Rural Expansion of Afghanistan's Community-based Healthcare (REACH) Program

Evaluation of the Refresher Training Program

March 2006

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LIST OF ABBREVIATIONS

AKHS	Aga Khan Health Services
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BDF	Bakhtar Development Foundation
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
BRAC	BRAC Afghanistan
CAF	Care for Afghan Families
CHA	Coordination of Humanitarian Assistance
CHC	Comprehensive Health Centre
CoAR	Coordination of Afghan Relief
DH	District Hospital
EPI	Expanded Program on Immunization
FFSDP	Fully Functional Service Delivery Point
FP	Family Planning
HMIS	Health Management Information System
HW	Health Worker
IMC	International Medical Corps
IMCI	Integrated Management of Childhood Illnesses
IUD	Intra Uterine Device
MCQ	Multiple Choice Questions
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
NBC	New Born Care
NGO	Non-governmental Organizations
NPO/RRA	Norwegian People's Aid/Rural Reconstruction in Afghanistan
OPD	Out Patient Department
PNC	Postnatal Care
POP	Progesterone Only Pills
REACH	Rural Expansion in Afghanistan of Community-based Healthcare Program
RT	Refresher Training
SCF	Save the Children Fund
TB	Tuberculosis
TOT	Training of Trainers
USAID	US Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

The REACH Program, started in 2003 under contract to USAID, aims to improve the health of women of reproductive age and of children under five by increasing their use of basic health services.

Four REACH technical programs conduct activities designed to foster the strategic objective by achieving three intermediate results:

1. Expanded access to quality Basic Package of Health Services (BPHS)
2. Improved capacity of individuals, families, and communities to protect their health
3. Strengthened health systems at the national, provincial, and district levels

REFRESHER TRAINING

As a consequence of the first intermediate result, 310 NGO grantee-operated health facilities are operational in 13 provinces of Afghanistan, with a total of over 900 doctors, nurses and midwives working in these facilities.

These staff were initially trained and employed during period of chronic conflict and training had been of a varied and *ad hoc* nature. In the light of the need to ensure service delivery of a standard quality, training of these staff in the core areas of the BPHS was deemed to be of significant importance.

This was the basis on which the mission statement of the Refresher Training (RT) Program was formulated, as stated below:

Mission Statement of the Refresher Training Program

> Health professionals in Afghanistan have had no uniform in-service training for the last 2 decades and have had a weak educational foundation even before then. The goal of the REACH Refresher Training Department is to improve the quality of healthcare at REACH facilities with eventual scale up nationally by providing clinically-oriented, competency-based refresher training for health professionals (particularly doctors, nurses, midwives, and lab technicians) and institutionalizing these efforts at the Ministry of Public Health (MOPH) level.

Strategy

The REACH team met with stake holders and provided technical leadership to develop RT faculty, standardize curricula and training materials, and monitor outcome indicators that meet international standards, using both national and international expertise.

REACH subcontracted training at the regional/provincial level to 4 non-governmental organizations (NGO) already providing relatively high quality health training in the REACH program areas and provided regular technical assistance to strengthen and standardize their work.

Targets

1. Four NGOs selected to provide refresher training for all doctors, midwives and nurses in REACH supported facilities and beyond in 13 provinces (≥ 440 nurses & midwives, ≥ 240 doctors; priority given to female health providers).

2. Eight training centers fully staffed and equipped near or in clinical sites in Bamiyan, Badakhshan, Baghlan, Faryab, Herat, and Takhar Provinces plus Kabul City, Kabul Province rural areas.

3. Training modules for Antenatal and Postpartum Care; Newborn Care; Child Health (WHO Integrated Management of Childhood Illness Curriculum); Family Planning and Infectious Diseases; BPHS; and Mental Health and Disability developed and available in English, Dari and Pashtu. The last module was added on as the BPHS was revised to include mental health and disability.

4. 700 doctors, nurses and midwives to be trained in 3 modules by the end of December 2005.

Evaluation

The evaluation of the Refresher Training was undertaken between November 2005 to March 2006. The Terms of Reference for the evaluation state:

> 'We are concerned to know what has been the impact of this training on the quality of care at health facilities. The competence of participants has been measured through written tests and observation of practical skills during and at the end of each course. We now plan to survey a sample of health facilities to observe and evaluate the quality of care and question staff and their supervisors about the impact of the courses on the organization of care in the clinic and the delivery of care by health staff.'

The evaluation was widened to include an overview of the achievements of the REACH team and of the NGOs contracted to undertake the training in order to document and derive lessons from the program.

Methodology

A desk review of the program was carried out to document and review targets and other program aspects.

A meeting with the managers of the training NGOs was arranged to elicit their perception of the strengths and weaknesses of the program. A similar meeting was arranged with the senior managers and supervisors of the implementing NGOs. Since representatives of only 5 NGOs attended this meeting, individual interviews with most of the remaining implementing NGOs were conducted.

The assessment of clinical skills was carried out for antenatal care, post natal care, family planning and child care as guided by the integrated management of childhood illness (IMCI). Standards based tools were designed according to the guidelines of the training manuals for observation. Additionally, evaluators were asked to record sputum smear

examinations against male and female out-patient department (OPD) attendance for all patients over five years of age for the last six working days.

Field assessment of the skills of doctors, nurses and midwives was undertaken by 3 teams of observers. These observers were chosen from trainers who had worked for the training NGOs. Since the observers had to evaluate clinical skills according to the training guidelines and needed to have the requisite clinical knowledge, this was deemed to be the most suitable pool of observers, though this might have introduced a bias towards finding improved skills amongst staff. This bias was minimized by trying to ensure that staff from one training NGO evaluated another region or that they worked in mixed teams.

The teams were expected to be made up of 2 men and 1 woman but since it was possible to recruit only 2 women evaluators, 1 team comprised 2 men only. The team with only 2 male evaluators did face some constraints in assessing care during ante-natal and post-natal care and family planning consultations but were able to see at least one patient for each module per clinic. One woman evaluator completed only 2 of the 3 planned provinces; the remaining province was assessed by an all male team.

Staff were also asked to answer questionnaires comprised of representative questions from the post test questionnaires to assess their retention of knowledge after a period of 6 to 8 months.

The sample was selected for convenience, while ensuring that the facilities were representative of the provinces supported by REACH, the areas of responsibility for the training NGOs, and the various implementing NGOs.

RESULTS

DESK REVIEW AND PERCEPTION OF NGO STAFF REGARDING RT

RT Strategy and Targets

The RT program achieved its targets of contracting 4 NGOs to carry out the RT, developing materials, providing technical assistance to NGOs, and having 8 training centers fully equipped and running near clinical sites. The Bamyan Province site was not suitable and was closed after some time.

The RT program was not able to meet the target of training 700 doctors, nurses and midwives in 3 modules each. A total of 1911 people went through training. All 1911 did 1 module, 902 of these completed 2 modules, and only 461 persons were trained in 3 modules - about 20% of these were non REACH staff. The target set was probably unrealistic as sending clinic staff for such an intensive course of trainings meant that they would be out of service for long periods of time. Staff from remote areas had difficulty in traveling in winter. In some areas there was a large staff turnover. In some areas the implementing NGOs were not able to recruit sufficient numbers of female staff.

The internal target set with the training NGOs of training 110 nurses/midwives and 60 doctors in 6 modules was not met for many of the same reasons. However, the training NGOs did meet their training activity targets.

The strategy of contracting 4 NGOs to deliver training, with REACH developing materials and providing them financial and other resources along with technical advice, resulted in an improved capacity of about 60 trainers. The training courses were competency-based and included manuals for trainers, participants, and for reference, with case studies and pre- and post-test questions. This competency-based approach was new to Afghanistan and so was the analytical and participatory approach that underlay the whole initiative. This has resulted in a pool of trainers available to Afghanistan to take continuing medical education forward.

Perception of Training Managers and Senior Managers of NGOs

The managerial cadre of both training and implementing NGOs stated the following:

- The RT has improved the skills of clinic staff as evidenced by the increased number of patients, deliveries, insertion of IUDs, as well as increased and improved referral of sick children and good implementation of IMCI.
- The RT course started much later than the BPHS implementation and should have started earlier.
- The training courses were scheduled back to back and caused problems for both training centers and implementing NGOs. Staff had to be out of clinics for too long and too frequently. Training centers did not get enough time between courses to prepare for the next one.
- Information regarding the training schedules was not shared with the implementing NGOs in time or well in advance; this made it difficult for the implementing NGOs to inform the facility staff in time to attend the courses.
- Staff in remote areas had difficulties attending training courses in the winter.
- Nurses and midwives should be trained separately from the doctors and separate teaching materials should be developed for them.
- Pashto translations should be available as the Pashto speakers had difficulty with Dari materials.
- The Dari translations had problems; some notes were missing, some were wrongly translated and generally the Dari translations should be simpler.
- It has sometimes been difficult to find numbers and types of patients needed for the practical work.
- The pool of trainers have developed improved skills in curriculum design, learned to use participants, trainers and reference manuals, case studies and competency based materials. Training tracking and reporting systems have helped them manage the training.

> "The training promoted analytical thinking, group discussion improvisation and has been the biggest contribution of the training program." (Acting Country Director, IMC)

FIELD ASSESSMENT

The evaluation field assessment included visits to 24 Basic Health Centers (BHC), 44 Comprehensive Health Centers (CH), and 6 District Hospitals (DH) operated by 15 NGOs in 9 provinces where staff were evaluated. Security concerns in some areas meant

that teams were not able to visit some of the planned clinics and had to choose another option.

Knowledge Retention

A total of 215 health facility staff answered the relevant portion of the questionnaires. Of these 215, 11 said that they attended all 6 modules. The pass mark for the post tests was 75% immediately after training. It was considered that 65% after a period of six to eight months would be reasonable.

Findings*:* 74% of doctors obtained scores of 65% or more in the questionnaires; only 42% of the nurses/midwives scored 65% or more.

The managers of both the NGOs and the training centers stated that the nurse/midwives had difficulties with the learning materials. This may be due to the fact that the nurses/midwives have had different learning experiences; some of them have not had the standard training needed and are deployed because of the shortage of staff. The knowledge retention scores support the statement of the managers.

Assessment of Clinical Care: Ante-natal Care (ANC), Post-Natal Care (PNC), Family Planning (FP) and Integrated Management of Childhood Illness (IMCI)

The tools designed for the evaluation were standards-based. The scores for each component of care highlighted the strengths and weaknesses of care provision. There was no baseline assessment for comparison. It was felt that if the standards-based scores proved to be reasonable and if specific issues in each module that were newly introduced were also implemented, it would indicate a transfer of learning. These specific measures were new treatment interventions for the areas of care assessed.

	ANC	PNC	FP	IMCI
Average Total Percentage Score Clinical Standards	73%	64%	81%	88%

IMCI was the service where the taught standards were best applied. PNC scored the least.

The weaknesses identified were:

- .Caregivers did not give iron/folate for the prescribed three months as per guidelines (all caregivers did prescribe iron/folate but only for 1 month).
- They did not give pregnant women mebendazole and few women got Vitamin A in the postnatal visit.
- Physical examination of women in the PNC visit did not receive adequate attention.
- Blood groups of pregnant women could not be tested in some laboratories since there was no reagent or technicians did not know how to do the test.
- Counseling skills need strengthening across the board

The strengths were:

- The ARI treatment in the IMCI module was very well implemented; caregivers achieved a score of 98%.
- All the clinical score averages were fairly good. All except the PNC score showed that 70% or more of standards were implemented.
- The analysis of IUD insertion in clinics that had at least one female health provider in the last 4 months of 2004 and 2005 were compared. This showed that in 2004 one-quarter of these facilities inserted IUDs. In 2005, one-half of them inserted IUDs. The number of IUDs inserted per month per facility went up from 2 in 2004 to 6 in 2005. This particular skill needed to be taught before the IUD insertion could increase and is a direct indication of a transfer of learning.

The scores for the physical facilities that would be needed to deliver adequate services were more uniform and had fewer weaknesses. These weaknesses were:

- The IMCI chart, mothers' record, and referral slip were absent in a significant number of cases.
- Along with the absence of patient record forms for IMCI, temperature and weights of children were not taken in a significant number of cases.
- Patient records were not standard and not memory independent/action oriented, except in a few NGOs.

Tuberculosis (TB) Diagnosis

The percentage of OPD patients seen in the last six working days above the age of five who were sent for sputum examination, was assessed as an indicator of the index of suspicion for TB. In a country like Afghanistan, 7-10 percent of OPD patients should be examined for sputum smears in order to detect 80-100 percent of TB sputum positive cases.

The results showed that this best done in Herat, where 3.5 percent of OPD patients were sent for sputum smear. It was lower in the other provinces. The laboratory staff in Takhar and Baghlan provinces were away on training courses during the assessment, so obviously sputum smears would not be carried out. No comments can be made on performance in these 2 provinces for this indicator.

The development of the TB program has been slow in Afghanistan. Over the period of writing the manual and of implementing training, the case definition of TB changed from cases with productive cough, with or without fever, for more than 3 weeks to more than 2 weeks. Over the same period, the case definition for TB with the MoPH HMIS department was productive cough with or without fever for three months. The national TB program is just being implemented and the monitoring component is not yet in place.

So while TB diagnosis does not show improvement, the supporting components of the TB program are not in place.

CONCLUSIONS

The RT Program has significant achievements to its credit. It has introduced a system of competency-based learning to the country and developed a set of materials in the subjects which are in line with MoPH policies. Revision of these materials in order to develop a set of materials to train nurses and midwives separately should be undertaken. Tranlsation of the materials into Pashto and simpler Dari are important concerns. Simplifying the English materials is equally important. The materials should include newer policies. Some policies need to be reconsidered; the issue of including progesterone-only pills (POP) among the FP choices is one as it is difficult to train the health provider in a large range of choices. In addition, POPs are associated with increase risk of ectopic pregnancies and higher failure rates. Other modules such as infection prevention and malaria for staff in endemic areas can be expanded. New modules can be added such as rational drug use and gynecology and complicated pregnancies for female doctors.

The RT program trained 1911 people in at least one module; 461 of these completed 3 modules.

The impact of the training on practice is seen clearly in the IMCI module. The weaknesses within this module are largely those of supply of resources. IMCI is a very structured and algorithmic module. It has been implemented in many parts of the world and has been well tested. Monitoring and supervision are built into the training; trainers are used as monitors.

In the ANC, PNC, FP and infectious diseases (TB) modules, the standards are reasonable but unevenly implemented. These modules are not formulated in the same structured manner as the IMCI module. There was no strategy to train supervisors or orient managers to new policies and standards. While this is a gap in the RT program, the fundamental gap lies within the REACH program design. Supervision and monitoring has been included but REACH's Fully Functional Service Delivery Point (FFSDP) quality assurance methodology, but this system is currently a health management tool only. While this is very valuable, clinical standards are not addressed. Had this been different, the RT program would perhaps have included training design and strategy for supervision. The teaching and supervision should be standards-based in order to optimize transfer of learning and maintenance of skills in the field.

Training has placed an unanticipated burden on NGOs, i.e., the need to continue delivering health services while also sending staff to training courses. The training schedule should be slower paced; other training such as that conducted by WHO and the MoPH – Expanded Program on Immunization (EPI) should be better coordinated so that staff are not absent from clinics for long periods of time.

The RT strategy of developing 7-8 regional centers and developing a cadre of trainers is of great value. This can be taken forward in a similar fashion where all health service delivery organizations can procure ongoing medical education for their staff. This approach should be approved and accredited by MoPH. MoPH may also consider the issue of requiring all health staff to undergo continuing medical education for renewal of licenses. This would require donor coordination in order to fund and develop these

centers, fund NGOs to provide training, standardize course fees, and in the long term develop self sustaining accredited training centers.

EVALUATION OF REFRESHER TRAINING

BACKGROUND

REACH

Launched by Management Sciences for Health (MSH) in May 2003 under contract to the United States Agency for International Development (USAID), the REACH Program aims to improve the health of women of reproductive age and of children under five by increasing their use of basic health services.

Four REACH technical programs conduct activities designed to foster the strategic objective by achieving three intermediate results, listed below along with the component activities under each result:

Expanded access to quality Basic Package of Health Services (BPHS)

- Expanding coverage of basic essential obstetric care, child health and family planning services and TB control by increasing the number of health facilities and community outreach.
- Improving the capacity of health providers to offer services in rural areas and in health facilities.
- Developing a social marketing program for contraceptives and other health products.

Improved capacity of individuals, families, and communities to protect their health

- Implementing behavior change communication to promote healthful practices through public health education programs, including interpersonal communication and counseling by community health workers and community midwives and through multi-media campaigns.

Strengthened health systems at the national, provincial, and district levels

- Improving the capacity of the Ministry of Public Health (MOPH) to plan and manage, allocate resources, increase human capacity, strengthen the health information system, monitor and evaluate the BPHS program, make management and policy decisions based on data, and manage the essential drug supply system at national and provincial levels

REFRESHER TRAINING

As a consequence of the first component of the above results, 310 NGO grantee operated health facilities are operational in 13 provinces of Afghanistan, with a total of over 900 doctors, nurses and midwives working in these facilities. These staff have been trained and employed during a period of chronic conflict and training had been of a varied and as hoc nature. In the light of the need to ensure service delivery of a standard quality, training of these staff in the core areas of the BPHS was deemed to be of significant importance.

Mission Statement, Refresher Training Program

Health professionals in Afghanistan have had no uniform in-service training for the last 2 decades and have had a weak educational foundation even before then. The goal of the REACH Refresher Training Department is to improve the quality of healthcare at REACH facilities with eventual scale up nationally by providing clinically-oriented, competency-based refresher training for health professionals (particularly doctors, nurses, midwives, and lab technicians) and institutionalizing these efforts at the Ministry of Public Health (MOPH) level.

Refresher Training Program Strategy

The program strategy had the following components:

1. ***Meeting with key stakeholders*** (MOPH, NGOs, health facilities, international agencies, universities, etc.) that are working in health education and on quality of health services to identify priority areas for refresher training and secure their collaboration.

2. ***Subcontracting training at the provincial level*** to NGOs already providing relatively high-quality health training in these regions, and provide regular technical assistance to strengthen and standardize their work.

3. ***Providing technical leadership*** to develop faculty, standardize curricula and training materials, and monitor outcome indicators that meet international standards, while taking advantage of international and national expertise. Refresher training programs in the 13 REACH provinces can be viewed as a first effort to launch a national, standardized in-service education program.

4. ***Working with the MOPH and associated bodies*** to strengthen testing and certification infrastructure, professionalize health workers, and establish national training management systems.

Targets

- Four NGOs selected to provide refresher training for all doctors, midwives and nurses in REACH supported facilities and beyond in 13 provinces ($\geq$ 440 nurses & midwives, $\geq$ 240 doctors; priority given to female health providers).
- Eight training centers fully staffed and equipped near or in clinical sites in Bamyan, Badakhshan, Baghlan, Faryab, Herat, and Takhar Provinces plus Kabul City, and Kabul Province rural areas.
- Training modules for Antenatal and Postpartum Care; Newborn Care; Child Health (WHO Integrated Management of Childhood Illness Curriculum); Family Planning and Infectious Diseases; BPHS; and Mental Health and Disability developed and available in English, Dari and Pashtu. The last module was added on as the BPHS was revised to include mental health and disability.
- 700 doctors, nurses and midwives to be trained in 3 modules by the end of December 2005.

EVALUATION OF REFRESHER TRAINING PROGRAM

Terms of Reference

The Terms of Reference for the evaluation of the program stated the following:

> 'We are concerned to know what has been the impact of this training on the quality of care at health facilities. The competence of participants has been measured through written tests and observation of practical skills during and at the end of each course. We now plan to survey a sample of health facilities to observe and evaluate the quality of care and question staff and their supervisors about the impact of the courses on the organization of care in the clinic and the delivery of care by health staff.'

The evaluation design was broadened to include an overview of achievements of the program at the level of the REACH team and at the level of the NGOs contracted to undertake the training of the clinical staff, with the intent to document and derive lessons learned from this enterprise.

Methodology

Desk Review: The documents and reports of the REACH team were reviewed and analyzed: NGO monthly reports, monitoring reports and training database.

Meeting with Training Managers: A meeting was held with training managers of all 4 NGOs and the REACH team where perceptions of the impact of the training, views as to the strengths and weaknesses of the program were elicited.

Meeting with Senior Managers/Supervisors of Implementing NGOs: A meeting with the program managers and senior supervisors of the grantee NGOs was held in order to obtain their perceptions of the impact of the training and the strengths and weaknesses of the refresher training. Only 5 NGOs participated in this meeting; therefore the managers/supervisors of other grantees were met with individually. It was not possible to meet all of the grantees since they were not in Kabul over that period, but feedback was sought from 13 of the 19 grantees.

Field Assessment: The impact of the training program was assessed in 3 components:

1. Retention of learning; representative questions from the post test questionnaires were compiled and all clinical staff assessed were asked to answer those modules in which they had received training.
2. Transfer of learning; application of skills in clinical practice
3. The health staff were interviewed in order to obtain their perspective of the training program and its impact on their practice.

Clinical Skills Evaluation

- A sample of doctors, nurses and midwives were observed in the health facilities and skills in the fields of ANC, PNC and FP were assessed. The diagnosis of TB and index of suspicion for TB was assessed by obtaining the total number of OPD patients in the past 6 days and the number of cases who had sputum examinations over the same period as ascertained form the laboratory. The IMCI evaluation examined general case assessment as well as correct treatment for acute respiratory infection (ARI). This tool was composed of extracts from the IMCI monitoring tool. As this evaluation was carried out over the winter months, when malaria is not a problem, this was not included in the evaluation. Leishmaniasis is treated by specialist facilities and therefore, after consultation with the REACH team, it was decided that assessing skills in diagnosis and treatment of these cases would be more difficult. It was also decided that since newborn care and delivery care would require very long visits as the volumes of deliveries in facilities is low, these 2 areas would not be evaluated. Mental health and disability evaluation would also depend on the presence of these cases which would not necessarily be present at the time that the evaluators would visit the facility.
- The tools for the assessment of skills specify the standards for care based on the training materials and especially on the clinical guidelines that had been developed for ANC, PNC and FP. These tools are similar to the standards-based management tools being used in the monitoring of the essential obstetric care and infection prevention programs. These tools were field tested in Kabul, Shakardara, and Qarabagh. They were then translated into Dari. Based on the field tests, a level of competency was defined against which the sample was compared.
- Laboratory technicians were not included in this evaluation since at the time of the evaluation, their training was still ongoing.

Sampling Methodology

It was decided to undertake the assessment through convenience sampling for the following reasons:

- The assessment covered reproductive health and used women surveyors. Their deployment meant that issues of security and willingness to travel were an issue that was taken into account. Afghan women also find overnight stay in clinics difficult in Afghanistan
- The assessment took place over the winter months and access to remoter areas was limited

The main criteria for defining the sampling frame was to observe staff from all grantee NGOs and to also ensure that the sample represents the work of all 4 NGOs contracted to undertake the refresher training program. While it was thought desirable to have representation by province as well, there are areas where security and weather posed constraints and it was not possible to include them. In total, nine of the 13 USAID/REACH supported provinces were visited and 24 BHCs, 44 CHCs, and 6 DHs were included in the evaluation. Facilities operated by 15 of the 19 implementing NGOs were visited and 215 health staff answered relevant parts of the questionnaire. It was decided to evaluate mainly CHCs and DHs as these have larger numbers of staff and the likelihood of staff from these facilities having participated in refresher training would be greater.

A list of BPHS facilities by grantee NGO and their locations were obtained, with maps showing location, access and terrain. After discussion with the grants management officers, the names of 8 to 13 facilities were selected as possible sites for observation of clinic staff. The observers were asked to contact the NGO offices to confirm the accessibility of clinics and try and visit 8 facilities per province.

The observers/surveyors were selected from the pool of trainers who implemented the training program. While this introduced some possible bias in their work (trainers might be keen to prove their training had impact), this was balanced by the need to have people who are knowledgeable about the training content and expectations. In order to minimize bias, except for one team, the teams were made up of staff from more than one training NGO.

Eight observers were recruited and two teams comprising one woman and two men were formed. The third team comprised of 2 men only. More women did not apply for these posts as they were not prepared to travel to these remote areas. One of the female evaluators left before completion of the evaluation because of personal reasons having completed 2 of the 3 provinces assigned to that team.

The observers were trained over a period of 2 days in the use of the survey tools and a team leader assigned to each team.

The observers visited a clinic for a day. Observation of patients was done during working hours and the questionnaires were administered after work so that patient care was affected as little as possible. Clinic staff were asked to carry on with their work as normal and no interference in care was undertaken, unless considered absolutely necessary by the observer.

Feedback was given to clinic staff about strengths and weaknesses of care although monitoring/supervision was not the prime purpose of the visit.

Constraints

1. The absence of a woman on some of the evaluation visits made it difficult for the team to observe the provision of care directly and also limited the numbers of female cases observed for ANC, PNC and FP.
2. In some areas, the grantee advised that a woman should not travel to particular areas and that advice was followed.
3. Though the team visited 5 to 10 facilities in each province, in some clinics, staff had not been trained in some of the modules and in others, staff were away at trainings or workshops. This was due to a number of reasons: staff turnover, the clinics were in remote areas and had received invitations late and the training NGO had not assigned sufficient places for training. This was true of Ghazni, Takhar and Kabul provinces.
4. In Takhar and Baghlan provinces, the laboratory technicians were away at a training and therefore very few patients were referred for sputum smears.
5. One clinic in Baghlan Province was in an insecure area; it was advised that the women should not visit that clinic.
6. Ghazni Province is a very conservative area and the all male team had problems in observing sufficient numbers of consultations with female patients or observing care provided directly during the consultation.
7. The teams made an attempt to meet the Grantee Managers at the provincial offices in order to ascertain which of the clinics on their list had trained staff. The offices did not have a list of trained staff. One clinic in Ghazni Province was closed for an unofficial holiday without consultation with the provincial office.
8. Fewer patients came to the clinics for PNC. Since it was the winter, the women may have been reluctant to come to the clinics with their newborns. In addition, it is a custom to stay at home for 40 days after birth.

EVALUATION FINDINGS

A. DESK REVIEW

A.1. Achievements, REACH Refresher Training Team

1. All stakeholders were met and consulted. The MoPH-led capacity building groups were not dynamic enough to lead the curriculum and resource development tasks.
2. The Refresher Training manuals were developed in consultation with the main stakeholders with expertise in the relevant sector. Reference manuals, trainers' manuals and trainees manuals were developed; additional resources were also identified.
   In Phase 1 of the program, materials were developed for:
   - Antenatal and Postnatal Care
   - Family Planning and Infectious Diseases
   - New Born Care.

   In Phase 2 of the program from July to November 2005, resource materials were prepared for:
   - Mental Health
   - Disability
   - BPHS.
3. The 4 NGOs, CHA, IMC, IbnSina and AKHS, were contracted to undertake the training in June 2004, with agreements to operate centers in the identified locations.
4. The trainers were trained in a series of training of trainers (TOT) workshops, details in Table 1
5. Training centers were monitored to ensure standards of teaching; details in Tables 2 and 3
6. All training centers were provided with training materials, reference materials and budgets to purchase audiovisual and other equipment and to run the training courses.
7. Monitoring visits to assess transfer of learning were planned but due to the constraints of staffing and time, only one visit was undertaken.

Table 1: Training Courses for Trainers

Course	Dates	Conducted by	No. of Participants	
			Male	Female
Orientation	14 – 15 June 2004	REACH	20	17
IMCI	5 – 19 Sept. 2004	IMC	16	7
TOT, ANC, PNC, NBC	8 – 13 Jan. 2005	REACH	33	24
TOT, ANC/PNC	1 – 5 May 2005	IMC	4	17
TOT, Mental Health, Disability, BPHS	17 July to 4th August 2005	REACH	28	26

Table 2: Monitoring Visits to Training Centers

NGO	No. of Monitoring Visits
AKDN	3
CHA	3
IbnSina	3
IMC	3

Table 3: Main Conclusions of Monitoring Visits

1. The majority of trainers had taken part in a training for effective skills
2. In 2 out of 3 IMC trainings monitored, only about a half of the trainers had been trained in that particular module for IMC
3. In 1 out of 3 IbnSina trainings monitored, all trainers were not trained in that particular module
4. Though the same number of visits were made to all training centers, not all of the modules were observed – staffing constraints made this difficult to achieve
5. Teaching methodology was fairly satisfactory over all 4 NGOs
6. Some difficulties in coordination with hospitals for practical work were observed
7. Trainers did not seem to move around the room very much and this may be related to the fact that these buildings are not purpose built and space is not ideal. The same problem was observed during practical training.
8. Slides, both for multi media and overhead projector, tend to be very densely written
9. Course materials and contents were generally followed and resource materials provided to participants
10. Practical training is sometimes hampered by the fact that the facility does not use the relevant patient card and checklist
11. All centers were well equipped

A.2. Achievements of Training Centers

Each training NGO was asked to cover the staff of health facilities nearest to the training center. There was some overlap in the areas near Kabul as both IbnSina and IMC have training centers in Kabul. Each NGO was set targets of 110 nurses/midwives and 60 doctors to be trained in 6 modules by the end of December 2005.

Budgets were given to each of the four NGOs to cover the costs of transport, accommodation and perdiems (at the MoPH rates) for the trainees.

Table 4: Training Achievements against Targets

NGO	Number of Participants Trained (Target=1020 each)	Percent of Planned People Trained
AKHS	1071	105%
CHA	742	73%
IBNSINA	998	98%
IMC	858	84%

Table 5: Total Number of Courses conducted by Module

NGO		MODULES							
		FP / ID	ANC / PNC	NBC	IMCI	MH DISABILITY	BPHS	TOTAL	
IBNSINA		8	7	9	8	7	7	**46**	
IMC		7	7	8	8	7	7	**44**	
AKHS	BDK	3	3	3	2	3	3	**17**	**TOTAL AKHS= 53**
	BGL	3	3	3	3	3	3	**18**	
	TKR	3	3	3	3	3	3	**18**	
CHA	HRT	6	5	6	6	4	5	**32**	**TOTAL CHA=57**
	FRB	5	3	4	5	3	5	**25**	
GRAND TOTAL		**35**	**31**	**36**	**35**	**30**	**33**	**200**	

As can be seen from Tables 4 and 5, the training NGOs met their targets for participants and conducted training in all the modules.

The RT Program was able to meet 60% of the program target of at least 700 people completing 3 modules (Table 6).

Table 6: Number of Courses Attended by Number of People

	Number of Courses	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Number of People		1911	902	461	232	107	31	1

As can be seen in Table 6, the total number of people who went through 6 trainings is 31. **The training NGOs were not able to meet their target of training 110 nurses and 60 doctors in 6 modules each**.

All the modules had practical components and there were some constraints in achieving this:

- In some areas there were not enough patients (not Kabul)
- In some areas, the hospitals did not allow the male participants to undertake the practical component on female patients (ANC/PNC, FP)

Table 7: Competency Rates of Trainees

	IBNSINA	IMC	AKHS			CHA	
			Badakshan	Baghlan	Takhar	Herat	Faryab
Number of Courses Held	46	44	17	18	18	32	25
Number of Participants	998	858	345	374	352	414	328
Number Participants Competent PreTest	288	276	56	221	94	160	96
Number Participants Competent PostTest	915	781	322	368	314	337	308
Percent of Participants Competent PreTest	**29%**	**32%**	**16%**	**59%**	**27%**	**39%**	**29%**
Percent of Participants Competent PostTest	**92%**	**91%**	**93%**	**98%**	**89%**	**81%**	**94%**

As can be seen from Table 7, the percent of participants who achieved competency (scores of 75% or more) in the post-tests ranged from 80 to 90% as compared to about 30% in the pre-test. Baghlan Province is a notable exception as the percent of participants who achieved competency was a remarkable 59% in the pre-test. The staff from Badakshan scored the lowest score in the pre-test; about a half of that of staff trained in other provinces.

B. NGO STAFF PERCEPTIONS OF REFRESHER TRAINING

B.1. Assessment of Refresher Training With Managers of the Training Centers

The managers of the training programs operated by CHA, IbnSina, IMC and AKDN were requested to participate in a meeting where their perspectives of the program and its impact on quality of services delivered could be sought.

The list of participants is attached as Appendix 1.

Organization

- All managers were aware of contracts and targets and were involved in target setting.
- They were not aware of the 3rd round of contracting; i.e 3rd round did not affect the training center or targets – targets are in contracts and have not been changed. However, staff of the new grantees were included in training after some complaints from the grantees that they had not been included.
- Budgets were prepared by NGOs and approved by REACH. However, NGOs were not fully aware of the numbers of trainers needed for IMCI training and also did not realize that the training load would present challenges to the numbers of trainers they would need.
- IMCI requires that trainers be trained first by the MOPH IMCI team. The cost of the first two rounds of training that covered IMCI and the TOT was covered by WHO but the training for IMCI follow up was not. The MOPH team required per diems for this but NGO centers could not pay as it is forbidden under USAID rules and therefore not budgeted. Clinical trainers in the hospitals presented the same problem for IMCI training.

- REACH provided the training centers with adequate budgets to furnish centers appropriately and with adequate audio visual aids and other training resources.

> The contractual and implementation arrangements between REACH and the training NGOs were clearly understood and implemented. There were some financial issues concerning the IMCI follow up training which had not been budgeted and was not in the REACH remit.
> REACH provided the training centers with adequate budgets to furnish centers appropriately and with adequate audio visual aids and other training resources.

Targets and Difficulties in attaining targets

- Weather prevented travel of participants
- Security was a problem in some areas, not allowing participants to attend training
- Invitation time to participants should be appropriate and reminders nearer the time should be sent out to optimize attendance
- Targets for nurses and midwives were too high – there are not so many nurses and midwives available (however the REACH/NGO Grantee HR database shows that there are 587 nurses and midwives in grantee facilities)
- Grantee NGOs did not agree to send staff because clinics, especially BHCs, would be closed
- The 'trained in 6 modules' target means that 1 person would be out for 12 weeks of training and about 24 days of travel time – a total of 16 weeks. This is a difficult for any NGO
- The training courses were too close together because of the tight targets – trainers did not get a break of 1 week between trainings
- In some areas, some of the grantee staff refused to attend as per diems were lower than other organization provided. CHA stated that staff from SCF-UK and SCF-US did not attend some courses for this reason.

> The training program was very intensive and this resulted in some difficulties for the implementing NGOs to send staff. Grantee NGOs sometimes did not send staff, especially from BHCs, as this would mean that their BHCs would be closed for that time. Some NGOs did not have sufficient numbers of nurses or midwives to send to the training courses.
> The intensity of the back-to-back trainings resulted in the trainers having little time between courses for a rest or to prepare for the next course.

Technical Support from REACH

- In the early stages of the programs, training manuals were not provided in time for the courses, REACH had stated that they would provide all manuals for participants, but this proved to be impossible. The problem was solved by asking NGOs to photocopy these and agree to fund the photocopying costs
- The manuals were not appropriate in the following ways:
    a. Were not written for the 3 different levels of staff, i.e., doctors, nurses and midwives. The latter two cadres had difficulty in following them.
    b. The New Born Care module was written for the hospital level of care and staff
    c. The translation was weak. Initial translation was undertaken by the training NGOs; the deadlines for the translation were tight and the English was often

difficult. The translations were revised by REACH through outsourcing and the translations actually became more problematic

d. There was no Pashto version
e. The curricula need revision for about 5% to 10% of the technical content
f. The case studies were mostly good but some were not unsuitable to the Afghan cultural context

- Some staff from remote areas were not trained staff and had difficulties using materials and the training
- Some immigrant staff (e.g., women from India who had married Afghans and staff who had grown up in Tajikistan) had difficulties with using materials in Dari and/or with teaching in Dari.
- The pretest questionnaires were easy and the post test questionnaires were difficult. Translation of questionnaires was a part of the problem. The English version was also sometimes difficult to understand so that trainers were not able to explain fully. Afghans have not developed the habit of using multiple-choice questionnaires (MCQ) for testing and the post test questions were MCQs
- The trainers were trained in the modules before the training of clinical staff began
- The knowledge and skills of the trainers have improved after this program. They have learned to use learning objectives, development of curriculum, the use of case studies, the use of different manuals for reference. The reporting system was very good and has contributed to the improvement of organization of training. Their skills in the use of audio visual aids has improved.
- The monitoring visits by REACH were very supportive, with good feedback provided. Strengths and weaknesses were discussed. REACH staff were always accessible in case of any problems.

There was an initial problem of the supply of the training manuals which was later solved.

Some of the translation is incorrect and leads to confusion. There is no Pashto translation. Some of the participants who are immigrants from Tajikistan and India had problems with the Dari materials.

There should be a different set of materials for nurses and midwives. The difficulty of the pre-test and post-test questionnaires is different. Some of the case studies are not appropriate to the Afghan context.

The trainers have learned curriculum development skills, the use of case studies and have developed further teaching skills. Previously they had not used trainers' guides, reference manuals, and participants' manuals.

The monitoring visits of REACH were supportive.

Impact of Training

- The participants' skills and knowledge improved and were applied. IMC stated that in follow up visits to Bamyan they observed changes in the attitude of staff – the ANC/PNC care had improved. The staff were more motivated to undertake normal deliveries. In Ghazni and Bamiyan, IMCI is being implemented
- IbnSina stated that IMCI is being implemented in Gardez

- AKHS stated that there was more prompt referral of sick children and mothers with problems
- The participants felt that their knowledge and skills had improved. There were specific requests for some courses to be repeated

Recommendations:

- There should be more training in the mental health and disability modules
- The training of different cadres should be separate. CHA trained nurses and midwives separately and this did address the earlier difficulty
- The organization and management of the courses should be different with some space between trainings.
- There should be some visits to regional training centers so that trainers can learn and observe different training methods
- The materials should be revised for language and some of the technical content.

It is of note that although the trainers stated that about 90% of the trainees were the same people who went through the 6 modules, this is not borne out by the data base. Table 6 shows that only 31 people went through 6 courses.

Main Strengths:

- A large number of health workers have been trained using a standard curriculum
- There are now well equipped training centers
- The knowledge and skills of trainers have improved
- Standard training materials have been developed
- An excellent reporting system has been developed
- The training centers received good support from the REACH team.
- The training resulted in improvement of the clinic staff. IMCI is being implemented and has resulted in prompt referral of sick children. When trainers had occasion to go on field visits they observed a change in the attitude of staff and that ANC and PNC had improved. Staff were motivated to undertake more deliveries.

Main Weaknesses:

- Poor translation of training materials
- Very tight training schedules
- The targets were too high, taking many staff out of work
- Nurses/midwives had difficulties during training in the same groups as doctors - should have different materials and should be trained separately
- There were difficulties in providing practical training especially for IMCI in the early stages as all participants were at the Indira Gandhi Hospital
- There were some weaknesses in the coordination between hospitals and training NGOs that resulted in poor support from the hospital staff for practical work. These were later smoothed out (CHA had no problems with the Herat and Faryab hospitals as clinical training sites)

B. 2. Assessment of Refresher Training With Senior Staff of NGO Grantees

The senior managers and supervisors of NGOs were requested to attend a meeting where their perception of the RT, its organization, impact, constraints and recommendations could be sought. Only 5 NGO of the 19 grantee staff were able to attend. Therefore, individual meetings were conducted with the others. All NGO were not met with as some do not have head offices in Kabul and some were busy with other work in the provinces.

B.2.a. Plenary Meeting with the NGO Senior Staff

The list of participants is attached as Appendix 2.

Organization of Refresher Training

- Training started late; the first round of contracts started in November 2003 and the training started in November 2004
- Only 5-6 day's notice was ordinarily given for courses; this is not sufficient notice to ask staff from remote areas to attend because there are no phones or radios in these areas.
- Sometimes the information regarding the course was not correct, e.g., the invitation would say that an ANC/PNC course was being held but it would be something else. This would occur because other course participants could not attend and therefore the course would be changed.
- Sometimes participants were sent back without training because the course was cancelled or it was too full but advance information was not sent to the grantees
- Participants sent to one course were transferred to another course in order to fulfill center targets
- One CHC in Farza, an area in Kabul with no problems of distance, has no staff trained in IMCI
- Fewer staff working for STEP have been trained as compared with staff of other NGOs, even though their clinics are in Kabul
- No training needs assessment was carried out prior to the training
- AHDS in Kandahar is experiencing a staff turnover of 50% due to insecurity. Other NGOs are experiencing a turnover of 0-10%
- In areas of difficulty, e.g., Kandahar, there is only one midwife per clinic. This raises the question of whom to send for training when maternal care is a program priority and where the area is conservative and it is necessary to have at least one female staff to deliver services to women
- Twenty to twenty-five staff were invited to the trainings from an NGO area; this meant that the running of clinics was difficult
- The tight training schedule created a tension between achieving targets for programs and sending staff for training
- NGOs were not consulted about the training program at the start.
- There were/are other trainings in addition to the REACH RT organized by the vertical programs – WHO for TB, Malaria, EPI, etc. This aggravated the time lost by staff from work while attending training
- No feedback was given to grantee management regarding staff attendance or performance

The training schedule was too demanding and created problems for the implementing NGOs who had to meet program targets and send staff for training.

There were problems with the organization of training due to late invitations especially for staff working in remote areas.There was an additional burden of training since other organizations also organized training courses with conflicting timing.

The Refresher Training Program started much later than the BPHS service delivery program.

No feedback regarding the trainees was given to the grantee NGOS.

AHDS was experiencing a 50 percent staff turnover in Oruzgan and Kandahar; the other NGOs are experiencing a 105 turnover. This means that clinic staff who are trained, leave the area and there is no resulting benefit to the area.

Impact of Training

- IMCI skills are being used in clinics and this has improved child care
- The training of doctors, nurses and midwives in the same group may have made it difficult for nurses an midwives (nurses/midwives have different learning capacities; they might be hesitant to participate fully in the discussions)
- There does not seem to have been much difference in the skills of nurses and midwives at the clinic level after training
- The drugs recommended for mental health care are not included in the BPHS list
- Many NGOs did not send supervisors for training so the supervisors did not acquire the same skills
- The NGOs did not see much improvement in areas other than IMCI but there was some improvement in knowledge in FP/ANC-PNC etc.
- SDF stated that their clinics were supervised using a checklist and this showed that staff were implementing guidelines
- STEP has an after training evaluation protocol but other NGOs did not

The IMCI training has resulted in improved child care.
Training of nurses and midwives may have resulted in the perception of some that there is not much improvement in their skills.
Supervisors were not trained in the same modules.
The drugs that are cited in the mental health module are not included in the BPHS list.

Recommendations

- Refresher training should start at the beginning of program implementation
- HMIS should be included in the training programs
- A training needs assessment should be carried out before the training. Some felt that the grantees should carry this out; others felt that clinic heads should do this
- Some felt that the curricula and TOT should be given to the grantees and they should train their own staff, but some felt that the benefit of interaction with the staff of other organizations would be lost in this way and that the training should be conducted at specific centers
- Training should be conducted separately for nurse and midwives and for doctors as there were two problems for the nurses and midwives: the first being their capacity to use the

materials and learn at the same rate and the second was that of being inhibited by doctors and not participating fully
- There should be training for supervisors and managers in the same fields
- NGO senior staff did not have any comments on the resource materials as they were not familiar with them
- Training events for vertical programs and these RT courses should be better coordinated
- Feedback should be given by the training NGOs to grantee NGOs regarding attendance and performance
- Managers should be invited to spot check training to make sure that staff were attending regularly
- The schedules for training should be drawn up for 6 months and given to grantee NGOs so that they can plan staff attendance well.

B. 2.b. Interviews with Senior Staff of Other NGOs

Interviews were held with senior staff of the following organizations:
- AKHS, CoAR
- BDF
- SCF-US
- BRAC
- IMC
- CHA
- NPO/RRA

A list of the staff met is attached as Appendix 3.

Organization of Refresher Training

- The RT program was initiated late into the health service delivery program
- Those NGOs that worked in Herat stated that CHA had a good plan and had shared their training plan with the implementing NGOs so that it was possible to inform staff in time
- BRAC said that IMC had planned training 2 to 3 months in advance and shared it with them and that they had also sent reminders to optimize attendance in the courses.
- NGOs from other areas stated that they had problems with very little notice of training, sometimes only verbally. The training NGOs that were responsible for their areas did not share their training plans in advance for methodical planning.
- Clinic staff were absent for long periods sometimes and that made it difficult to achieve indicator targets.
- NPO/RRA stated that while this might be a problem, it was a greater problem to have untrained staff delivering health services.
- Most NGOs were concerned that the training NGOs did not have place for all their clinic staff to attend trainings
- BDF did not agree with the REACH strategy to train through 4 NGOs. They felt that it would have been better to train the trainers of each NGO so that they could ensure that all staff were trained.
- NPO/RRA and the BDF Ghazni program deliberately sent their supervisors for training. BDF sent their 3 training managers and the cluster manager; NPO/RRA sent 4 of their supervisors.
- BRAC sent its supervisors and all clinic heads for training.

Impact of Training

- Most senior staff said that the training had made an impact on the clinic staff. Examples of improvement in skills and knowledge from BRAC are that:
    - after training, 45 to 50 IUDs were inserted per month in an area that serves 17,000 people
    - >200 depo provera doses were given per month after training
    - they started ORT corners in the clinic after the training
- BRAC arranged a special meeting with the Manager of the RT program to plead for the continuation of the training.
- All NGOs felt that the IMCI module is implemented well.
- AKHS said that their midwives who had attended ANC, PNC and FP training had requested supplies that were specified in the training.
- CHA staff had requested NBC materials after training.
- Many NGOs felt that the number of deliveries in their facilities had gone up after training. IMC said that the numbers of deliveries in the Jalalabad area in a CHC had gone up to 35 to 40 a month.
- Many of the NGOs felt that contraceptive use had increased after the training.
- SCF-US said that for them, FP remains the weakest program, though this could be because they have insufficient female staff in clinics and the BCC program is weak and that uptake is the problem rather than skills.
- They also said that the counseling skills of staff trained by both SCF and through REACH were better than those trained only through REACH. They used the child survival package for this purpose.
- Many stated that the increase in the numbers of patients was related to the training.
- Interestingly, IMC and AKHS stated that the community in some areas had communicated that there was an improvement in the attitude of staff towards patients.
- In some of the provinces, it was not possible for clinic staff in remote areas to get through snow to attend training.
- SCF-US stated that the CBHC program had management and supervision built into it as there was a training of supervisors, though it started late. Supervisor training should be built into refresher training.

Recommendations

- All the NGOs felt that the training should continue though some revision should be undertaken. It is important because of the varied quality of staff, staff turnover, and a number of staff who had not yet been trained.
- Infection prevention training should be expanded and key NGO staff trained in order to disseminate this to the majority of their staff.
- Growth monitoring was not taught properly.
- The rational use of drugs should be included.
- For the endemic areas of malaria, the one-day training of malaria management was not enough.
- SCF-US felt that teaching still tends to be didactic, more lecture than any other methods, and that this was a problem especially for areas like Faryab where women had low learning capacities.
- The taskforce should revise the curriculum and training methodology with the trainers.
- The NGO trainers should be trained so that they can impart training to their staff.
- Some trainers did not have a sufficient breadth of knowledge of a particular technical subject. This should be remedied.
- A mentoring system to be included in the program should be considered. Supervisors should be trained in the same technical aspects.

B. 2.c. Perceptions of Senior Staff of NGOs Responsible for Training

- IMC, which had participated in the curriculum development, said that they felt that this process was not started in time due to unsuccessful attempts to involve the MoPH in the process.
- IMC also felt strongly that time (3 months) should have been allotted at the end of this project cycle to revise the curriculum in light of the experience of the trainers.
- IMC received their first tranche of money late so that they had to use their own funds to start up the training center. The subsequent allotments were not delayed.
- AKDN had special problems in starting up the training center in Badakshan as the Provincial Health Director delayed agreements to the construction of a center in the hospital. This proved not to be possible and they had to locate it in a rented building.
- The Refresher Training Program interruption will mean that trained staff will move on and this will be a loss.
- The Dari version of the NBC module had translation problems.
- In Faizabad and Faryab, it is difficult to find the numbers and type of patients needed for the practical training.
- The trainers have improved in both knowledge and skills. Though the volume of training to deliver was a problem, this resulted in an improvement in training capacity and gave young trainers a chance to work with more skilled ones, providing a good mentoring environment.
- The training of staff from various NGOs provided a forum to get to know each other which is a valuable outcome.

> "The training methodology promoted analytical thinking, group discussion, improvisation and has been the biggest contribution of the training program. This differs greatly from the methodology used in the Kabul Medical University."
>
> (Country Director, IMC)

FIELD ASSESSMENT OF FACILITY STAFF FOR TRANSFER OF LEARNING

The three teams of observers visited 74 Health facilities in 9 provinces (see Table 8) and observed 215 health care workers. Each team was responsible for evaluation of three provinces.

Table 8: Facilities by Province that were Evaluated

Province	District Hospitals	CHCs	BHCs	Total No. Facilties
Kabul	1	6	1	**8**
Ghazni	1	4	3	**8**
Bamyan	0	4	3	**7**
Paktia	0	5	3	**8**
Herat	1	5	3	**9**
Jawzjan	2	4	4	**10**
Faryab	1	5	3	**9**
Takhar	0	6	3	**9**
Baghlan	0	5	1	**6**
Total	**6**	**44**	**24**	**74**

Two teams had a female staff with them and had no problems in observing care of ANC, PNC and FP patients. One of the female evaluators had to leave the evaluation process after completing 2 provinces. The other (all male) team was only able to observe a limited number of female patients.

Data compilation was a continuous activity in the field and finalized on return to Kabul, where it was entered into a computer by the evaluation teams. The data was entered and analyzed using Excel.

A. Retention of Knowledge

Table 9: HW by Category who Achieved 75% and 65% Scores at Test

Health Worker Category	Total Numbers	Number Achieving a 75% Score (percent	Number Achieving a 65% Score (percent)
Doctors	74	31 (42)	55 (74)
Nurses/Midwives	134	26 (19)	56 (42)
Others	4	0 (0)	3 (75)

Since the score for competency at the post-test was 75%, this was used as a bench mark. A score of 65% was also used, assuming that a 10% drop in learning after a gap of 6 to 8 months was to be reasonably expected.

Table 9 shows that nearly three-quarters of the doctors were able to achieve scores of 65 percent but only slightly more than 40 percent of nurses/midwives were able to achieve those scores. This matches the comments by both training managers and senior managers of the NGOs that the nurse and the midwives had difficulty in learning in the same group as the doctors. They had also stated that the nurses and the midwives found the resources difficult both as for the language and the technical materials. Since the nurses deployed in the work force currently have a varied previous learning experience and have had different training periods, this is perhaps to be expected.

Table 10 shows that staff in different provinces had different knowledge retention levels.

More of both groups (doctors and nurses/midwives) achieved scores of 65 percent or higher in Takhar, Baghlan and Herat provinces. In Bamyan, only 41 percent of midwives had good retention levels whereas 100 percent of the doctors achieved the 65 percent or greater level of knowledge retention. In Ghazni and Faryab, the doctors performed reasonably well but the nurses/midwives did not. Neither group did not very well in Kabul, Paktia, and Jawzjan.

Training Managers and Senior Managers of the NGOs commented that they felt that there were problems in teaching the doctors and nurses/midwives in the same classes with the same materials. It is possible that the nurse/midwife groups in Paktia, Jawzjan, Faryab, Bamyan and Ghazni were trained using non-standard curricula during the conflict years and therefore have different learning experiences. These are mainly provinces where implementing NGOs have also had difficulty in recruiting female staff and have stated that they use staff who have had some training on the job.

Table 10: Percent of Health Care Workers by Province who achieved a Score of 65% or More

Health Care Worker Category	**Takhar**		**Baghlan**		**Bamyan**		**Herat**		**Kabul**		**Ghazni**		**Paktia**		**Jawzjan**		**Faryab**	
	T	***%***	***T***	***%***	***T***	***%***	***T***	***%***	***T***	***%***	***T***	***%***	***T***	***%***	***T***	***%***	***T***	***%***
Doctors	8	75	10	80	7	100	10	90	9	56	7	71	11	55	6	33	8	88
Nurses/Midwives	10	70	15	80	17	41	17	71	19	47	18	50	14	29	13	15	11	0
Others	0	0	0	0	0	0	4	75	0	0	0	0	0	0	0	0	0	0

Note: T= Total number of clinical staff who participated
%= Percentage of staff who achieved scores of 65% or more

B. Clinical Performance

B.1. Antenatal, Postnatal, Family Planning, IMCI

Table 11: Antenatal Care

ANC: 82 CASES

	Maximum Score (standards)	Average Percentage Score Obtained	Number of Scores=<70%
History Taking	7	83	6
Physical Examination	8	87	6
Laboratory Tests	3	76	36
Treatment	4	48	73
Counseling	3	69	51
Average Percentage		**73**	
Room	6	84	14
Equipment	3	97	6
Records	4	81	13
Average Percentage		**87**	

9 cases seen by doctors (11%), the rest by nurses/midwives

Table 11 shows the percentage of standards implemented during ANC services for all ANC cases seen. Overall, 73 percent of standards for the clinical components were observed.

The treatment and counseling components are the weakest. There are four standards for treatment:

- iron/folate for 3 months,
- mebendazole in the second or third trimester,
- TT as per schedule
- any other treatment if needed.

Iron/folate is prescribed for all mothers but only for a month. Some staff state that this is due to insufficient supply and some state that mothers will not take the iron/folate if it were to be given for a long period.

Table 12 shows that none of the 67 women seen for ANC had received mebendazole. In Andkhoy DH, Jawzjan Province, the staff of a clinic had prescribed mebendazole previously when the clinic was supported by MSF but this practice was discontinued by the NGO currently supporting the clinic.

The lower score obtained for laboratory tests was due to the absence of ABO reagents and some staff not testing urine for protein/glucose.

Counseling also scored just below 70 percent.

The facilities standards scored well. The evaluation teams commented that in some clinics, registers were not present and the staff used ordinary note books. In some cases there were no patient record cards.

Table 12: Vitamin A & Mebendazol Prescription During PNC & ANC Visits

Province	Vitamin A (PNC)	Mebendazole (ANC)	No of HF	No of ANC cases	No Of PNC Cases
Kabul	0	0	8	7	2
Ghazni	0	0	8	5	3
Paktia	2	0	8	10	4
Herat	0	0	9	10	2
Faryab	0	0	9	12	4
Jawzjan	1	0	10	5	4
Takhar	2	0	9	13	6
Baghlan	1	0	6	14	4
Bamyan	1	0	7	11	4
Total	7	0	74	87	33

Table 13: Post Natal Care

PNC: 33 CASES

	Maximum Score (standards)	Average Percentage Score Obtained	Number of Scores=<70%
History Taking	8	72	15
Physical Examination	8	64	24
Treatment	4	45	19
Counseling	4	75	8
Average Percentage		**64**	
Room	6	89	2
Equipment	4	89	4
Records	4	74	4
Average Percentage		**84**	

3 cases seen by doctors (9%), rest by nurses/midwives

Fewer PNC cases were seen than were observed for ANC because fewer women come for PNC. It is traditional in Afghanistan that women do not go out of the house for 40 days after giving birth, and this may be the cause of women not seeking PNC readily.

Overall, 64 percent of clinical standards were implemented. This is lower than that of ANC. Treatment standards are poorly implemented. There are 4 standards in this component:

- Fe/folate for 3 months
- Vit A capsule given at the PNC visit
- Refer baby for vaccination
- Prescribe medication for other problems if needed

Table 12 shows that only 7 of the 33 women who came for PNC were given Vit A. In Andkhoy DH, Jawzjan Province, the caregivers had Vit A capsules on their tables and gave the women seeking PNC the Vit A capsule during the consultation.

No women were given iron/folate for 3 months, though they were given iron/folate for 1 month.

The physical examination component also scored poorly. The caregivers did not seem to regard this as important.

Counseling scored better in the PNC cases than in the ANC cases but all the components of the clinical care scored below 80% (compare with ANC).

The facilities standards scored 84%. Again, in some clinics patient registers and cards were not present.

Table 14: Family Planning

FP: 67 CASES

	Maximum Score (standards)	**Average Percentage Score Obtained**	**Number of Scores=<70%**
History Taking	8	84	9
Physical Examination	4	84	7
Laboratory Tests	1	94	4
General Counseling	3	76	42
Method Specific counseling & prescription		68	28
Average Percentage		**81**	
Room	6	88	12
Equipment	6	86	12
Records	2	89	15
Average Percentage		**88**	

8 cases seen by doctors (11%), rest by nurses/midwives

81% of the clinical standards were implemented, which is a higher score than for ANC or PNC.

The components which were weaker, were the general counseling and the method specific counseling; the latter being the weakest of the two.

The facilities standards scored above 80% for ANC, PNC and FP.

Most of the cases seen for ANC. PNC and FP were seen by nurses/midwives. Only 11 percent of the cases were seen by female doctors. The evaluation teams said that the female doctors saw the gynecology cases and the cases with complications. This raises questions of task divisions and of appropriate training. Should the female doctors receive, in addition to the training in the 6 modules designed, training in gynecology and complications of pregnancy and delivery?

Table 15: REACH Supported Health Facilities with at least One Female Health Care Provider (Total = 192 Facilities) Inserting IUDs

	Sep. – Dec. 2004	**Sep. – Dec. 2005**
Percentage of Health Facilities Inserting IUDs	25%	48%
No. Of IUDs inserted per facility per month	2	6

Source: HMIS REACH, March 2006

The proportion of health facilities inserting IUDs went up to nearly 50 percent after the refresher training. Senior managers of implementing NGOs have stated that IUD insertion rates went up after training. The statistics support this statement. IUD insertion is a skill that was imparted to providers in a 2-day intensive training course. These data confirm a direct transfer of learning for a particular skill.

Table 16: Integrated Management of Childhood Illness

IMCI 220 CASES

	Maximum Score (standards)	**Average Percentage Score Obtained**	**Number of Scores=<70%**
Case Assessment	5	86	26
Prescription	3	94	39
Prescription ARI	2	98	10
Counseling	4	74	74
Average Percentage		**88**	
Examination area	8	68	111
Case Management Tasks	6	70	130
ARI Drugs in stock	1	100	0
Average Percentage		**79**	

17 (7%) cases seen by midwives, 37 (17%) by male nurses, 11(5%) by female doctors, balance by male doctors (71%)

IMCI is the best implemented module and scores highest for transfer of learning in the clinical care; a score of 88%.

Counseling scores the lowest of all the clinical components.

The facilities standards in the components of examination area and the case management tasks scores do not match the other scores.

The examination area assessment requires that the IMCI chart, the mother's card and the referral slip should be present. This was not the case in some clinics.

The case management tasks included weighing the child, which was not carried out in some clinics.

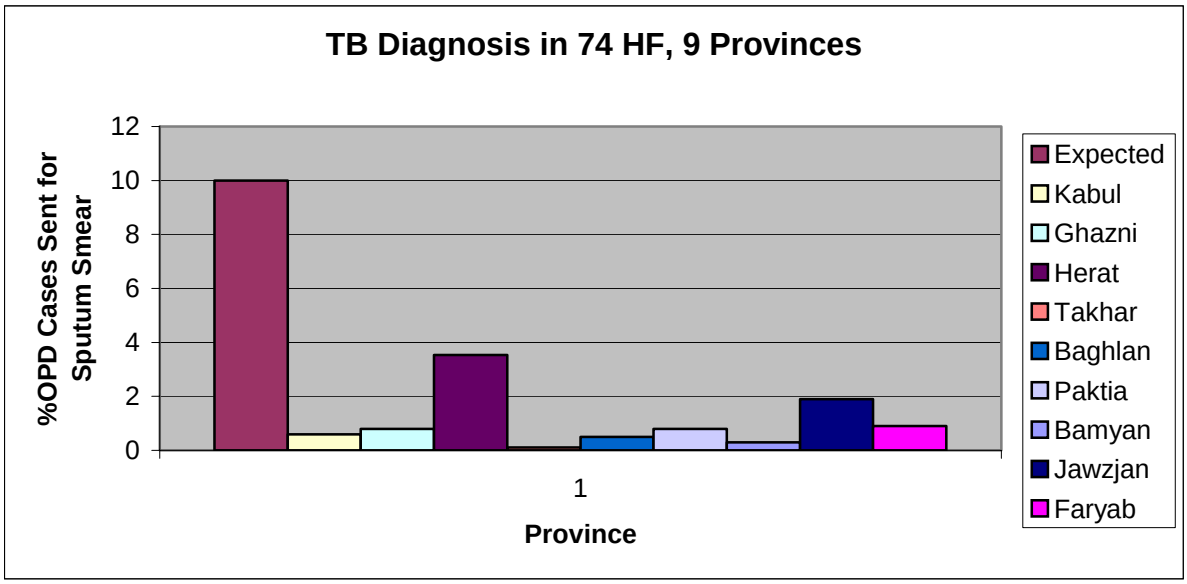
Prescription for ARI includes the following:

- Cases of pneumonia who received a full course of antibiotic correctly
- Cases who did not need antibiotics and were not given antibiotics

This was carried out in most cases and scored 98%.

B. 2: Index of Suspicion for TB

Figure 1: TB Diagnosis in the Past 6 Working Days, 74 Health Provinces



The evaluators ascertained the numbers of patients above the age of 5 years who were seen in the last 6 working days in both the male and female OPD. They then went to the laboratory and ascertained the numbers of patients who had been to the laboratory for sputum smear examination.

In a country like Afghanistan with the current TB load, 7-10 percent of the adult patients should be sent for sputum examination in order to diagnose 80-100 percent of sputum positive patients. As can be seen from Figure 1 above, about 3.5% of patients were sent for sputum smear in the health facilities seen in Herat, which performs the best. The lab technicians in Takhar and Baghlan were away at a training course so patients there were obviously not referred to the laboratories. The index of suspicion and the numbers of patients sent for sputum examination is low overall.

DISCUSSION

REACH REFRESHER TRAINING, TARGETS AND ACHIEVEMENTS

The REACH Team developed teaching materials for the 6 modules that were felt necessary to carry out the BPHS. They contracted the training to 4 NGOs with previous experience in training. They carried out TOT courses in both teaching methodology and technical areas for a majority of the trainers who were involved in the training of the implementing NGOs.

Training Materials

The training materials were well designed and developed. However, in light of the results of the field evaluation, the following issues need to be considered and addressed:

- Separate curricula and materials should to be developed for nurses/midwives
- Some of the contents should be expanded: e.g., infection prevention, teaching of malaria to staff working in endemic areas
- Some modules should be discussed and added: e.g., gynecology, complications of pregnancy
- The training of supervisors should be added and a supervisory skills training module designed. Supervisory tools that are standards based should be developed. These standards should be used to revise the training materials and also in the training of the supervisors.
- The current modules should be revised so that they are in line with any revised or newly developed MoPH policies
- Patient records should be standardized so that they are memory independent and action oriented and the training modules should incorporate training in their use.
- The training manuals and materials are primarily written in English and then translated to Dari. The English should be simply written so that translation does not present undue difficulty. Translation into Pashto should be completed as Pashto speakers have had difficulties with the Dari materials.

Training skills

About 60 people have acquired improved skills in curriculum design, the use of role plays and case studies, the use of and development of participants guides and trainers manuals in addition to the reference manual and a wider range of training methodologies.

Eight training centers have been supplied with a full range of audio visual aids, teaching models and reference materials. A system of reporting and tracking training activities by the centers has been designed and used.

Targets

Sixty percent of REACH's program target of training at least 700 REACH supported clinic staff in 3 modules was achieved; 461 people were trained in 3 modules.

The target given to the training NGOs of training 110 nurses/midwives and 60 doctors in 6 modules each was not achieved – only 31 people were trained in 6 modules. This figure was obtained from the training database at the time of the evaluation. This database has not been completely cleaned and may change once the cleaning is completed. However, it is not likely to be dramatically different.

However, NGO activity targets were met. Each training NGO was to have trained 1020 participants. 85% to 90% of this was achieved by the various training NGOs.

The implementing NGOs had difficulties in complying with the requests for trainees to be sent to the centers. They did not wish to have their staff absent from the health facilities for too long. In some of the locations NGOs did not have sufficient female staff to send. Staff from clinics in remote areas were not able to travel in the winter to the training centers.

The targets were probably not realistic in the period of time that the refresher training was implemented. With the importance of meeting service delivery targets, it is not possible to send so many staff for repeated training events in the span of 1.3 years.

The whole system of staff training needs assessment, staff selection, and records of trainings that staff have had needs to be strengthened. Software for databases similar to the training database or the MoPH database might be made available to the NGOs with training so that training can be better targeted and not duplicated.

The FFSDP includes staff training needs assessment at the clinic level. However, clinic management within the NGO system is not 'decentralized'. In the current RT strategy, the training NGO rather than the clinic makes the training activity plans. If this plan is not available to the implementing NGO at the regional and clinic level, it is not possible for the two to be optimally synchronized. Often it is the regional offices that identify staff to be sent for training. As stated above, the NGO systems for training management should be strengthened.

KNOWLEDGE RETENTION

Knowledge retention amongst the doctors generally was reasonable. Only 42% of the nurse/midwife cadre were able to score 65% marks.

There were differences amongst the staff at different provinces. Both doctors and nurses/midwives in Kabul, Paktia and Jawzjan faired poorly. Doctors in Faryab, Bamyan and Ghazni faired reasonably. Both doctors and nurses/midwives in Takhar, Baghlan, Herat did well. (Table 10).

The performance of nurses and midwives is in keeping with the observation of the trainers and senior managers that this group had difficulties with the teaching materials. The variation across provinces needs to be investigated.

TRANSFER OF LEARNING, IMPACT OF REFRESHER TRAINING

The field evaluation looked at clinical care in selected modules in 2 levels:

1. The clinical care in its relevant components against the standards that were defined from the training manuals. Along with this, the necessary facility standards that would be prerequisites to the provision of the clinical care.
2. In each module, some standards were looked at that were considered new additions and looked at to see if these were implemented:
    - Was iron/folate prescribed for 3 months at a time in ANC and PNc visits?
    - Was mebendazole given to women during ANC visits in the second or third trimester?
    - Was Vit A given to women coming for PN care?

- Were antibiotics prescribed correctly for children with pneumonia and conversely. Not unnecessarily prescribed for children who did not need it?
- Were sufficient numbers of adult patients diagnosed as suspected symptomatic respiratory infection and sent for sputum smear examaniation?

Clinical care was generally reasonable. While there is no baseline against which improvement can be measured, it is reasonable to assume that the training provided did have an impact on clinical care. The health facilities that had atleast 1 female helath care provider were looked at for IUD insertion. 25% of these health facilities inserted IUDs in the last 4 months of 2004. this number went up to 50% of these. This is an indicator of a specific transfer of learning.

However, the impact was not uniform across modules and within a module there were specific areas of weakness.

Post natal care was the weakest applied module. Physical Examination and treatment were the weakest components in the PNC skills seen.

Antenatal care was better applied but treatment and laboratory skills were the weakest areas.

Family Planning scored better but the method specific counseling skills and the general counseling skills were the weaker components.

IMCI was the best applied module, scoring 88% overall in the clinical standards. However, the facilities score for IMCI were weaker for examination area and the cases examination tasks. IMCI charts, mothers' records and referral form were not present. This is a supply issue.

Children were not weighed in some clinics and not some children did not have the their temperatures taken. Some children were not given the first dose of antibiotic in the clinics.

The evaluation teams have said that the IMCI patient records were not supplied to them until news of the evaluation reached the implementing NGO. Case Management tasks tended to have gaps when there was not patient record form.

Across all the modules assessed, counseling skills scored relatively lower and were uniformly weaker.

When specific tasks were looked at (Table 11), it was seen that ANC and PNC patients were not given iron/folate for 3 months; ANC patients were not given mebendazole and many PNC patients were not given Vit A.

Antibiotic prescription for pneumonia was very well carried out and appropriate.

The IMCI module is a module that has been applied across the world for many years and is designed in a highly structured and algorithmic form. It has monitoring tools and has a very large practical component.

The ANC and PNC module while competency based, is not as highly structured as the IMCI module. This may explain why the new policies were not applied. Part of the explanation lies in the fact that the supervisors and managers of the implementing NGOs were not trained so that they did not have the same information. This was quite clear in the interviews of the senior managers. Only 1 of the mangers could correctly state that iron/folate should be prescribed for 3

months. This means that the supervisors will not reinforce the application of these new interventions and may even discourage this practice. The evaluators who were also trainers stated that these new policies were not repeated or emphasized sufficiently in the training materials.

Once, standards for the other modules are defined and tools finalized to provide standards based care and supervision, it should be possible to apply the same structure to the other modules.

CONCLUSIONS

The Refresher Training Program has significant achievements to its credit. It has introduced a system of competency-based learning to the country and developed a set of materials in six modules that are in line with MoPH policies and support the BPHS. It has trained a pool of about 60 trainers in the use of this competency based training and materials. The training was made accessible to all the implementing NGOs supported by REACH through the seven regional centers, using and enhancing the capacities of 4 NGOs to do so.

It has trained 1911 health staff in 1 module atleast. 461 of these have been through 3 modules.

The impact of the training on practice is seen clearly in the IMCI module. The weaknesses within this module are largely those of supply of resources. IMCI is a very structured and algorithmic module. It has been implemented in many parts of the world and has been well tested. Monitoring and supervision are built into the training; trainers are used as monitors.

In the ANC, PNC, FP and infectious diseases (Tb) modules, the standards are reasonable but unevenly implemented. These modules are not formulated in the same structured manner as the IMCI module. However, the improved child care due to the implementation of the IMCI skills and the increase in insertion of IUDs clearly shows that training has enabled the implementation of MoPH policy.

There was no strategy to train supervisors or orient managers to new policies and standards. While this is a gap in the RT program, the fundamental gap lies within the REACH program design. Supervision and monitoring has been included but the FFSDP system is currently a health management tool only. While this is very valuable, clinical standards are not addressed. Had this been different, the RT program would perhaps have included training design and strategy for supervision. The teaching and supervision should be standards based in order to optimize transfer of learning and maintenance of that in the field.

Training has resulted in a burden on NGOs of simultaneously delivering health services and sending staff to training courses. The training schedule should be slower paced; other training such as that conducted by WHO, MoPH – EPI etc should be better coordinated so that the staff are not absent from clinics for long periods of time.

The learning and teaching materials need some revision and augmentation.

Revision of the teaching materials in order to develop a set of materials to train nurses and midwives separately should be undertaken. Translation into Pashto and simpler Dari are important concerns. Simplifying the English materials is equally important.

The revised materials should include any newly developed policies. Some policies may need to be reconsidered; the issue of including progesterone only pills in the FP armoury is one. It is difficult to train the health provider well to deliver a large range of choices. In addition, Progesterone only Pills are associated with increase risk of ectopic pregnancies and higher failure rates.

Other modules such as infection prevention and malaria for staff in endemic areas can be expanded. New modules can be added such as rational drug use and gynaecology and complicated pregnancies for female doctors.

The RT strategy of developing 7 – 8 regional centers and developing a cadre of trainers is of great value. This can be taken forward in a similar fashion where all health service delivery organizations can procure ongoing medical education for it staff. (Currently, it is only in the REACH program and the REACH supported provinces that training of health facility staff is carried out in a systematic manner.)

MoPH could consider approving and accrediting the regional training centers. MoPH may also consider the issue of requiring all health staff to undergo continuing medical education for re licensing etc. This would require donor coordination in order to fund and develop these centers, fund NGOs to procure training, standardize course fees and in the long term develop financially self sustaining accredited training centers.

LIST OF APPENDICES

Appendix 1

List of Training Managers in Meeting

Participants:

Dr. Amin Alizai	REACH RT Program Officer
Dr. Ehsanullah	RACH RT Evaluator
Dr. Shafiqa Gharwal	IbnSina Training Manager
Dr. Alia Hamid	IMC Training Manager
Dr. Ghotai Sadiq	CHA Herat Training Manager
Dr. Shirin Hakimi	CHA Faryab Training Manager
Dr. Joyenda	AKHS Training Support Officer
Dr. Panna Erasmus	REACH Consultant, Evaluation RT

Appendix 2

List of Participants, Meeting with Senior Managers/Supervisors of Grantee NGOs

15.12.05

1.	Dr. Amin Alizai	Refresher Training Officer
2.	Dr. Ehsanullah	Refresher Training Evaluation Officer
3.	Dr. Iain Aitken	Program Manager, Training and Education
4.	Dr.M. Kabir	Provincial Health Manager, AHDS
5.	Dr. Saied	Medical Coordinator, AHDS
6.	Dr. Abdul Ahad	Project Supervisor, CAF
7.	Dr. Naziha	Master Trainer, STEP
8.	Dr. Ahmad Wali	Training Officer, STEP
9.	Dr. Mahmood Zia	HMIS Officer, SDF
10.	Dr. Sefatullah	Health Coordinator, SDF
11.	Dr. Panna Erasmus	REACH Consultant, Evaluation RT

Appendix 3

List of Senior Managers/Supervisors Interviewed

1. Dr. Shafiq Yari	Regional Maanger, NPO/RRA
2. Dr. A. Tariq Ihsan	Senior Health Manager & Advisor, SCF – USA
3. Dr. Mangal	Program Manager Health, CoAR
4. Dr. Muqtadir	Head of Monitoring and Supervision, CoAR
5. Dr. Dawood	Manager, Technical Support Services, BRAC
6. Dr. Qahar	Tb Control Officer, BRAC
7. Dr. Shahed ul Rashid	Team Leader, USAID Program, Paghman, BRAC
8. Dr. Qudratullah Nasrat	Program Director, BDF
9. Mr. J, Rahmani	Executive Officer, Development, BDF
10. Dr. Masood	Ghazni Project Manager, BDF
11. Dr. Shaqayak	MCH Advisor, BDF
12. Ms. Zohra Shafiq	PME Program Manager, BDF
13. Dr. Niyamat	Health Program Manager, AKHS
14. Dr. Suzanne Griffin	Acting Country Director, IMC
15. Dr. Rita	Acting Medical Director, CHA

Appendix 4

ASSESSMENT OF ANTE-NATAL CARE

Health Facility ID----------
Case number---------
Date of Visit----------
Persons Responsible for Visit----------
Service Provider Name----------F
Qualification & Position in Clinic----------
Month of Receiving ANC/PNC training----------
Place and NGO Responsible for Training----------

SECTION 1: HISTORY TAKING

PERFORMANCE STANDARDS	**VERFICATION CRITERIA**	**Y,N,N/A**	**COMMENTS**
1.History Taking	Observe history taking and observe medical records for the following: o Provider's manner is polite and open with patient----- o Asks about relevant past medical history and records, depending on whether it is a first visit or a follow up visit---------- o Asks for a detailed obstetric history if it is a first visit or is recorded on the card (no. of pregnancies, children born, children living, age and sex of children, place and method of deliveries, esp. last delivery, any complications in pregnancies, labour and post partum)---------- o Asks for LMP and calculates EDD or term of pregnancy---------- o Asks for foetal movements---------- o Asks for any other complaints and signs and symptoms---------- o Asks TT history and for TT card		
TOTAL =7			

2. Physical Examination	Observe provider perform physical examination for: o Provider respects patient privacy and dignity---------- o Looks for pallor in conjunctiva and oral mucosa and palms---------- o Takes blood pressure---------- o General examination if first visit or record in card ---- o Measure fundal height -------- o Palpates abdomen for foetal lie and position---------- o Hear foetal heart---------- o Examine for oedema----------		
TOTAL =8			
3. Laboratory test	Refers patient for: o HB---------- o Blood group---------- o Urine glucose/protein----------		
TOTAL =3			
4. Treatment	Treats patient or counsels as follows: o Fe/folate for 3 months (preventive or as treatment)---- o Mebendazole once in 2nd or 3rd trimester or in record- o TT according to schedule---------- o Treatment for any illness----------		
TOTAL =4			
5. Counselling	Counsels for the following: o Counsels for next AN visit (4 visits at 16, 24 to 28, 32, 36 weeks; more for women with problems)-------- o Counsels for nutrition (eats 2 extra snacks)---------- o Discusses birth plan----------		
TOTAL =3			

SECTION 2: ROOM

PERFORMANCE STANDARDS	VERFICATION CRITERIA	Y,N,N/A	COMMENTS
1. Room	Check if the following are present: o Waiting room for patients---------- o Examination room that gives privacy to patient-------- o Heating in winter---------- o Chair for patient to sit on---------- o Examination bed with stool for climbing on bed------- o ANC/PNC clinical guidelines is on provider's desk –-		
TOTAL =6			
2. Equipment	Check if provider has the following: o BP apparatus---------- o Stethoscope---------- o Foetoscope----------		
TOTAL =3			
3. Records	Check if provider has the following: o Patient register---------- o ANC/PNC card---------- o Does the ANC/PNC card help the worker to carry out the necessary tasks for ANC?---------- o Do they have job aids/IEC material that helps the health worker to carryout the necessary tasks for ANC?----------		
TOTAL =4			

Observer must ask the provider the following question:
Do you have difficulty in providing quality AN care to patients because of a lack of equipment or drugs? If yes, please tell what particular equipment or drugs are lacking:

Appendix 5
ASSESSMENT OF POST-NATAL CARE

Health Facility ID----------
Case number----------
Date of Visit----------
Persons Responsible for Visit----------
Service Provider Name----------
Qualification & Position in Clinic----------
Month of Receiving ANC/PNC training----------
Place and NGO Responsible for Training----------

SECTION 1: HISTORY TAKING

PERFORMANCE STANDARDS	**VERFICATION CRITERIA**	**Y,N,N/A**	**COMMENTS**
1.History Taking	Observe history taking or medical records for the following: o Provider's manner is polite and open with patient----- o Checks the woman's ANC/PNC card or asks patient history of delivery (date, mode, complications)---------- o Asks how she is feeling, has any pain, heavy vaginal bleeding, fever or weakness---------- o Asks if there are any problems with bladder or bowel function---------- o Asks about the condition of the baby and if it breast feeding satisfactorily---------- o Asks if baby is vaccinated and checks card---------- o Asks for mother's TT status and check card---------- o Asks if she if she wishes to space or limit the family--		
TOTAL = 8			
2. Physical Examination	Observe the provider carrying out the following: o Washes hands or uses alcohol rub(if water, soap or run available)---------- o Checks temperature----------		

	---------- o Measures BP---------- ---------- o Checks conjunctiva, oral mucosa and palms for pallor-- ---------- o Looks at breasts and nipples-- ---------- o Palpates abdomen for uterine height and firmness (at umbilicus in 24 hours, at 1 week midway between umbilicus and pubic symphysis, cannot be felt abdominally after 2 weeks)--- ---------- o Washes hands, Puts on gloves and examines vulva and perineum for tears, swelling, pus, faeces or urine coming out of vagina, washes hands---------- o Checks if lochia is normal or foul smelling----------		
TOTAL = 8			
3. Treatment	Observe if provider does the following: o Prescribe Fe/folate for 3 months or more---------- o Prescribe Vit A capsule-------- ---------- o Refer for baby's vaccination-- ---------- o Prescribes medication for other problems ----------		
TOTAL = 4			
4. Counselling	Observe if provider undertakes the following: o Post partum and hygiene counseling (danger signs)--- o Nutrition counseling---------- ---------- o Breast feeding counseling----- ---------- o FP counseling (delay of next birth, methods)----------		
TOTAL = 4			

SECTION 2. ROOM AND EQUIPMENT

PERFORMANCE STANDARDS	VERFICATION CRITERIA	Y,N,N/A	COMMENTS
1. Room	Check if the following are present: o Waiting room for patients---------- o Examination room that gives privacy to patient-------- o Heating in winter---------- o Chair for patient to sit on---------- o Examination bed with stool for climbing on bed------- o Water and soap available----------		
TOTAL = 6			
2. Equipment	Check if provider has the following: o BP apparatus---------- o Stethoscope---------- o Gloves for perineal examination---------- o Thermometer----------		
TOTAL =4			
3. Records	Check if provider has the following: o Patient register---------- o ANC/PNC card---------- o Does the ANC/PNC card help the worker to carry out the necessary tasks for PNC?---------- o Do they have job aids/IEC material that helps the health worker to carryout the necessary tasks for PNC?----------		
TOTAL =4			

The observer must ask the provider the following question:

Do you have any difficulty in providing quality PNC to the patients?

Appendix 6
ASSESSMENT OF FAMILY PLANNING CARE

Health Facility ID---------- Case Number--------
Date of Visit----------
Persons Responsible for Visit---------- M/F
Service Provider Name----------
Qualification & Position in Clinic----------
Date/s of Receiving ANC/PNC training----------
Place and NGO Responsible for Training----------

SECTION 1: HISTORY TAKING

PERFORMANCE STANDARDS	**VERFICATION CRITERIA**	**Y,N,N/A**	**COMMENTS**
1.History Taking	Observe if the provider does the following: o Is friendly and open with the patient---------- o Affords the patient privacy---------- o Takes a general past medical history if this is the first visit or has recorded on the patient card and asks specially for smoking, any other current treatment esp. for TB or epilepsy---------- o If this is a follow up visit, any problems Reproductive history: no. of children born and living, sex, age of last child---------- o If youngest child is less than 6 months, is mother breast feeding exclusively---------- o LMP and irregularities if any---------- o Eliminates possibility of pregnancy by asking menstrual history, intercourse after last period, signs and symptoms of pregnancy, within 7 days after the start of the last period, 4 weeks post partum, 7 days post abortion and breast feeding exclusively for child less than 6 months)----------		

	---------- o Contraceptive history, past use and experience of contraceptives---------- Presence of vaginal discharge----------		
TOTAL = 8			
2. Physical Examination	Observe if provider carries out the following: o Examines for jaundice and anaemia---------- o Takes BP and pulse---------- o General examination if indicated from history--------- o Pelvic examination just before IUD insertion----------		
TOTAL = 4			
3. Laboratory test	Does the provider refer the patient for: o Pregnancy test only if LMP was 6 weeks or less-------		
TOTAL = 1			
4. General Counselling	Does the provider explain the following: o The range of contraceptives that are available and suitable for client (i.e. COCs not suitable for beast feeding mother with child less than 6 months)--------- o Uses flip chart to show the range---------- o Helps client to choose and counsels for specific method----------		
TOTAL = 3			
METHOD SPECIFIC COUNSELLING			
LACTATIONAL AMENORRHOEA			

	STANDARDS	Y,N,N/A	COMMENTS
5. Counselling for LAM	Does the provider explain: o Is a good method for both mother and baby o Is effective only if mother breast feeds exclusively and fully for 6 months (atleast every 4 hrs in the day and every 6 hours at night, on demand and till baby is full with no water or other liquids or foods) o The mother will need to use another method after 6 months and must come to the clinic before the 6 month period		
TOTAL = 3			
6. **Counselling for condoms**	Does the provider explain the following: **A. Action** o A condom prevents sperm from reaching the egg		
TOTAL =1			
	B. Advantages and Disadvantages o Explains that condoms have no systemic side effects, can be used by breast feeding mother and will protect against STIs including HIV o A person may be allergic to condoms		
TOTAL = 2			
	C. Use o That they need to be used with each act of intercourse o Demonstrates the use with pictures on flip chart o Advises on safe disposal o Advises on good storage		
TOTAL =4			
	D. Prescription o Gives or prescribes adequate supply (atleast 12 condoms or		

	3 pkts) o Explains if can be purchased in shops		
TOTAL =2			
GRAND TOTAL = 9			
POPS			
	STANDARDS	**Y,N,N/A**	**COMMENTS**
7. Counselling for POPs (for both POPs and COCs, the provider should ask for previous use of pills. A woman who often forgets should use another method)	Does the provider explains the following: **A. Action** o Prevents pregnancy by preventing the egg and the sperm from meeting (thickening mucous in cervix)		
TOTAL = 1			
	B. Advantages and Disadvantages o Explains that this is a good method for breast feeding mothers but is less effective than COCs o Has to be taken every day at the same time o Can cause irregular periods		
TOTAL = 3			
	C. Method of Use o Must start on the 1st day of the next period, after 6 weeks of delivery if breast feeding,		

	immediately post abortion o If pill is later than 3 hours or missed there is a risk of pregnancy o If late, take late pill immediately, if later than 3 hours, take immediately and use condom or abstinence for 7 days o If missed more than 1 pill, take 2 per day till back on schedule, use condoms or abstinence for 7 days o If bleeding starts, use new packet 7 days later o If patient has severe vomiting/diarrhoea, she should continue POPs and must use condoms o Must return to clinic to check for pregnancy if she has missed 2 or more periods		
TOTAL = 7			
	D. Prescription o Gives/prescribe 3 + 1pkts and a pkt of condoms o Shows the patient a pkt of pills to explain use o Discusses rumours heard and past experiences o Advise on return visit		
TOTAL = 4			
GRAND TOTAL = 15			

COC			
	STANDARDS	**Y,N,N/A**	**COMMENTS**
8. Counselling for COCs (for both POPs and COCs, the provider should ask for previous use of pills. A woman who often forgets should use another method)	Does the provider undertake the following: **A. Action,** o Works by stopping ovulation and preventing the sperm and egg meeting (thickening cervical mucous and stopping egg from attaching to uterus)		
TOTAL = 1			
	B. Advantages and Disadvantages o Explains that this is a good effective method but not suitable for breast feeding mothers before child is 6 months old as it decreases milk o Will reduce menstrual cramps and menstrual blood loss and therefore reduces/prevents anaemia o Can have children soon after stopping pill o Needs to be taken daily o Can cause nausea, headache, weight gain, spotting, chloasma but if pill taken at night may reduce nausea and headache. Most side effects will stop with use o If side effects are severe, she can return for another method		
TOTAL = 6			
	C. Use o Explains that she must start on the 1st day of the next period or within 7 days, immediately post abortion or within 7 days o She must take 1 pill every day and start the next packet when the current packet is finished. She will have a period in the last 7 days of the packet		

	o If missed more than 1 pill, take 2 per day till back on schedule o If she has missed 2 or more pills, take 2 pills a day till back on schedule and use condoms/abstinence for 7 days o If bleeding starts, use new packet 7 days later o If patient has severe vomiting/diarrhoea, she should continue COCs and must use condoms/abstinence till symptoms are past		
TOTAL = 6			
	D. Danger Signs and Return o Explains danger signs for which she must stop the pills and asks return clinic o Must return to clinic after 3 months of the 1st round and check blood pressure		
TOTAL = 2			
	E. Prescription o Provider gives/prescribes 3 months supply, 1 spare packet and 1 pkt. of condoms o Shows the patient a pkt of pills to explain use o Discusses rumours heard and past experiences o Advises on return visit		
TOTAL = 4			
GRAND TOTAL = 17			
DMPA/DEPOT PROVERA			
	STANDARDS	**Y,N,N/A**	**COMMENTS**
9. Counselling for DMPA	Does the provider explain the following: **A. Action** o DMPA acts by preventing sperm from meeting egg (by thickening the cervical mucous), prevents ovulation and stops egg from attaching to		

	the uterus o		
TOTAL = 1			
	B. ADVANTAGES AND DISADVANTAGES o It is a very effective method and effects last for 3 months o Can be used by breast feeding mothers after 6 weeks after delivery o Decreases period cramps and bleeding thus reducing anaemia o Can be used without any other person seeing the woman taking something every day o It is an injection and requires a trained person to give it o It is not reversible until after the 3 month period o After stopping the injection it can take up to 4 months for the woman to become pregnant o Many women put on some weight		
TOTAL = 8			
	C. Use o The injection can be given any day within 7 days of the start of menses o It can be given on any day if provider is sure that patient is not pregnant but patient should not have sex for the next 7 days or must use a condom o It can be given within 7 days post abortion o It can be given after 6 weeks after delivery o The patient must have an injection every 3 months but can be given 2 weeks earlier or later. If client is more than 2 weeks late and not pregnant, she should use condoms/abstinence for 7 days after injection		
TOTAL = 5			
	D. Danger Signs and Return		

	Explains that most women will bleed less in their periods but some may bleed heavily. If the woman has very heavy bleeding she should return to the clinic		
TOTAL = 1			
	E. Prescription o The Provider should give/prescribe the depot provera and should inject it in the deltoid muscle. o Should set up a return date for the client		
TOTAL = 2			
	IUD		
8. Counselling for IUD	Does the provider explain the following: **A. Action** o The IUD works by preventing the sperm from reaching the egg and not allowing the egg to attach to the uterus		
TOTAL = 1			
	B. Advantages and Disadvantages o It is a very effective method that will prevent pregnancy for 10 years o Can be used by pregnant women o A woman can get pregnant immediately once the IUD is removed o May come out of the uterus by itself o There may be cramps and heavier bleeding for the first few months o Cannot be used by women who have pelvic infections or purulent vaginal discharge within the last 3 months , vaginal bleeding or women who have tumours in the uterus; the provider will need to do a pelvic examination first		
TOTAL = 6			

	C. Use The provider explains the following o The provider will insert the IUD after examining the client PV o There will be 2 strings that can be felt and the client should check every month and return to the clinic if she cannot feel them		
TOTAL = 2			
	D. IUD insertion o The provider washes hands and gloves before examining perineum and vagina o The provider examines client PV o Changes gloves, cleans perineum, inserts speculum, cleans cervix, inserts sound, adjusts copper T length using no touch technique, inserts IUD gently, removes sepculum, disposes of waste correctly, washes hands o Advises the patient regarding checking for the strings of the IUD in the vagina monthly o Keeps the patient for about 15 minutes to make sure she is well before sending her home o Gives/prescribes ibuprofen for pain o Reminds client to return if any complications arise		
TOTAL = 7			

SECTION 2: ROOM AND EQUIPMENT

PERFORMANCE STANDARDS	**VERFICATION CRITERIA**	**Y,N,N/A**	**COMMENTS**
1. Room	Check if the following are present: o Waiting room for patients o Examination room that gives privacy to patient o Heating in winter o Chair for patient to sit on o Examination bed with stool		

	for climbing on bed o Water and soap are available		
TOTAL = 6			
2. Equipment	Check if provider has the following: o BP apparatus o Stethoscope o 1 of each kind of contraceptive to demonstrate o Flip cards for explanation o Contraceptives for administration		
TOTAL = 5			
3. Records	Check if provider has the following: o Patient register o FP card		
TOTAL = 5			

Observer must ask the provider the following question:

Do you have difficulty in providing quality FP care to patients because of a lack of equipment or drugs? If yes, please tell what particular equipment or drugs are lacking:

Appendix 7
IMCI Assessment Form

Clinic Name:
Observer Name:
Date of visit:

Insert a Y if procedure carried out correctly, an N if procedure not carried out correctly and a NA if case not seen
The observer must see atleast 3 cases and one of this must be a case of ARI
Each Y is counted as 1 point, each NA is counted as 1 point and each N is counted as 0 points
%age correct is calculated as the total of the scores of cases seen and divided by the total number of cases seen, e.g., if the total is 3 points for 3 cases seen, the %age is 3/3 X100 = 100%

	Quality of Case Management	**Case 1**	**Case 2**	**Case 3**	**Case 4**	**Total**	**% Correct**
No.							
	Standard 1 - Case Assessment						
1	Cases assessed for all 4 danger signs						
2	Cases assessed for presence of cough, diarrhoea, fever						
4	Respiratory rate counted correctly						
5	Case examined for chest indrawing						
6	Cases whose immunization status was correctly checked						
	TOTAL AND AVERAGE % CORRECT						
	Standard 2 A Prescription						
1	Cases needing an antibiotic or antimalarial are prescribed correctly						
2	Cases of ear infection who received a full course of antibitotics at the health facility						
3	Cases who should have received immunization according to schedule, received it the day of the visit						
	TOTAL AND AVERAGE TOTAL						
	Standard 2 B Prescription ARI						
1	Cases of pneumonia who received a full course of antibiotics correctly						
2	Cases who did not need antibiotics not given antibiotics						
	TOTAL AND AVERAGE % CORRECT						

	Quality of Case Management	Case 1	Case 2	Case 3	Case 4	Total	% Correct
	Standard 3 Counselling						
1	Cases who should receive immunization in the future according to schedule, identified and correct instructions given						
2	Caretakeers of children <2 years asked about breastfeeding and complementary foods (assess feeding)						
3	Caretakers of children given antibiotic or antimalarial drug advised how much to give, times per day and number of days						
	TOTAL AND AVERAGE %age CORRECT						

IMCI Equipment Form

Clinic Name:
Observer Name:
Date of visit:

Insert a Y if procedure carried out correctly, an N if procedure not carried out correctly and a NA if case not seen
This sheet needs to be filled only once for every clinic

	Y/N/NA	%age Correct
Standard 4 Examination Area		
Enough space to see patient?		
Chair and table for health worker?		
Chair for caretaker?		
Watch or timing device?		
IMCI chart booklet?		
IMCI patients recording form?		
mother's cared?		
Referral card?		
TOTAL AND AVERAGE %age CORRECT		
Standard 5 Case managment Tasks		
Weighs Patient?		
Takes Temperature?		
Assesses and classifies illness?		
Prscribes drug?		
Instructs on giving drug?		

Gives first dose of drug?
TOTAL AND AVERAGE TOTAL

Standard 6 Availability of drugs in stock on day of visit

Cotrimoxazole or amoxicillin
TOTAL AND AVERAGE %age CORRECT

Appendix 8

TB Case Detection Form

Clinic Name:
Name of Province:
Name of NGO Managing Clinic:
Name of Observer:
Date of Visit:

1.Number Cases Seen in Male OPD for the last 6 days(not including the day of visit) ☐

2.Number of Cases Seen in Female OPD for the last 6 days(not including the day of visit) ☐

3.Number of Cases Seen in Laboratory for Sputum Examination in the last 6 days ☐

% Cases Diagnosed as Suspected Respiratory Infection (SRI) = 3/(1+2)X100 (as below)

$$\frac{\text{Total number of Cases Seen in Laboratory for Sputum Examination}}{\text{Total number of Male and Female OPD Cases seen in 6 days N}} \text{ X100}$$

Appendix 9

Interview with Health Care Provider

Name of NGO----------
Name of Health Care Provider Interviewed----------
Position----------
Modules trained in ANC PNC FP ID IMCI NBC Mental Health Disability BPHS
Place of training----------
Training NGO name----------
Name of person conducting Interview----------
Date----------

1. Do you think that your knowledge and skills? Give 3 examples

2. Has it become easier for you to provide quality services in the job that you do in the clinic/hospital? Give 3 examples

3. Were you able to use your new knowledge and skills in the clinic after the training? If not, why? Did your NGO provide you with the equipment or drugs that you need to do your job according to the training guidelines?

4. Do you think that the supervisors who from your NGO who visit you know as much as you do about the modules that you have been trained in?

Appendix 10

Interview with Supervisors/Managers

Name of NGO----------
Name of Supervisor/Manager Interviewed----------
Position----------
Name of person conducting Interview----------
Date----------

5. What did you think of the organization of the refresher training? Did you get information regarding trainings in time?

6. Was the budget adequate to improve training facilities and did you get the allotments in time? (only for the 4 NGOs)

7. Do you feel that your trainers have improved capacity to train after the partnership with REACH? Please give examples (only for the 4 NGOs)

8. Did you send your supervisors for training in all the modules?

- Number of supervisors
- Number of supervisors sent for training in atleast 3 modules

9. Do you think that the facility staff have improved knowledge and skills after the training? Any examples

10. Do you think that the quality of care in your clinics has improved after the training of your staff? Any examples or indicators that show this.

Appendix 11

GUIDELINES FOR THE USE OF THE REFRESHER TRAINING TOOLS

Background

There are 7 sets of tools (forms) that need to be used when you visit the health facility to assess the clinical skills of the staff according to the plan. These are:

1. Assessment of Antenatal Care
2. Assessment of Post Natal Care
3. Assessment of Family Planning
4. Assessment of IMCI
5. Assessment for Suspected TB Sputum Examination
6. Interview with Health Care Worker
7. Questionnaire

Facility Visit

The first task when you visit the clinic is to meet with the head of the clinic and explain why you are there. You are there to assess the effect of the refresher training program and it is an assessment that will require that some staff are observed while they are carrying out consultations with patients. Staff who have received refresher training will also be interviewed and asked to complete a questionnaire. Explain that in order not to delay patient care, the interviews and the questionnaires will be done after work hours as is suitable to the staff.

Check which of the staff has received training and specifically, which of the female staff has received training in ANC, PNC and FP. These are the staff whose work will be observed. Meet these staff with the clinic head and explain the purpose of the visit. Also explain that though this visit is an assessment of the REACH program, you will provide feed back to the staff before you leave.

Do not observe staff who have not received training in atleast 1 of the 3 modules. If a staff has received training only in ANC/PNC then only observe that aspect of care. Do not observe that staff for FP.

When you begin the observation, take care not to use the chair that is meant for the patient.

Use of the ANC, PNC and FP Assessment Forms

The Assessment forms start with the general details of the health facility and thehealth care worker. Please fill this section first. You will observe 3 cases of each of the components: ANC, PNC and FP. You will therefore be observing the same worker with 3 different cases. The case number for the first case of ANC will be 1, the second case will be 2 and the third case will be 3.

Each tool has a set of standards in the first column and a set of verification criteria in the second column. The details of the consultation that you will observe are the verification criteria. Please look at the example below:

PERFORMANCE STANDARDS	**VERFICATION CRITERIA**	**Y,N,N/A**	**COMMENTS**
1.History Taking	Observe history taking and observe medical records for the following: o Provider's manner is polite and open with patient----- o Asks about relevant past medical history and records, depending on whether it is a first visit or a follow up visit---------- o Asks for a detailed obstetric history if it is a first visit or is recorded on the card (no. of pregnancies, children born, children living, age and sex of children, place and method of deliveries, esp. last delivery, any complications in pregnancies, labour and post partum)---------- o Asks for LMP and calculates EDD or term of pregnancy---------- o Asks for foetal movements---------- o Asks for any other complaints and signs and symptoms---------- o Asks TT history and for TT card		

The first observation is whether the health worker is polite and open with the patient. If the answer is yes, write Y in the third column against that observation. If the answer is No, write N in the third column. If there are observations that are not applicable then you will write NA. For example, when you observe the abdominal examination and the woman is on 14 weeks pregnant, it is not necessary to palpate the abdomen for foetal position and lie. Then the observation will be NA.

The second section of each form is an assessment of whether all the equipment is there to provide the care. You can fill that in the beginning of the session. Remember to ask each health care worker if there is any equipment or medicine that he/she needs that is not present in the clinic currently.

The fourth column is space for any comments you might have. For example, no lab tests were done because the lab tech was on leave. (If this is a BHC, lab tests are NA.)

Scoring of the forms

Once you have completed the forms and at the end of the day, go through each form
Check that there is a Y, or N or NA against each observation.
Each standard has a total possible score. Each Y and each NA is counted as 1 point each.
Enter the total score at the end of that section.

Family Planning Tools

The Family Planning forms are a bit different. The section in the method specific counseling is broken down into A, B, C and D. Each of these has a total possible score. Enter this score. At the end, there is a grant total for each method. The score obtained for the method specific counseling and prescription is judged against the total possible score for that method only. The grand total is the total possible score for that method.

Use of the IMCI Assessment Form

The IMCI tool is based on the tools used by the MoPH and the WHO. It has been shortened a bit to look especially at ARI though it looks at other things that are important. It has been divided into sections which are called standards. The observer should see atleast 3 patients and atleast 1 of them should be a case of ARI as this is the big problem in this season. The observer can see up to 4 cases in order to make sure that atleast 1 case is that of ARI.

Again, the observer must use a **Y, N or NA** for the procedure observed. A **Y** is used if the procedure is correctly carried out. A **N** is used if the procedure is not carried out correctly. A **NA** is used if the procedure is not applicable. A b scores 1 point, a **N** scores 0 points and a **NA** scores 1 point. The %age correct is calculated as follows:
(Total score/Total cases seen) X 100
For example, if all cases of 4 seen are assessed for cough, diarrhoea and fever, the total score is 4. The %age correct is 4/4 X100 = 100%.

No.	Quality of Case Management	Case 1	Case 2	Case 3	Case 4	Total	%age Correct
	Standard 1 - Case Assessment						
1	Cases assessed for all 4 danger signs						
2	Cases assessed for presence of cough,						

diarrhoea, fever

4 Respiratory rate counted correctly

5 Case examined for chest indrawing

6 Cases whose immunization status was correctly checked

TOTAL AND AVERAGE %age CORRECT

Standard 2 A Prescription

1 Cases needing an antibiotic or antimalarial are prescribed correctly

2 Cases of ear infection who received a full course of antibitotics at the health facility

3 Cases who should have received immunization according to schedule, received it the day of the visit

TOTAL AND AVERAGE %age CORRECT

At the end of each section the score for the standard is totaled and the average %age correct is calculated and entered.

Standards 4 and 5 are concerned with equipment and drugs and need to be filled only once for that clinic.

Use of Suspected TB Cases in 6 days

The observer must use the patient OPD register in the male and female sections. The total number of male cases seen in the last 6 days, not including the day of the visit is calculated and entered in the box. The same is done for the female OPD patients. All patients are counted; the reason why they came to the clinic OPD does not matter.

The observe must go to the laboratory and from the laboratory register, count the number of cases that have been seen for sputum examination. This is entered in the appropriate box.

Use of Tally Sheets

Use 1 tally sheet for each NGO seen in that province. You can use the same sheet if you see more than 1 clinic run by that NGO.
There are 4 sections to the tally sheets. The first section is for ANC:

A. ANC

1. Number of Cases Given Iron/Folate for 3 months

Total Number =

2. Number of cases given Mebendazole in Second or Third Trimester for Prophylactic Deworming

Total Number =

Look at the forms for ANC that have been filled out for that day and collect the information about iron/folate and mebendazole prescription in the 4th section of standard. Tally the number that have been given iron/folate for 3 months. If a woman has a complicated pregnancy and is asked to come back after 2 weeks or 1 week and has been given enough iron/folate for that time, this can be counted as appropriate prescription.

The section for PNC is filled out in the same manner.

The section for job aids/IEC materials is designed to record any wall charts, charts for cards etc that tell the health care worker what they should do. For example, a chart for family planning that tells the health care worker the important messages to give during counseling. In 1 clinic we saw a prescription slip that tells the health worker that she/he must prescribe iron/folate and TT vaccination. This counts as a job aid also.

The section for patient records or cards that help guide the health worker as to what history, what examination, what lab. tests, what prescriptions to carry out are the last section in this form.

The total number for 1 NGO in that province are tallied and totaled in this form at the end of every day and every provincial visit.

Interview with Health Provider

The first section is the general information regarding the health care worker and facility. There are 5 questions in this form. Discuss the questions a little bit with the worker in order to get the best answer.

Questionnaire

There are 65 questions from each of the modules that REACH has designed. Questions are divided into each module and the name of the module is written at the beginning of each section.
Tell the health care workers that they need to answer questions only from those modules that they have had refresher training for.

Explain that these are like their posttest questions and that they must read the instructions at the beginning of the question.
Make sure that they are not talking to each other and that they sit a little bit far apart from each other.
When a health care worker finishes a questionnaire, ask what modules they have been trained in and check that they have answered questions for all these modules.