standardized benefit package is provided for defined target populations dwelling around most peripheral health care facilities (Health Houses and Health Posts). This package includes maternal and child health care, family planning, oral health, symptomatic treatment of common symptoms, screening for diseases like diabetes and hypertension, mental health, early case detection for diseases like HIV/AIDS, malaria and tuberculosis, environmental health, and school health.

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1 M. assai - WHO report on emergency preparedness in Islamic Republic of Iran 2023

The Health House is the most peripheral rural facility in the network, covering an average of 1500 individuals. A male and a female villager known as BEHVARZ staff each health house and they are native to the place they work so familiar with the culture, language and needs of the community they serve. Based on the network master plan 19096 health houses have to be established to cover the whole rural population. Out of these planned facilities, 17958 (94%) health houses are active providing health services for the time being and cover more than 90% of the rural population. (Table 1)

Table 1: Planned and available health facilities

Health facilities	Health Houses	Health Posts	Rural Health Centers	Urban Health Centers
Planned	19096	6389	3121	2951
Available/ functional	(94%)17958	(88%)5638	(91%)2838	(94%)2783

Source: Health Netwiork Management Center, MoH- April 2022

Behvarzes are selected among young, interested and at least high school graduate indigenous (to the places that they will serve poulation/ their own villages) individuals and are trained in a 18 month training course in Behvarzi training center located at the ecenter of each district. Behvarzes are multipotential community health workers (CHWs) who have enough skills for delivering active PHC services.

The Rural Health Center, the second level of service provision, is a village-based facility that covers one to five health houses in the same or neighboring villages, not farther than 40 Km, under its supervision. On the average, the population covered by each rural health center is about 9000. Based on health network master plan 3121 rural health center are needed to cover the whole rural population. From these, about 2838 (91%) rural health centers have been established till now and are busy playing their role in the network.

Figure 1: Organogram of the Health Network System in I.R of Iran

Ministry of Health and of Health and Medical Education

Provincial Universities of Medical Sciences and Health Services

Emergency Management Center

Director of District Health Network

U &R EMS posts

Behvarzi Training School

District Health Management Center

District General Hospital

Maternity facility

Urban Health center

Urban Health center

Health House

Health House

Health House

Health Posts

Health Posts

Health Posts

A health team consisting of General Practitioners (one per 4000 individuals), midwife, nurse and a number of health experts work in each rural health center. This center is the first managerial and referral level in the rural health network system. In addition to administrative and supervisory function, the health team provides outpatient medical and more advanced health services for the covered population. Simple laboratory and imaging services may also be provided by the selected rural health centers but recently these services are outsourced specially at urban areas.

To reduce maternal mortality, that was about 90 per 100,000[2] live births in 1990, it was planned to construct maternity facilities next to about one per 5 rural health centers. As a result of improving access to hospitals, maternity facilities were not utilized as expected and keeping them active was not justifiable any more in many areas. Therefore, most of them were closed and for the time being, in remote areas where population access to hospitals has still remained poor, the maternity facilities are functional. All over the country there are only 250 maternity facilities still continued to assist normal deliveries.

The Urban Heath Posts are responsible for delivering PHC to the urban inhabitants in a way similar to the health houses in rural areas. Each urban health post covers a population of about 12500 individuals. Three family health experts (at least one of them should be midwife), one environmental health expert, one disease managing expertise staffing each urban health post. Based on the health network master plan about 6389 urban health post have to be established to cover the whole country urban population. From these planned health posts, 5638 (88%) are active, providing PHC services to their catchment population.

2 Special Reporting Committee on Iran Floods 2019

Urban Health Center, which is functionally similar to rural health center, has 3 to 5 health posts under its supervision. Two general practitioners, mainly for visiting/ screening patients, supervising health posts and referring cases who are in need of management at higher level, work in each urban health center. Private sector has a predominant role in providing curative services in urban settings. From 2951 urban health centers that have to be established based on the health network master plan, 2783 (94%) are active for the time being.

District management health center is ambulatory and preventive managerial health center and is responsible for planning, training and education, logistic, administrative affairs, monitoring and supervision of the district health network system. The directorate of district health network is the coordinator of all activities and health programs at district level including linkages of district general hospital with the ambulatory health care facilities.

The Ministry of Health and Medical Education (MOHME) is responsible for both education of health sciences and provision of health services. In each province, a state university of medical sciences and health services is responsible for these activities. Therefore, in addition to district health networks, other types of health faculties and teaching hospitals are also part of this organization in each province. As a result of this organizational unity, academic staffs have been more or less involved in health system management, evaluation and research. It is hoped that close cooperation between scientific and executive bodies facilitates the movement of Iran’s health system towards more efficient, equitable, and sustainable service provision.

Justification and objectives for Internationalization of health service delivery in IUMS

Well established infrastructure for delivery of PHC in IUMS, strong commitment of H.E. Chancellor of the university and his deputies particularly International and Public health affairs) and willingness of local health authorities to host managers and experts from the countries of the region to exchange experiences on PHC and eventually meeting UHC targets are reasons for raising the idea of internationalization of health services delivery in few districts under supervision of IUMS.

Table 2 shows district management centers (DMC) and its population coverage under supervision of IUMS. Therefore, in long term the project will cover a population above 5.5 million.

Table 2: district health management canters under IUMS

Districts	Population	Districts	Population
Shahriyar	844,869	Baharestan	565,025
Robat Karim	455,673	North West DMC	1,929,645
Ghods City	339,382	West DMS	1,044,486
Malard	380,690		
Total Population		5,559,770	

Source: Office of the Deputy for public health IUMS

Objectives

1) Establishing a well-qualified field of service delivery for the PHC managers and experts from the countries of Eastern Mediterranean Region (EMR) or other WHO regions;
2) Assessing current service delivery in different levels of care in terms of quality and quantity of PHC service delivery;
3) Improving quality and quality of service delivery through supportive supervision, coaching and performing continuous field visits;
4) Strengthening health network system based on WHO PHC Framework of Action (approved by the member states during WHA 2020);
5) Institutionalizing the community engagement and sustained intersectoral action as the main pillars of PHC; and
6) Organizing a series of capacity building workshops for the PHC managers and experts from other countries within and outside EMR using improved field of service delivery supported by WHO and other interested UN agencies and partners.

Implementation step

Step 1: Health service delivery assessment based on WHO PHC framework of action

In this regard an assessment questionnaire has been developed consists of 14 levers of PHC framework of action (core strategic and implementation levers). The levers were modified to fit with Iranian health system infrastructure and priorities (table 3). For each lever a set of indicators totally 75 indicators were identified that is basis for initial assessment and further evaluation of the project.

Table 3: The 14 levers for assessment of quality and quantity of district health system

Access & Coverage	Follow-up mechanism for defaulters	Governance
Comprehensiveness and Quality of care	**Financial hardship and population satisfaction**	**HWF training and in-service training/ refresher courses**
Population Acceptability, community engagement and their satisfaction	**Care Providers Satisfaction**	**Environmental & Occupational Health and Emergency Preparedness and Response**
Human Resources, Physical Space and Medical Equipment	**Supply of vaccines, medicines and other biologics**	**Social Determinants of Health**
Monitoring, Supervision and Health Management Information System	**Referral Channel**	

Step 2: Finalization of the assessment tool and briefing the senior experts and management of project site (model district namely Qods District)

Two sessions were coordinated and facilitated to finalize the tool and briefing the senior experts from the Public Health Deputy Office and the project implementation site on their role and how to observe, assess and document findings, so that an evidenced based result is expecting from this assessment (Annex 1). It was planned to assess 25% of health houses, 25% of health posts and adjacent rural and urban health centers; however, considering quite manageable we decided to assess all 19 Health posts and 2 health houses.

To expedite assessment, process the service delivery units from the sample site were divided among the senior experts from Deputy of Public Health Office as well as the local priority health related programs' managers at district level. The assessment has been initiated on 21 August and completed by 1st September 2023. **(Annex 1)**

Step 3: Assessing the service delivery using a questionnaire that has been completed by 5 teams of experts from different fields of service delivery. This has been compiled and analyzed to identify successful experiences/ innovations as well as weaknesses **(Annex 2).** This has been carried out by the senior adviser Dr Mohammad Assai Ardakani, former adviser to H.E. Minister of Health and Medical Education and the former WHO Representative Pakistan with nearly 36 years' experiences in PHC and health system development. Dr Assai has designed the questionnaire and started to work on this project from 23 July 2023.

Step 4: Develop plan of action to improve service delivery based on the assessment' result

The senior adviser, along with the experts from the international affairs deputy and public health deputy office of the IUMS in addition to the district level managers and experts facilitated two days planning workshop and came out with actions to improve service delivery at project site considering the guiding principles suggested by the WHO PHC framework of action. This has been finalized on 3-4 September 2023 **(Annex 2)**.

Step 5: implementation of the plan of action by the district health authorities

Implementation of plan of action and agreed interventions filling the gaps in service delivery required high level political commitment mainly from the chancellor of IUMS as well as technical support from the deputies for international affairs and public health affairs. This should be complimented by WHO and other interested UN agencies and partners technical and financial support.

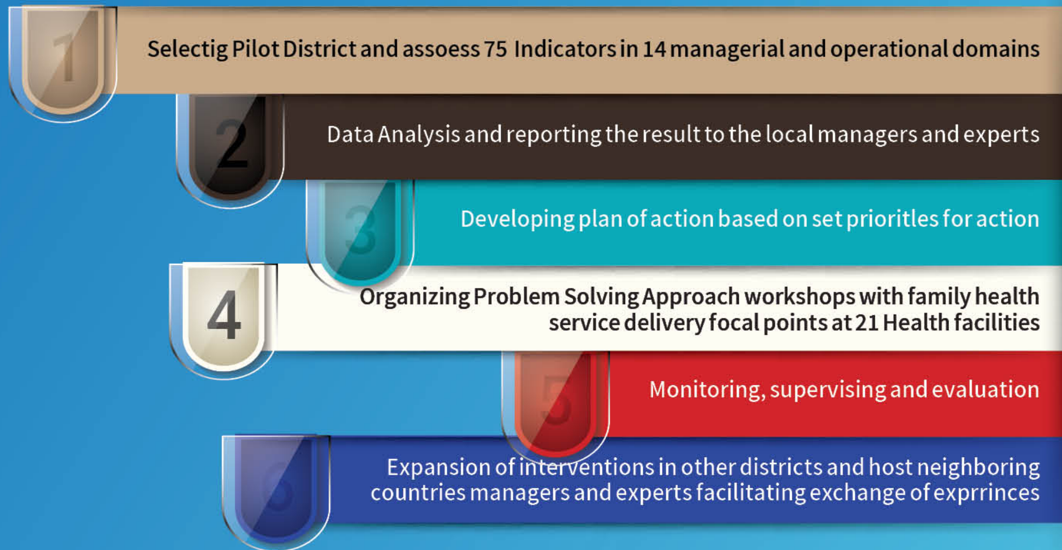
Step 6: Design and organize a capacity building course for the managers and experts from other countries of the EMR and other interested regions to share experiences and benefit from the improved field of service delivery created by the IUMS.

Expectations from WHO, UNICEF and other UN Organizations:

1. Providing technical support for Operationalization of WHO PHC framework of action in I.R of Iran (as a model in Iran University of Medical sciences and Health services);
2. Facilitate exchange of experiences between MSs on WHO PHC framework of action virtually with EMRO and other possible countries;
3. Participate in final evaluation of project to assess impact of interventions to improve the relevant indicators in compare with the initial assessment result;
4. Support creation of a model educational field on service delivery

"strengthened PHC services based on WHO PHC framework of action advised by WHA 2020";

5. Facilitate organizing national and international workshops to share experiences on the subject and if applicable recognize IUMS (selected implementation site) as a training site for improved PHC services.



S #	Main Activities	Time line	Responsible officer/ unit
1	Drafting a questionnaire for service delivery assessment and briefing experts and health system managers	From 23 – 30 July 2023	Dr Assai as senior adviser to the project
2	Finalizing assessment questionnaire	1st August 2023	Senior experts from deputies for INT and public health affairs
3	Selection of assessment site and assessment team members	1st August 2023	Senior managers from deputy for public health affairs
4	Completion of service delivery assessment in 25% of the health (facilities (Rural & Urban	From 21 August to 10 Sep 2023	Assessment team supervised by the project' senior adviser
5	Compilation and analysis of the assessment questionnaire	Aug 2023 11	Project' senior adviser
6	Organizing a consultative meeting to identify successes/ innovations and weaknesses based on assessment results	Sep 2023 3-4	Public Health Deputy and Manger of the model district assisted by the Project' senior adviser
7	Develop a plan of action (PoA) to improve quality and quality of service delivery based on WHO PHC Framework of Action	Sep 2023 3-4	Senior experts and managers of the District Health Center
8	Initiating implementation of agreed PoA	From 2 September for a period of 3 months	Senior experts and managers of the District Health Center supported by the deputies for INT affairs and Public Health affairs and also Project' senior adviser
9	Evaluate achievements by redoing assessment tool	From 2-7 December 2023	Project' senior adviser
10	Reporting the progress of the project including its evaluation and outcomes	From 9 – 21 December 2023	Project' senior adviser
11	Plan/ design a 5 days course participated by the PHC managers and experts from other countries of the Region	From January 2024 onwards	Deputies for international and public health affairs
12	WHO and other partners support for deploying experts from other countries of the region and organizing a 5 days capacity building course	From February 2024 Onwards	WHO and other interested partners
13	Organizing and facilitating a 5 days capacity building course	March 2024	Deputies for international and public health affairs

18 The result of service delivery assessment in 21 health care facilities of Shahr Ghods District

Five teams each composed of 3 experts among senior experts and managers of Ghods Health management center has been formed to assess existing situation using WHO Primary Health Care framework of action adapted by World Health Assembly in 2020. 75 indicators in 14 domains have been agreed and the team performed existing care delivery status ended in 10 days' period. The assessment forms have been analyzed and accordingly it was realized that 18 indicators need to be improved on gradual basis. The assessment team were advised using the health profile of the catchment population specially at risk population, assess knowledge and skill of care providers, communication skill, interview with clients and their own judgment based on their vast supervisory and monitoring experiences.

1. **Mothers interpretation on growth monitoring chart of their own child:** although growth chart is well recorded in the majority of visited health files, however, during consultant's visits/ fact checking it was realized that mothers are not well trained how to interpreting about the growth of their own child. Therefore, considering importance of child development and growth it was decided to include this indicator in the list of the interventions for improving service delivery quality.
2. **Exclusive breast feeding (EBF) among children who reached age of 6 years:** Ministry of Health expectation about EBF is only 37%, but in few health posts the EBF is much lower than MOH' expectation. Considering importance of EBF and its impact on child growth it was decided also to include this indicator in the list of the interventions for improving service delivery quality.
3. **Antenatal care at least 6 times during pregnancy:** this indicator in the 6 Urban and 1 Pre Urban health posts is less than expectations, however in other health facilities antenatal care reached above expectations by follow up mechanism in place by the health care providers. The MoH expectation for ANC is just 50% at urban areas that need to be revised. In one of the health centers (Eshrati) the families prefer to approach private gynecologists for the ANC, therefore it was not possible to extract actual figure. In Shahid Mortazavi health post the ANC was 27% and in Imam Hassan 20%.
4. **Screening psychosocial disorders and addicts in the catchment population:** this indicator in one pre urban health post and 5 urban health posts is reported non-satisfactory. In Inanloo health posts the follow up of psychiatrists and gener-

al physician has reached 52%, while in Imam Hassan health post is not satisfactory. All these are due to only one visit of psychiatrists per facility in a week that the number has to be increased or the GPs and healthcare providers should be given short term training.

5. **Care of the elderly and people suffering from Non- Communicable Diseases (NCDs):** during consultant's visits/ fact checking it was realized that very limited number of elderly are approaching health facilities and there were long delayed in care taking by the elderly within catchment area of the visited health facilities. Considering high number of elderly compare to 10 years ago and importance of NCDs among young and old population it was decided to include this indicator in the list of the interventions for improving service delivery quality.
6. **Identification and training of health volunteers:** Iran's experiences has shown that health volunteers can have substantial impact on population coverage, improving health indicators, follow up defaulters and making sure that health care services are delivered on time to the at risk groups. The assessment has shown that number of health volunteers due to cultural differences among neighborhood is much lower that expectations.
7. **Standards for the health facilities' physical space, its safety and security and need for any renovations:** the assessment revealed that 5 urban health posts and one pre urban health posts don't have enough safe and secure space for service delivery, the number of rooms are not enough for the clients to feel secure while taking care, in number 1 health posts and Mahmoodian and Ali Asghar health posts the waiting area is so small. Baharan and Shahid Hossaini's health posts are out of standards. The water and Sanitary LAB at Nimeh Shaaban health post and its dentistry facility need renovation.
8. **Vital Horoscope (health information Toll installed on the wall of the health facility):** Vital Horoscope is a simple, friendly used tool created by Iran PHC system 4 decades ago. Considering that Vital Horoscope can be counted as an Image for Iranian PHC it was advised that it should be installed at all health facilities, noting that only health houses ar rural areas having a valid and updated Vital horoscope on the wall.
9. **Using the power of health volunteers for follow up mechanism:** considering low number of volunteers the care providers mostly follow up defaulters by phone, the people in need of continuum care may miss opportunities of using available services at the health facilities. It was advised that the number of health volunteers must be reached up to the accepted standards in a 6 months' period. It is worth mentioning that at rural areas BEHVARS (Community Health Workers) are following up defaulters (if any!) ensuring delivery of PHC in an active way.

10. **Number of people who don't use any kind of health insurance:** unfortunately ate facility level this indicator can't be extracted from the Electronic profiles while at managerial and district level this can be extracted.
11. **Availability of essential Medicines at least for the use of one month as stock:** due to overall medicine distribution policy the health facilities cannot be expected to store essential medicines for one-month usage.
12. **Allocation of required budget for implementation of health activities:** considering many issues including imposed sanction the districts health network system is facing with limitation in budget allocation.
13. Identifying at risk places and hot numbers pacing it on the board of each health facility. In 3 urban health posts and one rural health facility this was not appeared on the board, however within 48 hours after assessment this is now appeared at all health facilities!
14. **Identification of HOT numbers** (Fire distinguishing centers, Ambulances, Red crescent) on the main squares, high ways, visible places at neighborhood: it was not placed in any sites.
15. **Percentage of educated people 12-65**
16. **Percentage of women as head of the households**
17. **Percentage of men 25-65 with no jobs/ income**

The electronic health profile can't extract these indicators

18. **Access to the standards physical space for physical exercise and greenery areas:** the greenery areas in Ghods is at the level of national standards, however free access to physical exercise facilities need to be considered by the city managers.

Developing plan of action to improve service delivery

Considering assessment' result and areas that need to be improved the expertise from Iran university of medical sciences and Shahr Ghods district attended a two days' session to come out with a plan of action that can be find in Annex 2. The time line activities are designed in a way having maximum impact on the predicted outcomes, in addition to the responsibilities and monitoring indicator for each activity. A summary of action plan is as follow:

- Coverage & Access to the health services
- Comprehensiveness and Quality of Care
- Population Acceptability, engagement and their Satisfaction
- Human Resources, Physical Space and Medical Equipment
- Monitoring, Supervision and Health Management Information System
- Follow-up mechanism for defaulters
- Financial hardship and population satisfaction
- Care provider’s satisfaction
- Supply of vaccines, medicines and other biologics
- Referral Channel
- Governance
- HWF training and in-service training/ refresher courses
- Environmental & Occupational Health and Emergency Preparedness and Response
- Social Determinants of Health

Harmonization Workshops for the Care Providers of the Health Facilities, 10 and 16 October 2023

The initial assessment of service delivery in 21 health houses and health posts of Shahr-e-Ghods has shown that 3 major issues should be targeted to improve service delivery, these are:

1) Expansion of Women Health Volunteers program (WHVs),
2) Improving Antenatal Care (ANC), child care and increasing Exclusive Breast Feeding (EBF) practice and
3) Increasing elderly care coverage and care of the people suffering from non- communicable diseases (NCDs).

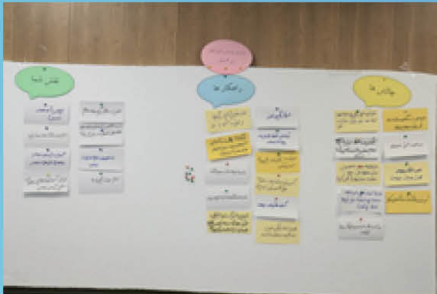
The Iran University of Medical sciences and Health Services has organized two workshops (one on 10th and the other one on 16 October) participated by around 40 care providers working at 21 health facilities of Shahr-e-Ghods. These workshops aim to engage care providers in identifying major challenges within their catchment population related to the above mention 3 priorities, actions to overcome challenges and the role of the care providers in filling the existing gaps.

Each workshop consists of 3 sessions that have been facilitated by Dr Mohammad Assai Ardakani, adviser to the undersecretary for International Health Relation. The sessions articulated in a full participatory approach where care providers divided into groups of 3 participants and requested them to discuss and come out with Top 3 challenges, Top 3 actions to overcome challenges and Top 3 main roles in filling the gaps. Each team/group requested to write down the outcome of their discussions on 3 colorful Cards and paste it on the wall as shown in the below photos. Each session took 90 minutes and that includes discussions and removing overlaps and repetitions between outcomes of the working groups.

Outcome of ALL working groups discussions on expansion of WHVs program

Outcome of ALL working groups discussions on Improving Care of Elderly and coverages of people with NCDs

Group photo of the second batch of care providers dated 16 Oct 2023


Outcome of ALL working groups discussions on Improving ANC, child care and increasing EBF

Active participation of care providers in identifying challenges, actions and role of the family experts in filling the gaps

Free discussions/ sharing ideas/ innovations between facilitator and participants

It is expected that outcome of these two workshops will be implemented by the care providers of 21 health facilities, monitored and supervised by the experts from the undersecretary for public health department as well as experts/ managers from district level. The supervisors will ensure improving in service coverage and moving towards meeting Universal Health Coverage targets.

Annex 1. Assessment questionnaire in line with WHO PHC Framework of Action

This questionnaire should be filled for 25% of rural and urban health facilities including health houses, health posts, rural and urban health centers making evidences on success factors/ innovations and weaknesses on service delivery at each level of service delivery point. Please be realistic and honest in documenting your positive and negative points, so you can improve the quality and quality of service delivery based on realities and available facts and figures.

#S	Indicators in coherent 14 levers at rural, urban and pre urban levels		Completely Agree	Agree	Disagree	Completely disagree
Coverage & Access						
1	of people have easy access to PHC ser- 100% (vices (maximum 20 minutes walking distance	Rural areas				
		Pre -Urban				
		Urban areas				
2	Number of health facilities are based on original master plan for Health Network System	Rural areas				
		Pre -Urban				
		Urban areas				
3	of at-risk groups (pregnant mothers, 100% children<5, people with communicable diseases, refugees, elderly, youth 18-29 years and adolescents 5-18 years old) are covered by the health system	Rural areas				
		Pre -Urban				
		Urban areas				

4	All people suffering from NCDs (CVDs, DM, High BP and cancers) receive continuum care	Rural areas				
		Pre -Urban				
		Urban areas				
5	of children 1-5 years are vaccinated 100% against Pantavalen 3 and MMR 2 vaccines	Rural areas				
		Pre -Urban				
		Urban areas				
6	of children <5 have active Growth Mon- 100% itoring Chart (one kept at the facility and one (with mother	Rural areas				
		Pre -Urban				
		Urban areas				
7	of children under 66 months are Exclu- 100% sively breast Fed	Rural areas				
		Pre -Urban				
		Urban areas				
8	All people with communicable diseases (TB. Malaria, HIV/AIDS) are investigated based on syndromic management and care system	Rural areas				
		Pre -Urban				
		Urban areas				
9	All pregnant mothers at least received 6 times ANC during their pregnancy period	Rural areas				
		Pre -Urban				
		Urban areas				

10	and social All people with mental disorders problems and addicts are screened and covered by the health facilities and refereed to the (upper level (GP/ psychiatrics	Rural areas				
		Pre -Urban				
		Urban areas				
11	All children at school age have health files and receive relevant service package based on national instructions	Rural areas				
		Pre -Urban				
		Urban areas				
12	All people > 60 are screened, diagnosed and under control receive relevant service package for Hearth Diseases, DM, Cancers, Osteoporosis and common cancers	Rural areas				
		Pre -Urban				
		Urban areas				
13	Number of health facilities are based on original master plan for Health Network System	Rural areas				
		Pre -Urban				
		Urban areas				
14	People have physical/ financial access and High quality of care to diagnostic facilities (LAB, X-Ray and other para-clinics either government (or private clinics	Rural areas				
		Pre -Urban				
		Urban areas				

Comprehensiveness and Quality of Care						
15	All people have access to preventive, curative and palliative care without financial hardship	Rural areas				
		Pre -Urban				
		Urban areas				
16	The healthcare services are delivered based on Family Practice Approach	Rural areas				
		Pre -Urban				
		Urban areas				
17	Consultative care and social/ cultural support including empowerment are provided to the needy groups[1]	Rural areas				
		Pre -Urban				
		Urban areas				
18	During last one year "adverse impact related to vaccination, injections, dressing, prescriptions of medicines etc" are reported	Rural areas				
		Pre -Urban				
		Urban areas				
19	The on-time continuity of care is planned and delivering to the at-risk groups	Rural areas				
		Pre -Urban				
		Urban areas				

1 For example, established and active district multisectoral committee chaired by the Governor, discussed and find solutions for socio-economic and cultural short comings

20	Safety box for vaccines and dental care injections are available and all injections are safely injected	Rural areas				
		Pre -Urban				
		Urban areas				
21	All people with NCDs are advised for LAB test every 6 months and recorded in their electronic health file	Rural areas				
		Pre -Urban				
		Urban areas				
22	Pregnant mothers and children < 5 are screened for Anaemia and children receive service package for healthy child	Rural areas				
		Pre -Urban				
		Urban areas				
Population Acceptability, engagement and their Satisfaction						
23	People receive PHC services with full satisfaction and approach health facilities based on their wills	Rural areas				
		Pre -Urban				
		Urban areas				
24	The health volunteers (one per 20-60 households) are selected, and attend regularly training sessions organized by the relevant health facilities	Rural areas				
		Pre -Urban				
		Urban areas				

25	Community based/ neighborhood-based projects prepared and implemented in the area/s	Rural areas				
		Pre -Urban				
		Urban areas				
26	The health volunteers assessed social, cultural and financial needs and shared with the relevant development sectors	Rural areas				
		Pre -Urban				
		Urban areas				
27	The volunteers from other sectors (development sectors volunteers) have joint health related interventions/ project	Rural areas				
		Pre -Urban				
		Urban areas				
Human Resources, Physical Space and Medical Equipment						
28	All HWF are recruited based on national family health plan/ defined standards	Rural areas				
		Pre -Urban				
		Urban areas				
29	All health care facilities equipped with essential equipment such as BP apparatus, weighing scales, Cold chain equipment, Desk top, Phones etc	Rural areas				
		Pre -Urban				
		Urban areas				

30	All health facilities equipped with necessary office furniture including signboard	Rural areas				
		Pre -Urban				
		Urban areas				
31	All health facilities have standard physical space and safety measures are well considered	Rural areas				
		Pre -Urban				
		Urban areas				
32	The health facilities in need of renovation received repaired and renovations	Rural areas				
		Pre -Urban				
		Urban areas				
Monitoring, Supervision and Health Management Information System						
33	The supervisors are visiting health facilities plan are available for at least once every 3 weeks visits and all reports/ findings are record in a special booklet and reported to the district health management	Rural areas				
		Pre -Urban				
		Urban areas				
34	of population have active electronic 100% health file	Rural areas				
		Pre -Urban				
		Urban areas				

35	The health facilities are divided among health system experts for monitoring and supervision	Rural areas				
		Pre -Urban				
		Urban areas				
36	Vehicles for S&M are available at district level	Rural areas				
		Pre -Urban				
		Urban areas				
37	The Vital Horoscopes are kept updated at rural and urban facilities	Rural areas				
		Pre -Urban				
		Urban areas				
Follow-up mechanism for defaulters						
38	The healthcare services to the at-risk groups are actively follow up and if necessary are delivered at their door step	Rural areas				
		Pre -Urban				
		Urban areas				
39	The healthcare services to the at-risk groups are recorded in their electronic health file and reported to the upper level	Rural areas				
		Pre -Urban				
		Urban areas				

40	The power of influenced local people are used for activating the follow up mechanism	Rural areas				
		Pre -Urban				
		Urban areas				
Financial hardship and population satisfaction						
41	All PHC services are free of charge	Rural areas				
		Pre -Urban				
		Urban areas				
42	The ambulatory care is delivered with government TARIFF or covered by health insurance system	Rural areas				
		Pre -Urban				
		Urban areas				
43	of population are covered by one of the 100% national health insurance schemes	Rural areas				
		Pre -Urban				
		Urban areas				
44	The un insured people are recorded and list of them are available for registration/ follow up	Rural areas				
		Pre -Urban				
		Urban areas				

Care providers satisfaction						
45	The salary of the care providers is paid on time	Rural areas				
		Pre -Urban				
		Urban areas				
46	Countenance and punishment are used as tools for increasing insights for better services delivery	Rural areas				
		Pre -Urban				
		Urban areas				
47	The senior health managers at district level listen to the staff and having good behavior and morals (e.g: a suggestion and complains box is (fixed on the wall	Rural areas				
		Pre -Urban				
		Urban areas				
48	The staff can be promoted (based on the Government rules and regulations) and environment are fit for higher education if they desired	Rural areas				
		Rural areas				
		Pre -Urban				
		Urban areas				
Supply of vaccines, medicines and other biologics						
49	The essential medicines are available according to the standard pharmacopeia list	Rural areas				
		Pre -Urban				
		Urban areas				

50	Vaccines and other biologics are stocked for at least next one month	Rural areas				
		Pre -Urban				
		Urban areas				
51	Essential medicines are stocked for at least next one month	Rural areas				
		Pre -Urban				
		Urban areas				
52	The usage of medicines and vaccines are recorded regularly in the special booklets/ at electronic reporting tools	Rural areas				
		Pre -Urban				
		Urban areas				
53	The electronic prescriptions are well established based on family practice programme	Rural areas				
		Pre -Urban				
		Urban areas				
Referral Channel						
54	All patients in need for referrals are referred using referral slips and registered electronically in the system	Rural areas				
		Pre -Urban				
		Urban areas				

55	The feedback is received and available from higher level for the referred patients	Rural areas				
		Pre -Urban				
		Urban areas				
56	The referred patients are following up after return form higher level	Rural areas				
		Pre -Urban				
		Urban areas				
57	The referred patients are satisfied by the morals and interventions of the higher level/s	Rural areas				
		Pre -Urban				
		Urban areas				
Governance						
58	Sufficient financial supports for delivery of comprehensive and high-quality care allocated to the district health center	Rural areas				
		Pre -Urban				
		Urban areas				
59	The district health mangers are committed to community engagement and do all their efforts for increasing community participation and developing neighborhood-based projects runs by the people	Rural areas				
		Pre -Urban				
		Urban areas				

60	The district health mangers are committed to sustained intersectoral collaborations and relevant examples / evidences are available	Rural areas				
		Pre -Urban				
		Urban areas				
61	The private sectors are active part of family practice program	Rural areas				
		Pre -Urban				
		Urban areas				
HWF training and in-service training/ refresher courses						
62	Based on monitoring visits regular in-service courses (at least every 2 months) are designed and implemented for the HWF	Rural areas				
		Pre -Urban				
		Urban areas				
63	Short term in-service training sessions are planned of the new commerce	Rural areas				
		Pre -Urban				
		Urban areas				
Environmental & Occupational Health and Emergency Preparedness and Response						
64	All food shops are screened and electronic health files are available for them	Rural areas				
		Pre -Urban				
		Urban areas				
65	100%of people have access to safe drinking water	Rural areas				
		Pre -Urban				
		Urban areas				

66	of population have access to safe sanita- 100% tion and sewage system	Rural areas				
		Pre -Urban				
		Urban areas				
67	of population benefit from safe and clean 100% garbage collection and disposal system	Rural areas				
		Pre -Urban				
		Urban areas				
68	of population have access to Greenery 100% areas with NO air pollution	Rural areas				
		Pre -Urban				
		Urban areas				
69	All at risk areas are recognized, identified in addition phone number of Police, fire distinguishers, EMS, Red Crescent, main source of water etc are recorded on the boards for the people to see and know if and when is needed	Rural areas				
		Pre -Urban				
		Urban areas				
70	The defined groups of community e.g: youth and women volunteers are selected and trained to help their neighborhoods on healthy life style in addition to prevention/ mitigation, and providing first aids at the time needs and before rescue team arrives	Rural areas				
		Pre -Urban				
		Urban areas				

71	The hot lines are recorded at sign boards in different squares/ main roads phone	Rural areas				
		Pre -Urban				
		Urban areas				
Social Determinants of Health						
72	of population (expected population 100% above 12-65 years of old) having at least prima-(ry school education (men and women	Rural areas				
		Pre -Urban				
		Urban areas				
73	All women 15-60 years old who are head of the households having jobs and income	Rural areas				
		Pre -Urban				
		Urban areas				
74	All men 25-65 years having jobs and income	Rural areas				
		Pre -Urban				
		Urban areas				
75	All people have access to the physical activities' facilities like parks/ gyms etc	Rural areas				
		Pre -Urban				
		Urban areas				

Annex 2. Plan of Action for strengthening Health System in Ghods District "Pilot district for PHC framework of action"

Activities	Responsibilities	Deadline
Access and Coverage		
Establishing 10 Health Posts & 2 UHCs according to the PHC National Expansion Plan: - Identification of the geographical sites - Coordinating with Governor for allocating required Lands/ appropriate places to rent - Visit available sites by experts - Removal of legal restrictions in purchasing Lands - Estimate BUD required - Visit to the Provincial Governor for solution in land allocation in Ghods District	Ms Ahmad Khaniha and Mr Ebrahimi	Till March 2024
Child Nutrition and Growth Monitoring Cards		
Improving Child Nutrition (50% of Mothers of Children< 5 have Growth Monitoring charts) - Improving quality of Supportive supervision and Monitoring - Organizing Group Problem Solving Workshop for 40 of family health experts working at facility level - Monitoring progress of work at service delivery points	Ms Khosravi and Ms Valipoor	Continuous process

Coverage Of Exclusive Breast Feeding		
Increase coverage of Exclusive Breast Feeding[1]: - Organizing Group Problem Solving Workshop for 40 of family health experts working at facility level - Improving quality and quantity of Breast-Feeding counseling by 10% compare to the last calendar year - Increasing number of mothers who are in need of counseling from the Health Posts and Health houses - Providing additional technical support/ training to the Breast-Feeding Counseling experts working at the Maternity Hospitals - Increasing % of counseling on EBF among mothers who recently give birth - Quarterly basis supportive supervision, monitoring progress of the EBF indicator and refresher courses for care delivery staff if needed	Ms Khosravi and Ms Valipoor	Continuous process

1 According to the instructions by the MoH expectations for EBF is 37%, in Ghods District is 30%, however we target 100 % of children under 6 months to EBF

Periodical Health Care to Youth and Elderly		
Screening and delivery of services at least once/ year to 30% of Youth and Elderly population in the catchment area of each health facility: - Organizing Group Problem Solving Workshop for 40 of family health experts working at facility level - Invite Youth and Elderly in the catchment area by care providers of health posts and health houses for receiving the package of services available in digital network system - Using opportunities created by Family Practice package to cover all youth and elderly specially in afternoon sessions (facilities implementing Family Practice are functional in the afternoon sessions too) - Delivery of care to the residence of elderly house located in Ghods city - Using services of women health volunteers to encourage elderly to approach on time for receiving care - Care delivery in the collection points of youth and elderly	Ms Syedi, Ms Khosravi and Ms Valipoor	Till March 2024

High Coverage Antenatal Care at least for 6 times during pregnancy		
Expectation for ANC is 50% but presently it is 30% in health posts: - Organizing Group Problem Solving Workshop for 40 of family health experts working at facility level - Call for encouraging pregnant mothers to approach for ANC - Screening of pregnant mothers and identify total number of expecting mothers - Using opportunities created by Family Practice package to cover all pregnant mothers specially in afternoon sessions (facilities implementing Family Practice are functional in the afternoon sessions too) - Telephone call to all pregnant mothers and invite them to approach health facility for ANC - Increasing pregnant mothers' satisfaction through reducing waiting time for ANC - Determining target pregnant mothers and comparing actual coverage with expected targets	Ms Khosravi and Ms Valipoor	Till March 2024

Screening of people with mental and social disorders/ violence and addictions		
Screening and covering people with mental, social disorders: - Facilitating delivery of socio-mental care to the people with mental and social disorders - Using capacity of Sardar Solaimani Hospital for care delivery through psychiatrics, psychologists and social workers (one day presence of psychiatrics at each health post is not enough considering high demands of population) - Implementation of prevention of addiction within catchment area of each health facility - Increasing number of psychiatrics at each health facility or plan for group education and counseling - Short term training of health experts working at health posts on mental health - Establishment of safe houses for the victims of domestic violence	Ms Sadeghzadeh	Till March 2024

Community satisfaction, engagement and acceptability		
Selection and training of women health volunteers to encourage members of households to receive their timely healthcare services: - Organizing Group Problem Solving Workshop for 40 of family health experts working at facility level - Extracting people who delay in receiving their healthcare services and sharing it with volunteers for follow up - Filling the PHC reporting templates for screening NCDs and communicable diseases by eth volunteers - Encouraging people to benefit from the available services by Volunteers - Reaching one volunteers per 20-50 households - Identifying locality health and social barriers and needs by the volunteers and plan to overcome shortcomings - Locating appropriate places for volunteers gathering like parks, mosques, cultural centers etc - Constant monitoring and supportive supervision to the volunteer's performance	Ms Zakipour	Continuous process

Human resources for health, medical supplies, office equipment and physical space		
Renovation of physical spaces: - Assessing needs for physical spaces renovations and needs for furniture and medical equipment - Estimate budget requirement to cover urgent needs - Performing renovations and purchasing medical and office equipment s based on priorities - Distributing medical and office equipment based on standards of health facilities - Estimate needs for number and cadres of health workforce and find a way to absorb required HWF	M Ms Ahmad Khaniha and Mr Ebrahimi	Till March 2024
Preparing list of the individuals without health insurance coverage		
Number of individuals without health insurance coverage is only possible at the level of health houses; preparing this list will facilitate to coordinate with health insurance companies and increase coverage: - The SINA digital Family Folder site should allow screening of Not insured individuals, this will be requested from IUMS - Manual recoding by health workers at the time of receiving any services by individuals	Ms Ramezani	October 2023

Governance		
Limitation of Budget allocation: - Reporting the performance and need for additional budget to the chancellor of university - Overall needs assessment in the health facilities - Prediction of required budget in the annual budgeting review - Follow up resource allocation form IUMS and public health deputy office - Request budget allocation for infrastructure of health system to the governor	Dr Mirsharifi	Till March 2024
Environmental Health		
Swage system even at urban areas is not up to standards (only 52% of households has access to improved sewage management and sanitation): - Follow up implementation of the 2nd phase of sewage management project - Follow up community complaints related to the sewage management - Referring the violators of wastewater to the legal authorities - Follow up decisions made by the health committees related to the swage management - Periodical visit to the sewage management site of the city and reporting back to the governor and other legal authorities	Enj Parvizi	Till March 2024

Installation of key phone numbers (fire stations, police, security, hospital, EMS etc) at the health facility boards to be contacted by the community if and when is needed: - Dispatching key phone numbers to all health facilities - Ensure the numbers are installed on board and readable by the visitors	Enj Parvizi	October 2023
Social Determinants of Health		
No data related to SDH can be extracted from SINA digital registration for family health files: - Literate population 12-65 - Ladies head of the households with Jobs and income - Men 25-65 who has jobs and income All above should be requested from the management of SINA digital family health registration to include it in the system	Ms Ramezani	Till March 2024
Access to greenery areas, parks, physical exercise facilities and clean air: - Raising the issue in the health committee of the governor house - Visit the physical exercise facilities on periodical intervals and monitor usage by the community - Visit parks and other similar places to ensure safety, free form any violence and stray dogs	Enj Parvizi	Till March 2024

List of the equipment needed to support the field of service delivery in Shahr Ghods district

Equipment	Quantity needed	Equipment	Quantity needed
Desk tops	10	Wooden file	5
Laptop	2	Color printer	1
Wooden Library	10	B&W printer	10
Meeting chair	20	Photocopy machine	1
Operators' chair	20	Gaz AC	2
TV 40 Inches	2	White Board	10
Photography Camera	1	Van Automobile*	2
Total Funds needed (approximately)			IRR 9,840,000,000 Equal USD 196,800

The price of Vans is not included*