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Quality Assurance for Health Promotion Services in Primary Health Care Centers

Thesis

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By

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﴿ وَلَقَدْ آتَيْنَا دَاوُودَ وَسُلَيْمَانَ عِلْمًا
وَقَالَا الْحَمْدُ لِلَّهِ الَّذِي فَضَّلَنَا
عَلَى كَثِيرٍ مِنْ عِبَادِهِ الْمُؤْمِنِينَ ﴾

صدق الله العلي العظيم

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Dedication

This work dedicated to:

The source of courage and kindness to

Dear parents

Dear wife, and **daughters**

Brothers and **sisters**

Friends

Those who participated in this study

With love and all respects

Researcher

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Abstract

Health promotion was defined as enhancing a person's living, working, and physical surroundings as well as their education and leisure, which is clear as insuring their health. It is a planned, system-wide effort that touches on a person's life. The value of quality, the cornerstone of the healthcare system, is rising quality underlies the capacity of the industry to progress and promote health, which positively influences and enhances patient satisfaction.

A descriptive cross-sectional study was conducted in primary health care centers in southern of Babylon province, – Iraq. The objectives of this study were to assess the job performance of health care workers, assessing the consumer satisfactions and the primary health care center infrastructures. In order to assess the quality assurance of the health promotion program from October 2022 to June 2023 on an appropriate sample of (60) health service providers working in the health promotion units, and 240 participants (consumers). The sample was randomly selected from (10) primary health care centers.

The results of the study showed that the job performance of health workers in primary health care center was fair. Average score (2.07) was obtained on a Likert scale, while consumer satisfaction in primary health care centers was moderate. While managers ’answers and observation to the current organizational structure of the PHCC was moderate.

The study concluded that the assessment of quality of PHCC structure find lack of the financial resources and shortage health care provider in health promotion units. Lack of training for all health workers who implement health promotion program. The level of consumer satisfaction was indication as moderate.

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LIST OF ABBREVIATIONS

Abbreviation	Text
DF	degree of freedom
GDP	Gross Domestic Product
HBM	Health Belief Model
HbA1c	Hemoglobin A1c level
HS	Highly significant
IEC	Information-Education-Communication
IOM	Institute of Medicine
MOH	Ministry of Health
NCQA	National Committee for Quality Assurance
PHC	Primary Health Care
PHCC	Primary Health Care Center
QA	Quality assurance
STDs	Sexual Transmitted Diseases
SES	socioeconomic status.
SPSS	Statistical Package for Social Sciences
SDGs	Sustainable Development Goals
U.S	United States
WHO	World Health Organization

Chapter One
Introduction

Chapter One
Introduction

Alma-Ata, was defined primary health care (PHC) as "essential health care based on practical, systematically sound and socially suitable methods and technology made universally available through people's full participation and at a budget that the community and country can give. It is the central function of the health system and it's the first level of contact, bringing health care as close as possible to where people live and work". (Henry,B.2020)

Primary health care services in Iraq are changeable according to people ages. There are broad practitioners' clinics, professionals (pediatric, obstetric, internal medicine, skin and venereal), maternal and child health, health promotion activities, emergency services as well as laboratory services in the clinics with second level and above. Moreover, physiotherapy services in some of clinics with fourth level are there (Public Health Law in Iraq No. 89. 1981).

Like many other nations of the world, Iraq views non-communicable diseases as one of the most significant public health issues. The statistics of the Ministry of Health showed that cardiovascular diseases, cancerous diseases, diabetes, and chronic respiratory diseases constitute 50% of the causes of death. And the premature death rate for ages (30 - less than 70 years) (reaches about 300 / 100,000) of the population due to this disease. Additionally, studies have revealed that it accounts for around 50% of the health years lost in society. The early detection system at basic healthcare facilities revealed that 20,000 new instances of hypertension in adults aged 20 and older and 8,000 new cases of high blood sugar in adults aged 40 and

older were each documented yearly. The prevalence rates of smoking, hypertension, and blood lipid levels among adults have all somewhat declined, according to the results of the nationwide surveys. However, rates of diabetes and overweight/obesity are also rising. Particularly among women, there is still a sizable portion of the population that does not lead healthy lives in terms of physical activity and wholesome eating practices. Furthermore, it was shown that 12% of persons who are 18 years of age and older are at risk of cardiovascular disease. Early detection services and accessible healthcare at all levels are top priorities for the Ministry of Health's departments. The social and financial toll that chronic diseases place on society, together with the sustainability of the need for health care, remain significant obstacles. (MOH.2018)

A comprehensive issue like the (Health Promotion services) could improve an outcome because one of primary health care's goals is to increase health quality (WHO.2022).

Health promotion is a "resource for daily life, not the purpose of living," as described by the Ottawa Charter (Wu, Jo & Florin,2021). Health promotion broadly describes the state of one's physiological, psychological, and social well-being. Concerning both the demands for mental health in healthcare services and health policies as well as the individual quality of life, this definition provides a foundation in values for health promotion. (O'Hara & Taylor. 2023)

Integration of health promotion initiatives into clinical practice hasn't always been simple, though. Lack of resources, organizational culture, and subpar design are just a few of the challenges associated with implementing health promotion that have been studied. (Sharma & Sharma 2017)

Health promotion actions help to achieve the main goals of health programs by (Improving individual knowledge and skills via health, education, and information-education-communication (IEC), enhancing community action based on social mobilization, using negotiation and mediation to create supportive and health-protective settings, through advocating and pushing for sensible rules, regulations, and economic and financial restraints that support growth and health, and reorienting health care around consumer requirements and preventative measures). (WHO.2018)

Some of the most important ways to promote health include good nutrition, regular exercise, refraining from harmful behaviors and drugs, protecting oneself from accidents, recognizing disease symptoms early from a physical perspective, exercising self-control with one's feelings, thoughts, and emotions, managing stress, maintaining, and adjusting interpersonal relationships from a social perspective. (Gossage-Worrall, R., Hind, D. *et al*. 2019).

Health promotion services and programs face many obstacles, including (Participants may find it difficult to pay for services or programs due to higher poverty rates, health-related cultural and social norms, limited health literacy, and imperfect health perceptions, disparities in education and linguistics; a lack of accessible public transit, low population density for program economies of scale coverage; unpredictable job hours or unemployment, the accessibility of resources to support staff, successful facility utilization, and program execution, and a lack of options for eating well and exercising). (Silva, K.L. et al. 2014)

The value of quality, the foundation of the healthcare system, is increasing. Quality underpins the ability of the industry to advance and

promote health, which favorably impacts and raises patient satisfaction. In order to produce health, quality necessitates maximizing practitioner competence and material inputs. (Backhouse A, & Ogunlayi F. 2020)

Quality of health is "the extent to which health services for individuals and populations increase the likelihood of desired health outcomes and are congruent with current professional knowledge," according to the Institute of Medicine in Washington. (MD, Kevin & MD, MPH. 2012).

Donabedian used literature on health-related subjects to create the framework for quality evaluation and the proposed approach, which is made up of three essential components:

1. Structure: this entails evaluating the sufficiency of resources, such as structures and equipment, organizational procedures, and the quantity and caliber of medical professionals. (McCullough, Kylie & Andrew. 2022)
2. Process: This refers to adhering to the guidelines for providing high-quality medical care, which includes taking a patient's clinical record, performing a physical assessment, ordering diagnostic procedures, attempting to justify a diagnosis and course of treatment, demonstrating technical proficiency, demonstrating preventative management, coordinating and maintaining care, and making sure the patient is satisfied with the care received. These behaviors, which include altering one's lifestyle, learning about one's health, speaking out for oneself, and advocating, show how well local health professionals perform in various areas. (Besor O, Manor O & Paltiel O, et al. 2020)
3. Outcome: investigates if an individual's current or future health condition can be linked to how they obtained medical care. A further method for evaluating the influence of the healthcare system on population health is to

measure communicable and chronic conditions, as well as health quality. (McCullough, Kylie & Andrew. 2022)

1.2. Importance of the study

Due to policies, wars, and the economic embargo that began in 1990 and lasted until 2003 after the U.S invasion, Iraq is one of the nations that has experienced an extremely high level in chronic and communicable diseases and infant death rate as a result of medical disorders and unfavorable environmental conditions. Wars and political unrest contributed to a worsening and an increase in morbidity and mortality rates. One of Iraq's provinces is Babylon. There are around two million people living in the province, and between 2010 and 2017 there were 12943 fatalities of children under five. Thus, research must be done in this area to provide health officials with the information they need to develop an effective plan for reducing mortality (Hussain, A. & Lafta, R. 2019).

One of the most essential aspects of life is good health because it provides us with resources for daily living. Therefore, the promotion of health plays a significant role in society and all levels and types of decision-making. The ecological perspective on health and health promotion holds that not only do people have a duty, but also communities, society, and its authorities. (Kiran R & David C, et al. 2021)

It has been acknowledged that health promotion is an essential component of health improvement (Nina, S. Rehn.2013). In addition to personal qualities, societal, cultural, and structural factors can also have an impact on one's health on various levels. Hence, a comprehensive strategy for health promotion has been promoted (WHO.2018). In many nations, the discussion of public health and the creation of health policy has been greatly

influenced by this strategy, particularly the Ottawa Charter for Health Promotion (Carrad, A. Parrish AM, et al. 2021). As a result, there is a need for greater information on health promotion that is based on the methods and tenets of the Ottawa Charter.

The Eastern Mediterranean region, which consists of 21 nations, saw a 51% decline in the under-five mortality rate from 102 deaths per 1,000 live births to 50 deaths per 1,000 live births between 1990 and 2017. Although at a slower rate, the neonatal death rate has reduced by 35% since 1990. 458,000 infant deaths occurred in 2017, accounting for more than 54% of all deaths of children under the age of five.

Regarding the Sustainable Development Goals, by the end of 2017, seven of the 22 countries in the Region had under-five mortality rates that were higher than the global target for 2030 (25 deaths/1,000 live births), while eight countries had neonatal mortality rates that were higher than the global target for 2030 (12 deaths per 1000 live births). The top four causes of infant deaths were prematurity (21%), pneumonia (15%), obstetric issues (13%), and neonatal sepsis (9%). Pneumonia, diarrhea, and infections are still the main causes of death among kids under five years of age. Humanitarian crises are one of the main causes of the region's chronically high baby and child mortality rates, which account for the highest incidence of neonatal fatalities globally. (MOH. 2018)

Almost one-fifth of the people in the Area are teenagers (129 million). The region's low- and middle-income nations have the second-highest adolescent mortality rate in the world—115 fatalities per 100 000 people. Group violence, legal interference, drowning, lower respiratory diseases, and interpersonal violence are the top five causes of death for teenagers. Group

violence and legal interference, iron deficiency anemia, traffic accidents, depressive disorders, and childhood behavioral problems are the top five factors contributing to lost disability-adjusted life years in teenagers. (Yarifard, K. & Tajvar, M. 2022)

The number of fatalities from traffic accidents worldwide is the third highest in the Eastern Mediterranean Region (18 deaths per 100,000 inhabitants). The majority of deaths occur in middle-income nations, whereas the overall death rate in high-income nations is three times that of comparable nations globally. The two demographic groups most impacted by crashes are men and small children. (Yarifard, K. & Tajvar, M. 2022)

In times of crisis, the region's second-worst (37%) prevalence of violence against women is made worse. In 2018, aid was provided to countries to assist them in enhancing how their health systems respond to gender-based violence in both routine and emergencies. Assistance was also provided for the development of action plans in Egypt, Jordan, Morocco, Pakistan, Sudan, Tunisia, and the United Arab Emirates as part of the WHO's global drive to integrate gender-based violence into health response in emergencies. Furthermore, helped were Afghanistan, Iraq, and the Syrian Arab Republic. (WHO. 2018)

Over 100 million individuals live in the Eastern Mediterranean region who are disabled, according to the estimates provided by the World Health Organization, which indicates that 15% of the population has a disability of some kind. According to statistics, the prevalence rates of disability in the Region's nations vary from 0.4% to 4.9%. There are approximately 4.9 million blind people, 18.6 million people with low vision, 23.5 million people who are visually impaired, and 10.7 million people who suffer from hearing

loss that prevents them from working. The Middle East and North Africa accounted for 3% of all seniors with severe hearing loss. (Ayoub, J. & Al Jawaldeh, A. 2022)

A fundamental concern for enhancing health and maintaining the quality of life is health promotion. To guarantee the caliber of services offered in the field of health promotion activities, primary healthcare clinics must-have criteria for health promotion. Additionally, the current study attempts to evaluate the quality assurance of "Health Promotion services" in PHCCs in the southern of Babylon governorate based on the findings of earlier studies and statistics that have been made public. This assessment concentrates on requirements for the organizational structure, medical professionals, and clients in order to examine the quality assurance of the Health Promotion activities.

1.3. Statement of the study

“Quality Assurance for Health Promotion Services in Primary Health Care Centers”

1.4. Objectivess of the study:

This study's objectives are to:

1. Assess the quality assurance for health promotion services in primary health care centers.
2. Identify relationship between job performance of health workers’ and theirs socio-demographical data.
3. Assess customers’ satisfaction toward health promotion services in primary health care centers.
4. identify the relationship between customers’ satisfaction and their characteristics.

4. Find out the relationship between structure, job performance of health worker and customers' satisfaction.

1.5. Definition term

1.5.1. Quality assurance (QA)

1.5.1.a. Theoretical definition

Quality assurance is an essential mechanism for ensuring reliable data collection and maintaining confidence. (Kuhring et al.,2020).

1.5.1.b. Operational definition

The degree to which quality of health promotion services that can be obtained as a result of an evaluation of quality services, components of the structure, and health workers competency in implementing of the programs and strategies at primary health care level, and the customers' satisfaction.

1.5.2. Health promotion

1.5.2.a. Theoretical definition

A method of giving people more control over their health and helping them get healthier. (O'Hara & Taylor. 2023)

1.5.2.b. Operational definition

Its implementation of preventive and improvemental strategies increases the quality of life of all groups in the community.

Chapter Two
Review of Literature

Chapter Two

Review of Literature

This chapter reviews the relevant literature on the evaluation of quality assurance of health promotion services.

2.1. History and Overview

In 1945, the term (Health promotion) was first used by (Swedishman Henry E. Sigerist). By improving a person's living, working, and physical environments as well as their education and leisure, is described as ensuring their health. It is a planned, system-wide effort that touches on a person's life (Annapuranam, K. 2020).

Concern for the maintenance and improvement of public health has a long history. When discussing the origins of health promotion as an organized field, most people point to the 1974 publication of A new perspective on the health of Canadians by (Marc Lalonde, Canada's) health minister at the time. It was the first time that health promotion was specifically included in a national government policy statement (Chiu, C. & Chang, E. Y. 2020). As interest in health promotion grew, the first global conference was held in (Ottawa, Canada, in 1986). The attendees at the meeting all agreed on the Ottawa Charter of Health Promotion, a document whose beliefs and tactics have guided much of the growth of health promotion across the world (Kumar, S., & Preetha, G. 2012).

As the need for a worldwide public health organization developed, Ottawa hosted the initial international conferences on Health Promotion in

1986. Many programs were begun by worldwide organizations, governments, and local societies in the direction to achieve this goal by the year 2000 and beyond. The (Ottawa Charter) outlined three key health improvement strategies to rise the variables that support health: mediate, facilitate, and advocate (through collaboration across all sectors). (WHO,2023)

Since then, the WHO Global Health Promotion Conferences have established and developed the global principles and action areas for health promotion. Most recently, the 9th global conference (Shanghai 2016), titled 'Promoting health in the Sustainable Development Goals: Health for all and all for health', highlighted the critical links between promoting health and the 2030 Agenda for Sustainable Development. Whilst calling for bold political interventions to accelerate country action on the SDGs, the Shanghai Declaration provides a framework through which governments can utilize the transformational potential of health promotion. (WHO,2017)

The early 1920s of the 20th century marked the beginning of the history of the Iraqi health system. In the 1970s and the beginning of the 1980s, Iraq saw improvements in a number of important health outcomes. The healthcare system is inefficient, and access is unequal. It is a capital-intensive, hospital-oriented model that depends heavily on imported drugs, medical supplies, and even healthcare employees. Although the system functioned rather well, not much information about health services was gathered. As a result, services only partially met population health needs and there were few cost-effective public health strategies. The levels and distribution of the human resources for health that are still available are

insufficient (WHO.2016). Iraq's healthcare system is largely controlled and receives a set amount of government funds each year. According to the World Health Organization, there are 1,145 primary health clinics run by middle-level staff and 1,185 medical facilities. In total, there are 229 hospitals, 61 of which are academic institutions. The World Bank reports that over the past ten years, government spending on healthcare has soared: expenditures were 2.7% of GDP in 2003, but by 2010, they had increased to 8.4%. (WHO.2018).

2.2. Quality Assurance

Quality assurance (QA) Identifying areas for improvement, understanding and interpreting data, planning and making changes, and tracking performance over time. External supports are characterized as a variety of technical assistance, learning activities, and tools and resources supplied by entities outside of the practice that can help practices with QI (Taylor et al., 2014).

The Standards of quality assurance provide a set of measures that can be applied across services and settings and used as a quality assurance mechanism for providers to test whether minimum standards are met as a quality improvement mechanism. Health care standards are developed to support efforts in maintaining and improving the quality of healthcare. (Schweppenstedde et al., 2014)

2.3. Defining Quality of Care

There are many definitions of quality of care, but the Institute of Medicine (IOM) has proposed one that captures well the features of many

other definitions which received wide acceptance is “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” (Institute of Medicine, 2001), this definition does not provide much guidance to a researcher interested in developing a measure or set of measures. A subsequent IOM report specified seven aims of a high quality medical care system that are more specific:

- Safe – avoiding injuries to patients from the care that is supposed to help them.
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- Patient-centered – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient – avoiding waste, in particular waste of equipment, supplies, ideas, and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status. (Rockville. MD, 2022)

2.4. Quality of Care Measures

there are multiple approaches to measuring different aspects of quality of care. One of the first comprehensive works that focused on quality of care was published in a series of three books by Avedis Donabedian. A subsequent article (Donabedian, 1965) summarized that work. Donabedian proposed that one could assess whether high quality care is provided by examining the structure of the setting in which care is provided, by measuring the actual process of care, and/or by assessing what the outcomes of care are. (Berwick, D., & Fox, D. M. 2016).

Structure refers to the characteristics of the setting in which care takes place. Measures of the setting used might include characteristics of: Physicians and hospitals (e.g., a physician's specialty or the ownership of a hospital); Personnel; and/or, Policies related to care delivery. (Ameh, S., *et al*. 2017)

Increasingly, view structure as not just the way clinics and hospitals are organized and operated, but by the policies they have in place that affect care quality. For example, processes for monitoring and promoting quality, incentives for high quality care, etc. can have an influence on how well care is delivered. A motivation for focusing on structure is the premise that the setting can be a strong determinant of care quality and given the proper system, good care will follow. For example, one would expect care to be of higher quality when all staff are clear about their roles and responsibilities, when there are strategies for monitoring adherence to recommended

procedures, and there are systematic approaches to continuously improving care quality. (Cheng, E. M., *et al* .2014).

Process measures assess whether a patient received what is known to be good care. They can refer to anything that is done as part of the encounter between a physician or another health care professional and a patient, including interpersonal processes, such as providing information and emotional support, as well as involving patients in decisions in a way that is consistent with their preferences. (Lilford, R. J., Brown, C. A., & Nicholl, J. 2007).

Outcomes refer to a patient's health status or change in health status (e.g., an improvement in symptoms or mobility) resulting from the medical care received. This includes intended outcomes, such as the relief of pain and unintended outcomes, such as complications. Although the term outcomes is sometimes used loosely to refer to results such as mammography rates, such measures are actually process measures in the Donabedian sense. There is also a category of measurement called intermediate outcomes. This includes measures like Hemoglobin A1c levels for people with diabetes and blood pressure measurements. These intermediate outcomes are often closely related to other health outcomes. (Pantaleon L. 2019)

2.4.1. Structure Measures

Probably the main advantage and attractiveness of structure measures is that they are concrete and usually easy to assess. For example, it is relatively easy to determine whether an intensive care unit has a specialty physician available 24 hours a day or if a health plan provides incentives to

physicians who meet high standards of care, the training of physicians, whether a clinic specializes in particular types of care (Wilson, IB., et al., 2015), or the number of procedures performed per year.

Structural characteristics that did not receive a great deal of attention when Donabedian did his important research include organizational culture, including to the priority that a clinic or hospital gives to quality as well as leadership, policies and procedures for maximizing the quality of care. The main disadvantage of such measures is that often the association between structure and process and/or structure and outcome are not well-established and developing evidence for such associations is difficult. One of the reasons for this is that the link between structure and process or outcome measures of quality are often very complex and consequently. Another weakness is that the most accessible structural variables often lack specificity. For example, one can relatively easily determine if a person is board certified in infectious diseases but it is much harder to develop a measure of the quality of that training or the extent to which the physician uses that knowledge or skills (Office of Behavioral & social sciences. 2023)

2.4.2. Process measures

Process measures attempt to answer the question “Did this patient receive the right care,” or “what percent of the time did patients of this type receive the right care?” Such measures are typically developed based on the known relationship between a process and outcomes. For example if one was examining the quality of care received by a patient with diabetes, one might assess whether the patient had undergone an annual funduscopic examination

by an ophthalmologist or whether the patient's feet were professionally examined annually. Such measures are used because research has demonstrated a link between those processes and important outcomes, such as retinopathy or foot amputations. A nurse or medical-record technician trained in quality assessment could compare what was done to what should have been done, and the result would be expressed as the proportion of times that the criteria were met. (Lucyk K & McLaren L. 2017)

Such measures or criteria are typically developed by first identifying the condition of interest, and then synthesizing research evidence to create evidence-based guidelines for clinical care. Once one has identified the part of the medical care process that will be used, one defines patients who are eligible to receive care on the basis of guideline, create criterion to determine which patients received care in accordance with guideline, and divide number who received care in compliance with guideline by number of patients eligible to receive care (Rosenbaum E & Grossmeier J, et al. 2020)

Researchers increasingly are recognizing that it is not adequate to simply assess individual processes of care, but rather groups or processes, or "bundles" of activities that need to occur to lead to a better outcome. For example, researchers attempting to prevent catheter related bloodstream infections learned from prior research that multiple activities, such as hand washing, full barrier precautions, skin antisepsis with chlorhexidine, avoiding the femoral site during catheter insertion, and removing unnecessary catheters are all necessary to achieve the best outcomes (Lipitz-Snyderman, et al., 2011). Similarly, interventions to prevent ventilator associated pneumonia included a mechanical ventilator "bundle" consisting

of use of semi recumbent positioning, daily interruption of sedation infusions, and prophylaxis for peptic ulcer disease and deep venous thrombosis (Berenholtz, et al., 2011).

Even when there are data supporting the appropriateness and effectiveness of a process or procedure, there often is more than one evidence-supported way to treat a condition. Frequently, for example, different approaches to treatment (e.g. radiation, versus surgery for prostate cancer) are developed and thought to be best by physicians in different specialties. This situation has given rise to a field of research referred to as comparative effectiveness research. It is also important to recognize that for many treatments that are "preference sensitive" whether or not a particular treatment or procedure is appropriate depends on patient (Sepucha & Mulley Jr, 2019)

Sometimes, processes of care are too complicated for completely explicit criteria. For example, determining when a problem occurred or when an adverse event was preventable, may require some clinical judgment. Such measures tend to be less reliable and usually provide less compelling evidence than measures with a strong research base, however. Even with the most careful protocols, there inevitably are many sources of variation in the way implicit criteria are implemented. (Sullivan, et al., 2017)

Some of the advantages of process measures are that they are very specific, understandable to patients and providers, and in many cases can be easier than outcomes to measure. They also answer the intuitive question a provider might have: "am I doing the right thing for a patient? A related

strength is that they are actionable because they indicate what should be changed. They also can be used to make inferences about individual providers. Disadvantages of process measures include the fact that we do not know how many processes of care are related to outcomes. Another shortcoming is related to the fact that sometimes hundreds, if not thousands of things are done in the course of caring for a patient with a complicated condition and it is difficult to develop and use enough measures to form a comprehensive assessment. (Mihic J, Novak M, et al. 2015)

2.4.3. Outcome Measures

There is a long history of using outcomes to assess care quality. The use of outcome data to evaluate health care dates back more than 150 years. In the 1830s, a physician named Pierre- Charles-Alexandre Louis started a group in Paris that discussed the use of statistics to examine patterns of medical care and outcomes. In 1838, a physician from that group named George Norris returned to the United States and examined the survival of patients who had an amputation. In subsequent work Norris compared surgery outcomes at the Pennsylvania Hospital with those of hospitals in other cities and counties. During the same period, Florence Nightingale developed innovative ways of presenting statistics to illustrate seasonal variations in patient mortality in the military field hospital she managed. She later used similar techniques to describe the conditions of medical care in the Crimean War (Bostridge, 2018).

To use medical outcomes as a quality measure, one must usually calculate rates of certain outcomes for a group of patients since outcomes are

determined by many factors and thus one usually assesses whether the probability of death, for example is higher or lower for one group compared to another. One could also develop explicit a priori criteria to determine whether the observed results of care are consistent with the outcome predicted by a model that has been validated on the basis of scientific evidence (Pantaleon L. 2019). For example, one might assess if the population of patients with diabetes and specific clinical characteristics are better or worse than expected.

Outcomes now have been incorporated into a broad range of health care activities. Physicians providing clinical care routinely ask patients about outcomes to guide their therapy. In clinical research, patients' outcomes provide a measure of the effectiveness of different medical interventions. Outcome measures also have been used in health care organizations and systems to assess quality and guide efforts to improve it. (Ofili OU. 2014)

Over the past decade there have been an increasing number of efforts to release information on patients' outcomes publicly. There also have been attempts to provide outcome data on health plans. For example, the National Committee for Quality Assurance (NCQA) reports rates of low birth weight and hospitalization rates for patients with asthma. Most of the efforts to monitor and/or report outcomes systematically have focused on mortality or other outcomes such as in-hospital complications, and physiologic function. However, such measures do not adequately reflect the full range of variations in health affected by care that are important to individuals. It is also important to measure the impact of medical and surgical care on symptoms, functioning, and emotional well-being. (Mohamed EY, et al. 2015)

2.5. Health promotion.

Health promotion, according to the Ottawa Charter, is the process of empowering individuals to enhance control over and improve their health. From here, new definitions have been proposed. The definition of empowerment is the process of empowering individuals to increase control over the determinants of health and consequently improve their health. The method through which individuals and communities are given more power over the factors that affect their health, leading to an improvement in that health, as described by (Inkoom, L., Ansu-Mensah, M., Bawontuo, V. et al. 2022). According to the Bangkok Charter (Muraille, Eric. 2021), health promotion is the process of giving people more autonomy over their health and its determinants in order to improve their health. Not all interpretations are provided here. Rootman and colleagues discovered that although they differ, they all have three characteristics: an emphasis on bettering overall health or wellbeing, individual and/or environmental objectives, and procedures or activities. (Pederson, Ann & Rootman, Irving. 2017)

However, the definition offered by the Ottawa Charter (Wu, Jo & Florin, Oprescu. 2021), which is often mentioned in professional and scholarly literature, has drawn particular attention. The ideas and actions specified in the charter have influenced the national frameworks and policies of many countries.

2.6. Factors Influencing Health

Making plans to counteract potential health hazards is one strategy to improve wellness and reduce the incidence of disease. Risk and protective

variables have a direct impact on an individual's health and sickness outcomes because of health determinants (Baum F, Fisher M. 2014). Health determinants, risk factors, and protective factors are all phrases that can often be used interchangeably, which can lead to confusion. The following factors may have an impact on a person's physical and mental health, it can be divided to two types:

2.6.1. External factors

In terms of socioeconomic status (SES), If the person doesn't have any money, or if don't have enough money, his health suffers. Health problems often go untreated because of a lack of money and access to care caused by poverty. Stable job and a positive work environment are beneficial to one's well-being. Conditions in the Real World Reducing pollution in the air, water, and at the source, getting rid of hazardous waste, providing safe housing, and bolstering community security are all positive for people's health. People are better able to cope with disease when they have support from family, friends, and the community. Having access to high-quality medical treatment is crucial to improving and sustaining one's health. To put it simply, the health of individuals, their families, and their communities is impacted by government policies. Some examples of such efforts are gun control legislation, vaccines, and programs to discourage smoking. Besides genes, environmental factors also play a role in determining one's health, and this includes one's family's medical and health records. Signs, symptoms, and prognosis vary depending on the illness kind and other biological factors. The health of a kid later in life is greatly influenced by their prenatal and early childhood environments. Socioeconomic reasons, financial inequality, and

difficulties gaining access to healthcare all contribute to disproportionately high incidence of sickness among members of racial and ethnic minorities. (Public Health Agency of Canada. 2010).

2.6.2. Internal factors

Genotype; Inherited genetic composition influences health and disease susceptibility. A person's ability to make healthy decisions and gain access to high-quality medical treatment is greatly improved by their level of education. An individual's health is influenced by their level of health literacy, or their ability to find, read, comprehend, and use health information. Signs, symptoms, and prognosis vary depending on the illness kind and other biological factors. Gender; There are significant health disparities between the sexes, including a shorter life expectancy for males and greater sickness rates for women. People's health is affected by a variety of cultural factors, including beliefs and behaviors towards health and sickness. (Andayani, Sri & Pudjibudojo, Jatie & Tjahjono, Evy. 2021).

Researchers have come a long way in reducing the prevalence of sickness over the 20th and 21st centuries. Many people now have longer life spans and better health than previous generations. This improvement in longevity and quality of life is not the result of advancements in medicine, but rather, illness prevention, according to the Office of Disease Prevention and Health Promotion (2015). (Taylor J, O'Hara L, 2021)

When it comes to avoiding illness, health promotion is the first line of defense. To enhance one's health, health promotion is defined as the process of enabling people to increase control over their health and its determinants. According to this concept, health promotion takes into account both the

individual and their environment. (International Union for Health Promotion and Education. 2016)

Health promotion consists of two interrelated components: (a) health education; and (b) environmental initiatives that encourage healthy lives. Education on health is essential to promoting health in every population. The discipline of health education is highly specialized, employing carefully thought-out methods informed by pedagogical philosophies. It allows people of all ages and backgrounds to have access to the resources they need to make educated decisions and acquire the skills they can put into practice. Primary, secondary, and tertiary levels of care are all places where health promotion methods are implemented (Gregg J, O'Hara L. 2017).

Diseases can be avoided entirely by primary preventive measures. The aim of these policies is to encourage and support healthy lifestyles. Efforts made to mitigate a disease's predisposing circumstances are classified as primary prevention. Vaccinations, smoke-free work environments, and prenatal care are just a few examples. The goal of secondary preventative measures is to slow the progression of an existing illness. These methods are employed once a person has been exposed to a disease or is in danger of contracting it. Early illness detection tests are one such instance. People with an illness or risk factors for disease are identified via screenings. (Boyd RC, Castro FG & *et al*. 2022)

2.7. Approaches to health promotion

Health promotion, as defined by (Rootman et al. 2017), includes a wide variety of interventions targeted at bettering people's health and the health of their communities. Whilst health professionals may have different

perspectives on the scope of health and health promotion, there is consensus on the significance of values like participation and empowerment (Pederson, Ann & Rootman, Irving. 2017).

The various approaches can be thought of in terms of their content (such as drug use, physical activity, nutrition, mental health, and healthy and safe environments), target audience (such as population strategy, risk-group strategy, or a specific age group), context (such as an environment or policy segment), and working methods and practices (such as political influence, community action, preventive service practices, and cooperation). Starting with the definition given above, we can say that a comprehensive health promotion strategy uses a variety of population-based approaches or working methods to address multiple behaviors or contents (such as tobacco use, physical inactivity, and mental health) among multiple target populations in multiple community locations or contexts (such as schools, workplaces, healthcare facilities). The term general health promotion has also been used to refer to initiatives designed to enhance public health by addressing a range of social and behavioral issues, such as alcohol use, poor food, inactivity, and psychological discomfort (McLaren L, Masuda J, et al. 2020).

Although focusing on various demographic groups is somewhat studied, the level of actors and the actual content of health promotion are where the present research places its main attention. The notion of health promotion activities is similar to universal health promotion, another characteristic of health promotion principles, and intersectoral cooperation and community participation are seen as factors facilitating health promotion activity. The research is located within the setting of municipalities, to be

more explicit. As a consequence, in the next section, we'll explore the importance of health promotion. (Powell K, Thurston M, 2017)

However, the definition offered by the Ottawa Charter, which is often mentioned in professional and scholarly literature, has drawn particular attention. The ideas and actions specified in the charter have influenced the national frameworks and policies of many countries. The Ottawa Charter shifted the emphasis of health promotion from an individual, disease-oriented, and behavioural model to the determinants of health at numerous societal levels and in a variety of contexts. (de Gruchy J. 2019)

2.8. Health promotion strategies and enabling factors

The Ottawa Charter lays forth a number of methods for improving public health, and this research examines three of them in particular: bolstering community action, reorienting health systems, and constructing healthy public policy. To do this, it examines individuals who serve as symbols of community organizing, medical care delivery, and public policy in their respective localities. We're talking about PHC workers, and city council members all at the local level. The substance of the various actors' health promotion acts includes the approach of building supportive surroundings. It is widely accepted that the approach of building one's own capabilities is the bedrock of taking charge of one's own health and well-being. While this aspect of health promotion has not been formally investigated, it is generally thought to be a fundamental strategy for many of the involved parties, particularly PHC workers. (Weaver GM, Mendenhall BN, et al. 2018)

2.8.1. Enhancing communal activity

"Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies, and implementing them to achieve better health. At the heart of the process is the empowerment of communities, their ownership, and control of their own endeavors and destinies" (Ottawa Charter, WHO 1986)

Increasing communal activities may help to improve local health in several ways. We previously established that partnerships, community involvement, and community empowerment are crucial components of health promotion, and that cooperative community efforts are required to develop the determinants of health via partnerships. Communities used to be primarily thought of as sites from which to effect broad behavioral changes in health. According to the current paradigm in health promotion, communities are considered as dynamic systems with strengths and capabilities that may be transformed and supported to improve the health of their members (Baum F. 2011). Community involvement and self-determination are emphasized in WHO health promotion activities as essential components of health. The dynamics of community participation may be examined via the prism of local non-profits. (Robinson M, Smith JA. 2022)

According to the Jakarta Charter 1997 (WHO, 2023), establishing cooperation between the various societal sectors, including non-governmental, governmental, public, and private organizations, will be one of the biggest challenges in the coming years in order to release the resources for health promotion that are kept in these institutions. The Bangkok Charter

emphasizes that communities and civil society are responsible for developing and implementing measures for health promotion. One factor contributing to the effectiveness of community involvement is that an individual's behaviour is influenced by the patterns of behaviour, norms, and attitudes in their living area, as the rainbow depiction of health determinants illustrates (Nina, S.Rehn. 2013). According to (Blomfield & Cayton, 2010), the reason why many community interventions are unproductive is because they don't try to engage with communities on a deeper level or organize them for action as a group. They think that communities need to be co-producers of health care. There are several predisposing circumstances that make health promotion activities easier; Adequate understanding of social structures and health-related issues, as well as the necessary knowledge, abilities, and prior success in engaging in community participation; an environment that accepts and encourages active community engagement; a sociocultural and political setting that encourages public awareness on an individual and collective level, knowledge acquisition, and discussion of issues and problems affecting individual and community well-being. (McPhail-Bell K, Bond C, et al. 2015)

One approach to think about a community's inclination to act in favor of its own health promotion is via its capacity, which is generally acknowledged as a crucial factor in the accomplishment of such initiatives. Community capacity is the ability of a community to identify, mobilize, and address social and public health issues. Community capacity includes participation, leadership, skills, resources, values, social and interorganizational networks, community power, critical reflection, a sense of community, and knowledge of the community's past. (Barnfield A, et al. 2020)

The concepts of individual and group effectiveness are also included in Bandura's social cognitive theory even though they originate from a separate field. In light of Bandura's theory and the extension of the concept of personal agency to collective agency, it is fascinating to investigate the potential role that people's beliefs in their collective efficacy to accomplish social change may play as a predictor of health promotion activities. (Jancey J, Barnett L, et al. 2016)

According to (Raeburn and colleagues, 2012), health promotion in a global society is increasingly reliant on policy and regulation, but it still largely depends on the inner layer characteristics of communities and individuals. The authors believe that building community capacity is a bottom-up, empowering approach to health promotion as opposed to a top-down, deficit-focused approach. This larger umbrella phrase includes concepts like participation, social capital, social networks, civil society, and nongovernmental organizations. They also stress that the process of establishing community capacity is primarily one that is controlled by the people, who choose specialists in the methods they see most useful and suitable. They conclude from their research that health promotion may need independent community effort in an environment with supportive policies and cooperating major stakeholders, even in a global society. In order to address community engagement in health promotion, the present research investigates the function of local volunteer organizations, their resources, and the variables that influence their participation in health promotion activities.

2.8.2. Refocusing health services

"The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components." (Ottawa Charter, WHO 1986)

The Ottawa Charter's action plan to reorient health care has gotten the least systematic attention. The goals of this approach were to strike a healthier middle ground between prevention and treatment, and to place a stronger emphasis on both population and individual health outcomes. (Wise & Nutbeam, 2017) propose two primary explanations for the lack of interest in this tactic:

1) The health services' role in addressing the social and environmental determinants of health has been largely overlooked in health promotion.

2) In the health care industry, political and public emphasis has been focused on the price, accessibility, and availability of tertiary services.

Hospitals and modern health services in general should be reoriented, according to the European World Health Organization (WHO) network for Health Promoting Hospitals (HPH) (Yaghoubi, M., Javadi, M., et al. 2016). The four pillars on which the WHO HPH movement is based are promoting patient health, staff health, a focus on health promotion in the workplace, and community health in the catchment area. (Johnson & Baum, 2011) emphasize the significance of teamwork in this context, contending that in order for

health care institutions to create settings that promote community health and improve patient care, they must cooperate with patients, families, other service providers, and the general public. However, the implementation of changes that penetrate the whole organization and its culture, and by extension, all health professionals, seems to be necessary for HPH programs to succeed.

Additionally, according to (Whitehead ,2014), health services as a whole need to change their emphasis to public health, which calls on health professionals to focus on the larger determinants of health in their job. The great majority of participants in a recent study of Swedish medical professionals said that health services may have a significant impact on improving public health (Nina, S.Rehn. 2013). Additionally, the study found broad consensus that a health-focused approach is required for effective healthcare. Despite the fact that the majority of respondents believed the whole health service was accountable, almost half of respondents said PHC was mainly in charge of disease prevention and promotion.

It indicates that health services in the majority of countries need to expand health promotion and disease prevention measures in order to improve population health outcomes. Additionally, it seems that primary healthcare's health promotion policy goals are not being reached. According to empirical study, personal characteristics including gender, age, specialty, self-perceived health status, critical reflection, knowledge and skills, and attitudes and beliefs may have an impact on the delivery of health promotion and preventive services (Fry D.2019). While physicians may understand the significance of their role in preventing lifestyle-related disease, the research

by (Jacobsen et al. 2015) shows that many have concerns about the effectiveness of intervention and moral hesitations about offering patients lifestyle counselling. Practice nurses were more likely to take part in self-organized health promotion activities than were health visitors in group and community-wide activities, according to research. Although their work is centered on the wellbeing of the person, midwives appear to place a premium on community-based strategies for health promotion. Health care workers at PHCs have reported a greater readiness to include health promotion and disease prevention into their job than hospital workers have, with women reporting a greater willingness than males.

(Alderwick, H., Hutchings, A., *et al*. 2021). argue that in order to address the current state of health, the workforce must have a holistic perspective on public health, the capacity to collaborate across sectors, and the knowledge and experience to influence policymakers. It is therefore necessary to invest in training for the workforce. The necessity to increase an organization's institutional capacity in addition to its human resources is stressed by advocates of capacity building, a more recent subject of interest in the literature on health promotion. Similar to this, (Hogg, *et al*. 2009) emphasize the importance of organizational structures, emphasizing the need for those that support the practice of health promotion if the organization's strategy is to improve in this area. Empirical study shows a favorable correlation between organizational factors and initiatives to promote health. Health promotion is hampered by time and work constraints, a lack of staff, financial incentives, a lack of focus on treatment continuity, inconsistent advice, a lack of guidelines, and vague objectives. According to a recent Canadian research, staff members at community health centers are more

likely to engage in health promotion activities than those at other kinds of primary care institutions. At community health centers, there are more female primary care doctors, more registered nurses, longer wait times for appointments, and smaller panel sizes. (Joffres et al. 2004) include partnerships, general organizational interest, and support from management and boards/municipal councils as features that make health promotion simpler to execute in different kinds of organizations. On the other hand, (Robinson et al. 2022) found that although insufficient motivation and competing priorities were among the main impediments to health promotion activities, committed and well trained staff were the key enablers. (Tamanal, J. M., & Kim, C. H. 2020) assert that by placing a high priority on health, businesses may promote a culture that promotes illness prevention and highlights the importance of leading a healthy lifestyle. (Benson and Latter. 1998) emphasized the requirement for nurses to feel empowered in order to empower others and emphasized the significance of organizational culture or philosophy as a factor in nursing practice. Similar to this, health professionals who have never assisted emancipatory processes in their own work cannot be expected to do so, according to (Germann and Wilson. 2004). Last but not least, (Robinson et al. 2022) propose that outside factors including partnerships and cooperation, demographics, and the political climate may have an impact on health promotion initiatives in diverse organizations. The entire scale of the issue is yet unknown, however, due to the paucity of research on the precise components of health-service organizations and the environments in which they operate that support health promotion initiatives.

2.8.3. Creating effective public policies

"Health promotion goes beyond health care. It puts health on the agenda of policymakers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health." (Ottawa Charter, WHO 1986)

The goal of healthy public policy is to provide an environment where individuals may make healthy choices and improve their health, making it a major tactic in health promotion (WHO 2023). This strategy's significance has been emphasized on several occasions, since it creates the conditions necessary for the success of other methods. The importance of political commitment to health promotion's growth and success has been highlighted in recent overviews of health promotion initiatives. To rephrase, politicians and policymakers need to make health a priority. Due to its focus on the importance of health to national economies, the modern health in all policies approach is comparable to the agenda of healthy public policy making and is seen as the third policy wave of horizontal health governance.

Central to health promotion is the policy issue of community empowerment and involvement, which is intimately tied to the more general issues of the determinants of health and the function of local government in these matters. It is generally acknowledged that citizen participation is crucial for the creation of successful public policy. This is particularly important at the municipal level, where people' knowledge and opinions are most important in formulating solid public policy, according to (Dubowitz T, Orleans T, et al. 2016). Community participation requires the support of the political and administrative system to be effective and long-lasting at the local level, according to (Ricciardelli, A. 2018). Additionally, it has been said

that the federal and state governments of Finland foster a climate that allows NGOs to prosper.

Although many policy decisions in Europe are made at the European or even global level, the duty for implementing many other policy decisions still falls on the national and local levels in reality. Given this, it is imperative that all levels of government give the development of solid public policy top priority (Amaro H. 2017). Local government is essential in creating an environment that is favorable to health promotion in line with its mandate since the measures need a variety of strategies and actions on several levels and in numerous sectors. The development of healthy public policy, or policy for health promotion, does, however, still seem to be hampered, and it has been suggested that these hindrances may be attributed to the political and administrative institutions. Very little study has been done to look at how politics affects health policy, despite the fact that a lot of research has been done on the factors that contribute to health and sickness and how to address them. Given their crucial influence on the development of the profession, there are also compelling reasons to concentrate study on politicians' viewpoints on health promotion. (Santinha, Gonçalo, & et al. 2023)

2.8.4. Change of behavior

The Whys and Wherefores of health habit adoption are the subjects of several behavioral change theories. The factors that lead up to healthy habits are often the focus of these ideas. Self-efficacy and motivation are central to many of these beliefs. A person's self-efficacy is their confidence in their ability to complete a task, such as adopting a healthier lifestyle, based on their prior experiences with that task. It is believed that a person's level of self-

efficacy may be used as a predictor of how much effort they would put out to effect change. (Duckworth, A. L., & Gross, J. J. 2020)

Several theories of behavioral change have been criticized for placing too much emphasis on the person. Without taking into account things like the surrounding environment, social norms, economic concerns, or government regulations. Limits like exposure to violence, political unrest, and poor sanitation are disregarded in favor of studying how people's minds work. (Bicchieri C. 2016)

2.9. Previous Studies

2.9.1. First Study

A study was done by Mahasin A Altaha *et al.,* (2017). A cross sectional study design was employed to assess the quality of primary healthcare with respect to structure, consumer and care provider satisfaction, involving 600 clients and 150 care providers in Al Ramadi, West of Iraq from October 2012 to February2013. Structure was assessed by observation of available items and comparing them with a checklist of standards recommended by the Ministry of Health for PHC centers. Data were also collected using an interview questionnaire for clients and self-administered questionnaire for care providers. The study conclude that the quality of care was regarded as generally acceptable in terms of structure but with marked deficiency in human resources, and moderate deficiency of equipment and supplies. On the other hand, it was below average as perceived by clients and care providers.

2.9.2. Second Study

A study conducted by Basima J. Jasim. (2018). A descriptive design, using the evaluation approach, is study to Evaluation of quality of primary care services at primary health care centers in Baghdad City and to compare between these primary health care centers relative to such quality. A multistage probability sample of (36) health care centers was selected. The sample consists of (12) model centers, (12) urban centers, and (12) rural centers. A constructed questionnaire is composed of (23) items. It consisted of (5) parts that include intangible (5) items, reliability (5) items, response (4) items, emphasis and confidence (4) items and sympathy (5) items. Validity and reliability of the questionnaire are determined through pilot study. Data are collected through the use of the questionnaire and the interview technique as a means of data collection. Data are analyzed through the application of descriptive statistical data analysis approach of frequency, percentage, mean, range and total scores and inferential statistical data analysis approach of analysis of variance (ANOVA). Findings of the study indicate that the primary health care services at most of the primary health care centers have high quality and there is no difference between the primary health care centers based on such quality.

2.9.3. Third Study

A study carried out by Mohammed K. Mansur. (2020). A descriptive study, using the evaluation and comparative approaches, is conducted to evaluate health promotion program for the prevention of epidemics at primary health care centers in Baghdad city from October 15th 2019 through March 1st 2020. A purposive, non-probability, sample of (42) health promotion unit

officers were recruited from the same number of primary health care centers which were divided into (14) main, (14) sub and (14) family medicine primary health care centers in Baghdad City. Interview schedule instrument is constructed for the purpose of the study. Such instrument is comprised of (2) parts; Demographic information sheet and evaluation of health promotion program. Content validity and internal consistency reliability are determined the study instrument through pilot study. Data were collected through the use of the study instrument and the application of the interview technique as means of data collection. Data were analyzed through the application of descriptive statistical data analysis approach of frequency, percentage, total scores, ranges and mean and inferential statistical data analysis approach of analysis of variance. The study results indicate that the family medicine primary health care centers have implemented the health promotion program more sufficiently and effectively than main and sub primary health care centers.

2.9.4. Fourth Study

A study conducted by Huda S. Juma (2022). a descriptive study methodology was used. employed to evaluate the quality of primary healthcare concerning structure, process, and consumer satisfaction, involving (60) consumers and (10) main primary health care in Basra city for the period of October 15th, 2021 through May 1st, 2022. Non-probability “convenient” sample of (10) primary health care centers; A constructed questionnaire is composed of (71) items Structure (25) items, process (24) items, and the outcome (22) items were assessed by observation of available items and comparing them with a checklist of standards recommended by the

Ministry of Health for PHC centers. The validity and reliability of the questionnaire are established through the use of a preliminary pilot study. Data Collection is an important part of every project. The information has been gathered through the use of a questionnaire and the interview technique. Analyze the data. Through the use of a descriptive statistical data analysis technique based on frequency, percentage, mean, range, and total scores, as well as an inferential statistical data analysis strategy based on correlation and regression analysis. Findings of the study indicate that the primary health care most of the primary healthcare centers in Basra city have high quality the (70%) quality assurance related to the structure, the process (80%) of quality assurance related to services provided by the main primary healthcare centers, and the outcome (68.3%) of consumers were satisfied with primary health care services is no difference between the primary healthcare centers based on such quality

Chapter Three
Methodology

Chapter Three

Methodology

This chapter deals with the methodology that involves the design used in the research, administrative structures, test conditions, a research sample, tool building, data collection methods, and pilot tests, including analyzing data.

3.1. The study design

A descriptive cross-sectional study design has been carried out to assessment quality assurance for health promotion services in southern Babylon province (PHCCs), between the period 15 October 2022 to 10 June 2023.

3.2. Administrative approvals

Official statutory authorizations are obtained as the following: (Appendix A)

1-The approval of conducting this work was obtained from the Babylon University / Nursing College /higher education scientific research committee.

2- The official approval to work in primary health care centers was obtained from "Babylon Health Directorate".

3- Authorization was received from "the Training and Development Center in the Health Directorate of Babylon."

4- Approval was obtained from the directors of the Al-Hashimia sector in the Babylon Health Directorate.

3.3. Settings of the study

This study was carried out of Al-Hashimia sector which located in the south of Babylon Governorate, ten PHCCs are randomly selected by simple random sample technique (Shuffling method).

3.4. Sample of the study

Non-probability convenient sample were selected to assessing the study sample. The study sample divided into three groups as following:

3.4.1- Organization structure which includes (10) health promotion units in PHCCs**.**

3.4.2- Sixty health workers working in primary health care centers were enrolled in this study to know their job performance and implementing of the program (Health Promotion), the sample included all staff working in the health promotion unit.

3.4.3- Two hundred and fourty health services consumers to determine their level of satisfaction with the (Health promotion services)

Table (3.1) Distribution of primary health care centers, health workers and Consumers at Southern of Babylon governorate.

Centres	Staffs (F)	Consumers (F)	Structures (F)
Al-Qasim center	**7**	**25**	**1**
Al-Aoedien center	**6**	**24**	**1**
Al-Huda center	**6**	**24**	**1**
Al-Shomaly center	**5**	**28**	**1**
Al-Midhatya center	**7**	**25**	**1**

Al-Imam Ali center	**6**	**23**	**1**
Al-Ibrahimia center	**7**	**25**	**1**
Al-Sadiq center	**6**	**21**	**1**
Al-Zabar center	**4**	**23**	**1**
Al-Hsein center	**6**	**22**	**1**
Total	**60**	**240**	**10**

3.5. The study instruments

Comprehensive review of the literature on this topic was done to formulate, a suitable semi structured pre tested questionnaire under supervision of academic supervisors using the Guide to assess of Program Guidelines (Health promotion) issued by the World Health Organization (WHO, 2010). Three questionnaires were used. The total items in this questionnaire are (68) items (Appendix B).

3.5.1. Organization structure's questionnaire

The questionnaire consists of the following (Appendix B - Form A):

Domain 1: This part contains information about the infra-structure of PHCC consisting of (21) questions.

Domain 2: This part consists information about the services of PHCC, and consisting of (11) questions.

3.5.2. Health worker's questionnaire

The appropriate questionnaire is included (Appendix B – Form B)

Part 1: The section consists of profiles of the participants (socio-demographical information: age, gender, education level, years of employment in the health promotion units, marital status, residency, specialization, and state of training).

Part 2: the section contains profiles of job performance for the health care providers included (16 questions) data were collected by using a checklist to assess the job performance of health workers and aspects affecting performance of each health care provider.

3.5.3. Costumers (clients) satisfaction

The questionnaire is included (Appendix B – Form C)

Part 1: This part comprises the (socio-demographic status of the costumers, which consists of age, gender, educational level, marital status, residence, occupation, and purpose for visit).

Part 2: In this section, an assessment of consumer satisfaction with health promotion services, consisting of (20) questions.

3.6. Rating and scoring system

1- The organization structures score consists of 32 questions: The objective of (PHCCs) score was applied as (No = 1 point), and (Yes = 2 points).

2- The health worker job performance score consists of 16 questions: The performance score was applied as (Disagree = 1 point), (Neutral =2 points), and (Agree = 3 points).

3- The consumer satisfaction score consists of 20 questions: The consumer satisfaction score was applied as (Disagree = 1 point), (Neutral =2 points), and (Agree = 3 points).

The quality assurance score is computed for the total count of each of its components:

- The rating for organization structure's is rated as poor = (0-10.67), moderate (10.68-21.23), while good (21.24-32).

- For health workers and consumers is rated as a poor (1-1.66), and fair (1.67-2.33) while good (2.34-3).

3.7. Ethical considerations:

Ethical approval and permission have been obtained from the Babylon Health Department training and development center. The managers of the primary health centers were informed about the relevance and objectives of the study. The Babylon University of Nursing college ethics Committee approved the research protocol. Participants provided informed verbal consent before the interview after explaining the study objectives, and the information gathered was kept confidential during data collection and analysis. The names of the participants were replaced by code numbers to protect their autonomy. All data collected is used for research purposes only and stored in a password-protected computer files.

3.8. The validity of the questionnaire

A Validity relates to the extent to which the tool tests what it is meant to do. (Polit, 2020), for this reason, the instrument was reviewed by (11) experts in different fields in nursing and medical science (Appendix D).

A copy of the questionnaire was given to each expert and asked to appraise it critically and provide feedback on its consistency and adequacy, and accuracy of the contents. The majority of the experts agreed that the questionnaire was valid and acceptable for data collection and capable to collect data and achieve the objectives of this study successfully.

After the assess the validity of the questionnaire, some items were omitted, and other items were corrected according to the notes of experts, few changes were made based on the experts 'advice and suggestions, then the final version is ready to be implemented.

3.9. The Pilot study

A pilot study was performed from 15 February 2023 to 21 February 2023. Data are collected from (6) health workers, and (2) organization structures, and (25) consumers numbers in primary health care centers to achieve the following **Advantage of pilot study**:

1-Evaluation of the contents of the assessment tool (questionnaire) clarity, relevance and appropriateness.

2- To calculate a time needed for each interview.

3- Identification of obstacles that may be faced during the data collection procedure.

4- Determine the research instrument's reliability.

3. 9.a. Reliability of questionnaires

The consequence of the pilot study, the reliability determined by the Cronbach Alpha involved seeing in table (3.2)

1 to 32 questions on structures' **α = 0.886**

1 to 16 questions on health workers' skills practice **α = 0.745**

1 to 20 questions on satisfaction Consumers α = **0.927**

Reliability figures were achieved by the application definition following (waltz, Strickland, and Lenz, 2005).

$$r = \frac{k}{k-1}\left(1 - \frac{\sum Q^{2}}{QY^{2}}{}^{1}\right)$$

(Tab.3.2) Reliability indexes of questionnaire examined)

Questionnaire	Alpha (Cronbach)	Asses.
Organization structure' questionnaire	.886	Pass
Job performance questionnaire	.745	=
Consumers' questionnaire	.927	=

3.10. Methods of data collection

Collecting data for the organizational structure, a questionnaire is given to the director of the health center or his representative to answer it and by observing. The health worker is given a questionnaire to fill the socio-demographic variable. The second questionnaire for assess the job performance of the health care providers and aspects effecting on their performance, according to the predetermined checklist to assess the health worker performance this assessment done single handy by the researcher himself takes approximately 10 to 20 minutes. Regarding the assessment of consumers' satisfaction about the health promotion services this was done through face to face personal meetings by the same researcher to avoid the interpersonal variation (biases) and to increase the reliability of data collection. Each interview takes about 15 to 20 minutes to be completed. Ten questionnaires of costumers are excluded because it was filed wrong. Data collection is done out from 23 February to 13 May 2023.

3.11. Statistical data analysis

A data were analyzed using the utilization "statistical package of social sciences (SPSS) version 26",the following methods of study of statistical data we used to explain and analyzes the study results:

3.11.1. The descriptive way to statistical data analysis

It includes measurement of the following:

3.11.1.a. Descriptive as frequencies and percentages:

$$\text{Percentage (\%)} = \frac{\textit{Frequencies(F)}}{\textit{Size of smple}} \times (100)$$

3.11.1.b. Graphical presentation by pie- and other charts**.**

3.11.1.c. Summarized statistics such as Mean of the score (M.S).

$$\text{Mean } (\bar{x}) = \frac{\Sigma x}{n}$$

3.11.2. The inferential way to statistical data analysis

3.11.2.a. Liner Regression

3.11.2.b. Pearson correlation

$$r = \frac{N\Sigma xy-(\Sigma x)(\Sigma y)}{\sqrt{[N\Sigma x^2-(\Sigma x)^2][N\Sigma y^2-(\Sigma y)^2]}}$$

3.11.2.c. Chi-Square

$$\chi^2 = \sum_i \frac{(O_i - E_i)^2}{E_i}$$

3.11.2.d. The p-value of 0.5 or less was deemed significant.

Chapter Four
Results of the Study

Chapter Four

Results of the Study

Part one: Primary Health Care Centers.

Table 4.1. The distribution of PHCc and the number of health workers in health promotion unit and the required number according standers. **(n = 10)**

Name of PHCc.	Location	Number of workers	The required
Al-Qasim center	Urban	7	9
Al-Aoedien center	Rural	6	8
Al-Huda center	Urban	6	8
Al-Shomaly center	Urban	5	8
Al-Midhatya center	Urban	7	8
Al-Imam Ali center	Rural	6	8
Al-Ibrahimia center	Rural	7	7
Al-Sadiq center	Urban	6	6
Al-Zabar center	Rural	4	6
Al-Hsein center	Rural	6	7
Total		60	75

In table 4.1. The results showed that most PHCc (8 centers) contain fewer health workers than the number required to be available according to

the standards, while only (two centers) have the number of health workers according to the standards.

Table 4.2. The assessment of infrastructure of the PHCc. (n = 10)

Items		f.	%
Assessment of infrastructure			
1- Availability of a special room for the health promotion unit	No	7	70.0
	Yes	3	30.0
2- Public bathroom for clients.	No	7	70.0
	Yes	3	30.0
3- Private bathroom for staff.	No	1	10.0
	Yes	9	90.0
4- Basin and water tap.	No	6	60.0
	Yes	4	40.0
5- Seats for waiting.	No	2	20.0
	Yes	8	80.0
6- A hall dedicated and equipped to carry out educational seminars	No	7	70.0
	Yes	3	30.0
7- Waiting room for clients	No	10	100.0
	Yes	0	0.0
8- File cabinet	No	1	10.0
	Yes	9	90.0
9- phone	No	6	60.0
	Yes	4	40.0
10- Computer	No	9	90.0
	Yes	1	10.0
11- There is financial support from the Ministry to continue and develop the services of the Health Promotion Unit	No	7	70.0
	Yes	3	30.0
12- Screens to display educational videos in the clients' waiting areas	No	5	50.0
	Yes	5	50.0
13- Educational posters	No	1	10.0
	Yes	9	90.0
14- Optical data-show	No	6	60.0
	Yes	4	40.0

15- Camera for documenting seminars	No	9	90.0
	Yes	1	10.0
16- A wide place	No	8	80.0
	Yes	2	20.0
17- Adequate ventilation	No	2	20.0
	Yes	8	80.0
18- Appropriate lighting	No	5	50.0
	Yes	5	50.0
19- There are waste containers	No	2	20.0
	Yes	8	80.0
20- Seats are good and usable	No	9	90.0
	Yes	1	10.0
21- Files are organized and arranged	No	3	30.0
	Yes	7	70.0

In this table, the results show the characteristics of the infrastructure of PHCc and their services. As most of the centers (70%) do not have a special room for the health promotion unit. Also, most of them (70%) do not have bathrooms for customers. While (90%) have bathrooms for employees. Most of the health promotion units (60%) had a sink and a water tap. As for waiting seats, most of the centers had seats (80%). And (70%) of the PHCc do not have halls dedicated and equipped to conduct lectures and workshops. And all PHCc (100%) did not contain waiting rooms for customers. While (90%) of them have a cupboard for storing files. The results showed that half (50%) of the centers do not have screens in the customers' waiting areas. While the largest number (90%) contained educational posters. While (90%) of them have a cupboard for storing files. While the largest number (90%) contained educational posters. As for the environment of the place, the health promotion unit in most centers (80%) had a narrow space, but most of them had good ventilation (80%). Although most centers had seats to wait for

customers, (90%) of them were not sufficient and were not in a good condition for use. Also, most of the health promotion units (70%) had files arranged and organized.

Table 4.3. The assessment for services of the PHCc. (n = 10)

Items		f.	%
Assessment of services			
1- Providing advice and health guidance	No	4	40.0
	Yes	6	60.0
2- Organizing lectures to spread health awareness	No	5	50.0
	Yes	5	50.0
3- Organizing workshops and health events	No	10	100.0
	Yes	0	0.0
4- Using audio and visual means to spread and promote health awareness	No	9	90.0
	Yes	1	10.0
5- Using paper leaflets to disseminate important health information to promote health	No	1	10.0
	Yes	9	90.0
6- Supporting the health orientation with the modification of the health behavior of individuals and patients who frequent the center	No	10	100.0
	Yes	0	0.0
7- Raising awareness about the need to increase the rate of vaccinations	No	0	0.0
	Yes	10	100.0
8- Raising awareness about the importance of periodic breast examinations.	No	1	10.0
	Yes	9	90.0
9- Carrying out tests and surveys to know the risks and hazards in the environment and how to avoid them	No	10	100.0
	Yes	0	0.0
10- Finding suitable solutions with the concerned authorities to get rid of environmental damage and risks	No	7	70.0
	Yes	3	30.0
11- Recording and documenting the data of the beneficiaries of the unit's services and the date of their visit	No	0	0.0
	Yes	10	100.0

While the services in all health centers (100%) focused on increasing awareness to increase the percentage of vaccinations, and also most of them

(90%) were raising awareness and urging women on the necessity of periodic breast examination.

Table 4.4. The total score of assessment for PHCc's structure and services.

Name of the center	The score	The result
Al-Qasim center	21	Fair
Al-Aoedien center	7	Poor
Al-Huda center	19	Fair
Al-Shomaly center	18	Fair
Al-Midhatya center	23	Good
Al-imam Ali center	4	Poor
Al-ibrahimia center	13	Fair
Al-Sadiq center	18	Fair
Al-Zabar center	15	Fair
Al-Hsein center	12	Fair
The scale		
Poor = (0-10.67)	**Fair = (10.68-21.23)**	**Good = (21.24-32)**

Table 4.3. The results of the study on 10 PHCc found that most of them (70%) have fair infrastructure and services, while there was only one PHCc out of 10 that had most of the standard characteristics (23 scores). While there were two PHCc with weak services and infrastructure, they achieved (4 and 7 scores only).

Part two: Health workers.

Table 4.5. Frequency and relative frequency distribution of the study sample according to characteristics of health workers. (n = 60)

Health worker information	Subgroup	f.	%
	24-33	24	40.0

Age	34-43	22	36.7
	44-53	10	16.7
	54 and above	4	6.7
Sex	Male	32	53.3
	Female	28	46.7
Educational level	Diploma	31	51.7
	Bachelor's degree	29	48.3
	Postgraduate degree	0	0
Marital status	Single	12	20.0
	Married	48	80.0
	Widowed	0	0
	Divorced	0	0
Years of employment	1-5	25	41.7
	6-10	17	28.3
	11-15	15	25.0
	16-20	3	5.0
Residence	Urban	36	60.0
	Rural	24	40.0
Specialization	Bachelor's in Community health technology	22	36.7
	Environmental Sciences	1	1.7
	Diploma in community health	31	51.7
	Nurse	6	10.0
Training	Trained	60	100.0
	Untrained	0	0

Table 4.4. Depicts the characteristics of 60 health workers' participants. The trained was more dominant among the study sample with a

percentage of (100%). And (80%) of them were married compared to (20%) of them who were single. At the same time, males constitute the most significant number of the study group (53.3%) while The age group (24-33) is the largest age group (40%). Moreover, (51.7%) of them their educational level is a diploma. The results revealed that (51.7%) are diplomas in community health. The years of experience (41.7%) were from (1-5 years).

Table 4.6. Assessment the job performance of health workers and aspects influencing performance (n = 60)

Items		f.	%	Mean	Asses.
1. Participation in many training courses about health promotion	Disagree	8	13.3	2.23	Fair
	Neutral	27	45.0		
	Agree	25	41.7		
2. Participation in training course about communication skills and change of society behavior	Disagree	5	8.3	2.30	Fair
	Neutral	36	60.0		
	Agree	19	31.7		
3. Application of what has been learned	Disagree	2	3.3	2.42	Good
	Neutral	27	45.0		
	Agree	31	51.7		
4. Annual salaries and incentives are adequate	Disagree	36	60.0	1.40	Poor
	Neutral	24	40.0		
	Agree	00	00.0		
5. There is an atmosphere of good relations between colleagues in the primary health care center	Disagree	17	28.3	1.95	Fair
	Neutral	36	60.0		
	Agree	7	11.7		
6. The working environment is appropriate.	Disagree	31	51.7	1.60	Poor
	Neutral	26	43.3		
	Agree	3	5.0		
7. The distribution of tasks and responsibilities among the workers is considered good and fair	Disagree	29	48.3	2.17	Fair
	Neutral	29	48.3		
	Agree	2	3.3		
	Disagree	21	35.0	1.75	Fair

8. All workers perform their duties with high quality	Neutral	37	61.7		
	Agree	2	3.3		
9. The center can adequately fulfill the wishes of the attending patients	Disagree	29	48.3	1.70	Fair
	Neutral	29	48.3		
	Agree	2	3.3		
10. The centers conduct surveys to measure patients' satisfaction with the services provided to them.	Disagree	49	81.7	1.30	Poor
	Neutral	10	16.7		
	Agree	1	1.7		
11. The number of employees is sufficient and appropriate.	Disagree	9	15.0	2.17	Fair
	Neutral	29	48.3		
	Agree	22	36.7		
12. Employees receive training to implement the health promotion program	Disagree	10	16.7	2.17	Fair
	Neutral	35	58.3		
	Agree	15	25.0		
13. The programs are easy to implement	Disagree	7	11.7	2.45	Good
	Neutral	23	38.3		
	Agree	30	50.0		
14. The steps are appropriate and sufficient in educational programs	Disagree	5	8.3	2.55	Good
	Neutral	20	33.3		
	Agree	35	58.3		
15. The success of a health promotion program depends on the cooperation of the beneficiaries.	Disagree	0	0.0	2.80	Good
	Neutral	13	21.7		
	Agree	47	78.3		
16. Organizing training programs to continuously develop the skills of employees.	Disagree	5	8.3	2.27	Fair
	Neutral	39	65.0		
	Agree	16	26.7		
Likert scale Poor = (1-1.66) Fair = (1.67-2.33) Good = (2.34-3)					

Table 4.5. This table shows the results of health workers' assessment the performance of health workers and aspects affecting performance, the mean for incentives and salary was very weak (1.40), and the majority also thought that the work environment was not suitable (1.60). Also, their opinions were about the center conducting a survey on customer satisfaction

with services, as the vast majority disagree, with a mean of (1.30). While the majority agreed that health promotion programs were easy to implement (2.45) and the steps of procedures were sufficient and appropriate (2.55), and also that the success of health promotion programs depends on the extent of customer cooperation (2.80).

Table 4.7. Overall health workers' performance.

	Overall health workers' performance		
	scale	**(f)**	**(%)**
performance	Disagree	226	23.5%
	Neutral	435	45.3%
	Agree	299	31.2%
	Total	960	100.0%
Mean of score = 2.07			**Fair**
Likert scale	poor = (1-1.66)	fair = (1.67-2.33)	good = (2.34-3)

Table 4.6 shows the total result of the health workers' performance, as the total mean was (2.0 7), where the neutral was the highest percentage (45.3%).

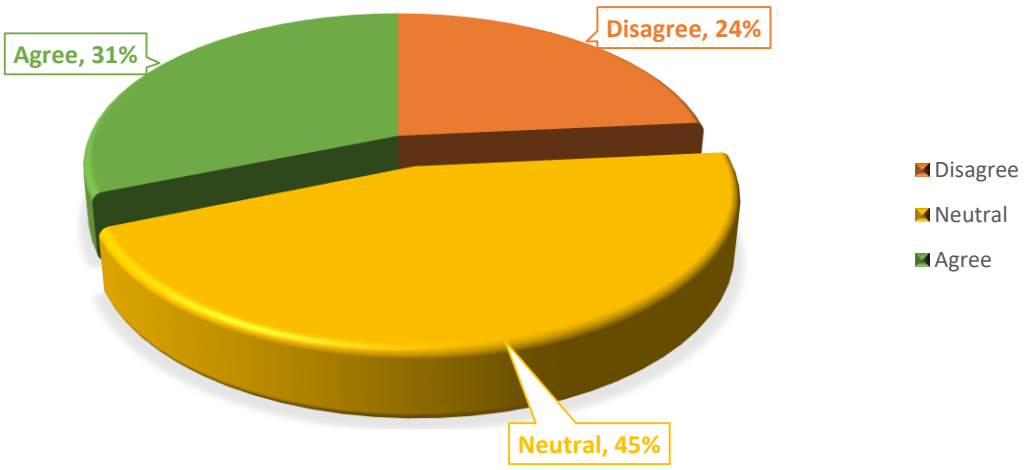

Figure 4.1. Distribution of the Overall health workers' performance.

Table 4.8. The relationship between the characteristics of the workers and their performance. (n=60)

Demographic Data	Groups	Overall evaluation			X^2	d.f	P-v
		poor	Fair	Good			
Gender	Male	0	23	8	1.243[a]	2	.537
	Female	1	22	6			
	Total	1	45	14			
Age	24-33	0	17	7	3.295[a]	6	.771
	34-43	1	16	5			
	44-53	0	9	2			
	54 and above	0	3	0			
	Total	1	45	14			
Level of education	Diploma	1	25	6	1.582[a]	2	.453
	Bachelor's degree	0	20	8			
	Total	1	45	14			
Marital status	Single	0	6	4	1.989[a]	2	.370
	Married	1	39	10			
	Total	1	45	14			
Residence	Urban	0	25	8	1.254[a]	2	.534
	Rural	1	20	6			
	Total	1	45	14			
Years of experience	1-5	0	16	7	6.089[a]	6	.413
	6-10	0	16	5			
	11-15	1	9	2			

	16-20	0	4	0			
	Total	1	45	14			
Specialization	Bachelor's in Community health technology	0	16	7	2.114[a]	6	.909
	Environmental sciences	0	1	0			
	Diploma in community health	1	25	6			
	Nurse	0	3	1			
	Total	1	45	14			
Name of the PHCc	Alaoedien	0	6	0	45.289[a]	18	.000
	Al-Huda	0	5	1			
	Al-imam Ali	1	5	0			
	Al-Midhatya	0	0	7			
	Al-Shomaly	0	2	3			
	Al-ibrahimia	0	7	0			
	Al-Qasim	0	7	0			
	Al-Sadiq	0	5	1			
	Al-Hsein	0	4	2			
	Al-Zabar	0	4	0			
	Total	1	45	14			

Table 4.7. The study found that the demographic data and the job performance of health workers and aspects affecting performance have no relationship, except for (The name of the PHCc), where the result was according to the chi-square (0.00), at $\boldsymbol{p \leq 0.05}$, and this means that there is a significant relationship between The name of PHCc and the job performance of health care providers.

Part three: The information of Customers.

These results are to all data about Customers, as follows:

Table 4.9. Frequency and relative frequency distribution of the study sample according to characteristics of Customers. (n = 240)

Characteristics		f.	%
Age	18-27	59	24.6
	28-37	86	35.8
	38-47	51	21.3
	48- and above	44	18.3
Sex	Male	93	38.8
	Female	147	61.3
Level of education	Illiterate	53	22.1
	Educated	49	20.4
	Elementary	25	10.4
	Intermediate & high school	45	18.8
	Diploma, Bachelor's, or Postgraduate studies	68	28.3
Marital status	Single	43	17.9
	Married	177	73.8
	widowed	18	7.5
	Divorced	2	.8
Residence	Urban	116	48.3
	Rural	124	51.7
Occupation	Government employee	64	26.7

	freelance job	71	29.6
	jobless	105	43.8
Reason for visit	For the purpose of treatment	78	32.5
	For the purpose of prevention	162	67.5

Table 4.8. This table reveals that most of the study sample of Customers age the majority of Customers fall in age is (28-37 years), which accounted for (35.8%). While depicting that most of the Customers' education level is Diploma, Bachelor's, or Postgraduate studies graduates which accounted for (28.3%) while Customers' gender reveals that the majority of Customers are females which accounted for (61.3%). The study presents that the majority of Customers are Married accounting for (73.8%). And also most of the samples were jobless (43.8%). And the majority of Customers who visit the PHCc came for the purpose of prevention with a percentage (67.5%).

Table 4.10. Satisfaction of the customers about the quality of health promotion services. (n = 240)

Items		f.	%	Mean	Assess
1. I sensed the staff's concern for me.	Disagree	128	53.3	1.65	Poor
	Neutral	68	28.3		
	Agree	44	18.3		
2. The cleanliness is good	Disagree	131	54.6	1.57	Poor
	Neutral	82	34.2		
	Agree	27	11.3		

3. The level of care and health information is adequate.	Disagree	87	36.3	1.84	Fair
	Neutral	105	43.8		
	Agree	48	20.0		
4. The staff is competent, knowledgeable, and well-trained, and they have earned my trust.	Disagree	96	40.0	1.81	Fair
	Neutral	93	38.8		
	Agree	51	21.3		
5. The techniques utilized to increase community health awareness are effective.	Disagree	178	74.2	1.28	Poor
	Neutral	57	23.8		
	Agree	5	2.1		
6. I had no difficulty accessing the center.	Disagree	19	7.9	2.51	Good
	Neutral	79	32.9		
	Agree	142	59.2		
7. I am treated promptly and without delay.	Disagree	69	28.7	2.02	Fair
	Neutral	97	40.4		
	Agree	74	30.8		
8. The time for the consultation was adequate.	Disagree	63	26.3	2.03	Fair
	Neutral	107	44.6		
	Agree	70	29.2		
9. Inquire as to the reason for my visit.	Disagree	44	18.3	2.41	Good
	Neutral	53	22.1		
	Agree	143	59.6		
10. Take my personal information.	Disagree	53	22.1	2.42	Good
	Neutral	34	14.2		
	Agree	153	63.7		
11. Information provided is simple and clear	Disagree	109	45.4	1.84	Fair
	Neutral	60	25.0		
	Agree	71	29.6		

12. They explain ways to avoid health problems	Disagree	124	51.7	1.75	Fair
	Neutral	51	21.3		
	Agree	65	27.1		
13. They explain the procedures and steps I must follow if I have a particular medical condition.	Disagree	116	48.3	1.73	Fair
	Neutral	73	30.4		
	Agree	51	21.3		
14. They encourage me to come back on time and follow up on my illness	Disagree	102	42.5	1.85	Fair
	Neutral	72	30.0		
	Agree	66	27.5		
15. The health worker welcomed me	Disagree	120	50.0	1.60	Poor
	Neutral	95	39.6		
	Agree	25	10.4		
16. The waiting room is comfortable and the number of seats is sufficient	Disagree	169	70.4	1.34	Poor
	Neutral	61	25.4		
	Agree	10	4.2		
17. The information displayed on the screen is useful and important to the auditors	Disagree	89	37.1	1.93	Fair
	Neutral	79	32.9		
	Agree	72	30.0		
18. The health worker maintains the privacy of references	Disagree	88	36.7	2.00	Fair
	Neutral	63	26.3		
	Agree	89	37.1		
19. I frequent the center to receive health care continuously	Disagree	21	8.8	2.17	Fair
	Neutral	156	65.0		
	Agree	63	26.3		
	Disagree	39	16.3	2.24	Fair
	Neutral	104	43.3		

20. I will go to this center if I need health care in the future.		Agree	97	40.4
Likert scale	Poor = (1-1.66)	Fair = (1.67-2.33)	Good = (2.34-3)	

Table 4.9. Shows that the lowest mean score is 1.28 with the item (The techniques utilized to increase community health awareness are effective), and 1.34 with the item (The waiting room is comfortable and the number of seats is sufficient), while the highest mean is 2.51 with the item (I had no difficulty accessing the center) and 2.42 with the item (The health worker take my personal information).

Table 4.11. Overall of Customer satisfaction

	Overall Customers satisfaction		
	scale	**(f)**	**(%)**
Costumers' satisfaction	**Disagree**	**1845**	**38.4%**
	Neutral	**1589**	**33.1%**
	Agree	**1366**	**28.5%**
	Total	**4800**	**100.0%**
Mean of score = 1.9002			**Fair**
Likert scale	**poor = (1-1.66)**	**fair = (1.67-2.33)**	**good = (2.34-3)**

Table 4.10. show the total score of Customer Satisfaction where was the overall mean of the responses of customers is (1.9002) according to Likert scale.

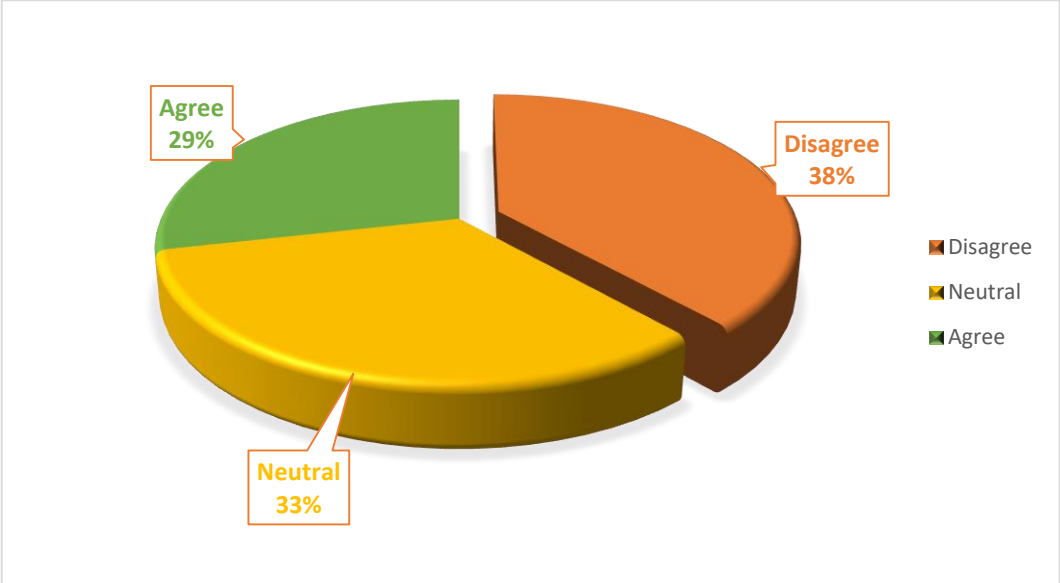

Figure 4.2. The Overall of Customer satisfaction.

Table 4.12. The Association between satisfaction scores and characteristics of costumers. (N =240)

characteristics	Groups	Overall evaluation			X^2	d.f	p-v
		Dis	Ne	Ag			
Gender	Male	38	34	21	1.822[a]	2	.402
	Female	55	66	26			
	Total	93	100	47			
Age	18-27	20	20	19	45.085[a]	8	.000
	28-37	42	30	14			
	38-47	18	30	3			

	48- and Above	13	20	11			
	Total	93	100	47			
Level of education	Illiterate	23	27	3	66.148[a]	8	.000
	Educated	35	8	6			
	Elementary	6	13	6			
	Intermediate & High school	6	18	21			
	Deploma, Bachelor's or postgraduate studies	23	34	11			
	Total	93	100	47			
Marital status	Single	30	5	8	33.633[a]	6	.000
	Married	58	80	39			
	widowed	5	13	0			
	Divorced	0	2	0			
	Total	93	100	47			
Residence	Urban	46	50	20	.788[a]	2	.675
	Rural	47	50	27			
	Total	93	100	47			
Occupation	Government employee	23	32	9	20.086[a]	4	.000
	free work	41	21	9			
	Not working	29	47	29			
	Total	93	100	47			

Reason for visit	for the purpose of treatment	28	32	18	.974[a]	2	.614
	for the purpose of prevention	65	68	29			
	Total	93	100	47			
Name of the center	Al-Aoedien	12	11	1	43.877[a]	18	.001
	Al-Huda center	2	16	6			
	Al-Imam Ali	12	8	3			
	Al-Midhatya	0	13	12			
	Al-Shomaly	15	9	4			
	Al-Ibrahimia	13	7	5			
	Al-Qasim	12	11	2			
	Al-Sadiq	8	8	5			
	Al-Hsein	9	8	5			
	Al-Zabar	10	9	4			
	Total	93	100	47			
X2= Chi-square Df= degree of freedom. P.value = <or = 0.05 was significant.							

Table 4.11. Reveal that there is a statistically significant "association" between the satisfaction scores with some socio-demographics of customers. At $p \leq 0.05$, such as (Age, Level of education, Marital status, Occupation, and the name of the center). While with (Gender, Residence, and Reason for a visit) there is a non-significant association with practice skills scores and socio-demographics at $p \leq 0.05$.

Table 4.13. Influence of Infrastructure and services of PHCc on Customer Satisfaction

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	.652	1	.652	21.869	.000[b]
Df= degree of freedom.		**P.value = or< 0.05 was significant.**			

Table 4.12. Show that there is an association between the satisfaction of customers with the Infrastructure and services of PHCc, according to the statistical analysis (Regression) at $p \leq 0.05$.

Table 4.13. Influence of the health workers' performance on customers' satisfaction.

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	1.688	1	1.688	38.050	.000[b]
Df= degree of freedom.		**P.value = or< 0.05 was significant.**			

Table 4.13. Results found that there is an association between the satisfaction of customers with health workers' performance, according to the statistical analysis (Regression) at $p \leq 0.05$.

Table 4.14. The correlation between the center, health workers, and customers' satisfaction according to Pearson Correlation.

Correlations				
	Model	satisfaction	center	Workers
Satisfaction	Pearson Correlation	1	.290**	.371**

	Sig. (2-tailed)		.000	.000
	N	240	240	240
Center	Pearson Correlation	.290**	1	.676**
	Sig. (2-tailed)	.000		.000
	N	240	240	240
Workers	Pearson Correlation	.371**	.676**	1
	Sig. (2-tailed)	.000	.000	
	N	240	240	240

Table 4.11. Reveal that there is a statistically significant association between the satisfaction of customers with infrastructure and health worker performance at $p \leq 0.05$, where according to (Pearson Correlation test) the p value was (.000) for all extremities.

Chapter Five
Discussion of the Results

Chapter Five

Discussion of the Results

In Iraq, PHCCs are the critical entrance to the health care system, where health practitioners provide primary health care, including Health Promotion programs, an internationally tested, predominantly community-based strategy for improving survival and reducing morbidity and mortality tension (Izudi, J. et al., 2017).

Health Promotion is a guide to promoting the health of the community and enabling people to control their lifestyle and habits. In the meantime, medical personnel who provide services should receive adequate training in communication skills, change of society behavior, teaching Methods, and healthy lifestyle. (Izudi, J et al., 2017).

The health worker must emphasize the implications of updating the understanding of primary health care professionals as advancements in scientific knowledge and practice become accessible. Mechanisms should exist to facilitate the transmission of learning to patients, particularly considering that prophylactic strategies are central in preventing disease. (Duke,E., et al, 2020)

During this chapter, the findings of the study are discussed in detail in the presentation of supporting evidence, as available in the literature and with regard to the aim of the study.

Part one: Assessment of the organizational structure and services.

Organizational considerations (structure) one of the three main elements of the Health Promotion protocol for improvement of health systems to ensure fair access to good quality care. Organizational considerations relate to mechanisms for delivering quality care to customers, including recommendations and policies, staff, training, budget, regulatory support, equipment, supplies, and facilities.

5.1.a. The demand of Health worker in Health Promotion unit. (Table 4.1)

The results of the study found that most of the centers had a shortage in the number of health workers, while the demand was higher than the existing one, as there were 8 health centers with a shortage of health workers. The reason for the shortage in the number of health workers is that the management in the primary health care centers concentrate the number of health workers in the most effective units that are reviewed by customers in greater numbers, so the health promotion unit usually suffers from a shortage of staff, and the current results agree with a previous study conducted at the University of Baghdad "Evaluation of Staff Variable as Component of Quality Improvement for Maternal and Child Health Promotion in Baghdad City’s Primary Health Care Centers". This study included 22 health centers in Baghdad, and found that the shortage in the number of health workers is about 50% of the actual number. (Saadoon N. 2012)

5.1.b. Assessment the structure of PHCc.

Such assessment has revealed that the organizational structure has experienced a lack of funds, and most of the PHCc does not contain a special room for the health promotion unit, the cleanliness is not appropriate, ventilation and lighting in most rooms are poor, there are little or no equipment needed to provide health care. The lack of sufficient funding by the authorities or that the administration does not have the authority to spend money in order to develop the health promotion unit and other units that are not visited by many customers. Where the authorities focus on units of high importance, such as vaccinations, the mother and child care unit, and others, which are considered major units and are visited by a large number of people. This study is consistent with a study conducted at the University of Babylon, "Aims to evaluate the quality of IMCI services in primary health care centers", which showed a lack of financial resources, a lack of adequate buildings and health facilities, and a lack of safety and security tools (Sakran. A, 2020).

5.1.c. Assessment of services of Health Promotion units in PHCc. (Table 4.2 & 4.3)

The results of the current study found that most of the services provided in the health promotion unit were weak, such as providing counseling, urging customers to modify healthy behavior and how to avoid chronic and communicable diseases, and there is a clear lack of awareness among the community, and a lack of awareness programs and workshops. And the lectures that would increase health awareness, this study is consistent with a study conducted at the University of Anbar (Assessment of the Quality of

Primary Health Care services in Al-Ramadi City, West of Iraq). (Sarhan, Y. & Altaha, M. et al 2017)

5.1.d. The total score of assessment for PHCc's structure and services. (Table 4.4)

The results of the current study found that most of the centers were evaluated as fair, two were evaluated as poor and only one was good out of 10 PHCc, and these results were consistent with the results of a study conducted in Baghdad on 42 health institutions in Iraq "Evaluation of Health Promotion Standards in the Iraqi Teaching Hospitals", where the results of the study showed that the infrastructure The services of most health institutions were of medium quality with mean (M = 2.9 ± 1.4). (Abid Ali, M. & Saadoon, N. 2016)

While the results of the current study were inconsistent with a study conducted in Basra for 10 PHCc "Evaluation of quality assurance at main primary health care center in Basra city", where the mean of the quality of the total infrastructure was 42.2, where the quality of the structures was at the highest level for most centers. (Huda S. & Hala S. 2022)

Part two: Health Workers' information

5.2.a. Distribution of Health workers' characteristics. (Table 4.5)

The current study found that most of the health workers in the health promotion units are 24-33 years old, and their service is less than 5 years, and most of them were specialized in the community health department. According to the survey, all workers in the health promotion units had received training and had courses to implement health promotion programs,

but they needed more training due to the increase in the rate of epidemics and chronic diseases.

5.2.b. the job performance of health workers and aspects that affective on it. (Table 4.6)

According to the results of the current study on job performance of health workers and aspects that affective on it, and by surveying the opinion of health workers in health promotion units, it was found that the work environment is not suitable for providing services at a high level, and salaries and incentives were few, and also most centers did not conduct a survey to measure customer satisfaction with services provided at the PHCc. While the results were positive and good about how easy the health promotion programs are, that their steps are sufficient, and that the health centers contribute and help in training and developing the expertise of health workers.

These results agree with the results of a study conducted in Baghdad (Evaluation of Health Promotion Program for the Prevention of Epidemics at Primary Health Care Centers in Baghdad City), which included 42 health centers. (Mansor M. & Khalifa M. 2020)

Manongi R et al study (49) has indicated that although financial incentives are important for health workers performance, they are not sufficient to motivate them. Supportive supervision, performance appraisal, career development and transparent promotion have been prioritized for improving the services they deliver.

5.2.c. The overall score for Health workers' job performance. (Table 4.7)

The overall results of job performance of health workers and aspects that affective on it, according to the study the job performance of the health

workers, indicated that the practice and services provided in the PHCc in the south of Babylon Governorate were of fair quality, with a mean of 2.07 according to the triple Likert scale, and these results were in agreement with the results of a study conducted at Al-Anbar "Assessment of the Quality of Primary Health Care services in Al-Ramadi City, West of Iraq" to assess the quality of primary healthcare with respect to structure, consumer and care provider satisfaction, involving 600 clients and 150 care providers in Al Ramadi (Altaha, M. & Elethawi, Y. 2017).

However, the results disagree with the results of a study conducted in the province of Baghdad "Evaluation of Quality of Primary Health Care Services at Primary Health Care Centers in Baghdad City: A Comparative Study", in which a multi-stage probability sample consisting of (36) health care centers was selected. The sample includes (12) typical centers, (12) urban centers, and (12) rural centers. The results were in This study showed that most of the health centers were of high-quality services, and this difference in the results is due to the fact that the researcher used special criteria in selecting the centers, and the research methodology was different in several aspects in evaluating the services. (Jasim, B. 2018)

5.2.d. The relationship between the characteristics of the workers and their job performance. (Table 4.8)

The study revealed, using chi-square, the extent to which services are affected by the characteristics of health workers, where the p-value was greater than 0.05 in all data (age, gender, marital status, place of residence, etc.) except for the name of the PHCc that to which the health worker belongs, the p-value was (0.00), and this shows that the quality of services and the effectiveness of the performance of health workers depend mainly on

the level of quality of the structures of PHCc and the extent of management efficiency in overcoming difficulties and finding solutions to increase the performance of health workers and thus improving the quality of services provided. This study coincided with the results of a study conducted in Morocco (Primary health care services in Morocco) in 2021 with 272 health professionals. The study found that most health workers are dissatisfied with the level of services provided in the health center, and this is due to the incompetence of the health center management. (Koubri, H. & Hami², H. 2022)

Part three: The information of Customers.

5.3.a. Satisfaction of the Customers about the quality of health promotion services. (Table 4.9)

The level of customer satisfaction is considered the result in the method of assessing the quality of services provided in health institutions, as the results showed that customers were satisfied with some trends in services while there were aspects they were not satisfied with, as customers were satisfied with a high level about the ease of access to the health center and Preserving the privacy of customers, writing down their data, and inquiring about their visit each time, while they were not satisfied with the cleanliness of the place and about the effectiveness of the health center's role in increasing and spreading health awareness in the community. Also, there was no waiting room and the seats were insufficient. Some of them are not suitable for use, and some customers have noticed the lack of attention from health workers towards them.

While the overall statistics showed the level of customer satisfaction was at a fair level regarding the quality of services provided in primary health care

centers, where they were satisfied with some aspects and dissatisfied with other aspects, and where the overall average was (1.9002) according to the Likert scale.

The results of the current study are consistent with a study conducted to assess the quality of primary healthcare with respect to structure, consumer and care provider satisfaction, involving 600 clients and 150 care providers in Al Ramadi, West of Iraq, And its results were consistent with the current study in terms of ease of access and visiting the center next time and in terms of maintaining privacy, while it was not consistent in certain aspects such as the cleanliness of the place and the efficiency of the waiting room or seating, and also in terms of advice and health education. (Mahasin A Altaha, Yaseen T Elethawi 2017). The reason for the difference in the results is due to the criteria by which the health centers were selected and that the study area is different, as the researcher used in the previous study a different methodology in terms of selecting samples. (Researcher)

5.3.b. The Association between satisfaction level and characteristic of customers. (Table 4.10)

The results of the current study indicated using statistical analysis (chi-square) to find a relationship between the level of customer satisfaction and their characteristics, with a p-value< 0.05, and the statistical results found that (Age, Educational level, Occupation, Marital status, and name of PHCc) p-value = (0.00), which means that it had a significant effect on the level of customer satisfaction. These results were consistent with the results of a study conducted in Baghdad "Caregivers' Satisfaction toward Under-Five Health Care Services Provided at Primary Health Care Centers in Al Karkh, Baghdad" to assess the extent of satisfaction, where the study found that there

was a significant effect between (Age and Educational level) and the level of customer satisfaction, while (Occupations) had no effect. (Lamia D. Al Deen & Abeer A. Fadhil 2020)

While these current results did not agree with a previous study conducted in the city of Hilla on 8 PHCc, where the study found that there is a significant relationship between the level of satisfaction of customers and demographic data only in terms of (place of residence) (Sakran. A, 2020). The reason for this discrepancy in the results is attributed to the fact that the study was conducted in a different location and there are other aspects and criteria upon which the researcher relied.

5.3.c. The correlation between customer satisfaction, health worker job performance and the quality of the structure and provided services

The current study showed, using regression and the Pearson coefficient in the statistical analysis, that there is a significant relationship between the level of customer satisfaction and the quality of the infrastructure and services provided in the primary health care centers, where the P value was equal to 0.00, as the health centers were of a high degree in the evaluation. Which was conducted through the questionnaire, whose clients had the highest level of satisfaction and indicated a higher desire to visit the same health center. And this result was in agreement with most of the studies conducted for the purpose of measuring the level of satisfaction among customers, such as the study (Bouhalfaya, B. 2020) that was conducted in the city of Umm El-Bouaghi in Algeria found there is a significant correlation between the quality of services and the level of customer satisfaction, as the higher the quality of services and the infrastructure of the health institution, the level of customer satisfaction increased with it.

And the study also found that there is a significant correlation (p-value = 0.00) between the extent of customer satisfaction and the satisfaction of health workers. And this became evident through the results found by the current study, where the health centers that had a good structure and management, the health workers were more efficient in performing their work, and thus the customer satisfaction was at a higher level (Researcher). And these results were consistent with the results of a previous study conducted in western Iraq to assess the quality of services provided in the primary health care center, where the study showed that the level of customer satisfaction depends heavily on the job performance of health workers. (Altaha, M. & Elethawi, Y. 2017)

And another study was conducted in Saudi Arabia to measure the effect of job performance on the level of quality of services provided at King Salman Specialist Hospital in the city of Hail, and by using regression and Pearson coefficient in statistical analysis, there was a significant correlation between the extent of health workers' satisfaction and the quality of services provided, and therefore Affects customer satisfaction with the services provided. (Al-Hawas, Y. 2020)

Chapter Six
Conclusions & Recommendations

Chapter Six

Conclusions & Recommendations

As a result of the previously stated work, the study can appropriately derive conclusions related to the study findings and suggest recommendations on these conclusions.

6.1. Conclusions

6.1.1. Organizational Structure

6.1.1.a. The assessment of quality of (PHCC) Organization (structure) found lack of the financial resources and shortage health care provider in Health promotion units that must be available to support the implementation of the program and achieve its requirements.

6.1.2. Health workers

6.1.2.a. The level of practice skill of health workers and the extent of their orientation to perform their duties and provide health care with higher efficiency depends mainly on the quality of the primary health care center's infrastructure and the process of services provided.

6.1.2.b. Lack of training for all health workers in service for health care providers to implement Health promotion program.

6.1.3. Customers satisfaction

6.1.3.a. The level of consumer satisfaction was an indication of fair.

6.1.3.b. The level of customer satisfaction is closely related to the job satisfaction of health worker

6.1.3.c. The level of customer satisfaction depends highly on the quality of services and the efficiency of the health center's infrastructure

6.2. Recommendations:

Through the conclusions, the study can recommend that:

6.2.1. Organizational Structure

6.2.1.a. The Ministry of Health can make great efforts to improve the organizational structure and provide financial resources to improve the quality of health promotion program to improve community health.

6.2.2. Health workers

6.2.2.a. Health care workers have to be presented with better education and opportunities for well-structured training courses in the area of health promotion programs.

6.2.2.b. Increase the number of staff trained on health promotion programs at primary-health-care centers in both urban and rural areas through intensifying training courses program.

6.2.2.c. Health care workers have to be presented with better education and opportunities for well-structured training courses in the area of health promotion program

6.2.2.d. Improving teamwork perception among health workers to create a highly efficient work environment.

6.2.3. Customers

6.2.3.a. Public health advocates should concentrate on promoting and educating about health care through "health talks" that primarily focus on sanitation and health education, which may be done as patients wait in lines to be seen.

6.2.3.b. Consumers should be provided with the benefit-wise educational courses to promote their health which can be motivated and developed healthy community.

6.2.3.c. Further studies can be conducted on large sample sizes and nationwide oriented ones**.**

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Appendices

APPENDIX -A-

University of Babylon
College of Nursing
Research Ethics Committee

جـــامـعة بـــابـــل
كـــلية التمريـض
لجنة اخلاقيات البحث العلمي

Issue No:

Date: 20/ 3 /2023

Approval Letter

To, حسين سليم ضايع

The Research Ethics committee at the **University of Babylon, College of Nursing** has reviewed and discussed your application to conduct the research study entitled " **Evaluation of quality assurance for health promotion services in primary health care centers".**

The Following documents have been reviewed and approved:

1. Research protocol
2. Research instrument/s
3. Participant informed consent

Committee Decision.

The committee approves the study to be conducted in the presented form. The Research Ethics committee expects to be informed about any changes occurring during the study, any revision in the protocol and participant informed consent.

Prof. Dr. Shatha Saadi Mohammed
Chair Committee
College of Nursing
Research Ethical Committee
20/ 3 /2023

Ministry of Higher Education and Scientific Research
وزارة التعليم العالي والبحث العلمي
University of Babylon
College of Nursing
جامعة بابل
كلية التمريض
شعبة الدراسات العليا

العدد : ٤٧٧ ٠
التاريخ : ٥ / ٢ / ٢٠٢٣ م

Ref. No. :
Date: / /

الى / دائرة صحة بابل / مركز التدريب والتطوير
م/ تسهيل مهمة

تحية طيبة :
يطيب لنا حسن التواصل معكم ويرجى تفضلكم بتسهيل مهمة طالب الماجستير (حسين سليم ضايع منجي) لغرض جمع عينة دراسة الماجستير والخاصة بالبحث الموسوم:

تقييم ضمان الجودة لخدمات تعزيز الصحة في مراكز الرعاية الصحية الاولية .

Evaluation of Quality Assurance for Health Promotion Services in Primary Health Care Centers .

مع الاحترام ...

المرافقات //
- بروتوكول.
- استبانة.

ا. د. نهاد محمد قاسم
معاون العميد للشؤون العلمية والدراسات العليا
٢٠٢٣/٢/٥

صورة عنه الى //
- مكتب السيد العميد للتفضل بالاطلاع مع الاحترام .
- شعبة الدراسات العليا
- الصادرة .

E-mail:nursing@uobabylon.edu.iq
وطني 07711632208
المكتب 009647711632208

جمهورية العراق

وزارة الصحة دائرة صحة محافظة بابـــل المديـــر العـــام مركـــز التدريب والتنمية البشرية وحدة أدارة البحوث العدد : ٤٥٢ التاريخ: ٢٠ / ٢ /٢٠٢٣		Ministry Of Health Babylon Health Directorate Email:- Babel_Healthmoh@yahoo.com لأجل عراق اخضر مستدام ..سنعمل معا لترشيد استهلاك الطاقة الكهربائية والمحافظة على البيئة من التلوث

إلى / قطاع الهاشمية للرعاية الصحية الأولية

م// تسهيل مهمة

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية

تحية طيبة ...
أشـارة إلـى كتـاب جامعـة بابـل/ كليـة التمـريض / الدراسات العليا ذي العدد ٧٧٠٤ في ٢٠٢٣/٢/٥
نرفـق لكـم ربطـا اسـتمارات المـوافقة المبدئيـة لمشـروع البحـث العائـد للباحث طالب الدراسات العليا/ ماجستير(حسين سليم ضايع منجي).

للتفضـل بـالاطلاع وتسـهيل مهمـة المومـا أليـه مـن خـلال توقيـع وخـتم اسـتمارات أجـراء البحـث المرفقـة فـي مؤسسـاتكم وحسـب الضـوابط والإمكانـات لاستحصـال الموافقـة المبدنيـة ليتسـنى لنـا أجراء اللازم على أن لا تتحمل مؤسساتكم أية تبعات مادية وقانونية .... مع الاحترام

المرفقات :
استمارة عدد /٢

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية

الدكتور
محمد عبد الله عجرش
مدير مركز التدريب والتنمية البشرية
/ /٢٠٢٣

نسخة منه إلى :
- مركز التدريب والتنمية البشرية / وحدة أدارة البحوث مع الأوليات ...

Ministry of Higher Education and Scientific Research
University of Babylon
college of Basic Education
جامعة بابل
كلية التربية الاساسية

Ref. No.: العدد : ٩٨٨٢

Date: / / التاريخ: ٢٦ / ٦ / ٢٠٢٣

جامعة بابل / كلية التمريض
السواردة
العدد / ٤٧٦
التاريخ ٢٦ / ٦ / ٢٠٢٣

كلية التربية الاساسية
شعبة الموارد البشرية
الصادرة

الى/ جامعة بابل / كلية التمريض

م/ تقويم لغوي

نهديكم اطيب التحيات ...

كتابكم المرقم [illegible] برسالة

طالب الدراسات العليا / الماجستير (حسين سليم ضايع) الموسومة ب (**تقييم ضمان الجودة لخدمات تعزيز الصحة في مراكز [illegible]**) بعد تقويمها لغوياً واسلوبياً من قبل (أ.م. د. ميس فليح حسن) وهي صالحة للمناقشة بعد الاخذ بالملاحظات المثبتة على متنها.

...مع الاحترام ...

المرفقات/
- رسالة الماجستير
- إقرار المقوم اللغوي.

أ.د. فراس سليم حياوي
معاون العميد للشؤون العلمية
٢٠٢٣/٦/

نسخة منه الى/
- مكتب السيد العميد المحترم .. للتفضل بالاطلاع مع الاحترام
- أ. م.د.ميس فليح حسن .
- الشؤون العلمية.
- الصادرة.

ايناس//

العراق - بابل - جامعة بابل
بدالة الجامعة ٠٠٩٦٤٧٢٣٠٠٣٥٧٤٤
مكتب العميد ١١٨٤
المعاون العلمي ١١٨٨
المعاون الاداري ١١٨٩
وطني ٠٧٢٣٠٠٣٥٧٤٤
امنية ٠٧٦٠١٢٨٨٥٦٦
basic@uobabylon.edu.iq

Ministry Of Health
Babylon health directories
ALHashimia sector for P.H.C
Training&Human Development
Unit

وزارة الصحة
دائرة صحة بابل
قطاع الهاشمية للرعاية الصحية الاولية
وحدة التدريب والتنمية البشرية
العدد/ ٢٢٦٨
التاريخ/ / ٢٠٢٣

الى/ كافة المراكز الصحية

م/ تسهيل مهمة

إشارة الى كتاب دائرة صحة بابل /مركز التدريب والتنمية البشرية /وحدة البحوث المرقم ٢٥٣ في ٢٠٢٣/٢/٥ نرجو تسهيل مهمة طالب الدراسات العليا /ماجستير (حسين سليم ضايع منجي) في مراكزكم الصحية لغرض انجاز بحثه وجمع العينات على ان لاتتحمل المؤسسة اية تبعات مادية وقانونية مع الاحترام .....

الطبيب الاختصاص
عبد الرحيم مخيف حسن
مدير قطاع الهاشمية

وزارة الصحة
دائرة صحة بابل
قطاع الهاشمية للرعاية الصحية الأولية
العدد:
التاريخ:
/ / ٢٠

APPENDIX -B-

Evaluation of Quality Assurance for Health Promotion Services in Primary Health Care Centers

Form (A)

For the primary health care center

Questionnaire number ..... The date of filled ……

N	**Items**
1	Name of center ……
2	Location of the center ……
3	Number of workers in health promotion unit ☐ The number of workers required according standers ☐
4	**4 -Infrastructure of the health promotion unit** **A- Building and accessories:** -Availability of a special room for the health promotion unit ☐ -Public bathroom for clients ☐ -Private bathroom for staff ☐ -Basin and water tap ☐ -Seats for waiting ☐ -A hall dedicated and equipped to carry out educational seminars ☐ -Waiting room for clients ☐ -File cabinet ☐ -phone ☐ - Computer ☐ **B- There is financial support from the Ministry to continue and develop the services of the Health Promotion Unit** ☐ **C - The equipment/tools available to provide services in the health promotion unit:** -Screens to display educational videos in the clients' waiting areas ☐

	-Educational posters about specific diseases ☐ -Optical data display ☐ - Camera for documenting seminars ☐ **D- the environment:** - A wide place ☐ - Adequate ventilation ☐ - Appropriate lighting ☐ - There are waste containers ☐ - Seats are good and usable ☐ - Files are organized and arranged ☐
5	**4 -Services provided by the Health Promotion Unit:** **A- Health Education:** - Providing advice and health guidance ☐ - Organizing lectures to spread health awareness ☐ - Organizing workshops and health events ☐ - Using audio and visual means to spread and promote health awareness ☐ - Using paper leaflets to disseminate important health information to promote health ☐ **B- Promoting healthy behavior:** - Supporting the health orientation with the modification of the health behavior of individuals and patients who frequent the center ☐ - Raising awareness about the need to increase the rate of vaccinations ☐ - Raising awareness about the importance of periodic breast examinations. ☐ **C- Caring for the environment:** - Carrying out tests and surveys to know the risks and hazards in the environment and how to avoid them ☐ - Finding suitable solutions with the concerned authorities to get rid of environmental damage and risks ☐ **D- Recording and documenting the data of the beneficiaries of the unit's services and the date of their visit** ☐

Form B

For workers in the health promotion unit

Questionnaire number: ..... Date of filling: …….

The name of the center: ..... The location of the center: …….

The gender of the worker: 1- male ☐ 2- female ☐

Age: ☐

Level of education: 1- Diploma ☐ 2- Bachelor's degree ☐

3- Postgraduate studies ☐

Marital status: 1- single ☐ 2- married ☐

3- widowed ☐ 4- divorced ☐

Place of residence: 1- Urban ☐ 2- Rural ☐

Years of experience: ☐

Specialization: ☐

Training: 1- Untrained 2- Trained -

Please put a tick (√) in the appropriate answer box :

N	Items	Agree	Neutral	Disagree
1	Participation in many training courses on health promotion			
2	Participation in training course about communication skills and change of society behaviour			
3	Application of what has been learned			

4	Annual salaries and incentives are adequate			
5	There is an atmosphere of good relations between colleagues in the primary health care center			
6	The working environment is appropriate.			
7	The distribution of tasks and responsibilities among the workers is considered good and fair			
8	All workers perform their duties with high quality			
9	The center can adequately fulfill the wishes of the attending patients			
10	The centers conduct surveys to measure patients' satisfaction with the services provided to them.			
11	The number of employees is sufficient and appropriate.			
12	Employees receive training to implement the health promotion programme			
13	The programs are easy to implement			
14	The steps are appropriate and sufficient in educational programmes			
15	The success of a health promotion program depends on the cooperation of the beneficiaries.			
16	Organizing training programs to continuously develop the skills of employees.			

Form (C)

For clients and beneficiaries of the services of the Health Promotion Unit

Questionnaire number: ..... Date of filling: ……..

The name of the center: ..... The location of the center: ……..

Gender: 1- Male ☐ 2- Female ☐

Age: ☐

Education level: 1- Illiterate ☐ 2- Can read and write ☐

3- Elementary or intermediate ☐ 4- Preparatory ☐

5- Bachelor's or postgraduate studies ☐

Marital status: 1- single ☐ 2- married ☐ 3- widowed ☐

4- divorced ☐

Place of residence: 1- Urban ☐ 2- Rural ☐

Occupation: 1- Government employee ☐ 2- free work ☐ 3- Not working ☐

Reason for visit: 1- for the purpose of treatment ☐

2- for the purpose of prevention ☐

Please put a tick (√) in the appropriate answer box:

N	Items	Agree	Neutral	Disagree
1	During my visit to the Primary Health Care Center, I felt the care of the staff toward me.			
2	The cleanliness of the place is good.			

3	I am satisfied with the level of care and health information that I receive at this center.			
4	I feel that the staff is professional, well experienced and trained and they have earned my trust.			
5	I am satisfied with the procedures followed in the Primary Health Care Center in order to spread health awareness in the community.			
6	I did not find it difficult to reach the primary health care center.			
7	Every time I visit the primary health care center, I receive care in a short time and without delay.			
8	The time allotted for the purpose of the medical consultation was sufficient.			
9	Usually, when I visit a primary care center the health worker asks me why I am visiting.			
10	When I visit a primary care center in my area, they fill out my personal information.			
11	The health information provided by the health worker is simple and clear.			
12	The health worker explains ways to avoid health problems.			
13	The health worker explains the procedures and steps that I must take if I have a specific medical condition.			
14	The health worker urges me to come back on time and follow up on my illness.			
15	The health service officer welcomed me.			
16	The waiting room is comfortable and the number of seats is sufficient.			
17	The information displayed on the screen is useful and important to the clients.			

18	The health worker maintains the client's privacy.			
19	I frequent the center to receive health care continuously.			
20	I will go to this center if I need health care in the future.			

APPENDIX -C-

"تقييم ضمان جودة خدمات تعزيز الصحة المقدمة في مراكز الرعاية الصحية الاولية"

الاستمارة أ

خاصة بمركز الرعاية الصحية الاولية

رقم الاستبانة ..... **تاريخ ملء الاستبانة .....**

١- اسم المركز .....
٢- موقع المركز .....
٣- عدد العاملين في وحدة تعزيز ☐ عدد العاملين المطلوب ☐
٤- البنية التحتية لوحدة تعزيز الصحة
أ- البناء و ملحقاته :
- توفر غرفة خاصة لوحدة تعزيز الصحة ☐
- حمام عام للمراجعين ☐
- حمام خاص للموظفين ☐
- حوض و صنبور مياه ☐
- مقاعد مخصصة للانتظار ☐
- قاعة مخصصة و مجهزة للقيام بندوات تثقيفية ☐
- غرفة انتظار للمراجعين ☐
- خزانة لحفظ الملفات ☐
- هاتف ☐
- كومبيوتر ☐

ب- يوجد دعم مالي من قبل الوزارة لاستمرار و تطوير خدمات وحدة تعزيز الصحة ☐

جـ - المعدات / الادوات المتوفرة لتقديم الخدمات في وحدة تعزيز الصحة

- شاشات لعرض فيديوهات تثقيفية في اماكن انتظار المراجعين ☐
- بوسترات تثقيفية ☐
- عارض بيانات ضوئي ☐
- كاميرا لتوثيق الندوات ☐

د- بيئة المكان

- مكان واسع ☐
- تهوية مناسبة ☐
- إضاءة مناسبة ☐
- يوجد حاويات للنفايات ☐
- المقاعد جيدة و صالحة للاستعمال ☐
- الملفات منظمة و مرتبة ☐

٤-الخدمات المقدمة من قبل وحدة تعزيز الصحة:

أ- التثقيف الصحي:

- تقديم المشورة و الارشاد الصحي ☐
- تنظيم محاضرات لنشر الوعي الصحي ☐
- تنظيم ورش عمل و فعاليات صحية ☐
- استخدام الوسائل السمعية و البصرية لنشر و تعزيز الوعي الصحي ☐
- استخدام منشورات ورقية لنشر معلومات صحية مهمة لتعزيز الصحة ☐

ب- تعزيز السلوك الصحي:

- دعم التوجه الصحي مع تعديل السلوك الصحي للافراد و المرضى المترددين للمركز ☐
- التوعية حول ضرورة زيادة معدل التطعيمات ☐
- التوعية حول اهمية فحص الثدي الدوري للنساء ☐

ج- الاهتمام بالبيئة:

- عمل فحوصات و مسوحات لمعرفة المخاطر في البيئة و كيفية تجنبها ☐
- ايجاد حلول مناسبة مع الجهات المعنية للتخلص من الاضرار و المخاطر البيئية ☐

د- تدوين و توثيق بيانات المستفيدين من خدمات الوحدة و تاريخ زيارتهم ☐

"تقييم ضمان جودة خدمات تعزيز الصحة المقدمة في مراكز الرعاية الصحية الاولية"

استمارة ب

خاصة بالعاملين في وحدة تعزيز الصحة

رقم الاستبانة..... تاريخ ملء الاستبانة:..... ....

اسم المركز..... موقع المركز.....

- جنس العامل الصحي : ١- ذكر ☐ ٢- أنثى ☐
- العمر: ☐
- المؤهل العلمي : ١- دبلوم ☐ ٢- بكلوريوس ☐ ٣- دراسات عليا ☐
- الحالة الزوجية: ١- اعزب ☐ ٢- متزوج ☐ ٣- ارمل ☐ ٤- مطلق ☐
- مكان السكن: ١- مدينة ٢- ريف ☐
- سنوات الخبرة : ☐ سنة
- التخصص : ☐
- التدريب: ١- غير مدرب ☐ ٢- مدرب ☐

الرجاء وضع اشارة (√) في مكان الاجابة الملائم :

ت	الفقرات	اوافق	محايد	لا اوافق
١	المشاركة في العديد من الدورات التدريبية في مجال تعزيز الصحة			
٢	المشاركة في دورة تدريبية حول مهارات الاتصال وتغيير سلوك المجتمع			
٣	تطبيق ما تم تعلمه			
٤	الرواتب السنوية والحوافز كافية .4			
٥	يسود جو من العلاقات الطيبة بين الزملاء في مركز الرعاية الصحية الأولية			
٦	.بيئة العمل مناسبة			

٧	يعتبر توزيع المهام والمسؤوليات بين العاملين جيداً وعادلاً			
٨	يؤدي جميع العمال واجباتهم بجودة عالية			
٩	يمكن للمركز تلبية رغبات المرضى المعالجين بشكل مناسب			
١٠	تجري المراكز مسوحات لقياس مدى رضا المرضى عن الخدمات المقدمة لهم.			
١١	عدد الموظفين كاف ومناسب			
١٢	تدريب الموظفين على تنفيذ برنامج تعزيز الصحة			
١٣	البرامج سهلة التنفيذ			
١٤	الخطوات مناسبة وكافية في البرامج التربوية			
١٥	يعتمد نجاح برنامج تعزيز الصحة على تعاون المستفيدين.			
١٦	تنظيم برامج تدريبية لتنمية مهارات العاملين بشكل مستمر.			

استمارة (ج)

خاصة بالمراجعين و المستفيدين من خدمات وحدة تعزيز الصحة

رقم الاستبانة..... تاريخ ملء الاستبانة:..... ....

اسم المركز..... موقع المركز.....

- الجنس : ١- ذكر ☐ ٢- أنثى ☐
- العمر: ☐
- المستوى التعليمي :١- امي ☐ ٢- يقرأ و يكتب ☐ ٣- ابتدائية او متوسطة ☐ ٤- اعدادية ☐
٥- بكلوريوس او دراسات عليا ☐
- الحالة الزوجية: ١- اعزب ☐ ٢- متزوج ☐ ٣- ارمل ☐ ٤- مطلق ☐
- مكان السكن: ١- مدينة ☐ ٢- ريف ☐
- المهنة: ١- موظف حكومي ☐ ٢- اعمال حرة ☐ ٣- لا يعمل ☐
- سبب الزيارة: ١- لغرض العلاج ☐ ٢- لغرض الوقاية ☐

الرجاء وضع اشارة (√) في مكان الاجابة الملائم :

ت	الفقرات	اوافق	محايد	لا اوافق
١	خلال زيارتي الى مركز الرعاية الصحية الأولية شعرت باهتمام العاملين تجاهي			
٢	نظافة المكان مناسبة وجيدة			
٣	مستوى الرعاية و المعلومات الصحية التي اتلقاها في هذا المركز مناسبة			
٤	ان العاملين مهنيين ويتمتعون بخبرة جيدة و مدربين وقد حازوا على ثقتي			
٥	الإجراءات المتبعة في مركز الرعاية الصحية الاولية من اجل نشر الوعي الصحي في المجتمع فعالة			
٦	لم اجد صعوبة في الوصول الى مركز الرعاية لصحية الأولية .			
٧	كل مرة ازور فيها مركز الرعاية الصحية الاولية اتلقى الرعاية بوقت قصير و بدون تأخير			

٨	الوقت التي تم تخصيصه لغرض الاستشارة الطبية كان كافيا			
٩	عادة عندما أقوم بزيارة مركز الرعاية الأولية في منطقتي يسألني العامل الصحي عن سبب زيارتي			
١٠	عندما أقوم بزيارة مركز الرعاية الأولية في منطقتي يقوم الموظف المختص بتعبئة بياناتي الشخصية			
١١	المعلومات الصحية التي يقدمها العامل الصحي بسيطة و واضحة			
١٢	يقوم العامل الصحي بشرح طرق تفادي المشاكل الصحية			
١٣	يقوم العامل الصحي بتوضيح الإجراءات والخطوات التي يجب أن أقوم بها اذا كان لدي حالة مرضية معينة			
١٤	يقوم العامل الصحي بحثي على المراجعة في الموعد المحدد ومتابعة حالتي المرضية			
١٥	رحب بي موظف الخدمة الصحية			
١٦	غرفة الانتظار مريحة و عدد المقاعد كافٍ			
١٧	المعلومات التي يتم عرضها على الشاشة تكون مفيدة و مهمة للمراجعين			
١٨	يحافظ العامل الصحي على خصوصية المراجع			
١٩	اتردد على المركز لتلقي الرعاية الصحية بأستمرار			
٢٠	سوف اراجع هذا المركز اذا ما احتجت الى رعاية صحية في المستقبل.			

APPENDIX -D-

ت	اسم الخبير	اللقب العلمي	الاختصاص	مكان العمل	سنوات الخبرة
١	د. امين عجيل ياسر	استاذ	جامعة بابل \كلية التمريض	تمريض صحة الأسرة والمجتمع	٣٨
٢	د. سحر ادهم علي	استاذ	جامعة بابل \ كلية التمريض	تمريض بالغين	٣٤
٣	د. ندى خزعل هندي	استاذ	جامعة بابل \كلية التمريض	احياء مجهرية	١٧
٤	د. فاطمة وناس خضير	استاذ	جامعة الكوفة \كلية التمريض	تمريض صحة الأسرة والمجتمع	٣٠
٥	د. سلمان حسين فارس	استاذ مساعد	جامعة كربلاء / كلية التمريض	تمريض صحة الأسرة والمجتمع	٢٢
٦	د. منصور عبد الله فلاح	استاذ مساعد	جامعة الكوفة \كلية التمريض	تمريض صحة الأسرة والمجتمع	١٩
٧	د. غزوان عبد الحسين عبد الكاظم	استاذ	جامعة كربلاء\ كلية التمريض	تمريض صحة الأسرة والمجتمع	١٨
٨	د.اشرف محمد علي	استاذ مساعد	جامعة بابل\ كلية الطب	طب اسرة	١٧
٩	د. حيدر حمزة علي	استاذ مساعد	جامعه الكوفة \كليه التمريض	تمريض صحة نفسية	١٤
١٠	د. حسين منصور علي	استاذ مساعد	جامعه الكوفة \كليه التمريض	تمريض صحة الأسرة والمجتمع	١٢
١١	د. امير كاظم حسين	استاذ	كليه الطب \جامعه بابل	طب اسرة	١٠

المستخلص

تعزيز الصحة هو تحسين حياة الشخص وعمله ومحيطه المادي بالإضافة إلى تعليمه ورفاهيته وهو ما يعني بوضوح ضمان صحته. إنه جهد مخطط له على مستوى النظام ويمس حياة الشخص. إن قيمة الجودة وهي حجر الاساس في نظام الرعاية الصحية، حيث أن ارتقاء الجودة يكمن وراء قدرة الخدمات على التقدم وتعزيز الصحة، مما يؤثر بشكل إيجابي على رضا المرضى ويعززه.

أجريت دراسة وصفية مقطعية في مراكز الرعاية الصحية الأولية في جنوب محافظة بابل – العراق. كانت أهداف هذه الدراسة هي تقييم الأداء الوظيفي للعاملين في مجال الرعاية الصحية، وتقييم رضا المستهلكين والبنية التحتية لمراكز الرعاية الصحية الأولية. بهدف تقييم ضمان جودة برنامج تعزيز الصحة خلال الفترة من أكتوبر ٢٠٢٢ إلى يونيو ٢٠٢٣ على عينة مناسبة مكونة من (٦٠) من مقدمي الخدمة الصحية العاملين في وحدات تعزيز الصحة، و٢٤٠ مشاركاً (مستهلكين). تم اختيار العينة عشوائياً من (١٠) مراكز رعاية صحية أولية.

وأظهرت نتائج الدراسة أن الأداء الوظيفي للعاملين الصحيين في مراكز الرعاية الصحية الأولية كان معتدلاً, حيث تم الحصول على متوسط درجة (٢,٠٧) على مقياس ليكرت، في حين كان رضا المستهلك في مراكز الرعاية الصحية الأولية متوسطاً. و ايضاً كانت إجابات وملاحظات المديرين على الهيكل التنظيمي الحالي لمؤسسة الرعاية الصحية الأولية متوسطة.

وخلصت الدراسة إلى أن تقييم جودة هيكل مؤسسة الرعاية الصحية الأولية يجد نقص الموارد المالية ونقص مقدمي الرعاية الصحية في وحدات تعزيز الصحة. نقص التدريب لجميع العاملين الصحيين الذين ينفذون برامج تعزيز الصحة.

وزارة التعليم العالي والبحث العلمي
جـــامعـــــــة بـــــابل
كـــليـــــــــة التمـــــريض

ضمـان الجـودة لخدمات تعزيز الصحة في مراكز الرعاية الصحية الاولية

رسالـــة مقـــدمة

الى مجلس كليــة التمريض/جامعـة بابل كجزء من متطلبات نيل درجة الماجستير علوم في التمريـض

مـن قبـل

حســـين سلـــيم ضـــايع

بأشـــراف

أ. د. ناجـــي ياســر سعـــدون

ذو القعدة ١٤٤٤ هـ

حزيران ٢٠٢٣ م