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Integrated Supervision Training Course

For

Supervisors of First Level Care Facilities

Participant's Manual

DRAFT

**Pakistan Child Survival Project
Basic Health Services Cell
Ministry of Health
Government of Pakistan
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ABBREVIATIONS

ADHO	Assistant District Health Officer
AHI	Assistant Health Inspector
AIHS	Assistant Inspector Health Services
ARI	Acute Respiratory Illness
BHU	Basic Health Unit
CBA	Child-Bearing Age (woman)
CDC	Communicable Disease Control
CDD	Control of Diarrhoeal Disease
CSTU	Child Survival Training Unit
DHO	District Health Officer
DHQH	District Headquarters Hospital
DPT	Diphtheria, Pertussis, Tetanus
DSV	District Supervisor Vaccination
DTU	Diarrhoea Training Unit
EPI	Expanded Program of Immunization
FHT	Female Health Technician
FLCF	First Level Care Facility
FMO	Female Medical Officer
FSMO	Field Supervisor Medical Officer
GOP	Government of Pakistan
HI	Health Inspector
HIS	Health Information System
IDD	Iodine Deficiency Disease
IV	Intravenous
LHV	Lady Health Visitor
MCH	Maternal/Child Health
MO	Medical Officer
MOIC	Medical Officer In-charge
MS	Medical Supervisor
MTID	Management Training Institute for Doctors
NBSC	National Breastfeeding Steering Committee
NIPA	National Institute of Public Administration
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS/ORT	Oral Rehydration Solution/Therapy
PCSP	Pakistan Child Survival Project
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
RHC	Rural Health Clinic
RUI	Rapport, Understanding, Influence/intervening
TSV	Tehsil Supervisor Vaccination
TT	Tetanus Toxoid
WFP	World Food Program
WHO	World Health Organization

INTRODUCTION

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BACKGROUND OF THE PAKISTAN CHILD SURVIVAL PROJECT

During the 1970s Pakistan developed a Primary Health Care Programme to bring essential health and related services to people where they were living and to help them participate in their own care. The programme, which is ongoing, comprises the eight essential elements of primary health care defined by WHO and UNICEF in 1978 at Alma-Ata:

1. Education concerning common health problems, and methods of preventing and controlling them;
2. Promotion of adequate food supply and proper nutrition;
3. An adequate supply of safe water and basic sanitation;
4. Maternal and child health, including family planning;
5. Immunization against major infectious diseases;
6. Prevention and control of locally endemic diseases;
7. Appropriate treatment of common diseases and injuries;
8. Provision of essential drugs.

After ten years' experience with this programme, however, it became obvious that a comprehensive health care approach was too broad to bring about a sufficiently rapid reduction of Pakistan's high under-five mortality rate over the short term. Furthermore, evaluations revealed that health care providers in Pakistan were not adequately meeting childrens' health needs. The following reasons were cited:

- The basic training of medical students and paramedics did not include current child health information;
- In-service training was neither systematic nor well organized;
- The supervisory system in place was one of dictating and checking rather than a participatory, supportive model;
- Services did not focus on the four main reasons for the high child mortality rate.

In the early 1980s the Pakistan Child Survival Project, PCSP, was formulated to address these deficiencies in Pakistan's health care programme for children.

The PCSP is a primary child health care programme with a strong focus on the developing child and on improving first level health care services in the management of the four major child killers--diarrhoea, malnutrition, acute respiratory infections and childhood diseases preventable by immunization.

In addressing these four intervention areas, the project has developed six components:

1. Planning and Management
2. Training
3. Health Information Systems
4. Communication
5. Drugs and Logistics
6. Research

These components are interrelated and together address the needs of three essential groups--the administrators, the supervisors and the health care providers--in the establishment of an effective child health care delivery system in Pakistan.

TRAINING STRATEGY

The training component of the PCSP is a large and important one. It aims at effecting change in the behaviour of health service providers and consumers. Separate training sessions are held for Mos, paramedics and their supervisors.

The project has identified the specific and common responsibilities of child health care workers and child caretakers in meeting children's needs, not only in illness and recovery, but in the course of their normal development. The project aims to train health professionals at all levels to recognize children's health needs, and to meet these needs in the four specified intervention areas by working with facility staff and parents of the child.

Accomplishing these objectives requires attention well beyond training in clinical and health education skills. The PCSP training strategy includes the development of skills in management, administration, supervision and technical support for staff at various levels of the health delivery system. It exposes paramedics, MOs and their supervisors to the concept of in-service education as a requirement of professional development. Furthermore, the programme has a built-in supervisory and monitoring system to ensure that the knowledge and skills acquired in training are applied in the subsequent delivery of health care. In this course, the supervising officers will be exposed to the concept of supportive supervision and instructed on how to implement the supervisory and monitoring tools.

The four cornerstones of the PCSP training strategy are:

1. Continuing education as an ongoing professional responsibility
2. An integrated approach to health care delivery using teamwork
3. Child-focussed training involving the mother as a team member
4. Job-specific, competency-based training

CONTINUING EDUCATION AS AN ONGOING PROFESSIONAL RESPONSIBILITY

What is meant by “continuing education”?

Continuing education encompasses all of the learning opportunities a health professional takes advantage of in order to keep his or her medical knowledge and other relevant skills up-to-date. This may mean in-service training provided by the employer, or it may entail the health workers’s own initiatives to continue learning as an ongoing professional commitment.

Why is continuing education important?

Continuing education is important for health professionals in order to prevent the deterioration of knowledge and skills, to improve existing knowledge and skills and to become acquainted with new information and practices in medicine and health care delivery. In a field in which new knowledge doubles every ten years, continuing education is essential.

Who is responsible for continuing education?

In the health field, administrators, supervisors and health professionals are equally responsible for continuing education.

The health administrators are responsible for the development, implementation, monitoring and evaluation of continuing education policies and programmes in priority areas.

In-service training ensures quality health care by providing health professionals with opportunities to maintain their existing knowledge and skills and by keeping them up-to-date on new and current medical practices. The PCSP is working on the development of an in-service health education policy and the establishment of a continuing education system in the health sector. This course exposes supervisors to their roles in assuring the continuing education of their staff members.

The supervisor assesses his/her staff's performance and identifies individuals and areas requiring further training. He/she then confers with higher level administrators for individual or policy decisions. An effective supervisory system is therefore a prerequisite for relevant, practical in-service training.

The health team members are responsible for bringing their own needs for supplementary training to the attention of the supervisor. In addition, each health professional should keep abreast of current developments in the health field by reading medical journals and textbooks, by attending conferences, by listening to relevant radio and television programmes, and by discussing health questions and issues with colleagues.

As a supervisor you can encourage your staff to keep up-to-date.

Where does Pakistan stand with regard to continuing education policy?

Though the need for in-service training has been acknowledged for over 20 years, there is, to date, no actual in-service continuing education policy in Pakistan. Nor, in spite of major efforts by government and by donors, has the battle to lower child mortality rates produced satisfactory results. Today there is an urgent need to have an in-service continuing education policy at the national and provincial levels. The Government of Pakistan is currently developing such a policy. The PCSP, with assistance from USAID, is helping to formulate this policy and, is working to establish a responsive plan for a continuing education system in Pakistan's health sector.

With or without a continuing education policy, the supervisor has a professional obligation and the capability to provide some in-service training to those he/she supervises. The supervisor of a facility needs to develop and monitor in-service training at the facility. For example, a person joining a facility team needs to be oriented to the functioning of the facility so that he/she can be an effective member of the team. This orientation can be given by any member of the team--but a system has to be established. Similarly, teaching the staff a new procedure can be done at facility level either by the supervisor or a staff member.

When your staff attend an in-service training session, data on the personnel trained and the subject of the training is entered in the training register. Refer to this to assess training needs of your staff.

AN INTEGRATED APPROACH TO HEALTH CARE DELIVERY USING TEAMWORK

The PCSP approach is integrated in several ways. The four intervention areas are seen as part of an integrated system of health promotion, illness prevention and disease treatment. In this way, the needs of the whole child are addressed. Secondly, the approach is integrated in that it involves the health care staff, the health care officials and the mother or caretaker as active members of the health care team.

In Pakistan, primary health care services are delivered through a system of RHCs, BHUs and MCH centers. These services cannot be provided by any single person. It is not possible for any one health worker to acquire all the necessary skills and to have enough time to do everything to satisfy the multiple health care needs of an individual, family or community.

For the proper delivery of primary health care services a group of people trained in various skills will be required to work together as a team with the MO as the team leader, and with an RHC or BHU as a base. Everyone on the staff of the health centre, as well as the patient or his/her family and the community leaders, is a member of the health team. The health team works in both the health centre and the community to provide primary health care services. The DHO as a supervisor of the health facility team oversees their activities.

In the health centre the health team provides both care to individuals seeking medical aid and illness preventive and health promotive services. The patient is a crucial member of the health team because the staff is there to meet his/her needs. However, in order to provide primary health care to the community, the health team should work closely with community leaders and community development workers of other organizations. Representatives from the community also need to be considered members of the health team. The district level supervisor assures that the health team provides appropriate and adequate services to meet the community's health care needs through periodic visits for assessment and support to the staff.

The health team should communicate with the parents, families and community leaders to help:

- Identify health needs
- Determine priorities
- Identify each team member's role in seeking solutions to the identified and prioritized health needs
- Prepare a plan of action to meet the needs
- Teach about illness prevention and health promotion

For a team to function well, each team member must know:

- The objective of the team--to improve the health of the people through the delivery of primary health care services. For each service, there are specific duties for each of the team members. (See Appendix for responsibilities of MO, paramedic and supervisors.)
- The rules governing the affairs of the team--the government policies and regulations must be followed by the team members. As a supervisor you need to review these as indicated.

- The individual's responsibility--each member should understand the role he/she is required to perform as part of the team.
- The need for cooperation--team members should cooperate among themselves to achieve their objectives. As a supervisor you need to encourage and facilitate this cooperation.
- The authority of the team leader--members should respect the authority of the team leader who plans, organizes, directs and coordinates the team's activities and helps its members achieve their objectives. You as a supervisor need to make sure that the team respects and takes direction from the team leader.

All team members must work under the same principle--that of doing their jobs properly and showing interest in meeting the health needs of the people. No one member is more important than another. All are equally important. Each member should cooperate and coordinate with others to achieve the common goal. If one member fails to do his job properly, the performance of the entire team suffers. Thus, each member working in a team makes a significant contribution in helping the team to deliver essential health services to the community. You as a supervisor need to set an example.

As a supervisor you will see that the attention of the facility staff is focussed on the child as a whole and not on the disease condition alone. The child should be assessed for nutritional and immunization status and for any illness.

For all children coming to the facility, you will assure that the staff follows the case management guidelines for integrated child-focussed health services as listed in the chart on the following page.

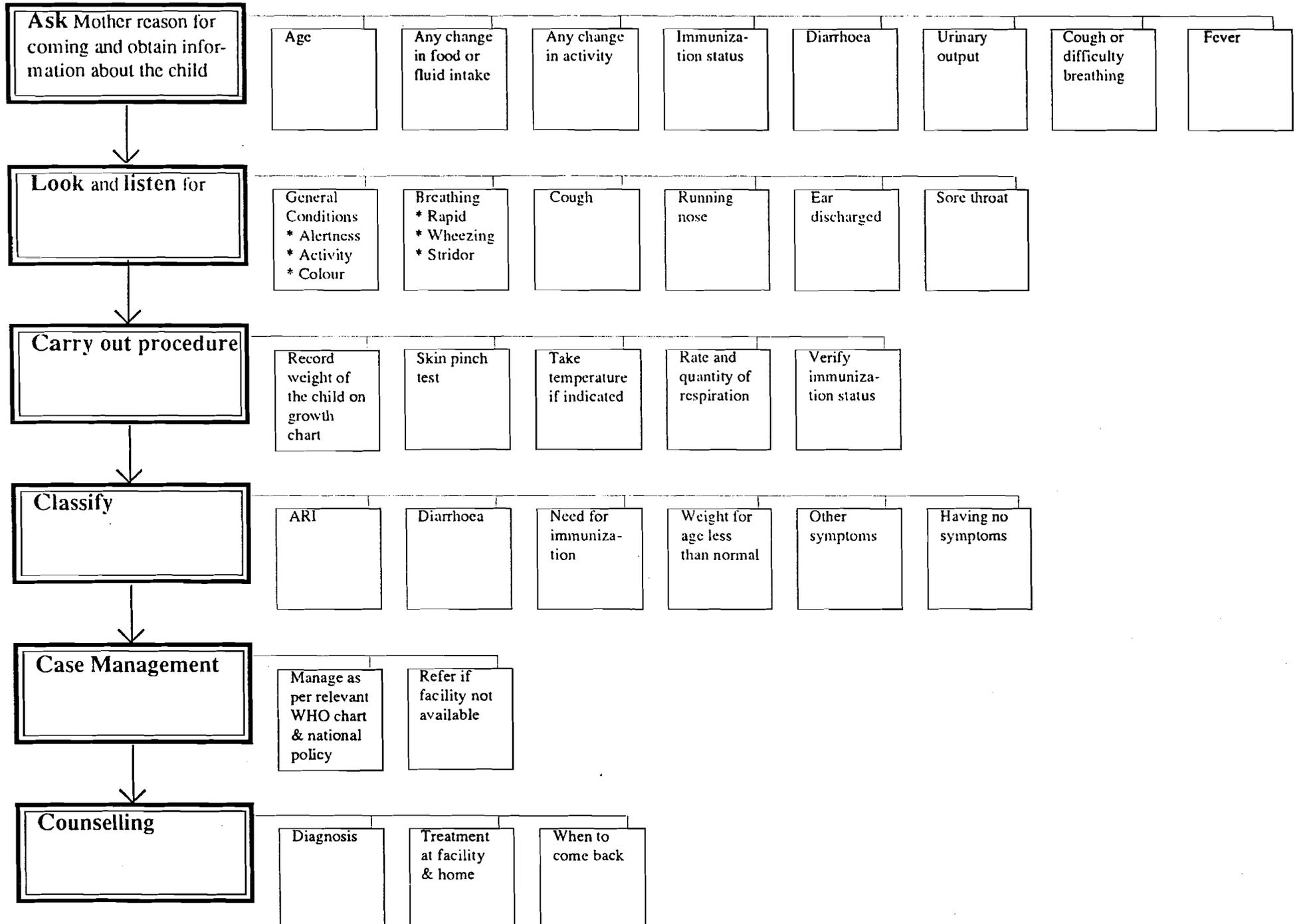
You will make certain that throughout the above process the mother will be involved, first, as information provider and then, as a responsible partner in prevention (immunization), health promotion (nutrition counselling) and management of the child's illness at the facility and at home.

CHILD-FOCUSSED TRAINING INVOLVING THE MOTHER AS A TEAM MEMBER

This entire programme is designed around the needs of the growing child. It is based also on the premise that proper history taking, diagnosis, treatment and follow-up care in the management of child illnesses or illness prevention must involve the full participation of mothers or caretakers. The PCSP has tried to use simplified language for communicating with mothers and is strongly

INTEGRATED CHILD HEALTH SERVICES IN FLCF

Child brought to FLCF



promoting improved interpersonal communication skills for health workers in order to involve Pakistani mothers, most of whom are illiterate, in the health care process.

Traditionally, child health care in Pakistan has focussed on the treatment of disease. The PCSP focusses on keeping children well or on helping them return to good health after they have been affected with an illness.

Central to this philosophy of child care is the mother, who plays an indispensable role in keeping a child healthy, in recognizing the first signs of illness when it occurs and, once an illness has been diagnosed and treatment prescribed, in providing the required continuation of treatment at home. The mother or caretaker is also an invaluable source of information regarding the child's health history.

It has been recognized that adequate care cannot be provided for children without the co-operation of a well-informed mother or caretaker. Most Pakistani mothers do not have sufficient knowledge and skills in disease prevention, treatment and follow-up care to adequately care for themselves and their children.

In order to teach mothers to participate in meeting their children's health needs, health care providers must first develop effective interpersonal communication skills. The majority of Pakistani mothers can neither read nor write. Instructions must be given in simple language and repeated time and time again. Simple demonstrations of procedures must be given. Mothers should be encouraged to repeat these instructions to ensure full understanding, and should carry out procedures under the watchful eye of a health provider until their competency is certain. Most importantly, the instructions must be given kindly and patiently to gain the mother's trust and give her confidence in her own ability to take a responsible role in the health care of her child.

The WHO has developed and tested simple, effective language and methods for diagnosis, treatment and follow-up care which mothers can easily understand. This approach is particularly effective in the treatment of diarrhoea and respiratory infections. Assessment terms such as "history taking", "observation", "palpation" and "auscultation" are replaced by the simple language of "asking", "looking", "feeling" and "counting". For examination, a stethoscope is replaced by the use of senses we all possess. These approaches, because of their simplicity, can be taught to mothers, and used by mothers, to determine whether or not the child is sick. In this training WHO's simple language and methods of case management are taught.

In a nutshell, the PCSP places great emphasis on the mother as an *information provider* and an *information receiver* throughout the process of diagnosis, treatment and follow-up care in the four intervention areas.

JOB-SPECIFIC, COMPETENCY-BASED TRAINING

The PCSP training package includes separate training units for paramedics, MOs, and supervising officers. During the training, all three categories of staff will have an overview of the others' training, in order to understand the responsibilities each has in the process of health care delivery. Briefly, the MO's training will have an emphasis on diagnosis and treatment of a condition, involving the mother. The paramedic's training will focus on carrying out procedures related to the MO's work and in counselling mothers on their role in developing and maintaining the health of their children. The supervisor's training will focus on his/her role in providing supportive supervision including essential materials and manpower, in monitoring and evaluating the post-training performance of the paramedics and MOs and in developing ways to support the implementation of the training.

This course for supervisors is of six days duration. The first day will cover the introduction to the course, role of supervisor, concept and type of supervision and tools of supervision. Day two will cover the topics of communication, nutrition and immunization, followed by diarrhoea and acute respiratory infections on the third day. Day four will summarize the first three sessions and lead to the topic of Integrated Child Survival Services and the supervisor's role in assuring adequate and appropriate children's services from the FLCFs.

The first four days will provide the supervisors with an overview of the content of training of MOs and paramedics and provide opportunities to discuss the supervisors' role in assuring effective delivery of integrated child survival services by FLCF personnel. Days five and six will consist of practical experience in using the Supervisory Checklist by visiting an FLCF, observing the operation of the facility and by filling out the checklist. Morning sessions will consist of visits and observations at an FLCF. In the afternoon sessions discussions will be held on the experience of using the checklist.

TRAINING METHODS USED IN THIS COURSE

This course uses a combination of training methods to impart the specific knowledge and skills required for supportive supervision. In other words, training is job-centered. Both the trainers and participants play an active role in the process of helping the supervisors improve their skills, acquire new knowledge and apply what they are learning to their day to day work. The following training methods are used:

1. **Lecture and discussion**--Theoretical content is presented by the trainer in lecture form followed by discussion based on the experiences of the participants and trainers.
2. **Audio visual aids**--Video tapes and wall charts are used mainly to demonstrate the case management process of diarrhoea and dehydration, and acute respiratory infections. Overhead projector and transparencies are used for nutrition, immunization and communication.
3. **Reading assignments**--Each participant is responsible for referring to the next day's training agenda and reading the topics for that day.
4. **Practical Experience**--Observation of FLCF staff performance is scheduled so that participants will have firsthand experience in the use of the Supervisory Checklist to document findings.

TEACHING METHOD	CRITERIA FOR USING THE METHOD
Lecture	<ul style="list-style-type: none"> - For a large group (50-100) - For providing knowledge - To determine existing knowledge
Discussion	<ul style="list-style-type: none"> - For a small group of 2 to 10 people - To explore feelings and attitudes
Demonstration and practice	<ul style="list-style-type: none"> - For a small or large group - For teaching procedures - When a teacher feels it is appropriate and when materials are available
Role playing	<ul style="list-style-type: none"> - For a small or large group - For interpersonal communication
Storytelling	<ul style="list-style-type: none"> - For a small group - For communicating new ideas and relating them to local conditions
Counselling	<ul style="list-style-type: none"> - For one to one - For a small group
Games	<ul style="list-style-type: none"> - For a small or large group depending on the game

Fig. 1 Research findings show that most people retain what they:

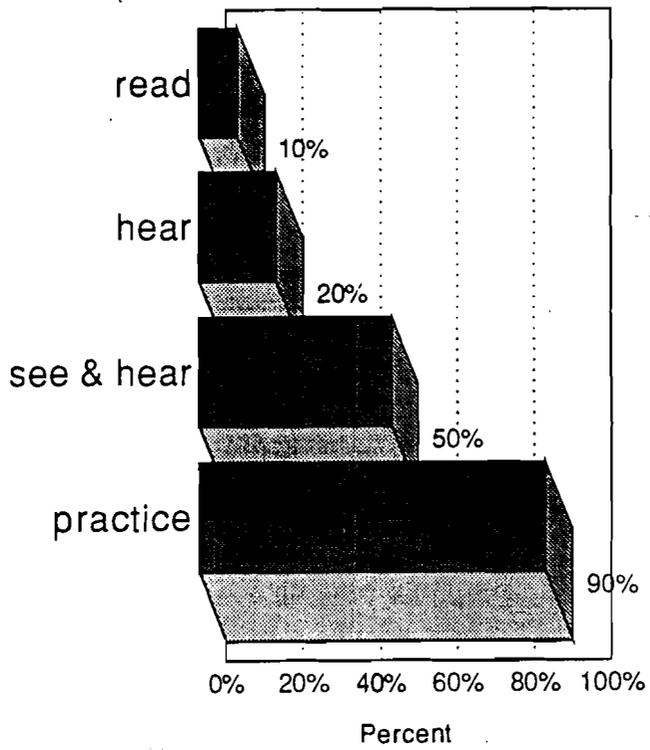
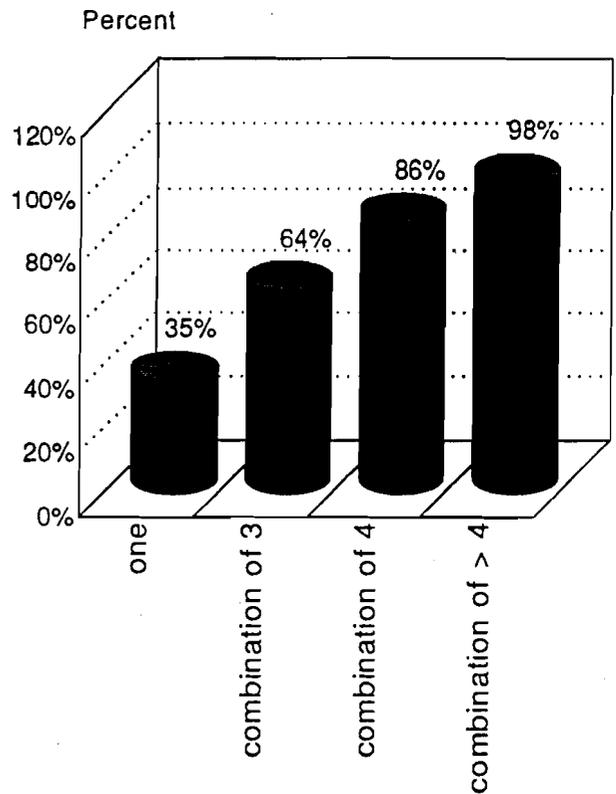


Fig. 2 Effectiveness of one or more teaching methods



CONTENT OVERVIEW

This training course for supervisors covers seven main topics which will be addressed in the following order:

- Management & Supervision
- Communication
- Immunization
- Nutrition
- Diarrhoea and Dehydration
- Acute Respiratory Infections
- Integrated Child Focussed Case Management Guidelines

The Training Module on each of the above intervention areas is taught in the following sequence:

- 1. Introduction to the Topic**
Background information is presented--such as the extent of the problem and the Government of Pakistan's policy. Participants are briefed as to the amount of time required for practical work and on the reading and written assignments for the module.
- 2. Learning Objectives**
These are introduced to increase the participants' understanding of the topic and of the knowledge and skills they need to develop in order to improve case management in their own facilities. The objectives are stated in the Participant's Manual at the beginning of each module.
- 3. Theory**
This section specifies the theoretical information which must be learned in order to satisfy the objectives outlined above. This section also includes an overview of the training given to other personnel.
- 4. Practical Work**
Each participant is given a Supervisory Checklist and an opportunity to observe staff performance during a role play in class or during management of a case in an OPD in order to become familiar with the checklist.
- 5. Evaluation**
Each participant is asked to complete an evaluation form at the end of each day.

MODULE 1

MANAGEMENT & SUPERVISION

LEARNING OBJECTIVES

LEARNING OBJECTIVES FOR INCREASED KNOWLEDGE AND UNDERSTANDING

Upon completion of this module, you will be able to:

1. State Government of Pakistan's policy for the provision of primary health care services and the supervisors' role in providing those services.
2. Define supervision.
3. List three areas in which supervisors need to improve in order to become effective.
4. State how district level supervisors' and MOs' responsibilities are similar and how they are different.
5. Describe the three methods of supervision and the give advantages and disadvantages of each.
6. Describe the Supervisory Checklist and Work Sheets, and list the steps in using them.
7. Describe the problem solving process and list the steps in it.

LEARNING OBJECTIVES FOR IMPROVING SUPERVISORY SKILLS

Upon completion of this module you will be able to:

1. Use the Supervisory Checklist for planning and performing a supervisory visit.
2. Apply the problem solving steps to problems commonly identified by the checklist.

INTRODUCTION

The Government of Pakistan has made it a high priority to provide primary health care coverage to the maximum number of people in the shortest possible time. Primary health care services are provided from the dispensaries, RHCs, BHUs, MCH centers and OPD of hospitals. Supervisors posted at district and tehsil levels are required to manage the facilities within their encatchment areas and to provide supportive supervision to the FLCF staff through visits to each facility at least quarterly.

RESPONSIBILITIES OF DISTRICT LEVEL SUPERVISORS

The district level supervisor is the administrative head of all FLCFs in his/her assigned area. He/she works closely with the MOIC in implementing the primary health care services with a special focus in child survival intervention areas.

The duties of the district level supervisor fall under three broad categories: management and coordination, supervision, and monitoring and evaluation.

1. MANAGEMENT AND COORDINATION

- Provides policy and programme guidelines to the MOs and paramedics of FLCFs.
- Reviews the job descriptions of the MOIC and the staff with the MOIC and explains his/her responsibilities and limitations.
- Receives requests for the resources required to provide child survival and other services; and arranges for quarterly deliveries and as otherwise needed.
- Assures that staff have been provided with all their entitled benefits, i.e., housing, utilities, leaves, training, etc.
- Coordinates activities with the Director General and the Divisional Director of Health Services and the Medical Superintendent of the District Headquarter Hospital; and regularly keeps each informed on the activities of the staff at the FLCF.
- Coordinates with the MS of DHQH on the training of staff and in facilitating referrals to and from DHQH.

- Coordinates with the Divisional Director of and/or Director General of Health Services in facilitating the implementation of health services from FLCFs in his/her area--including planning and releasing funds, posting essential staff and providing essential material resources.

2. SUPERVISION

- Visits each facility at least quarterly; meets with the staff to discuss implementation of the programme and any needs they may have, and provides guidance.
- Assures provision of quality health care including child survival services through observation and filling out of the Supervisory Checklist.
- Assesses need for and plans for scheduling of staff training.
- Participates in training at the facility or district level.

3. MONITORING AND EVALUATION

- Assesses the physical resources and condition of the building and arranges for needed repair and maintenance work.
- Assesses records/registers and forms on:
 - Status of service provided
 - Immediate notifiable diseases and preventive measures taken
 - Status of supplies, furnishings and drugs
 - Communication, i.e., telephone, letters, fax, telex
 - Training
- Submits quarterly reports or encloses the MOIC's reports on:
 - Number of patients attending the clinic
 - Percentage of patients receiving adequate care
 - Status of staff
 - Status of drugs, vaccines and other essential resources
 - Number of training events and the number of participants.
- Reports annually, or as indicated, on problems faced by his staff; how they were managed, and what problems remain to be solved in the following year.
- Submits annual budget for each facility based on the current year's expenditure and services provided.

SKILLS REQUIRED FROM DISTRICT SUPERVISORS

For you to be effective as a supervisor, you need to be equipped with skills in the following areas:

1. Technical/Clinical
2. Communication
3. Management and Supervision
4. Problem Solving

I. TECHNICAL/CLINICAL

To be able to carry out your supervisory functions, you need to be familiar with the responsibilities of the MO and the paramedical staff of the FLCF in the delivery of health care services. You must see that the FLCF staff provides quality health care to the community in all fields, especially in the following areas:

- Immunization
- Child Nutrition
- CDD
- ARI

The main objective in this training is to prepare you to supervise and assess the abilities of the facility staff to provide adequate and appropriate integrated case management services to the child coming to the facility. Adequate and appropriate services include diagnosis, treatment, counselling, referral and follow up services. It also means involving the mother or caretaker at each step of intervention.

Adequate case management includes the following steps:

- Assessment
- Classification
- Treatment
- Counselling and follow up in the four intervention areas

Management of each of the intervention areas will be covered in separate training modules.

2. COMMUNICATION

A supervisor has three primary functions in providing effective supervision--observing, intervening and reporting. These functions involve working with and through people to get the work done. Communication with both subordinates and superiors is vital for the efficient and effective delivery of health services. Since communication is a new field in the health sector, you

may not have received any training in the methods of communication. This training will familiarize you with the RUI model of communication which has been developed in Pakistan for use by health professionals. RUI stands for Rapport, Understanding and Influence or Intervening.

Rapport means establishing sympathetic relations with another person. This assures that the other feels accepted and respected. With a foundation of acceptance and respect, communication can flow more easily. Understanding requires empathy, the art of putting oneself in the position of another. With an empathetic attitude, one will more easily acquire the skills of listening carefully and asking relevant questions to get more information. Influence or intervening means producing or taking a desired action to solve or prevent problems.

These models have been further modified in accordance with the three supervisory techniques of observation, intervention and reporting. A separate training module on interpersonal communications will present these concepts in detail.

3. MANAGEMENT AND SUPERVISION

This module focusses on the concept of the health team working together and on the supervisors' responsibilities in managing the available resources including manpower, money, material, time and space as they pertain to the delivery of child survival health services offered from the FLCFs.

All of the activities of management are interlinked and for our purposes divided into two areas.

Management includes:

- administration/logistics
- coordination
- monitoring

Supervision includes:

- the process of helping an individual or group to get their assigned tasks completed
- training

Management is making efficient use of existing resources and getting people to work harmoniously together to achieve objectives. The MO as a team leader and you as supervisor share the same kind of management responsibilities: to make efficient use of the resources at hand (staff, budget, time, space, drugs, and equipment) in order to meet the health needs of the BHU's or RHC's encatchment area. The difference is that while he is responsible for his facility and the health team, you are responsible for managing all the health teams at the facilities in your assigned area. Since the rules and regulations governing the management of these resources are familiar to you, your responsibility is to help the MOIC understand them.

The concept of supportive supervision as part of overall management is fairly new. Managers are taught to work in a team: to identify problems, resources and solutions with the team. Since this is a new and different concept from the existing practice, a course for supervisors blending both

technical and managerial responsibilities in assuring delivery of adequate and appropriate child health services in the four child survival intervention areas has been developed. The process of supervision is the same for all illnesses or conditions. Therefore, it is assumed that focussing on these four major killers of children will demonstrate what effective supervision is and that those who are trained to be supportive supervisors in child survival intervention areas will use this process in other areas as well and become effective supervisors instead of only administrative inspectors.

4. PROBLEM SOLVING

Lastly, solving problems, is the most difficult task to perform, yet it is the one that is perhaps the most important. Solving a problem entails four steps that are easy to recite and difficult to execute.

1. Identify a problem.
2. Analyze the problem.
3. Generate a solution to the problem.
4. Implement the solution.

Some basic concepts related to each of these steps are given in a separate chapter of this module (page 36-39).

THE DISTRICT LEVEL SUPERVISOR AND THE MOIC OF A FACILITY

Everyone must work as a team to improve the health of the community. However, one person needs to take responsibility for the leadership of the team. Since the MO has many years of education and holds the senior position, he is considered the team leader. The MO is an MBBS graduate and is expected to act as the team leader and to provide direction and guidance in all the health centre activities. He should, therefore, be fully conversant with the area, its topography and its health needs. He will have both technical and managerial responsibility for running the centre. His technical responsibilities include diagnosis, treatment, referral and follow-up services for individuals who are sick, as well as for illness prevention and health promotive services.

An MO has spent five years in an academic institution learning his technical responsibilities. However, new knowledge and procedures develop rapidly in the health field. Therefore the MO is being trained in the Integrated Child Survival Course to update his essential knowledge and skills in primary child health care. He is expected to use his professional judgement and refer to additional technical resources (reference books, specialists, supervisors) anytime he is in doubt.

The MO is supervised by the designated ADHO/DHO. Since he receives no formal management training, yet is responsible for the administration and management of the health facility, you as a supervisor need to guide and teach him management responsibilities.

SUPERVISION

THE PROCESS OF SUPERVISION

Supervision is the art of overseeing the work of subordinates. It is a helping process--ensuring staff competence, effectiveness and efficiency, through observation, discussion, support and guidance. The supervisor plays a key role in creating a spirit of teamwork, cooperation and devotion to duty. You as a district/tehsil level supervising officer need to serve as a role model and to assist the MOIC to be an effective supervisor of his facility.

The supervisor at the district level, in addition to completion of his/her basic training at medical college, has had a number of years of experience in the treatment of illnesses and in managing administrative concerns. But because the field of supervision is new, this experience is based on trial and error. Many supervisors have not been introduced to the newer concept of supportive supervision. They have been exposed to the concept of administrative management by inspection which consists of checking performance and punishing.

There are three main styles of supervision:

- Autocratic
- Supportive (or democratic and participatory)
- A combination of the two

Supervisors who use an autocratic style are dictatorial, give orders and discourage feedback or questions about the orders. The health worker has no say in how the work is done. He has to carry out the order the way it was given. In this style of supervision, communication is one-way. The staff do not receive guidance from the supervisor regarding work performance, nor are they able to provide him with feedback. This work style tends to humiliate team workers, curbs initiative and makes them irresponsible or less responsible.

The second style of supervision is supportive. Supportive supervision is said to exist when the supervisor involves his team in identifying certain problems and together finding solutions to the problems within the available resources.

Team members like to be consulted in matters relating to their functions. They are then more interested in carrying out their duties, bettering the prospect of achieving the objectives. Therefore, the supervisor should include team members in planning, implementing and evaluating the services from their facilities. He should listen to them, encourage their participation and give each staff member increasing responsibility and recognition as skills improve. With supportive or participatory supervision health workers have a feeling of belonging to the team, thus motivating them to work harder. They will also accept decisions, discuss their doubts and may work with greater commitment, enthusiasm and self-confidence.

Supportive supervision is particularly effective for health workers in rural areas where visits by supervisors are infrequent. Under such circumstances, independence, self-reliance and confidence need to be developed.

The third style of supervision is combination of the first two. Neither of these first two styles described are applicable in all situations. This third supervisory style blends some of the autocratic with the supportive style.

On the whole, people like to be involved in planning and decision making. But the reality is that the staff of FLCFs are not involved in making policy decisions, yet are responsible for implementing them. In this case, you as supervisor have to see that government policy, such as immunizing children under one and the rational use of drugs in treatment of diarrhoea and acute respiratory infections, are implemented. You are being an authoritarian. But, you can soften this situation by involving your team in looking at the problems in implementing the policies and in trying to overcome these problems so that implementation is possible.

The decision on which style of supervision to use depends on the kind of work to be done and the kind of people to be supervised. You as a supervisor must adapt your style of supervision according to the needs and circumstances based on the following job and personnel factors:

- Job factors
 - The complexity of the job
 - The difficulty of the job
 - The need for quick decisions
 - The need for constant results
 - The need for creative work
- Personnel factors
 - The skill, reliability and experience of health workers
 - Their willingness to accept responsibility and to make decisions

Generally, as a supervisor you are dealing with people; therefore, adherence to the following points will make the supervisory task easier no matter which style you are using.

- Treat everyone fairly. Government rules and regulations assure fair treatment.
- Know and abide by government rules on:
 - Attendance
 - Performance
 - Leave
 - Discipline
 - Finance

- Treat all staff, regardless of their position, as being very important to the health team. Do not show favoritism.
- Show that you are interested in the welfare of each team member.
- Help each team member to take full responsibility for his/her particular job by praising good work and encouraging team members to take the initiative in their jobs.
- Be sensitive to the feelings of each staff member. Do not humiliate any team member. Humiliation breeds contempt and antagonism.
- Try to understand your staff's problems by encouraging discussion of and by offering assistance in solving the problems.
- Ensure sure that instructions are carried out.
- Demonstrate a willingness to make personal sacrifices to assist subordinates in times of crisis.
- Provide ongoing training. Giving support and guidance helps improve the skills of the team members.
- Be responsible for supervising the staff and for the maintenance of supplies, equipment, buildings and grounds.
- Use an authoritarian approach when necessary, such as in case of an emergency when there is no time for consultation.

TRAINING

Training is an educational process. It is the act of imparting knowledge and skills. Assessing the need for training and planning to meet these needs are part of the supervisory task.

Health care constantly changes as new ways of preventing, diagnosing and treating diseases are discovered. Health workers must always be ready to learn new methods, even after completing their basic training. The MO needs to continually assess his staff's knowledge and skills, providing learning opportunities as needed. In order to improve their abilities and the quality of service, the MO should obtain up-to-date reference materials for the staff's use. The district level supervisor should assist in providing these materials.

The district level supervisor should answer the following three questions to identify the needs of the staff and the available resources.

- **What needs to be learned?**
 - Observe the staff providing the service.
 - Use the checklist to identify his/her strong and weak areas in clinical skills.
 - Discuss your findings with the MOIC and the staff to see how you can help.
- **What is the best way to teach the subject?**
 - This answer depends the subject and who can teach it.
 - If reinforcing a routine procedure, an MO or other appropriate staff can provide the necessary instruction.
 - If a new procedure is to be learned, the staff may have to be sent to a training programme.
 - Always keep in mind that the principles of adult learning should be applied.
- **Where can the training take place?**
 - Once you have identified staff deficiencies, a training session can be held at:
 - The local facility
 - Arrangements can be made for participation in a scheduled training.
 - The district supervising officer or the MOIC should meet with the staff to explain what they are expected to learn during the training session.
 - After the training, the MOIC should observe their performances to determine how much they have learned.
 - The names of those who attended the training should be entered in the Training Register.

METHODS OF SUPERVISION

There are a number of methods of supervision that can be used to oversee the activities of those you supervise. The first is direct **observation**. The second is **review of record**. The third and most common and useful for your purposes is group or individual **meetings** or conferences. A checklist which includes the first two of these methods has been developed as a tool for you to use. You as supervising officer of the MOIC, must make certain that he/she is also using these methods in the day to day supervision of the facility. To supervise someone on the job, the supervisor must visit the work site as scheduled or as time permits. It is not possible for the

district level supervisor to visit his facilities frequently because of the distance and because of other responsibilities. However, it is possible for each supervisor to visit a facility once in a quarter or four times a year. And it is important to cover as much as possible in assessment, planning, monitoring and evaluation during each visit, using the Supervisory Checklist to document your observations and interventions. Information from these visits should then be incorporated in a report and sent to superiors in administration.

Observation. Observe staff members to assess how the case management process is implemented and how accurately procedures are followed. Observation is also identifying the problems and difficulties encountered in carrying out the tasks entrusted to different categories of workers.

The MO should be encouraged and supported to periodically observe staff performance to ensure that all staff are carrying out the work properly. The MO must ensure an orderly and clean working environment--the rooms, verandas and grounds. As part of assessment, the district level supervisor must carry out spot checks of the FCLF, observe the general attitude and functioning of all staff, and observe implementation of case management of children. Completing Section 1 of the Supervisory Checklist will help you assess the quality of care.

Review of Record. Review of records also helps with the assessment of supply and demand for services as well as staff performance. If records are well maintained, you know the staff are doing their jobs. Also the quality of the records and the quantity of resources in the register provide clues as to adequacy of the resources supplied to the facility. The MO should be instructed to periodically review the records to assess the adequacy of logistic support. The various types of records that are maintained at the facility are covered in the section on monitoring and evaluation. Completing the Work Sheets on Resource Management in the Supervisory Checklist will provide information on how well resources are managed by facility staff.

Meetings. Groups or individual meetings and conferences can help to clarify identified needs or problems. They are also useful in planning and monitoring activities. A regularly scheduled staff meeting facilitates teamwork. The MOIC should be encouraged to schedule staff meetings regularly to discuss work loads, resources and problems; and to discuss experiences whether rewarding, frustrating, or routine. A record of these meetings should be maintained to share with district supervisors during visits.

A staff meeting should be held on the day of a supervisory visit so that the supervisor may discuss his observations with the staff and involve them in planning and monitoring future activities. This forum can also be used to discuss group concerns or needs.

When an issue concerns one person, an individual conference will allow for privacy, freedom of expression and respect for the individual while saving time for those who are not involved.

A GENERAL RULE TO FOLLOW

Discussion of personal matters, discipline and evaluation should be dealt with only in an individual meeting.

MANAGEMENT

ADMINISTRATION

Administration is the act of managing an office. Sometimes the two terms administration and management are used interchangeably. In this course administration refers to the operation of health services based on government rules and regulations. A district health system based on primary health care is a more or less self-contained segment of the national health system. As DHO/ADHO you are responsible for the proper functioning of all the health facilities in your area. Similarly the MO is responsible for the proper functioning of the health facility of which he/she is in charge. In your position as administrator and supervising officer you should be able to provide guidance to the MO on all service and financial matters as per government rules. The most common rules are:

1. Government servants' conduct rules
2. Government servants' efficiency & discipline rules
3. Government servants' leave rules
4. Financial rules and delegation of financial powers
5. General instructions for drawing and disbursing officers
6. Pension rules
7. Provident fund rules
8. Purchase rules
9. Travel allowance rules
10. Medical attendance and reimbursement rules
11. Local Government Ordinance

Most of these are available in government publications. In addition, one of the most useful guidance/reference materials for an MO regarding health matters is the Medical Manual.

The DHO also must ensure that:

- All staff report for duty as per government rules for the winter, summer or Ramazan schedules. Everyone works the same number of hours. Some staff must be available to tend to any patients who come after hours or on holidays. The attendance register is maintained for this purpose.
- There is sufficient staff available to carry out the activities of the centre before approving or forwarding leave applications. When there is a staff shortage all personnel, including the MO, may have to take on additional responsibilities.
- The staff are paid regularly and on time. The MO is responsible for signing the pay bills for all the staff other than doctors. These should be prepared by the clerk seven to ten days before the end of the month and submitted to the DHO/ADHO after they are signed. During the first week of the succeeding

month, the clerk should collect and bring the cash to the centre. The MO must be present at the time of salary distribution to countersign all thumb impressions and to certify that payment has been made in his presence. He must sign against the entry in the cashbook for the total amount received and disbursed.

- The annual list of requirements for instruments, drugs, equipment, linen, clothing and other supplies is prepared in October for the following year and submitted to the district office. The supplies will be available from the district supervisor after sanction of the budget in June.
- Written instructions are available for the distribution of drugs and supplies, as well as for emergency local purchases, when the district office is unable to provide the requested items.
- A dispenser or an HT keeps an up-to-date inventory and stock register and is responsible for correct accounting.
- Vehicles are properly maintained and a logbook kept.
- A record of staff performance is kept and an annual confidential report is completed.
- The MO immediately notifies the district officer and takes any necessary action if there are indications of epidemics or disasters. (See Instructions for Immediate Reporting of Disease on page 133.

During your visit, you must observe staff activities under the MOIC and learn how they comply with the above points. You will need to provide necessary instructions, support and feedback.

COORDINATION

Coordination means the orderly management of group effort to provide unity of action in pursuit of a common objective. Coordination in the setting of an RHC or BHU needs teamwork--FLCf staff, DHO staff, community resources--in order to meet health needs of the community.

For example, when a feverish patient is brought to the RHC by his family, the health team must work together to make a diagnosis and provide proper treatment. When the doctor examines him and suspects malaria, he is referred to the laboratory for a blood test. The laboratory technician tests his blood and reports back to the MO. The MO prescribes treatment and finally a dispenser gives the prescribed drugs. At least four people coordinated their activities so that a sick person could receive treatment: the patient's family, the doctor, the laboratory technician and the dispenser. This is called intra-agency coordination.

It is often necessary to coordinate with outside organizations as well. This is called inter-agency coordination. Inter-agency coordination is essential for successful primary health care and involves both health institutions as well as other institutions, such as schools, law enforcement agencies, agricultural organizations and others.

The MO needs support and instruction from the supervisor to coordinate with:

- Community leaders
- Tehsil or District Headquarters Hospitals
- Other government offices and institutions such as schools, WAPDA, PH Engineering, the Agriculture Department, mosques and the police

MOs usually do well in coordinating their staff within the facility, but often feel hesitant about going to other organizations to seek help. This attitude and practice must change. The district level supervisor can bring about a change in the MO's behaviour and attitude by assisting in developing a list of the existing resources and organizations in the encatchment area. By determining what services and products these groups provide and by discussing with them how they can coordinate activities and resources, the FLCFs will provide better services to the community.

Health staff can develop a list of specific community resources by gathering the following information:

- Identifying information:
 - Name of the institution/service
 - Location: Address and landmarks; for example--near the mosque
- Who to contact:
 - Name and title of a person
- What are the requirements for using this resource?
 - Male or female
 - Age group
 - Conditions: unemployed, unable to read and write, poor, class eight passed, resident of the village, district, etc.
- How can one make use of this resource?
 - Apply in person
 - Request the service in writing
 - Be referred/directed through the community leader, Pesh Imam, government official, MO, etc.

★ When are the services of the resource available?

- Usual government office hours
- Specific days of the week or month
- Specific times of the year
- Twenty-four hours a day

Once the list of resources in the community has been developed, a system for using these resources must be devised. Members of various organizations together will look at how best to serve the community. This is coordination.

The DHO is responsible overall for developing and establishing a working relationship with various organizations within the district; while the MOIC is responsible for his/her encatchment area. The MO, especially, should establish a referral system from the union council to the RHC and from the RHC to the hospital. Developing this referral system will better serve the community.

The MOIC, in consultation with the DHO, should carry out the following steps to develop a referral system for the proper utilization of existing resources.

- The MOIC or his designated staff meet with the decision-making officials of each agency and develop a system of referral.
- Once the referral system is developed, the MO assists centre staff and the community to make appropriate use of the system.
- Meetings with officers from referring agencies should be arranged to exchange experiences, to compliment each other and to rectify any weak areas. The DHO should be present at some of these meetings.

The MOICs are not given any training in management and supervision yet have tremendous responsibilities in this area. You must provide support during your visits to the facility so that his/her skills in supervision improve.

MONITORING AND EVALUATION

Monitoring means watching the progress, achievements and standard of work of a programme. Monitoring can be done by every staff member with the help of a checklist, individual or group discussion and by reviewing records and reports. The first two items have been discussed.

Records and registers are the memory system of the facility and reports are the information system. Both records and reports are used to collect data on service delivery, resource management and community health needs.

Recently, the Federal Ministry of Health in collaboration with the Provincial Health Departments has developed a comprehensive Health Management Information System for First Level Care Facilities (HMIS/FLCF). A consensus has been reached during three consecutive National HMIS Workshops to replace existing forms and registers in first level care facilities by a revised set of data collection instruments (See table on page 35). For all these data collection instruments, detailed instructions have been developed and gathered in a comprehensive Instruction Manual for First Level Care Facility Staff.

At the district level, three data collection instruments have developed:

- DR1 - Supervisory Checklist
- DR2 - Training Register
- DR3 - Personnel Management Register

Under the new HMIS/FLCF a simplified reporting system will be used. Only three reports will be sent from the facility level.

- | | |
|------------------------|---|
| FF 1. Immediate Report | Reports on an immediate basis on disease outbreaks. In-charge of FLCF is responsible for filling in and transmission. |
| FF 2. Monthly Report | Reports comprehensive data on priority diseases, health care activities provided, and resources. In-charge of the FLCF supervises filling in and transmission. |
| FF 3. Yearly Report | Reports data for which more frequent reporting is not necessary; e.g., building/equipment/transport, drugs/vaccines/supplies and population data. In-charge of the FLCF supervises filling in and transmission. |

From the District level, one report will be sent:

- | | |
|---------------------------------|--|
| DF 1. Quarterly District Report | Reports on data collected at the district level: data from Supervisory Checklists, data from Household Based Surveys, and data on personnel postings and training. DHO supervises the filling in and transmission. |
|---------------------------------|--|

Data from FLCFs and district level reports are used to assess work progress in relation to targets or schedules, availability of staff and their performance, adequacy of the resources supplied and health service utilization by individuals in the community. This information is also used for planning and budgeting. It must be accurate and current. The district level supervisor works with the MOIC to assure proper collection and transmission of these reports. For proper planning the supervisor also needs to make sure his/her office staff properly completes the Quarterly District Report and forwards it as scheduled.

Detailed instructions for use of the Supervisory Checklist will be given later in this module.

FLCF-Based Data Collection Instruments

INDIVIDUAL PATIENT / CLIENT RECORD CARDS

- FC1 - OPD Ticket
- FC2 - Referral Form
- FC3 - Mother and Child Health Card
- FC4 - Family Planning Card
- FC5 - Investigation Request Form
- FC6 - TB Facility Card
- FC7 - TB Patient Card
- FC8 - Chronic Disease Facility Card
- FC9 - Chronic Disease Patient Card
- FC10 - Immunization Card
- FC11 - IDD Card

FACILITY RECORD KEEPING

I - SERVICE DELIVERY REGISTERS/CHARTS:

- FR1 - OPD Register
- FR2 - Abstract Register for Priority Diseases
- FR3 - Child Health Register
- FR4 - Mother Health Register
- FR5 - Family Planning Register
- FR6 - TB Register
- FR7 - IDD Register
- FR8 - Laboratory Register
- FR9 - Daily EPI Register
- FR10 - Permanent EPI Register

FACILITY RECORD KEEPING

II - ADMINISTRATIVE REGISTERS/CHARTS:

- FR11 - Population Chart of Catchment Area
- FR12 - Birth Register
- FR13 - Stock Register: Medicines/Supplies
- FR14 - Stock Register: Equipment/Furniture/Linen
- FR15 - Meeting Register
- FR16 - Daily Expense Register
- FR17 - Attendance Register
- FR18 - Log Book
- FR19 - Stock Register: Vaccines

PROBLEM SOLVING

Despite the fact that throughout our lives we are required to solve problems, we do not always do a good job of it. We fall into easy habits of jumping to conclusions, or avoiding problems, or passing our problems on to someone else. Fortunately, there has been progress in the area of systematic problem solving that helps one to avoid these mistakes. The problem solving process has been examined and broken down into a series of steps that, if followed, will speed the solution of most common health service problems.

There are only a few basic steps in the problem solving process but these may be expanded to additional steps if a problem is complex or difficult. We will start with the four basic steps and expand upon them as necessary:

1. Finding a problem
2. Understanding the cause of the problem
3. Generating a solution that responds to the cause of the problem
4. Implementing that solution

With the Supervisory Checklist these four steps are often sufficient as the strength of the checklist is that it finds problems and states them in terms that lead directly to an understanding of the cause of the problem and how to solve it.

For example: if the problem is that the MO does not check on the immunization of each child he sees and the cause of that problem is that he didn't know he was supposed to do that, the solution is to tell the MO that he should make that check for every child. This example may seem trivial because the solution is so obvious. However, when problems are found in such concrete terms, the solutions often are obvious and easy to implement.

Problem solving becomes more complicated when we move away from the checklist (and there are some problems that might be identified by the checklist where the solution is not direct and easily seen). The number of problem solving steps can grow quite long for complex problems where the causes are obscure, the possible solutions are numerous, and our knowledge about the effectiveness of the possible solutions is limited. Of course one wants to solve a problem in the fewest steps possible. To avoid performing unnecessary steps, the supervisor, or other problem solver, can ask himself a question at the conclusion of each step to see if he has to perform intermediate steps or can just do the main steps. The steps and questions are the following:

Step 1. Define a Problem

A problem is identified by using one of the checklists, by interviewing patients as they leave the clinic, from comments of staff, or from the HMIS.

Question: Is the problem stated in operational terms? Not in terms of a preferred solution (e.g., lack of a laboratory); and not in vague or abstract terms (e.g., poor communication, weak counseling, inaccurate diagnosis). If the problem is not stated in operational terms, the supervisor must keep asking why and what until he has defined the problem in concrete behaviors. For example, "Why do you say communication is poor?" If the answer is that the person doesn't receive the information she needs, ask, "What needed information don't you receive?" and so on.

When the supervisor is satisfied that the problem is stated as concretely as possible, then he may proceed to the next question.

Question: Are there more detected problems than can be addressed right now? The checklist will find lots of problems and the supervisor will frequently be faced with more problems than he can deal with in one visit. If there are too many problems to deal with, the supervisor must establish priorities among them to reduce the number of problems to a number that can be dealt with now. This is done by rating the problems on the basis of factors that the supervisor and staff believe are relevant to the problems they have found. Some common factors for rating problems include:

- Importance - is the problem an important one in that it either is concerned with an activity that is done a lot in the clinic (therefore the problem affects many people), or the problem is found in a critical activity that if done wrong, can have grave health consequences for patients?
- Visibility - is the problem one that people can see? If they cannot see the problem or its effects, they will be less interested in solving it.
- Feasibility - is it reasonably possible to solve this problem? Some problems -- but fewer than many people believe -- require resources to solve them; if those resources are not available then it is not feasible to solve them.
- Fast turn-around - can the problem be solved quickly while people are still interested in it?
- Appeal - does the problem appeal to staff because it affects them personally or they feel professionally concerned about it?

Question: Is the problem stated in terms of an outcome (e.g., 40 percent of blood slides are inaccurately read) which is the result of a process (in the blood slide example the process would extend from collection of the blood sample to final recording of the results) or in terms of a behavior (e.g., the technician does not know how to adjust the scope)? If the problem is the result of a process, then that process must be taken apart so that the activities that make up the process can be individually examined to see which one(s) cause(s) the problem.

Step 2. Understand the Cause

In a many instances where the problem has come from using the checklist, the cause will be immediately evident. For example, blood slides are not made because there are no slides available. More often, however, the supervisor will have to dig a little to understand the cause.

Question: Is the cause of the problem obvious? If it is not, the problem solver will have to collect data to generate possible causes.

Question: After collecting information on causes, does the information suggest the possibility of more causes? If so, then the supervisor must collect additional data on the newly discovered possible causes.

Question: Have data been collected to the point where educated guesses may be comfortably made about what truly lies beneath the problem? If yes, select the most probable cause(s).

Step 3. Generate a Solution

Once the most likely causes have been brought to light it may be relatively easy to generate possible solutions.

Question: Is the solution to the problem obvious from the cause? A cause of a problem which is lack of knowledge implies the obvious solution of training. However, a problem that is caused by a lack of motivation does not have an obvious solution. If the solutions do not come naturally from an understanding of the causes, the supervisor will have to generate a list of possible solutions.

Question: Are more solutions generated than can be implemented? If yes, then the supervisor will have to select the most promising solutions. This may be done by prioritizing them.

Question: Can the solutions be prioritized? Sometimes we find we know so little about the effectiveness of the different possible solutions that we cannot choose among them. If the solutions cannot be prioritized, the supervisor has to collect data on the effectiveness of the proposed solutions. This information may come from experts, from small field trials, etc.

Step 4. Implement the Solution

The implementation plan should be spelled out in the solution. If the supervisor has worked with the clinic staff in generating solutions and selecting the preferred solution, implementation will be easier.

Question: Is there any uncertainty about the effectiveness of the solution? If the cause of a problem was a broken microscope and the solution was to replace it, we can be pretty sure that the solution will be effective and no special follow-up is required. If, however, the problem was low vaccination coverage and the solutions being implemented were several, follow-up may have to take place on two levels. First, conduct special follow-up on the indicator that best reflects the problem as originally defined. If the problem was low vaccination completion rates, then that is the indicator that should be checked.

Question: Was the problem the result of a process? If so, in addition to assessing the indicator associated with the problem (e.g., vaccination completion rates), you also have to study indicators that tell whether the solutions were properly implemented. For example: if, in an attempt to improve vaccination completion rates, one of the solutions is to have each mother repeat the date of the next vaccination and point to that date on a calendar, then you should check to see if mothers are being asked to do that and whether, in fact, they are able to do it.

Question: Are the results of these evaluations positive? If not, go back to step 2 and repeat the cycle.

The point of all this is that a problem may be solved by racing through the four steps when the problem is simple and the solution self-evident. Or the problem can drag through 17 steps if the answers to the questions posed along the way so dictate.

SUPERVISORY CHECKLIST

The Supervisory Checklist is a district level data collection instrument for assessing the operational status of FLCFs within the encatchment areas. This is a tool for you to use not only in assessing but in planning, implementing and monitoring preventive and curative health activities so as to bring about an improvement in the quality of health care delivered by the FLCF, specifically in the area of child health services.

The Supervisory Checklist has two parts: a **set of worksheets**, and a **summary**.

The set of worksheets contains 15 worksheets, 9 for assessment of quality of care delivered for priority health problems, and 6 for assessment of resource management. You will first use relevant sheets from this package to assess the facility and staff performance. Your final scores from each of the case management or resource management sheets are then copied on the summary.

The Summary consists of four pages. The first page contains the identifying information on the institution to be visited and a supervisory visit preparation section for that institute. The second page covers individual case management and provides information on the quality of care on a three-point scale: poor, insufficient and appropriate. This page can be filled in only after completing the Individual Case Management Work Sheets 1 through 9 of the first set. The third page is on resource management assessment and provides information on the adequacy of equipment, personnel, procedures and record keeping. This page can be filled in only after completing the Resource Management Work Sheets 1 through 6 of the first set. The last page is for noting feedback on the visit.

HOW TO USE THE SUPERVISORY VISIT FORMS AND CHECKLIST

Previsit Activity

1. In preparing for a visit to a facility, be sure to have both parts of the checklist, the worksheets, and the summary.
2. Fill in the identifying information on the FLCF you are going to visit.
3. Photocopy from the Personnel Register, and take along the most recent personal status of that facility.
4. Fill in the date of your previous visit. This information is in your Supervisory Checklist used on the last visit or in your diary.
5. Study the Supervisory Checklist used on the previous visit:
 - * List all actions taken for that facility since your last visit.
 - * List any special needs or problems that you noted on your previous visit and any that have come to your attention through reports, complaints or suggestions from any source. These issues should be checked on during the current visit.
6. Mentally review the needs of the facility and make a list of any other requirements you need to address.

On site

Preparation

1. Review your list on the preparation sheet.
2. Decide what particular activities and/or areas you are going to assess.
3. Take out the relevant Work Sheets on Individual Case Management and/or Resource Management.

Observation

4. Explain to the staff that, as part of your supervision, you are going to observe facility activities. Instruct them to carry on with their normal routines.

5. Based on your observation, complete the work sheets.
6. Assign a final assessment score.
7. Continue the same approach in same room or with same staff, as time allows, until you have filled out all the work sheets you had planned to use on this visit. Assign a final assessment score for each work sheet.

Documentation

8. Transfer your final assessment ratings from the work sheets to the summary checklist in the appropriate sections of the Individual Case Management and Resource Management sheets.
9. On the last page, Feedback On The Visit, summarize your findings. Note down points to bring to FLCF staffs' attention. Refer to this summary checklist when discussing the status of the facility with the staff.

Intervention/Discussion (using problem solving approach)

10. Conduct a group meeting. Inform the staff of the following:
 - A. Achievements
 - Note improvements since the last visit. Compliment the staff on their achievements.
 - B. Problems/needs identification
 - List all problems you identified on the previous visit that still need further improvement.
 - Ask for any problems the staff want to list. Also add to the list those problems/needs you observed during this visit.
 - Discuss possible causes.
 - Prioritize the list of problems.
 - Discuss possible solutions.

- C. Agreed upon plan
- Ask first for staff's input on how identified needs/problems should be managed.
 - Give your recommendations/decisions.
 - Decide on the staff's and the supervisor's responsibilities to resolve the identified problems within a specified time frame.
- D. Review the problems and plan with the staff.
- E. Inform the staff on the date of your next visit.
- Conduct demonstration or training where and when feasible.

After the visit

Report

11. Complete the checklist.
12. Make a list of and plans for activities to be carried out.
13. File your checklist.

EXERCISES ON SUPERVISORY CHECKLIST

1. You will observe two role plays - First: a supervisory visit to an FLCF using the conventional approach. Second: a visit using the Supervisory Checklist. Discuss which one is more effective.
2. Use the Supervisory Checklist in different types of first level care facilities as explained by the trainers.

Supervisory
Checklist

INSTRUCTIONS

September 1, 1992

GENERAL INSTRUCTIONS

The supervisory checklist is a district level data collection instrument intended to improve quality of patient and facility management in first level care facilities.

1. Purpose

- 1.1. To help supervisors at the district level to assess as objectively as possible quality of case management and of resource management in first level care facilities under their responsibility.
- 1.2. To serve as a tool for continuing education of the staff in first level care facilities.
- 1.3. To provide to divisional, provincial, and national public health managers the necessary data for monitoring quality of care in first level care facilities.

2. Users

The supervisory checklist can be used by all types of district and tehsil/taluka level supervisors, such as District Health Officers (DHOs), Assistant District Health Officers (ADHOs), Taluka Officers, Assistant Health Inspectresses (AHIs), Field Supervisory Medical Officers (FMSOs), etc.

It can be used simultaneously by several supervisors, e.g. ADHO for curative care, AHI for maternal care etc. At the end of each quarter, the checklist should be available to the District Health Officer so that he can draft the Quarterly District Report.

3. Presentation

The Supervisory Checklist for First Level Care Facilities provides summary statements on all activities performed in the first level care facility. It first gives a framework for the preparation of a supervisory visit. It then has a Section 1 on Case Management, and a Section 2 on Resource Management. Finally it gives a framework for the provision of feedback to the health facility staff.

Following are a series of work sheets permitting the supervisor(s) to assess in detail the performance of the health staff for each of the activities in case management and in resource management, so that the statements given in the Supervisory Checklist can be made more objective.

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WORK SHEETS

Section 1: Individual Case Management

Following is a series of work sheets permitting to assess quality of care provided to patients/clients for priority health care activities:

1. Sick Child Under Five
 - 1.1 General Child Care
 - 1.2 Diarrhoeal Disease Case
 - 1.3 Acute Respiratory Infection Case
 - 1.4 Management of Nutritional Status
 - 1.5 Management of Immunization Status
2. Growth Monitoring in Child Under Three
3. Immunization Session
4. Prenatal Care
5. Delivery Care
6. Postnatal Care
7. Neonatal Care
8. Family Planning
9. Tuberculosis (follow-up)

Assessment by the supervisor is performed through **observation of the health care provider in action** (except for tuberculosis). During his supervisory visit, the supervisor selects a number of cases to be observed and uses the work sheets to make a detailed check on the case management. For most of the priority health care activities, standard case management guidelines are available and can be consulted in addition to the work sheets.

For each health care activity, observations on a maximum of five cases can be recorded. For each item, write in the appropriate box, one of the following scores:

- YES: Item was correctly performed by the staff
NO: Item was not or incorrectly performed by the staff
NA: Assessment of this item was not applicable for this particular case

At the end of the work sheet, 'Yes' and 'No' scores are totalled, and the percentage of 'Yes' scores out of the total 'Yes' and 'No' scores is calculated. These percentages can then be transferred to the supervisory checklist.

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Section 1: Individual Case Management Work Sheet 1: Sick Child Under 5	Institution Name: _____ _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5
	Work Area Set: <input type="checkbox"/> <input type="checkbox"/> Y N	Name of Staff: →				
1.	Rapport					
1.1	Was mother greeted?					
1.2	Was mother asked to sit down?					
1.3	Was mother asked reason for coming to the facility?					
2.	History					
2.1	Asks for age of child					
2.2	Asks change in eating/drinking pattern					
2.3	Asks change in bowel/urine output					
2.4	Asks for change in activity					
2.5	Asks for other symptoms					
2.I	Asks for child's immunization status					
2.N	Asks for nutrition intake assessment					
3.	Examination					
3.1	Looks at general condition (colour, alertness)					
3.2	Looks at condition of eyes, ears					
3.3	Looks at condition of nose, mouth, ear					
3.4	Looks at chest indrawing					
3.5	Counts respiration					
3.6	Takes skin pinch					
3.7	Takes temperature (if indicated)					
3.I	Checks Immunization Card					
3.N	Takes weight (child under 3)					
4.	Classification					
	Was child correctly classified?					
4.1	ARI case					
4.2	Diarrhoea case					
4.3	Case with other symptoms					
4.4	Case with no symptoms					
4.I	According to need for vaccines					
4.N	According to nutritional status					

K6

		Case 1	Case 2	Case 3	Case 4	Case 5		
5a	Management							
5.1	Were child's needs correctly managed? According to WHO protocol for ARI case According to WHO protocol for Diarrhoea case According to acceptable standards for other cases							
5.2	Refers complicated case appropriately							
5.I	Manages correctly immunization needs of the child							
5.N	Manages correctly nutritional needs of child							
6	Advice							
6.1	Explains to parents findings of child's condition							
6.2	Explains need/no need for drugs							
6.3	Explains when to bring back the child							
6.I	Gives appropriate immunization advise							
6.N	Gives appropriate nutritional advise							
7	Follow-up							
7.1	Gives appointment for next visit							
7.2	Checks if mother has well understood treatment/advice given and date of next appointment							
8.	Reporting							
8.1	Completes MCH card							
8.2	Completes OPD Register							
8.3	Uses Referral Forms							
							<u>Total 'Yes'</u>	
							<u>Total 'Yes'+ 'No'</u>	
For General Child Care (all cases) <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/	
For ARI Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/	
For Diarrhoea Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/	
For Immunization Management (2.I → 6.I) <i>Write number of 'Yes' scores over total number of 'I' scores</i>		/	/	/	/	/	/	
For Nutritional Management (2.N → 6.N) <i>Write number of 'Yes' scores over total number of 'N' scores</i>		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:								
General Child Care:							%	
ARI Case:							%	
Diarrhoea Case:							%	
Immunization Management:							%	
Nutritional Management:							%	

Section 1: Individual Case Management Work Sheet 2: Growth Monitoring in Child Under Three	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1.	Tares scale to 0 at the beginning of the weighing session							
2.	Asks mother for MCH card and if first time, issues an MCH card							
3.	Determines age of child as precisely as possible							
4.	Undresses the child before weighing							
5.	Reads weight correctly							
6.	Records age correctly on MCH card							
7.	Records weight correctly on MCH card							
8.	Explains result to mothers							
9.	Talks about need to maintain breast-feeding or good weaning practices							
10.	Explains mother if child needs special feeding or other attention							
11.	Asks mother if she had any questions about child's status							
12.	Gives appropriate appointment for next weighing							
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores over total 'Yes' and 'No' scores:							%	

Section 1: Individual Case Management Work Sheet 3: Immunization Session	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 4	
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →					
1.	Uses sterile needle and syringe for each injection						
2.	Uses correct syringe and needle						
3.	Gives injection at the correct place						
4.	Uses the correct route for injection						
5.	Records dates of immunization on appropriate cards and registers						
6.	Informs mother when the child needs to be brought back						
7.	Asks the mother to repeat the instructions to assure that she understood						
8.	Rinses and sterilizes reusable syringes and needles						
9.	Discards disposable syringes and needles						
10.	Discards opened vials of vaccines						
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.</i>		/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores over total 'Yes' and 'No' scores:						%	

Section 1: Individual Case Management Work Sheet 4: Pre-Natal Care	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →				
1. Rapport						
1.1	Friendly attitude					
1.2	Listens carefully					
2. History taking						
2.1	Checks medical/obstetric history on first visit					
2.2	Asks for last menses					
2.3	Probes into complaints					
3. Examination						
3.1	Checks pelvis on first visit					
3.2	Checks BP, weight, oedema, urine					
3.3	Checks fundus height					
3.4	Checks position baby >32 wks					
4. Classification						
4.1	Assesses gestation period					
4.2	Identifies correct risk level					
4.3	Identifies any need for referral					
5. Management						
5.1	Provides routine drugs (FFC)					
5.2	Completes TT vaccination					
5.3	Manages problems by protocol					
6. Advice						
6.1	Advices on feeding and rest					
6.2	Warns for smoking & drugs					
6.3	Advices place of delivery					
6.4	Explains signs of labour					
6.5	Explains how to conduct home delivery					
6.6	Advices emergency action					
7. Follow-up						
7.1	Gives appointment for next check-up					
7.2	Confirms date of next visit					
8. Reporting						
8.1	Completes MCH card					
8.2	Completes Mother Health Register					
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.		/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:						%

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Section 1: Individual Case Management

Institution Name: _____

Work Sheet 5: Labour and Delivery

Name of Supervisor: _____
(if different from front page)

Date of Supervision: _____
(if different from front page)

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1.	Rapport							
1.1	Helps mother to relax							
1.2	Instructs clearly and calmly							
2.	History taking							
2.1	Uses MCH card to check risks							
2.2	Identifies gestation period							
2.3	Identifies hours of labour							
3.	Examination							
3.1	Takes pulse, bp, temp.							
3.2	Checks pv bleeding, anaemia							
3.3	Counts contractions							
3.4	Checks position foetus							
3.5	Counts foetal heart rate							
3.6	Examines pelvis,cervix by VE							
4.	Classification							
4.1	Checks if labour < 12 hours							
4.2	Identifies foetal distress							
4.3	Identifies presenting part(s)							
4.4	Determines need for referral							
5a	Routine Management Labour							
5.1	Monitors pulse, bp 1/2 hourly							
5.2	Checks bladder/bowel							
5.3	Checks foetal heart 1/4 hourly							
5.4	Checks cervix/descend 2-hourly							
5.5	Gives sugary drinks							
5b	Management Normal Delivery							
5.6	Clean instruments/hands/perineum							
5.7	Controls slow delivery head							
5.8	Checks cord around neck							
5.9	Cleans mouth and nose of baby							
5.10	Checks if placenta complete							
5.11	Checks contraction uterus							
5c	Management complications							
5.12	Gives IV fluid if in shock							
5.13	Refers obstructed labour							
5.14	Resuscitates baby (protocol)							
6	Advice							
6.1	Explains risk of infection							
7	Follow-up							
7.1	Gives date for Postnatal Care visit							
8	Reporting							
8.1	Completes card and Mother Health Register							
Write number of 'Yes' scores over of total number of 'Yes' and 'No' scores		/	/	/	/	/		
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%	

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Section 1: Individual Case Management Work Sheet 6: Post Natal Care	Institution Name: _____ _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

Case 1 Case 2 Case 3 Case 4 Case 5

Work Area Set:	Name of Staff: →	Case 1	Case 2	Case 3	Case 4	Case 5	
<input type="checkbox"/> Y <input type="checkbox"/> N							
1. Rapport							
1.1 Friendly attitude							
2. History taking							
2.1 Reviews history using MCH card							
2.2 Determines maternal risk factors							
3. Examination							
3.1 Checks pulse and temp							
3.2 Checks breasts, palpate abdomen							
3.3 Checks perineum/lochia							
3.4 Checks legs for thromboses							
4. Classification							
4.1 Identifies postnatal risk/problem							
4.2 Identifies need for referral							
5 Management							
5.1 Provides routine care (protocol)							
5.2 Manages puerperal pyrexia							
6 Advice							
6.1 Promotes breast-feeding							
6.2 Explains breast and lochia care							
6.3 Counsels for family planning							
7 Follow-up							
7.1 Explains any high risk							
7.2 Confirms date of next visit							
8 Reporting							
8.1 Completes MCH card and Mother Health Register							<u>Total 'Yes'</u> Total 'Yes'+ 'No'
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores		/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%

GA

Section 1: Individual Case Management Work Sheet 7: Neonatal Care	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1. Rapport								
1.1	Shows interest in baby							
1.2	Keeps it on mother lap							
2. History								
2.1	Checks birth weight on MCH card							
2.2	Asks feeding history							
2.3	Asks immunization history							
3. Examination								
3.1	Checks respiration, pulse, temp							
3.2	Checks jaundice							
3.3	Checks umbilical stump							
3.4	Weighs and notes weight change							
4. Classification								
4.1	Identifies neonate's risks							
4.2	Determines weight gain since birth							
4.3	Identifies major problems							
4.4	Identifies need for referral							
5. Management								
5.1	Provides routine care according to protocol							
5.2	Manages respiratory distress							
6. Advice								
6.1	Encourages breast feeding							
6.2	Advises on immunization							
7. Follow-up								
7.1	Explains any high risk							
7.2	Confirms date of next visit							
8. Reporting								
8.1	Completes MCH card and Child Health Register						$\frac{\text{Total 'Yes'}}{\text{Total 'Yes' + 'No'}}$	
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%	

Section 1: Individual Case Management Work Sheet 8: Family Planning	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1. Rapport								
1.1	Friendly attitude/approach							
1.2	Effective communication							
2. History								
2.1	For selection of couple							
2.2	For determination of method							
3. Examination								
3.1	Blood Pressure							
3.2	Weight / weight change							
3.3	Breasts							
3.4	Genital tract							
3.5	Circulatory system/veins							
4. Classification								
4.1	Asks for couples preference							
4.2	Agrees on appropriate method							
5. Management								
5.1	Prescribes correct dose(s)							
6. Advice								
6.1	Explains and verifies client's understanding of correct usage of selected method							
6.2	Possible side effects							
6.3	What to do if they occur							
7. Follow-up								
7.1	How often and when to return for follow-up							
7.2	Where to go for re-supplies							
7.3	Confirms date of next visit							
8. Reporting								
8.1	Completes Family Planning portion of MCH Card or Family Planning/EPI Card							
8.2	Completes Family Planning Register							
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%	

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Section 1: Individual Case Management Work Sheet 9: Tuberculosis (follow-up)	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

Verify the Tuberculosis Register and five Tuberculosis Facility Cards presently in use. For each card, answer the following questions by Yes, No or NA

		Case 1	Case 2	Case 3	Case 4	Case 5
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N Name of Staff: → _____					
9.1	Was the patient correctly registered in the Tuberculosis Register?					
9.2	Was address filled in so that patient could be traced?					
9.3	Were default actions taken according to instructions?					
9.4	Were sputum smear controls performed according to instructions?					
9.5	Where appropriate, was the final status of the patient recorded and registered in the Tuberculosis Register?					
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.		/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:						%

Section 2: Resource Management

Following is a series of work sheets to assess resource management by the health care staff:

1. Laboratory
2. Community Development Activities
3. Personnel Management
4. Cold Chain Management
5. Physical Resources Management
6. Record Keeping System

These work sheets can help the supervisors to make a final assessment on the management of various resources by the facility staff. The results are transferred to the supervisory checklist.

Section 2: Resource Management Work Sheet 2: Community Development Activities	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

2.1 Is population chart posted visibly? Y N

2.2 Has it been updated for this year? Y N

2.3 Is a map of the catchment area posted visibly? Y N

2.4 Are the most important villages of the catchment area plotted on the map? Y N

2.5 Does staff actually know the target populations for various activities? Y N

2.6 Is the following health education material displayed in the centre?
On Oral Rehydration Y N

On Vaccination Program Y N

On Breastfeeding Y N

On Appropriate Weaning Practices Y N

On Family Planning Y N

Verify Meeting Register

2.7 Were meetings with community leaders or with health committees held during the last quarter? Y N

2.8 Were Health Education sessions held in surrounding schools during the last quarter? Y N

In health facilities with female staff (WMO, LHV, FIIT)

2.9 Does the staff maintain regular contacts and supervise the TBAs in the villages of the catchment area? NA Y N

Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.

Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:

60

Section 2: Resource Management Work Sheet 3: Personnel Management	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

Verify staffing pattern of the health facility, compare with information available in Personnel Management Register. Update Personnel Management Register where necessary.

3.1 Is a duty roster displayed in the health facility?
Y N

3.2 Are written job descriptions available to the staff?
Y N

3.3 Is the daily attendance register kept up to date?
Y N

Verify meeting register

3.4 Where an adequate number of staff meetings organized in the health facility during the last quarter?
Y N

Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.

Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:

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Section 2: Resource Management

Institution Name: _____

Work Sheet 4: Cold Chain Management

Name of Supervisor: _____
(if different from front page)

Date of Supervision: _____
(if different from front page)

4.1 Is refrigerator placed at correct position? Y N

4.2 Is plug secured? Y N

4.3 Are door and rubber of the door in order? Y N

4.4 Is floor around the refrigerator dry (no leakage)? Y N

4.5 Is thermostat working and set correctly? Y N

4.6 Is daily temperature sheet displayed and kept up to date? Y N

4.7 Are vaccines and dilutes at proper place in the refrigerator? Y N

4.8 Are vaccines stored within the limits of the expiry dates? Y N

4.9 Are the door shelves empty? Y N

4.10 Is there an automatic generator? Y N

4.11 Is there a voltage regulator? Y N

4.12 Are alternate arrangements made in case of power cut? Y N

Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.

Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores: %

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Section 2: Resource Management Work Sheet 5: Physical Resources Management	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

5.1 Are the following equipment/items in good working condition?

Sterilizer

NA Y N

Weighing Scale (adults)

NA Y N

Weighing Scale (children)

NA Y N

First Aid Kit

NA Y N

X-Ray machine

NA Y N

Others? *(Make suggestions)*

5.2 Physical Inventory Equipment/Furniture/Linen (once a year)

Select 10 items as reported in last yearly report.

Does physically verified status correspond with reported status for these 10 items? *If no, discuss results with IIC.*

Y N

5.3 Physical Inventory Drugs/Vaccines/Supplies

Select 10 items as reported in last monthly report.

Does physically verified balance correspond with reported balance for these 10 items? *If no, discuss results with I/C.*

Y N

5.4 Transport (if available)

Verify log book for proper use of vehicle. Discuss results with IIC.

The transport means of the health facility were appropriately used as verified through the log book.

Y N

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Section 2: Resource Management Work Sheet 6: Record Keeping System	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

- 6.1 All required registers and patient/client forms are in use according to the HMIS/FLCF Instructions Manual. Y N
- 6.2 Immediate reports for epidemic outbreaks were made up when necessary and duly completed. Y N
- 6.3 Immediate reports were sent out in a timely manner. Y N
- 6.4 Monthly reports were made up correctly from records and registers available in the centre. Y N
- 6.5 Monthly reports were sent out according to time schedule. Y N
- 6.6 Updated graphic representations on priority activities of the health facility are visibly displayed. Y N
- 6.7 All forms and registers are available in sufficient quantity Y N

Number of 'Yes' scores over total number of 'Yes' and 'No' scores _____ / _____

Final assessment:

Percentage of 'Yes' scores out of total 'Yes' and 'No' scores _____ %

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[Province] Health Department
SUPERVISORY CHECKLIST
For First Level Care Facilities

Institution Name:	Name of Supervisor:
Division:	Year:
District:	Quarter: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Tehsil/Taluka	Date of Visit: <input type="text"/> / <input type="text"/> / <input type="text"/>
Incharge Name:	

Preparation for Supervisory Visit

Date of previous visit: / /

Action taken since previous visit:

Are there special problems from previous visit that need to be followed during the current visit?

List: _____

Any special needs/requirements?

List: _____

Take the following documents with you or make photo copies of relevant parts.

1. Personnel Management Register
2. Last Monthly Report of the Health Institution
3. Last Year Report of the Health Institution (once a year)

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Section 1: Individual Case Management

Make final assessment on case management of the following health care activities using the scores obtained through the worksheets. For health care activities not performed in the supervised health facility, tick the box 'NA' (Not Applicable).

		Quality of Case Management			
		NA	Poor (<50%)	Insufficient (50 - <80%)	Appropriate (≥80%)
1.	Sick Child Under Five				
1.1	General Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2	Diarrhoeal Disease Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3	Acute Respiratory Infection Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4	Management of Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5	Management of Immunization Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Growth Monitoring in Child Under Three	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Immunization Session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Delivery Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Postnatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Neonatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Tuberculosis (follow-up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Section 2: Resource Management

Make final assessment on the management performance of the health staff for the following resources, using the scores obtained through the worksheets. For resources not available in the supervised health facility, tick the box 'NA' (Not Applicable).

1. Laboratory

1.1 Microscope in good working condition

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

1.2 Laboratory diagnosis of malaria is of acceptable quality.
(Malaria diagnosis correct for $\geq 80\%$ of slides)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

1.3 Laboratory diagnosis of tuberculosis of acceptable quality.
(Tuberculosis diagnosis correct for $\geq 80\%$ of slides)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

2. Community Development Activities

Management of community development activities is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

3. Personnel Management

Personel Management is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

4. Cold Chain Management

Cold Chain Management is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5. Physical Resources Management

5.1 $\geq 80\%$ of essential equipment is in good working condition

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.2 Physical inventory check for equipment/furniture and linen is satisfactory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.3 Physical inventory check for drugs/vaccines/supplies is satisfactory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.4 Transport means of the health facility were appropriately used

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

6. Record Keeping System Management

The Management of the Record Keeping System is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

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Feedback On The Visit

1. Improvements noticed since previous visit:	
2. Problems identified during previous visit that need still further improvement:	
3. Problems identified during this visit:	
4. Recommendations to Health Staff:	
5. Actions to be taken by supervisor:	
6. Problems to be followed at next visit:	
7. Date of next visit: _____	

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MODULE 2

COMMUNICATION

LEARNING OBJECTIVES

LEARNING OBJECTIVES FOR INCREASED KNOWLEDGE AND UNDERSTANDING

Upon completion of this module you will be able to:

1. State why an adequate system of communication is important for effective supervision.
2. List the three basic skills essential for communication.
3. List the skills required for establishing rapport.
4. List the skills required for understanding.
5. List the skills required for influencing.
6. Compare the differences and similarities in communication between health service provider and mother and between a supervisor and supervisee.

LEARNING OBJECTIVES FOR IMPROVING SUPERVISORY SKILLS

Upon completion of this module you will be able to:

1. Observe a staff-patient interaction and assess his/her ability to establish "rapport", "understand" the condition of the child and "influence" the mother on needed child care.
2. Use the Supervisory Checklist to assess and document the staff's ability to communicate with the mother of the child.
3. Use the information collected to give feedback to the staff on their performances and to make plans for maintaining quality in communication while providing child health services.

INTRODUCTION

A district level supervisor oversees the work of health team members of facilities within his/her geographical area. The overall purpose of this supervision is to assure that the health care being provided at the facility is of high quality, contributes to the well being of the community, and conforms to the technical and administrative policy norms.

Since supervisors are not on the premises every day, it is often challenging to supervise staff effectively. Given the distance of the facilities and the scope of the work, it is realistic to expect a district supervisor to visit the facility approximately four times a year. Given these factors and the nature of the work, this is not an ideal situation. Nevertheless, the supervisor has to try to do his/her best with limited resources of time; otherwise problems would go uncorrected. A key factor in minimizing problems within and outside the team is the establishment and maintenance of an adequate system of communication. This communication goes in two directions: upward to the leadership, and downward to the health care team.

A supervisor combines three methods in providing effective supervision.

OBSERVING: to assure that he/she correctly perceives staff and facility performance.

INTERVENING: through feedback, training, clarification and explanation.

REPORTING: to his/her superiors in the administration to communicate progress and problems requiring action at the next level of the system.

These functions rest on a very significant role that a supervisor must perform. He or she must be able to articulate clearly the "mission" or vision that planners and authorities have for the health care system. A key role in supervision and management is to assure that all members of the team are clear about the mission that guides and informs their work. The mission for the Government of Pakistan and for this group is to improve the health care system of the country.

Before proceeding to a discussion of the basic interpersonal communication skills associated with effective supervision, we will conduct an exercise to demonstrate and clarify what is meant by communicating the "mission".

EXERCISE 1

Role Play No. 1. A supervisor visits a facility for the first time since the MO and paramedics attended the Integrated Child Survival Training Course. He holds a staff meeting and asks those who have returned from the course what they are going to do to make the service integrated and child-focussed.

From this role play we should be clearer about the underlying approach and rationale for the supervisory role. The next portion of this interpersonal communication module will focus on presenting information and conducting practical exercises to assist participants in strengthening the interpersonal communication skills necessary to enhance their performances as supervisors. The Work Sheets on Individual Case Management of the Supervisory Checklist have been prepared for you to document your observation of staff performance.

OBSERVATION SKILLS

In order to guide health team members in the correct performance of their duties, the supervisor must be able to understand the current state of the performance of the team and the facility. This is done by observing staff performance, inspecting the physical facility, and reviewing records. While the latter two activities are relatively straightforward, observing staff performance is somewhat more challenging. The first requirement for effective observation is that the supervisor must know what the staff member is expected to do. This requires that the supervisor be clear about the job descriptions of the staff whom he/she will observe, as well as have (and be able to express) as clear an idea as possible of the standards of performance by which he/she will judge the performance of the health team member.

There is a second requirement for effective observation. The supervisor must be able to establish a climate with the health team member that puts the individual sufficiently at ease to permit the observation to take place in a natural environment. To do so, the supervisor must establish a good rapport with the staff member. This rapport must be based on the notion of supportive supervision, as discussed earlier. The supervisor must assure the staff member that the purpose of the observations (and subsequent interventions) are to help the supervisor work effectively.

If the supervisor has established a role as a supportive member of the team, who is there to help everyone understand the mission and to improve their skills in implementing a common mission, then the task of establishing a climate of rapport is relatively easy.

OVERVIEW OF MO AND PARAMEDIC TRAINING

MOs and paramedics were trained in the implementation of WHO case management guidelines. Incorporated in these guidelines are the steps of interpersonal communication between the mother and health service provider.

As supervisors may not have received this training, we will review the interpersonal communication principles. This will serve two purposes: one, it will assist supervisors to see what they should be monitoring in the provider-patient interactions; and two, it will introduce common principles and vocabulary which are applicable to supervisor-staff communication. This foundation will contribute to your understanding of how these principles apply both to the work of the health team and to your work as a supervisor.

In training the MOs and paramedics, we introduced a three-part summary of interpersonal communication skills. We demonstrated to them that by being alert to certain principles and practices, they could greatly increase the probability that patients would hear and act on what the provider was saying. The three elements of effective communication are Rapport, Understanding, and Influence.



Three key elements: Rapport, Understanding, and Influence are depicted in the Wheel of Interpersonal Communication

By rapport we mean the establishing of sympathetic relations with the other. In the case of the MO this means the mother; whereas with you, the supervisor, it means your staff. The elements of establishing rapport are the same for the supervisor-staff relationship as they are for the provider-patient relationship. Establishing sympathetic relations assures that the other person feels accepted and respected. With such a foundation of respect and acceptance, communication can flow more easily. The other person's fears of judgment or criticism are reduced, resulting in a greater likelihood that the individual can say what he/she wishes, and that the individual can take in the information or feedback that you wish to share.

Skills and attitudes needed to establish rapport

- Greeting the person with warmth and acceptance
- Giving your full attention
- Using appropriate language
- Showing respect and patience
- Being pleasant
- Showing concern and interest
- Sending positive nonverbal messages
- Avoiding judgmental responses
- Acknowledging the others' feelings

For the MO, the more he/she can apply these principles, the greater the likelihood that a patient will trust and be open to medical advice. And for you as a supervisor, the same holds true. If you can build rapport using these basic skills, you will be better able to create a climate in which you can observe the work you are there to oversee and have a positive effect on improving those areas that need further work. Old-fashioned approaches to supervision were based on asserting authority. While a certain authority is required, the modern supervisor knows that the outcome of his/her work is measured by improved performance. The more the staff member trusts and feels at ease with the supervisor, the more readily he/she will respond to guidance.

You may wonder about the principle of "avoiding judgmental responses." How can you give feedback without responding judgmentally? What is meant here is to focus on the objective information and to provide supportive coaching, rather than humiliating the other person. For example, if you observe that a provider has given incomplete or incorrect information, you can say: "Let's review the case management protocol for this problem," rather than saying: "You don't understand the first thing about treating x." Your goal is to improve the service, not to demonstrate your superiority.

If you observe and practice these skills of developing rapport, you will find that you have established a climate with your staff that will enhance both your ability to understand the individual's strengths and weaknesses and to provide the guidance and counsel that will lead to better performance.

Later in this session we will do a few role plays that will let us practice these skills in a supervisory setting.

The second element in the interpersonal communication training concerns what we call understanding. Here again, the skills are just as valid for supervisors as they are for service providers.

The attitude required to achieve understanding is sometimes called "empathy." A simple definition of empathy is "trying to put oneself in the position of the other." In supervisory relationships, there is often a certain tension felt by a person in the presence of the supervisor. This can affect the performance of the staff member. Likewise, patients at a health facility can be uncomfortable due to fears and a sense of social distance or inferiority with respect to doctors. The skills in which we train the medical and paramedic staff are designed to assure good quality communication and therefore, good quality care.

To both diagnose a health problem and a performance problem, one must understand what the other is trying to express and what needs to be observed and asked. With an empathetic attitude, one will more easily acquire the skills of listening carefully and asking relevant questions in order to diagnose the problem. The skills and attitudes required for accurate understanding of another are as relevant for supervisors as they are for MOs.

Skills and attitudes required for understanding

- Listening with concentration
- Avoiding interrupting
- Appreciating the view of the other person
- Asking questions in a manner that encourages the other person to respond
- Eliciting information from the mother about changes in the child's health status
- Avoiding "yes" or "no" questions
- Asking checking or probing questions

Checking or follow on questions are asked when the statement given does not provide a full answer. It is a common practice of people to only provide part of the information. In order to understand a situation or condition, complete answers are essential. An example of the checking and follow on questions used with mothers in better understanding a situation is given on the next page. You can use similar questions with a staff member.

First Checking Question	Mother's Response	Follow-on Checking Question
What will you do for your child's diarrhoea when you go home?	I will give him something to drink.	What if he refuses or vomits?
What will you give your child to eat?	Soft, mashed foods.	How often will you feed him?
How will you make the ORS solution at home?	I will mix the packet with one litre of water.	Can you show me how you do it?
How much ORS or other drink will you give to your child?	One small cup.	At what time of day will you do that?
How will you know if your child needs to come back to the health centre?	If he is not getting better.	How does he look when he is healthy?

You can see that the skills involved in assuring that a practitioner achieves understanding with a patient are parallel to the skills a supervisor needs to understand and establish rapport with the staff. When procedures are involved that you can not fully observe on a brief visit, you will want to ask checking and probing questions to determine whether the health team member has a sufficient level of mastery of the matter at hand.

The final portion of our interpersonal communication training of MOs and paramedics focusses on what we have called influencing. In our work with you, we have called this stage intervening. Once again, the analogy and parallel to your work as a supervisor is self-evident.

INFLUENCING OR INTERVENING

Once you have observed and understood, you may need to intervene or influence in order to recommend improvements and modifications in what the health team is doing. As we have been saying all along, the better the quality of your rapport and understanding, the greater the likelihood that you will be effective in offering constructive criticism to your staff. They will be convinced that you respect their work, understand their progress and problems, and can contribute to improving their performance.

The MOs have learned that influencing means producing or taking a desired action to solve or prevent problems. This is the stage where the MO builds upon the established rapport and understanding to move toward the actions necessary to support the child's health. This typically involves actions such as:

- Bringing the child for immunizations on schedule
- Giving appropriate treatment
- Advising the mother
- Advising other staff members
- Making sure that the message is correctly perceived
- Making use of the health facility
- Assisting the mother to understand and practice selected health behaviors at home
- Instilling confidence in the mother to maintain or change her behaviour

The skills and knowledge required for influencing

- Having up-to-date information on standard treatment guidelines and preventive methods
- Acknowledging and appreciating the mother for appropriate steps she has taken for the health of the child
- Speaking directly but calmly to the mother (or other person)
- Being specific rather than general
- Using language that the mother can understand
- Reviewing the advice and asking the mother to repeat the desired actions (checking that the other person understands)
- Providing key information in writing

Once again, the basic interpersonal communication skills in which the PCSP has been training MOs are clearly related to those required for effective supervision. Let's take a minute to discuss these similarities.

EXERCISE 2

Discussion:

- What does "RUI" stand for ?
 - How is communication between a supervisor and supervisee similar to that of a mother and a health service provider?
-

EXERCISE 3

Role Play No. 2. The MO is talking with a mother and a staff member. Carefully observe the points that help or hinder communication. You will be asked to form two groups. One group is to look for all points that hinder communication. List and present them. The second group will list and present what should have been done to remove the hindrances.

We have just seen how supervisors can support improved interpersonal communication in a health post setting. This is one of the functions a supervisor must undertake. The supervisor has many other functions all of which can be conducted more effectively by developing skills in the use of the RUI model.

REPORTING

At the beginning of this module, it was pointed out that for supervisors communication goes in two directions: upward, to the leadership and downward to the health care team. The upward communication is to report progress or to communicate problems requiring action. Routine reports are required to be sent from facility and district level to report progress.

The district level supervisor also needs to maintain communication with the team at the district, divisional and provincial levels for a number of reasons.

COMMUNICATIONS WITH THE HEALTH TEAM AT DISTRICT LEVEL

- Coordinates with ADHO and AIHS regarding supervisory visits to FLCFs.
- Communicates with M.S. DHQ hospital regarding referral of cases from FLCFs and training arrangements for FLCF staff.
- Directs preparation of annual and supplementary budgets at district health office for FLCFs according to their requirements.
- Takes action regarding postings.
- Transfers staffs of FLCFs.
- Takes action regarding administrative and financial matters relating to FLCFs.
- Takes action regarding training of FLCF staff.
- Receives and consolidates reports from FLCFs in the district.

COMMUNICATION WITH OFFICERS AT DIVISIONAL AND PROVINCIAL LEVELS

- Coordinates and follows the instructions of divisional and provincial authority regarding implementation of health programs according to provincial and national health policy.
- Requests for posting or transfer of personnel of FLCFs which are beyond the scope of district authority.
- Requests for release of funds according to the sanctioned budget.
- Obtains sanction for procuring material resources beyond the authority of the district office.
- Seeks approval for in-service training of FLCF staff.
- Submits reports as required under the regulations.
- Submits demands for annual budget requirements.
- Obtains sanction or approval under the financial and administrative rules and cases in matters beyond the powers of district health authority.
- Forwards ACRs in relevant cases.

Records of communication with district, provincial and federal levels and with other organizations need to be maintained. Communication can be verbal, written or by telephone. All written communications must be recorded. The government has developed guidelines for the use of the various methods of communication. The MOIC should be instructed when to use a telephone, letter, telex or telegram. Follow the suggested format for correspondence for letters, memo and DO letter.

Letter

The word letter ordinarily denotes a written message. The official letter is written in a specified form and is used for formal communication, such as:

- Letters addressed to official authorities should begin with the salutation "sir" and end with the subscription "your obedient servant".
- Letters addressed to non-officials or groups of persons should begin with salutation. "Dear sir/sirs" and should end with the subscription "yours truly" followed by signature and designation of person writing the letter.

Memorandum (Memo)

A memo is an informal method of official correspondence used in the following situations:

- With officers of equal status within the same provincial government or correspondence with subordinate offices
- In replying to petitions or applications

DO Letter

The DO letter concerns an official matter but is written in a personal style. It is used between government officers in the following cases:

- When the subject should receive the personal attention of the officer addressed
- When a delayed action needs to be brought to the personal notice of the officer addressed
- In cases of security or urgency
- In cases of a personal nature

EXERCISES

Supervisory Checklist Exercises

1. Observe a facility staff tending to a child and assess his/her communication skills using the Supervisory Checklist. Complete the following items on Individual Case Management Work Sheet #1: All of Items:
 - 1
 - 6
 - 7
 - 8

2. Attend a staff meeting, give feedback from your observation of the staff's communication skills. Identify both strong and weak points. Complement them on strong points. Plan together to strengthen weak areas. Inform staff of your next visit.

Section 1: Individual Case Management Work Sheet 1: Sick Child Under 5	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

Case 1 Case 2 Case 3 Case 4 Case 5

	Work Area Set:	Name of Staff: →				
	<input type="checkbox"/> Y <input type="checkbox"/> N					
1.	Rapport					
1.1	Was mother greeted?					
1.2	Was mother asked to sit down?					
1.3	Was mother asked reason for coming to the facility?					
2.	History					
2.1	Asks for age of child					
2.2	Asks change in eating/drinking pattern					
2.3	Asks change in bowel/urine output					
2.4	Asks for change in activity					
2.5	Asks for other symptoms					
2.I	Asks for child's immunization status					
2.N	Asks for nutrition intake assessment					
3.	Examination					
3.1	Looks at general condition (colour, alertness)					
3.2	Looks at condition of eyes, ears					
3.3	Looks at condition of nose, mouth, ear					
3.4	Looks at chest indrawing					
3.5	Counts respiration					
3.6	Takes skin pinch					
3.7	Takes temperature (if indicated)					
3.I	Checks Immunization Card					
3.N	Takes weight (child under 3)					
4.	Classification					
	Was child correctly classified?					
4.1	ARI case					
4.2	Diarrhoea case					
4.3	Case with other symptoms					
4.4	Case with no symptoms					
4.I	According to need for vaccines					
4.N	According to nutritional status					

5a	Management					
5.1	Were child's needs correctly managed? According to WHO protocol for ARI case According to WHO protocol for Diarrhoea case According to acceptable standards for other cases					
5.2	Refers complicated case appropriately					
5.I	Manages correctly immunization needs of the child					
5.N	Manages correctly nutritional needs of child					
6	Advice					
6.1	Explains to parents findings of child's condition					
6.2	Explains need/no need for drugs					
6.3	Explains when to bring back the child					
6.I	Gives appropriate immunization advise					
6.N	Gives appropriate nutritional advise					
7	Follow-up					
7.1	Gives appointment for next visit					
7.2	Checks if mother has well understood treatment/advice given and date of next appointment					
8.	Reporting					
8.1	Completes MCH card					
8.2	Completes OPD Register					
8.3	Uses Referral Forms					
		Total 'Yes'				
		Total 'Yes'+ 'No'				
For General Child Care (all cases)						
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/
For ARI Cases						
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/
For Diarrhoea Cases						
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/
For Immunization Management (2.I → 6.I)						
<i>Write number of 'Yes' scores over total number of 'I' scores</i>		/	/	/	/	/
For Nutritional Management (2.N → 6.N)						
<i>Write number of 'Yes' scores over total number of 'N' scores</i>		/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:						
General Child Care:						%
ARI Case:						%
Diarrhoea Case:						%
Immunization Management:						%
Nutritional Management:						%

MODULE 3

IMMUNIZATION

WHO material on EPI has been used extensively.

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LEARNING OBJECTIVES

LEARNING OBJECTIVES FOR INCREASED KNOWLEDGE AND UNDERSTANDING

During the training you will receive theoretical information and will also be exposed to practical situations which will increase your knowledge and understanding about:

1. Six vaccine-preventable diseases of childhood
2. Health services providers' responsibilities in delivery of immunization services to children and pregnant women/women of CBA
3. Skills in supervising the immunization activities at FLCF

You will receive the above information through lectures, reading material and discussion. On completion of the training you will be able to:

1. Define EPI.
2. State the extent of the problem of vaccine-preventable diseases.
3. State Government of Pakistan's policy regarding EPI.
4. State the targets of EPI.
5. State Immunization Schedules.
6. Describe the organization of the EPI programme and delivery of immunization services.
7. Describe the role of the MOIC in implementing the EPI programme at the FLCF.
8. Describe maintenance of the cold chain.
9. State how to find the monthly target population.
10. State how to carry out a monthly evaluation.
11. Describe how to fill in and interpret the immunization monitor chart.

LEARNING OBJECTIVES FOR IMPROVING SUPERVISORY SKILLS

Upon completion of this module you will be able to:

1. Observe and assess FLCF staff competency in carrying out immunization activities using supervisory work sheets.
2. Assess the availability and utilization of material resources for providing EPI services by visiting the EPI room.
3. Assess the quality of record keeping by reviewing the EPI register, temperature chart and stock register.
4. Identify strengths and constraints in the delivery of EPI services and determine the need for in-service training in EPI.
5. Give feedback to the facility staff on the findings after completing the Supervisory Checklist.
6. Compliment staff on achievements.
7. Meet with facility staff and work out a plan with them to solve the identified problems and improve EPI services.

INTRODUCTION

THE EXPANDED PROGRAMME ON IMMUNIZATION

EPI is a disease prevention activity aimed at reducing morbidity and mortality from childhood diseases preventable by immunization. These diseases are referred to as the EPI target diseases. They are diphtheria, pertussis (whooping cough), tetanus, neonatal tetanus, poliomyelitis, measles and childhood tuberculosis.

The EPI programme is a global programme. In many developing countries, it is being assisted by WHO, UNICEF and other donor agencies. In Pakistan the programme began in 1978 and continues today. The programme is monitored regularly, including field assessments. The global target of the programme is to provide immunization services against the six target vaccine-preventable diseases to over 95% of infants and women of child-bearing age by the year 2000.

EXTENT OF THE PROBLEM AND GOVERNMENT OF PAKISTAN POLICY

Infectious diseases are a major problem in Pakistan. Thousands of children die and many more are incapacitated or crippled for life with the complications of poliomyelitis, diphtheria, pertussis, tetanus, measles and tuberculosis.

Immunization has been recognized and accepted as one of the most important components in the prevention and control of communicable diseases. Immunization is a basic health service and has been integrated in PHC. Specific targets of the Government of Pakistan's programme are:

1. Attain an immunization coverage of 100%
2. Eradicate poliomyelitis by the year 2000
3. Eliminate neonatal tetanus by the year 1995
4. Reduce measles incidence by 95% by the year 1995
5. Reduce diphtheria incidence to a negligible level
6. Reduce pertussis incidence to a minimum level
7. Reduce childhood tuberculosis incidence to a minimum level

ORGANIZATION OF EPI SERVICE DELIVERY IN PAKISTAN

The Federal EPI cell, headed by the National EPI Manager, is responsible for:

- Making plans
- Health education
- Coordination with International Health Agencies

- Monitoring, training and evaluation of the programme
- Procurement of EPI supplies, vaccines, cold chain equipment and transport

Provincial governments are responsible for implementation of the EPI programme.

The programme is managed at:

- Provincial level by a programme manager
- Divisional level by Deputy Director/Divisional Director and FSMO
- District level by DHO, ADHO, DSV & TSVs.

EPI services are provided through:

- Static centers
- Outreach teams
- Mobile teams

RESPONSIBILITIES OF DISTRICT LEVEL SUPERVISORS

The district level supervisor has technical and administrative responsibilities in assuring adequate and appropriate immunization services.

1. Technical

- Ensure that children under 5 years of age and pregnant women coming to the facility are protected against vaccine-preventable diseases through immunization.
- Ensure that pregnant women and mothers coming to the facility are counselled regarding the need for immunization for themselves and their children.
- Maintain the cold chain, keeping all vaccines between 0° and 8°.

2. Administrative

- Fill all sanctioned posts.
- Ensure that the facility staff is properly trained in delivering EPI services.
- Ensure that each staff member knows his/her job description.
- Ensure that staff members carry out their duties according to the rules, regulations and schedule.

- Ensure that target and coverage rates agree.
- See that records are maintained properly and that reports are sent to the district office on schedule.
- Ensure that a proper place for immunization is available in the facility.
- Ensure that essential resources are available at the facility. (See page 134 for list of essential resources.)

Observe how the MOIC is carrying out his responsibilities in implementing EPI at the FLCF in five areas: technical, administration, supervision, training, coordination and monitoring.

OVERVIEW OF MO AND PARAMEDIC TRAINING

SUMMARY OF MOIC RESPONSIBILITIES

In implementing EPI, the MOIC is responsible for the technical, administrative, supervisory, training, coordination and monitoring activities of his/her facility.

1. Technical

- 1.1 Assess children and women attending the facility to determine immunization needs.
- 1.2 Properly immunize children and married women in the encatchment area.
- 1.3 Properly maintain the cold chain at FLCF and outreach clinics.
- 1.4 Ensure that the vaccine in stock is potent and unexpired and that staff carries out proper sterilization.
- 1.5 Ensure that staff knows how to test for damaged DPT and TT vaccine by spot checking.
- 1.6 Check that appropriate techniques are used by the staff in administering various immunizations.
- 1.7 Ensure that surveillance reports are sent to the DHO regularly every month.

- 1.8 Observe children and women being vaccinated and complete items 1 through 2 I, 3 I, 4 I, 5 I, 6 I and item 7 on the Work Sheet #1. Then enter the final score on Supervisory Checklist item #1.5 and 3.

2. Administration

- 2.1 Ensure that at least one staff member trained in EPI is always on duty.
- 2.2 Ensure that a female staff member is on duty.
- 2.3 Ensure that the necessary equipment and supplies are available and in working condition.
- 2.4 Ensure that the necessary forms, registers and cards are available at the immunization centre.

3. Supervision

The MOIC supervises the activities of static and outreach teams in:

- 3.1 Organizing an immunization session
- 3.2 Motivating the community for immunization
- 3.3 Preparing for an immunization session
- 3.4 Ensuring transportation of vaccines to outreach clinics at optimum temperature
- 3.5 Conducting an immunization station
- 3.6 Monitoring the availability and proper use of equipment and supplies

4. Training

- 4.1 Ensure that the staff responsible for implementing EPI guidelines are fully knowledgeable and skilled. If needed, arrange for training in coordination with DHO, ADHO or FSMO.

5. Coordination

- 5.1 Coordinate with DHO to ensure regular receipt of all immunization and related supplies to the centre.
- 5.2 Fill all sanctioned posts.
- 5.3 Evaluate immunization activities of his/her centre with DHO.

6. Monitoring

- 6.1 Ensure that the following records and reports are properly maintained:
 - Immunization card--given to each immunized child and pregnant woman
 - Daily vaccination register
 - Permanent vaccination register
 - Vaccine stock and temperature registers
 - Vaccination performance and vaccine consumption record
 - Monthly surveillance report of cases/deaths in vaccinated children from any of the 6 target diseases
 - Log book of the vehicle
 - Immediate report

MANAGEMENT OF IMMUNIZATION

The primary objective of the integrated approach to case management is to focus on the total health needs--preventive, curative and promotive--of the child rather than dealing with a single intervention. All women and children attending a health facility must be assessed for their immunization needs. For management of immunization the facility staff should carry out the following procedures:

Assessment:	Whether vaccinated <ul style="list-style-type: none">• vaccination card• BCG scar• History
Classify:	Stage of vaccination according to immunization schedule
Immunization:	If required, immunize according to the schedules.
Follow up:	According to the schedules

The programme focusses on immunizing children under one year of age (without rejecting eligible higher age groups) and women of child-bearing age. The National Immunization Schedule is presented in the following two charts.

**IMMUNIZATION SCHEDULE FOR CHILDREN
DOSE AND ROUTE OF ADMINISTRATION**

Vaccine	Dose	Site/Route		Age
BCG	0.05 ml or 0.1 ml	right upper arm	intradermal	soon after birth after one year of age
Polio	2 drops/dose*		oral	Birth - 14 days at 6 weeks---OPV 1 at 10 weeks---OPV 2 at 14 weeks---OPV 3 one year after OPV3 --booster
D.P.T	0.5ml**	lateral side of thigh	intramuscular	at 6 weeks---DPT 1 at 10 weeks---DPT 2 at 14 weeks---DPT 3 one year after DPT3 --booster
Measles	0.5ml	left upper arm	subcutaneous	9 months or soon after

* Check dose according to instructions on label/folder.

** Children having severe reaction to first injection of D.P.T should be given D.T. in the future.

There is no contraindication for vaccination except when the child is so seriously ill that he/she requires hospitalization.

For all fully unimmunized children 2-4 years old give two doses of D.T. (0.5 ml/dose), three doses of OPV and one dose of measles. **There must be at least a one month interval between each polio and D.T. vaccination.** Give one dose of BCG (0.1 ml/dose) if no BCG scar is present.

**TETANUS IMMUNIZATION SCHEDULE FOR WOMEN
WHO HAVE NOT RECEIVED TETANUS VACCINES**

Vaccine No.	When to immunize
TT 1	At first contact or as early as possible during pregnancy
TT 2	At least four weeks after TT 1
TT 3	At least six months after TT 2
TT 4	At least one year after TT 3
TT 5	At least one year after TT 4

DOSE: 0.5ml each time Check manufacturer's instructions.
ROUTE: Intramuscular injection in the upper arm

Note: Those women who received the 3-dose DPT series in early childhood, and have the card to verify so, will need three injections of TT during their child-bearing period (15 - 45 years of age). The first TT injection is to be given at first contact after reaching 15 years of age. The second injection is given one year after the first; and the third, one year after the second.

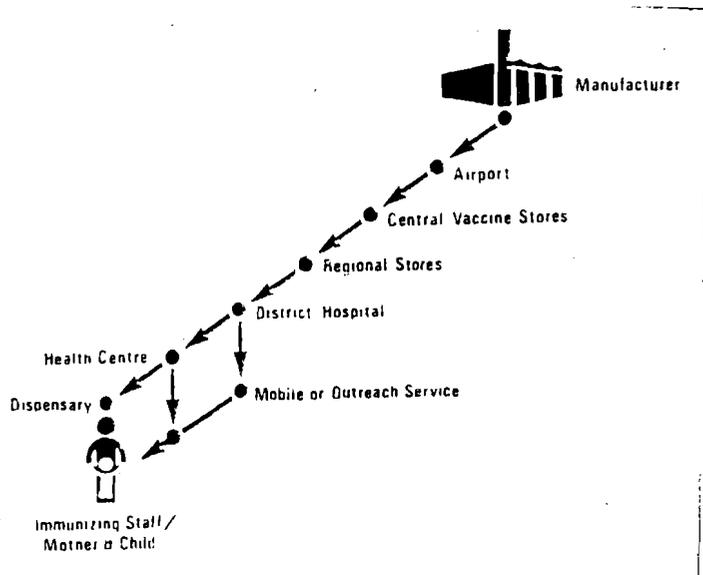


Fig. 4 The Cold Chain.

THE COLD CHAIN

GUIDELINES FOR MAINTENANCE OF COLD CHAIN AT FLCF

In their training, the MOs have been instructed on the maintenance of the cold chain. You as supervisor need to ensure that the following points are being practiced.

- In order to keep vaccines potent, it is crucial that all vaccines are stored at a temperature between zero and +8 degrees centigrade.
- To be effective, vaccines must stay cold from the time they leave the manufacturer to the time of their use.
- Before vaccines reach the health centre:
 - They must be collected from the station where they are issued and stored at the correct cold temperature in a refrigerator.
 - If they are carried to an outreach session, they must be transported in a vaccine carrier with frozen ice packs or ice.
 - They must be kept cold during transit.
 - The vaccine must be placed in a cup of ice while immunization is in progress.
- Each stationary RHC/BHU is provided with a refrigerator. Vaccine can be kept in good condition in an RHC refrigerator for one month, provided the recommended temperature is maintained.
- Once the vaccines are stored in the refrigerator, the temperature must be checked morning and evening with a thermometer and recorded. A sample record is given on page 125.

While you are visiting the EPI room you should:

- Identify those procedures that are being followed and those that are not.
- Record your findings on the Resource Management Work Sheet #4 on cold chain management.

Loading the refrigerator

- Keep vaccines on the TOP and MIDDLE shelves of the main compartment.
- Stack the vaccines carefully so that air can move between the boxes.
- Keep plastic bottles of water or spare ice packs on the LOWER shelf of the main compartment. (The water helps to keep the refrigerator working at a constant temperature.)
- Keep the diluent water to reconstitute measles and BCG in the main compartment with the vaccine.
- Have a special box in the main compartment to keep "RETURNED" vaccine that has been taken to an immunization session in a vaccine carrier.
- Freeze ice packs and ice cubes in the freezer.
- DO NOT put any food or drink in the vaccine refrigerator. Food and drink can make the refrigerator too warm.
- DO NOT put any vaccine in the door shelves. Vaccine is not cold enough in the door shelves.
- DO NOT keep "EXPIRED" vaccines or "PARTLY USED" vaccines in the refrigerator. These will have to be thrown away.
- If you have to keep these vaccines to show your supervisor, keep them somewhere outside the refrigerator and mark them clearly.
- KEEP THE DOOR CLOSED. Opening the door makes the refrigerator warm.
- When you must open the door, plan what you will do first. Then open the door, do what you have to do, and close the door again quickly.
- Try not to open the refrigerator door more than two or three times a day.
- If the electricity supply is cut off, do not open refrigerator door. If current is off for two hours, start the standby electrical generator (2.2 K.V, if available). For a longer time transfer the vaccine to cold box or vaccine carrier with ice until electricity comes on again.

Packing the Vaccines for the Outreach Clinic

See that the vaccine carrier is packed properly, observing the following points:

- Check the vaccine carrier to make sure that:
 - The lid fits tightly.
 - There are no cracks.
- Take the ice pack and/or ice cubes from the freezer and leave them on the table for 5 to 10 minutes to warm them up a bit. If the ice pack is too cold, it may freeze the DPT. When the outside of the ice pack is wet and not frosty, arrange the packs and/or ice cubes in the vaccine carrier as below:
- If using ice cubes,
 - Use only ice cubes in bags.
 - Put a bag of cubes at the bottom of the carrier.
 - Put the vaccines on the ice.
 - Put a bag of cubes on top of the vaccine vials.
- Pack first the vaccines that were taken to the last immunization session but which were not used. (Keep them in a special box in the refrigerator marked "returned".)
- Take the oldest vaccines that have been in the refrigerator for the longest time.
- Check the expiration date on the label of each vial. If the expiration has passed, do not use the vaccine. Take it out of the refrigerator and record it as "wasted".
- Close the refrigerator door.
- Put one ice pack inside each wall of the carrier, or a bag of cubes on the bottom.
- Put the vaccine vials in the middle of the ice.
- Place a thermometer with the vaccine to monitor the temperature.
- Put newspaper, cardboard or plastic foam around the DPT and TT vaccines, and between them and the ice packs. Do not let DPT/DT and TT vaccines touch the ice. They might freeze and get damaged.
- Put a bag of ice cubes or ice packs on top of the vaccines.
- Close the lid tightly.
- Keep the vaccines and diluent in the vaccine carrier until you are ready to use them.

A VACCINE CARRIER CAN KEEP VACCINES COLD FOR 36 HOURS IF YOU

**KEEP THE LID ON TIGHTLY
LEAVE ALL THE ICE INSIDE
KEEP IT IN THE SHADE**

Going to an immunization session, the health worker may use a public bus, a bicycle or any suitable conveyance. The immunization kit and vaccine carrier should be firmly packed onto the back of the cycle or other transport. The health worker should:

- Keep the vaccine carrier shaded.
- Go straight to the location of the immunization session.
- Not stop or delay on the way. The vaccines may become warm.
- Not go dangerously fast.

THE VACCINE STOCK AND TEMPERATURE REGISTER

The purpose of this form is to check on the supply and temperature conditions of vaccine on a daily basis for a full month to ensure that adequate amounts of vaccine are available and the quality, or potency, of the vaccine is guaranteed.

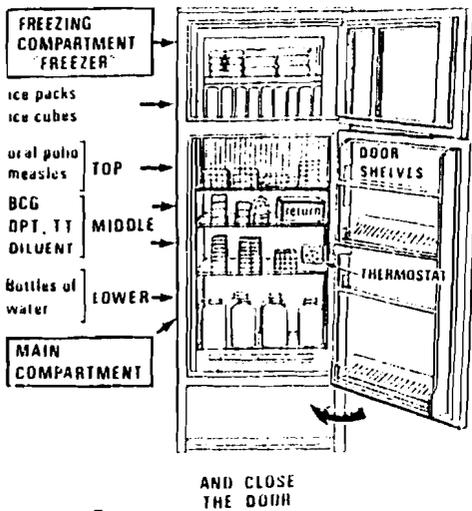


Fig.5
A health centre refrigerator showing vaccines stored correctly

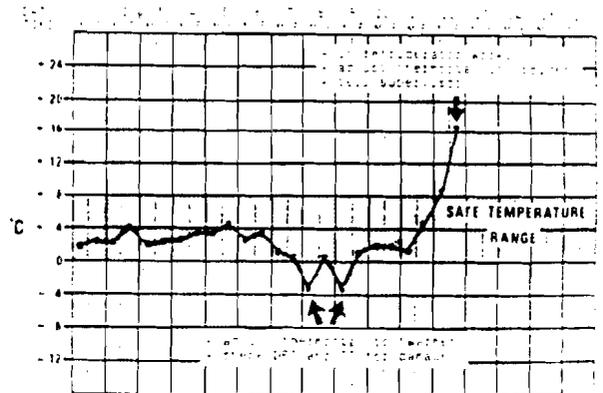


Fig.6 A refrigerator temperature chart. M—morning; E—evening

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MONITORING AND EVALUATION

FINDING THE MONTHLY TARGET POPULATION OF CHILDREN

To do the monthly evaluation you must know the MONTHLY TARGET POPULATION.

1. Find the TOTAL POPULATION of the areas served by the health centre or outreach site.
2. Determine the NUMBER OF BIRTHS PER YEAR. To do this, calculate 4% of the total population.
3. Find the monthly target population by dividing the yearly target by 12.

POPULATION X 4/100 = number of target children for one year

$\frac{\text{POPULATION X 4/100}}{12}$ = number of target children for one month

Example:

The population of your area is 10000.

The number of births per year is $10000 \times 4/100 = 400$

The number of new target children per year--the yearly target--is 400.

$\frac{400 \text{ yearly target}}{12} = 34 \text{ monthly target}$

The number of new target children per month is 34.

FINDING THE TARGET POPULATION OF PREGNANT AND CBA WOMEN

The target population of pregnant and CBA women can be calculated by the above method using the following percentages.

- Expected pregnancies = 4% of the population
- CBAs (15 - 49 years) = 22% of the population

The estimated quantity of doses for various vaccines are calculated on the basis of target population with a 50% reserve stock for BCG vaccine and a 25% reserve stock for other vaccines.

MONTHLY EVALUATION

To make a monthly evaluation:

1. Determine the percentage of the monthly target of children who received each vaccine for the month.

Example:

$$\frac{\text{Number receiving DPT 1}}{\text{Target for the month}} \times 100 = \text{Percentage immunized with DPT 1}$$

2. Determine the drop out rate by calculating the percentage of children who received the first dose but did not receive the remaining doses of the vaccine.

Example:

$$\frac{\text{Number receiving DPT 1} - \text{Number receiving DPT 3}}{\text{Number receiving DPT 1}} \times 100 = \text{Drop out rate}$$

3. Note if children sick with the target diseases are coming to the clinic. Keep a record of children who come to the clinic with these diseases. Count up the total every month and make a simple chart as below.

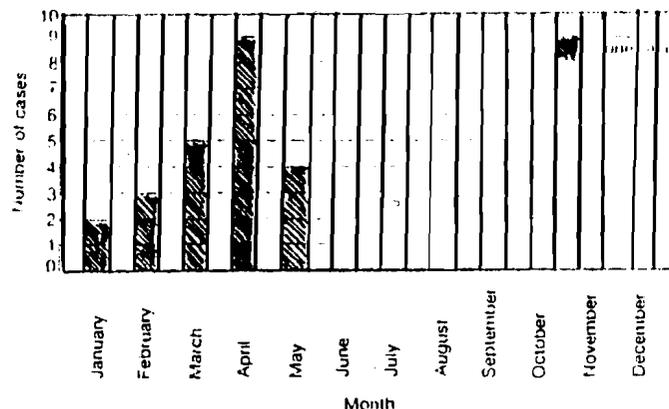


Fig. 7 Chart showing number of measles cases reported per month.

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4. Compare each month with the same month of the previous year. Check if the number of cases decreases or increases each year.
5. Ask WHY each child with one of the target diseases was not immunized.
 - Did the mother not bring the child for immunization?
 - Was the child not immunized because he/she was sick?
 - Did the child have the vaccine but it did not work? Why?
 - Decide what action to take in each case.

MONITORING MONTHLY IMMUNIZATION COVERAGE

To monitor the monthly immunization coverage at an FLCF calculate the percentage of the monthly target population of children and mothers that are immunized with each vaccine every month.

When you look at these figures for several months together, you can see approximately what percentage of children and mothers are being immunized. You can see whether a large or a small percentage is being reached; and you can determine if the numbers are increasing or decreasing.

A special monitor chart showing the same information in more detail is used to determine the cumulative total.

THE IMMUNIZATION MONITOR CHART

In some ways the monitor chart is like a child's growth chart. It shows how the numbers of immunized children in your area are growing.

Study the chart on page 131. There are twelve squares going across the chart, representing the twelve months in a year. The beginning of the year is on the left. The numbers on the right side of the twelve squares going up and down are the percentage of the yearly target population. Find the percentage target lines for 100, 75, 50 and 25 percent of the target.

All lines are at 0 as you starting monitoring at the beginning of the year. The lines rise as they progress across the chart, showing the growing number of children who should be immunized as the year passes.

Preparing the chart for your population

1. Fill in the target number scale using your own target numbers. First calculate your yearly and monthly target populations. Then use those target numbers to make the target number scale on the left side of the chart. Follow these steps:
 - 1.1 Put 0 in the bottom space.
 - 1.2 Move up one space and write the number for one month's target.
 - 1.3 Move up another space and put the number for two months' target.
 - 1.4 Move up one more space and write the number for three months' target.
 - 1.5 Continue to move up one space at a time, each time adding to the previous monthly target number.
 - 1.6 When you reach the top space, fill in the target number for twelve months.
 - 1.7 The yearly target is opposite 100 percent.
2. Write the months of the year from January to December along the bottom of the chart.

Filling in the chart

1. Use the chart to monitor one or several vaccines.
 - 1.1 Make a separate line on the chart for each vaccine.
 - 1.2 Write the number of doses given for each vaccine in the rows of spaces below the chart. Two rows of spaces are needed for each vaccine.
2. Write the number of doses given each month in the top row of spaces for each vaccine.
3. Write the total number of doses given in the year so far (all the previous months and this month added together) in the lower space. This is called the cumulative total.

Drawing the line on the chart

1. Find the line that goes up the chart at the end of the month.
2. Go up the line until you are opposite the number on the target number scale that is the same as the cumulative total for the vaccine.
3. Make a dot.
4. After a few months, join the dots to make a line for each vaccine.

Interpreting the chart

1. Determine which percentage line your own cumulative total line is near. This tells you approximately what percentage of your target population is being immunized as the year passes.

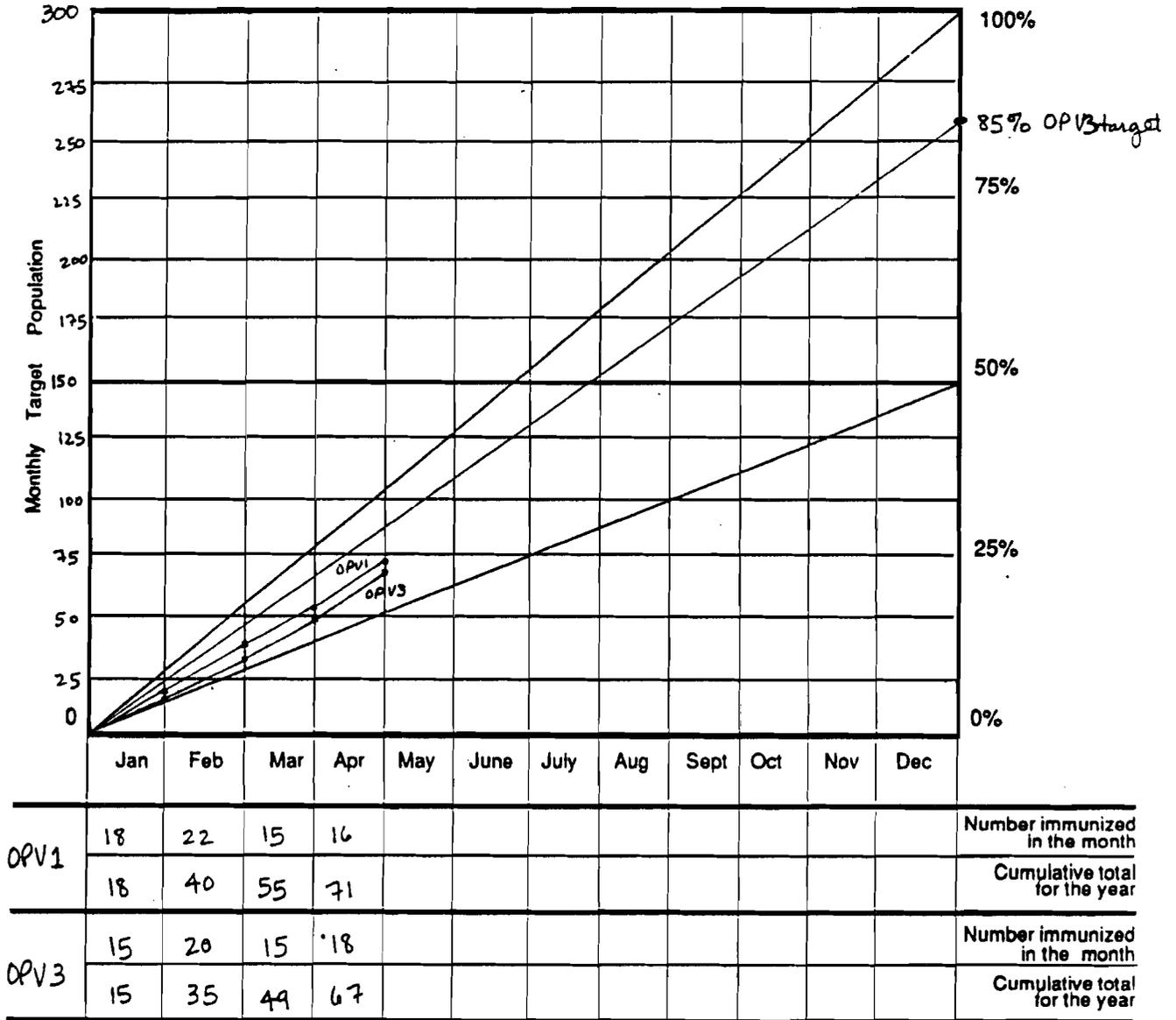
Observation of immunization activities

1. During a visit to an FLCF, look at the chart and compare the target with the actual number of immunization cases. You will then:
 - Compliment the staff on their achievements.
 - Ask for reasons for not reaching the target.
 - Modify the immunization plan based on the experience of the previous quarter.

Immunization Monitor Chart

Health facility: Okala health centre
 Year: 1991
 Vaccine: OPV1 and OPV3

Target population: 300
 Minimum coverage target for the year: 85% with OPV3



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Immunization Monitor Chart

Health facility: _____

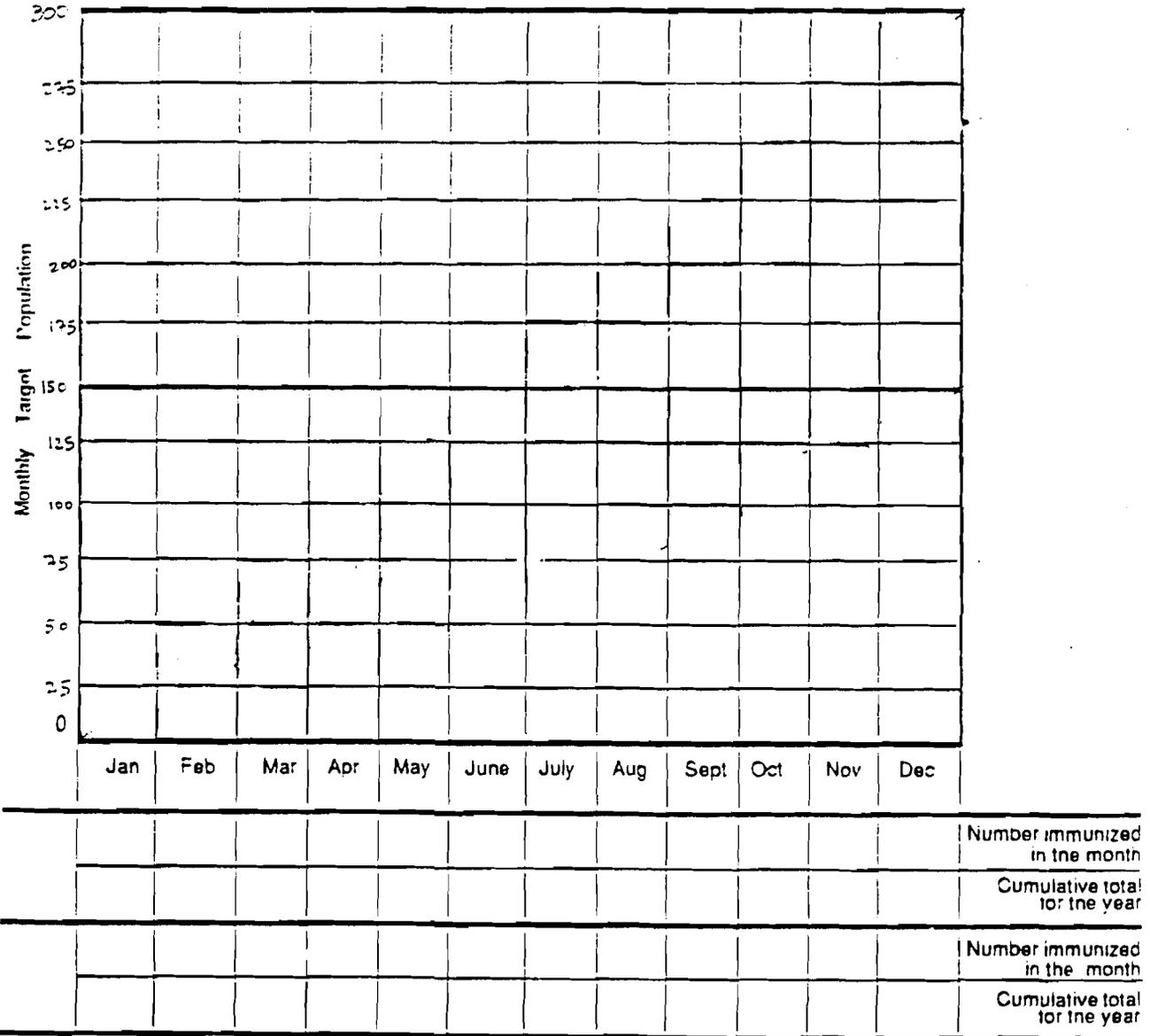
Target population: _____

Year: _____

Minimum coverage

vaccine: _____

target for the year: _____



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IMMEDIATE REPORT ON EPIDEMIC DISEASES

 Date: / /

<p>A. Identification No.: <input type="text"/></p> <p>B. Institution Name:</p> <p>C. Province:</p> <p>D. Division:</p> <p>E. District:</p> <p>F. Tehsil/Taluka:</p> <p>G. Union Council:</p> <p>H. Incharge Name: _____</p>	<p>Report within 24 hours to the District Health Officer any case of the following health problems. Use a separate sheet for each disease. Attach additional sheets if required.</p> <p> <input type="checkbox"/> 106. Cholera <input type="checkbox"/> 107. Suspected Meningococcal Meningitis <input type="checkbox"/> 108. Poliomyelitis <input type="checkbox"/> 109. Measles <input type="checkbox"/> Other disease which presents a serious epidemic threat, </p> <p>specify: _____</p>
<p>I. Signature: _____</p>	

1	2	3	4	5	6	7	8	9	10	11	12
Sr. No.	Date Reported	Date of Onset	Name/Father's Name	Sex M/F	Age	Address	Vaccination Status			Action Taken	Referred To
							Not Vacc.	Part. Vacc.	Fully Vacc.		
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											

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SUPPLIES AND EQUIPMENT

1. Forms/Registers

- EPI/Permanent Register: Vaccination
- EPI Register: Daily Performance
- Maternity and Child Health Card (Immunization cards)
- Case definition of EPI Target Diseases
- Immediate Report on Epidemic Diseases
- Monthly Report

2. Equipment

For Cold Chain

- Refrigerator
- Ice packs
- Vaccine carrier
- Thermometer to record temperature
- Temperature record chart

For Sterilization

- Steam sterilizer or boiling pan
- Small container for needles
- Stove
- Matches
- Timer clock

For Injections

- Syringes - 5cc, 1.00cc
- Needles for mixing, intramuscular, subcutaneous, and intradermal
- Forceps - 2 pairs
- Small tray with lid for syringes
- Metal file to open ampoules
- Two small dishes for swabs (one dry, one with spirit)
- Cotton
- Cotton cloth to hold ampoules

For Cleaning

- A bowl in which to soak used syringes and needles
- Box or bag to collect trash
- Box to take garbage away
- Handwashing items--soap, water, clean towel, etc.

3. Vaccines

- Tetanus Toxoid
- Polio Oral Trivalent
- DPT
- Measles Virus (Live, Attenuated, Dried)
- Diphtheria and Tetanus
- BCG (Dried)

EXERCISES

Classroom Exercise

In this set of exercises you will be given a situation in implementation of the EPI programme. Review the information and identify those areas that are satisfactory and those that require further action. For those requiring further action, suggest appropriate actions after completing the four steps of problem solving.

1. The centre's cold chain records were reviewed. It was found that the temperature was above 20°C for 5 days. When asked, centre staff said that the wick for the refrigerator needed to be replaced but that no wick had been available for four days.

Using the four steps of problem solving, state what you would do at each step.

2. The following table provides immunization activities of an RHC. Use this information and the four steps of problem solving to identify and solve the problem.

Vaccine	1990 Coverage	1991 Targets	1991 Coverage
BCG	60	80	65
DPT 3	45	75	53
OPV 3	47	75	50
Measles	40	75	53
TT2 + (given to pregnant women)	17	45	27
Protected at birth against neonatal tetanus		100% of number receiving DPT1	56%

3. During the visit to the facility you were informed that the drop out rate was high and the above table verified it. You also observed during a vaccination session that children and mothers were being properly immunized but they were not being told when to return.

Using the four steps of problem solving, complete this exercise.

4. During your observation in an EPI room, you noticed that the vaccinator had his work area well organized and neat. He gave the required vaccines using the correct dose and route. You reviewed the immunization cards of three babies between the ages of 6 to 12 months. None of these three babies had received BCG or measles vaccines. When asked why these vaccines were not administered on this day, the vaccinator replied that these vaccines are given on Saturdays only. What actions would you take in this situation?
5. You were observing the EPI room of a teaching hospital and were impressed with the vaccinator in his thoroughness in giving the vaccine, in recording and in cleaning the equipment. When you reviewed the EPI cards of all the children, you noticed that BCG was not marked on four cards. From talking to the mother, you discovered that all four children were delivered at that hospital.

What further information would you ask for and what actions would you take?

6. When you are visiting an RHC, the MOIC complains about the vaccinator who went on leave for two days and had not yet returned two weeks later.

What steps would you take?

7. During your visit to the facility you noticed that some parents were bringing their own plastic syringes to the immunization.

What action would you take?

8. Some mothers told the vaccinator that they wanted their children immunized because there had been some deaths in the village from measles. No measles had been reported to your office or on this visit.

What steps would you take on the basis of this information?

Supervisory Checklist Exercise

During the supervisory visit observe the immunization activities in the health centre and complete the relevant items in the attached Supervisory Checklist Work Sheets regarding the immunization procedure and related resource management items.

- Complete following items on Individual Case Management Work Sheet #1:

1 through 2.I

3.I

4.I

5.I

6.I

7.1 - 7.2

- Complete all items on Individual Case Management Work Sheet #3.
- Complete all items on Resource Management Work Sheet #4.
- Fill in the appropriate sections on Resource Management Work Sheet #5.
- Fill in the following items on Resource Management Work Sheet #6.

6.1

6.2

- Transfer your final score from the work sheets to the summary part of the Supervisory Checklist. On the Individual Case Management page answer:

1.1

1.5

3.

On the Resource Management page answer:

4

5.1 - 5.3

6.

- Summarize findings of your visit and give feedback:
 - On immunization practices
 - On availability and utilization of material resources
 - On record keeping and reporting

- Meet with the staff in groups and/or as individuals.
 - Identify strengths and constraints in delivery of EPI services.
 - Compliment staff on accomplishments in providing immunization services.
 - Give feedback to the facility staff on your findings.
 - Identify training needs for immunization and other areas; arrange for training.
 - Work out a plan with the facility staff to solve identified problems/constraints within a specified time frame.
 - Inform the staff of the date of your next visit.

Section 1: Individual Case Management Work Sheet 1: Sick Child Under 5	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

Case 1 Case 2 Case 3 Case 4 Case 5

	Work Area Set:	Name of Staff: →				
	<input type="checkbox"/> Y <input type="checkbox"/> N					
1.	Rapport					
1.1	Was mother greeted?					
1.2	Was mother asked to sit down?					
1.3	Was mother asked reason for coming to the facility?					
2.	History					
2.1	Asks for age of child					
2.2	Asks change in eating/drinking pattern					
2.3	Asks change in bowel/urine output					
2.4	Asks for change in activity					
2.5	Asks for other symptoms					
2.I	Asks for child's immunization status					
2.N	Asks for nutrition intake assessment					
3.	Examination					
3.1	Looks at general condition (colour, alertness)					
3.2	Looks at condition of eyes, ears					
3.3	Looks at condition of nose, mouth, ear					
3.4	Looks at chest indrawing					
3.5	Counts respiration					
3.6	Takes skin pinch					
3.7	Takes temperature (if indicated)					
3.I	Checks Immunization Card					
3.N	Takes weight (child under 3)					
4.	Classification					
	Was child correctly classified?					
4.1	ARI case					
4.2	Diarrhoea case					
4.3	Case with other symptoms					
4.4	Case with no symptoms					
4.I	According to need for vaccines					
4.N	According to nutritional status					

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5a	Management						
5.1	Were child's needs correctly managed? According to WHO protocol for ARI case According to WHO protocol for Diarrhoea case According to acceptable standards for other cases						
5.2	Refers complicated case appropriately						
5.I	Manages correctly immunization needs of the child						
5.N	Manages correctly nutritional needs of child						
6	Advice						
6.1	Explains to parents findings of child's condition						
6.2	Explains need/no need for drugs						
6.3	Explains when to bring back the child						
6.I	Gives appropriate immunization advise						
6.N	Gives appropriate nutritional advise						
7	Follow-up						
7.1	Gives appointment for next visit						
7.2	Checks if mother has well understood treatment/advice given and date of next appointment						
8.	Reporting						
8.1	Completes MCH card						
8.2	Completes OPD Register						
8.3	Uses Referral Forms						
							$\frac{\text{Total 'Yes'}}{\text{Total 'Yes' + 'No'}}$
For General Child Care (all cases) <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For ARI Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For Diarrhoea Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For Immunization Management (2.I → 6.I) <i>Write number of 'Yes' scores over total number of 'I' scores</i>		/	/	/	/	/	/
For Nutritional Management (2.N → 6.N) <i>Write number of 'Yes' scores over total number of 'N' scores</i>		/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							
General Child Care:							%
ARI Case:							%
Diarrhoea Case:							%
Immunization Management:							%
Nutritional Management:							%

Section 1: Individual Case Management Work Sheet 3: Immunization Session	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 4	
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →					
1.	Uses sterile needle and syringe for each injection						
2.	Uses correct syringe and needle						
3.	Gives injection at the correct place						
4.	Uses the correct route for injection						
5.	Records dates of immunization on appropriate cards and registers						
6.	Informs mother when the child needs to be brought back						
7.	Asks the mother to repeat the instructions to assure that she understood						
8.	Rinses and sterilizes reusable syringes and needles						
9.	Discards disposable syringes and needles						
10.	Discards opened vials of vaccines						
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.</i>		/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores over total 'Yes' and 'No' scores:						%	

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Section 2: Resource Management	Institution Name: _____
Work Sheet 4: Cold Chain Management	
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

- 4.1 Is refrigerator placed at correct position? Y N
- 4.2 Is plug secured? Y N
- 4.3 Are door and rubber of the door in order? Y N
- 4.4 Is floor around the refrigerator dry (no leakage)? Y N
- 4.5 Is thermostat working and set correctly? Y N
- 4.6 Is daily temperature sheet displayed and kept up to date? Y N
- 4.7 Are vaccines and dilutes at proper place in the refrigerator? Y N
- 4.8 Are vaccines stored within the limits of the expiry dates? Y N
- 4.9 Are the door shelves empty? Y N
- 4.10 Is there an automatic generator? Y N
- 4.11 Is there a voltage regulator? Y N
- 4.12 Are alternate arrangements made in case of power cut? Y N

Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.

_____ / _____

Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:

_____ %

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Section 2: Resource Management Work Sheet 5: Physical Resources Management	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

5.1 Are the following equipment/items in good working condition?

Sterilizer

NA Y N

Weighing Scale (adults)

NA Y N

Weighing Scale (children)

NA Y N

First Aid Kit

NA Y N

X-Ray machine

NA Y N

Others? *(Make suggestions)*

5.2 Physical Inventory Equipment/Furniture/Linen (once a year)

Select 10 items as reported in last yearly report.

Does physically verified status correspond with reported status for these 10 items? *If no, discuss results with I/C.*

Y N

5.3 Physical Inventory Drugs/Vaccines/Supplies

Select 10 items as reported in last monthly report.

Does physically verified balance correspond with reported balance for these 10 items? *If no, discuss results with I/C.*

Y N

5.4 Transport (if available)

Verify log book for proper use of vehicle. Discuss results with I/C.

The transport means of the health facility were appropriately used as verified through the log book.

Y N

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Section 2: Resource Management	Institution Name: _____
Work Sheet 6: Record Keeping System	
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

- 6.1 All required registers and patient/client forms are in use according to the HMIS/FLCF Instructions Manual. Y N
- 6.2 Immediate reports for epidemic outbreaks were made up when necessary and duly completed. Y N
- 6.3 Immediate reports were sent out in a timely manner. Y N
- 6.4 Monthly reports were made up correctly from records and registers available in the centre. Y N
- 6.5 Monthly reports were sent out according to time schedule. Y N
- 6.6 Updated graphic representations on priority activities of the health facility are visibly displayed. Y N
- 6.7 All forms and registers are available in sufficient quantity Y N

Number of 'Yes' scores over total number of 'Yes' and 'No' scores /

Final assessment:

Percentage of 'Yes' scores out of total 'Yes' and 'No' scores %

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Section 1: Individual Case Management

Make final assessment on case management of the following health care activities using the scores obtained through the worksheets. For health care activities not performed in the supervised health facility, tick the box 'NA' (Not Applicable).

		Quality of Case Management			
		NA	Poor (<50%)	Insufficient (50 - <80%)	Appropriate (≥80%)
1.	Sick Child Under Five				
1.1	General Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2	Diarrhoeal Disease Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3	Acute Respiratory Infection Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4	Management of Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5	Management of Immunization Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Growth Monitoring in Child Under Three	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Immunization Session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Delivery Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Postnatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Neonatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Tuberculosis (follow-up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Section 2: Resource Management

Make final assessment on the management performance of the health staff for the following resources, using the scores obtained through the worksheets. For resources not available in the supervised health facility, tick the box 'NA' (Not Applicable).

1. Laboratory

1.1 Microscope in good working condition

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

1.2 Laboratory diagnosis of malaria is of acceptable quality.
(Malaria diagnosis correct for $\geq 80\%$ of slides)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

1.3 Laboratory diagnosis of tuberculosis of acceptable quality.
(Tuberculosis diagnosis correct for $\geq 80\%$ of slides)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

2. Community Development Activities

Management of community development activities is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

3. Personnel Management

Personel Management is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

4. Cold Chain Management

Cold Chain Management is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5. Physical Resources Management

5.1 $\geq 80\%$ of essential equipment is in good working condition

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.2 Physical inventory check for equipment/furniture and linen is satisfactory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.3 Physical inventory check for drugs/vaccines/supplies is satisfactory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.4 Transport means of the health facility were appropriately used

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

6. Record Keeping System Management

The Management of the Record Keeping System is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

Feedback On The Visit

1. Improvements noticed since previous visit:	
2. Problems identified during previous visit that need still further improvement:	
3. Problems identified during this visit:	
4. Recommendations to Health Staff:	
5. Actions to be taken by supervisor:	
6. Problems to be followed at next visit:	
7. Date of next visit: _____	

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MODULE 4

NUTRITION

This material is taken from Nutrition for Primary Health Care Workers developed in Pakistan by a group of nutrition experts.

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LEARNING OBJECTIVES

LEARNING OBJECTIVES FOR INCREASED KNOWLEDGE AND UNDERSTANDING

Through lectures, reading and discussions you will increase your understanding of nutrition programmes in Pakistan and the health service provider's responsibilities in minimizing nutrition problems. On completion of training you will be able to:

1. State the magnitude and type of nutritional problems.
2. State Government of Pakistan policy.
3. Identify vulnerable groups.
4. Describe how nutrition service can be integrated into primary health.
5. Describe food groups and their functions in the body.
6. State an individual's daily food requirement based on age, sex and stage of development.
7. Describe the tools of dietary assessment for determining the nutritional needs of women and children.
8. Describe the process of growth monitoring of infants and children.
9. Describe how to complete a growth chart.
10. Describe how nutrition education can be effective in improving dietary practice.

LEARNING OBJECTIVES FOR IMPROVING SUPERVISORY SKILLS

During training you will be familiarized with the procedures related to nutrition services and given opportunities to observe MOs and paramedics. On completion of this module you will be able to:

1. Assess the staff's competency in nutritional needs assessment of infants and children, as well as pregnant and lactating women.
2. Assess the staff's competency in completing a growth chart and weighing pregnant women.
3. Assess the staff's competency in counselling women on meeting their and their children's nutritional needs.
4. Use the Supervisory Checklist in documenting the staff's competency, resource availability and the quality of nutrition service being provided.
5. Help the facility staff to identify their achievements and their weak areas in providing nutrition services.
6. Plan with the staff in improving nutrition services.

INTRODUCTION

MAGNITUDE AND TYPES OF NUTRITIONAL PROBLEMS IN PAKISTAN

Despite adequate food supply, malnutrition is widespread in Pakistan and remains a serious obstacle to efforts to improve health and reduce maternal mortality rates.

According to The National Nutritional Survey, 1985-86, the nutritional status of the population had not improved in ten years. The major nutritional problems that have been identified in Pakistan are protein-energy malnutrition (PEM), nutritional anaemia and goiter (iodine deficiency).

Fig. 8

Prevalence Stunting And Wasting Comparison 1985 and 1977 Surveys

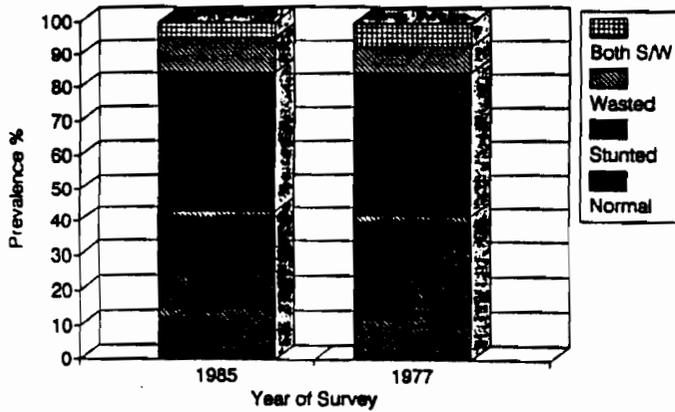
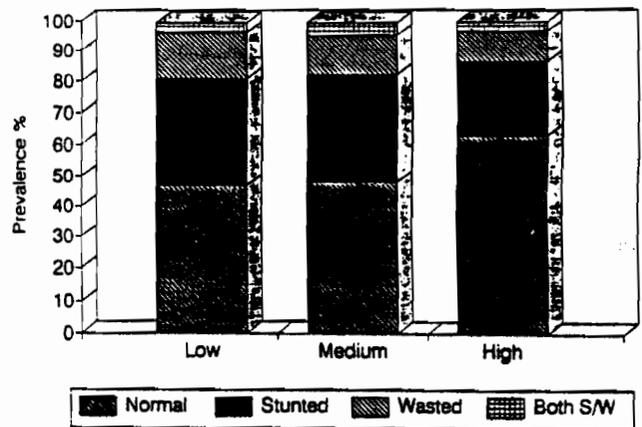


Fig. 9

Prevalence Stunting And Wasting Comparison By Socio-Economic Status



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The prevalence of anaemia was found to be about two out of every three children between seven months and five years of age, and 45% among pregnant and lactating women.

Iodine deficiency diseases are endemic in the northern areas of the country, and it is estimated that fifteen million people may be at risk.

Evidence of clinical Vitamin A deficiency is not common in Pakistan, but the magnitude of mild deficiency is not known and may be significant.

Only 43% of children under five years of age were found to be of normal nutritional status, while 42% were stunted (low height for age), 11% were wasted (low weight for height) and 4% were both stunted and wasted.

Prevalence Stunting And Wasting Pakistan 1985-1987

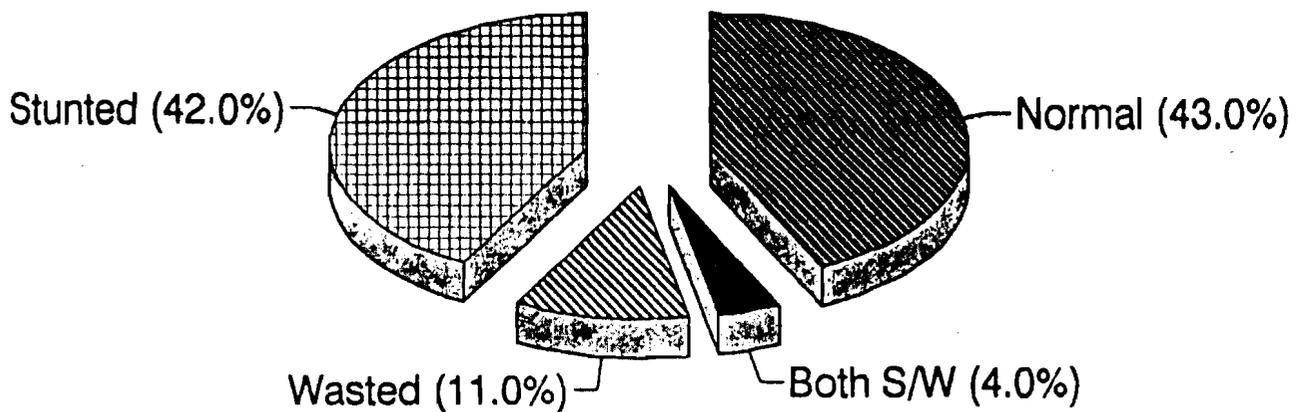


Fig. 10

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The survey results, as shown in the following graph, illustrate that usually high rates of wasting occur among Pakistani infants under one year old. One child in five is wasted even before six months of age, and the prevalence remains high in older children.

WASTING IN YOUNG CHILDREN PAKISTAN AND EXPECTED PATTERN

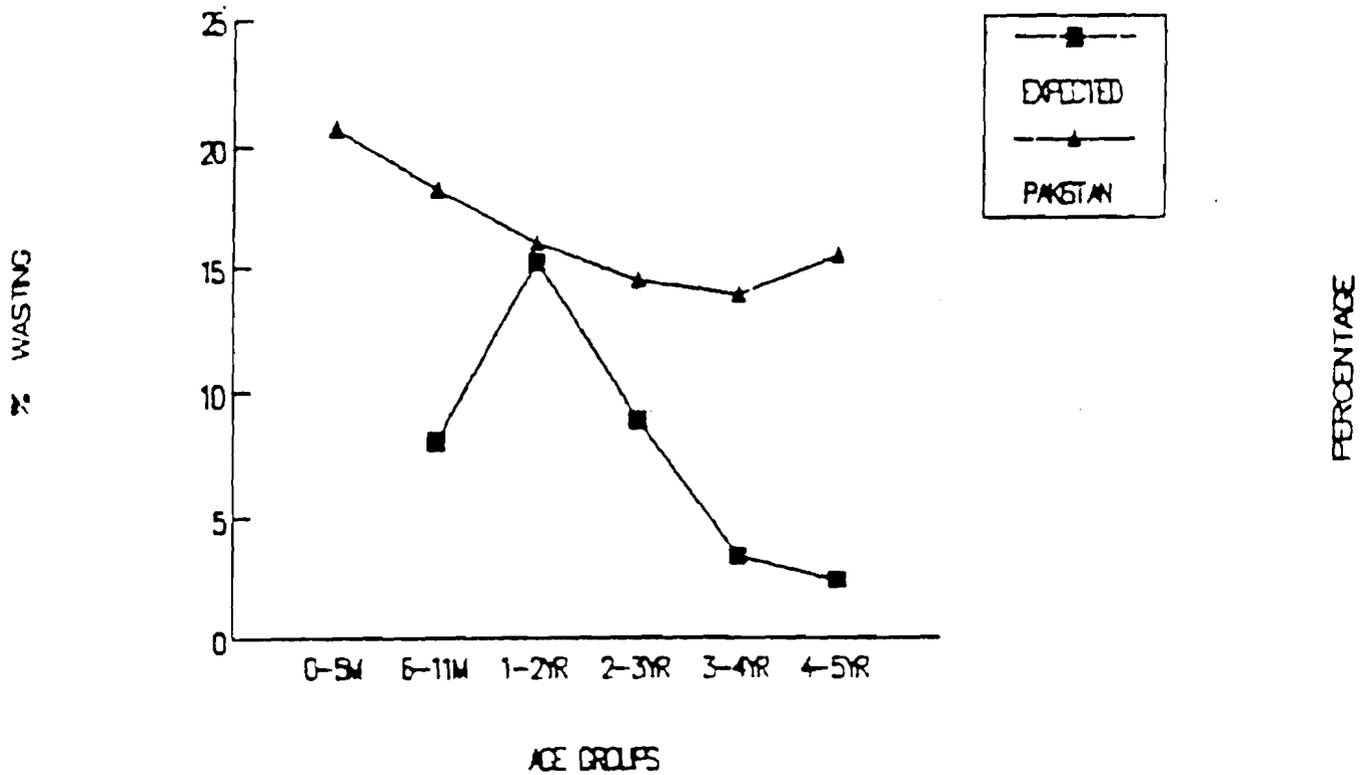


Fig. 11

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The following graphs prepared from survey findings regarding feeding of children show that:

- About 90% of infants are breastfed in the first few months of life; while breastfeeding rapidly declines up to age two.
- Only 14% of children age 4-6 months are consuming food in addition to milk.
- Only 55% of children age 10-12 months receive food other than milk.

BREAST FEEDING PREVALENCE PAKISTAN – BY AGE GROUPS

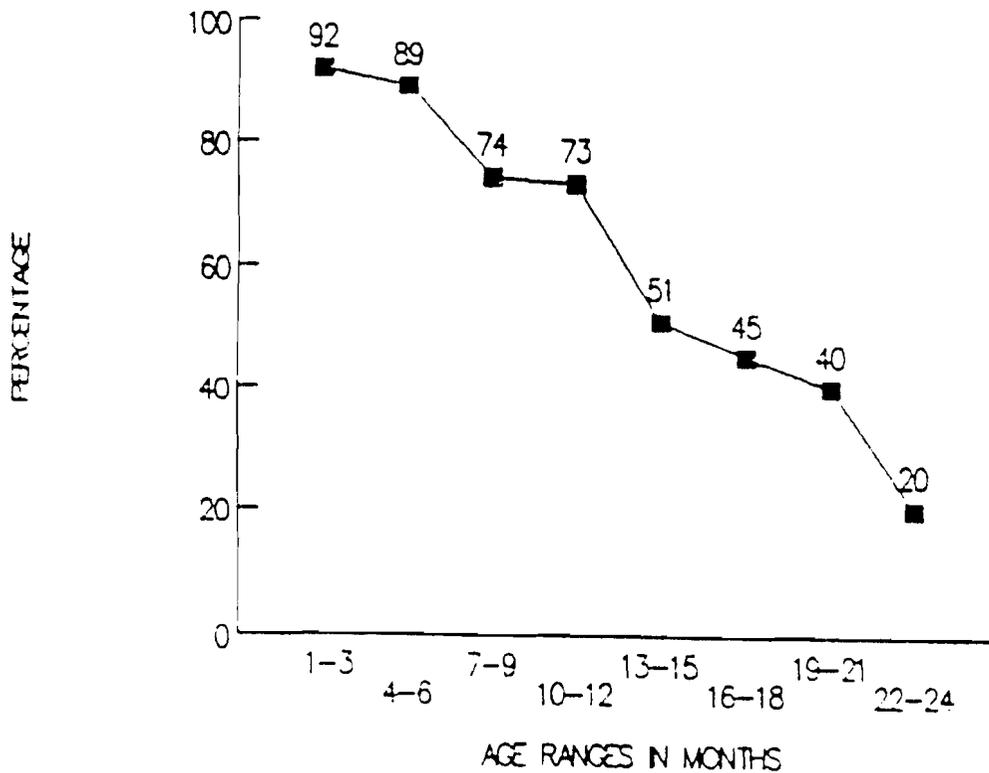


Fig. 12

CHILDREN EATING ANY FOOD PAKISTAN - BY AGE GROUPS

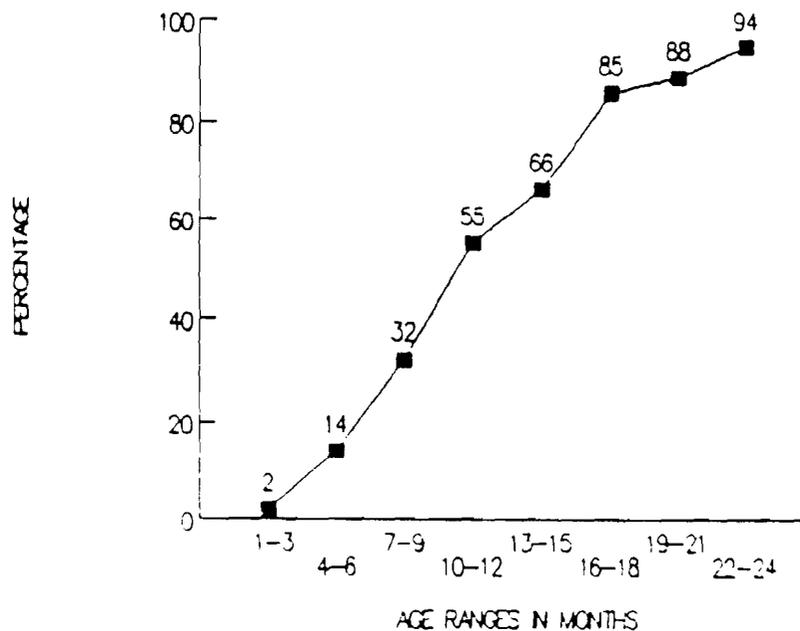


Fig. 13

It can easily be inferred from this situation that by adopting exclusive breastfeeding for infants and introducing appropriate weaning foods at the proper age the nutritional status of children in Pakistan can be much improved.

THE PREVENTIVE APPROACH

- Nutritional programmes can be cost effective when they focus on prevention.
- Good nutrition and proper feeding practices prevent other illnesses and disabilities.
- Many of the long-term consequences of protein energy malnutrition and micronutrient deficiencies are irreversible.
- Nutrition activities need to be integrated into ongoing primary health care programmes.

The preventive approaches that are most likely to be effective in combating malnutrition in Pakistan include promotion of breastfeeding, improved child feeding practices, better diets for adolescent girls and women, consumption of vitamin and mineral-rich foods, plus supplementation when necessary (iodized salt, prenatal iron and folate supplements).

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GOVERNMENT NUTRITION PROGRAMMES

Breastfeeding Policy

The National Breastfeeding Steering Committee develops policies and plans in collaboration with the Government of Pakistan and international agencies. It serves as the coordinating body and technical resource for all activities related to breastfeeding including training, research, programme planning and advocacy. It is also a resource for information and training materials on breastfeeding. The Committee plans to assist in training health workers at the district level.



Government of Pakistan
Ministry of Health, Special Education and Social Welfare

BREASTFEEDING POLICY FOR HEALTH FACILITY

BREAST MILK IS THE IDEAL FOOD FOR BABIES. THE HEALTH FACILITY SHOULD DO THE FOLLOWING TO PROTECT, PROMOTE AND SUPPORT BREASTFEEDING.

1. All health facility staff including doctors, health technicians, lady health visitors, vaccinators and community health workers shall work together to ensure the implementation of the breastfeeding policy.
2. All relevant health care staff shall be trained in the skills necessary to implement this policy.
3. Health facility staff shall ensure that all expectant mothers, at clinic visits or during outreach activities, receive education on the benefits and management of breastfeeding, the dangers of bottle feeding, and the dietary needs during pregnancy and lactation. Prenatal exams shall include breast examination.
4. At delivery, newborn infants, including premature infants, shall be put on the breast within one hour of delivery. Babies should be fed on demand, every 2-3 hours for a minimum of eight feedings within 24 hours.
5. Exclusive breastfeeding shall be promoted from birth to 4-6 months. No water, ghutti, fresh animal milk, infant formula or other liquid is to be given to an exclusively breastfed infant. Trained health care staff shall help mothers having breastfeeding problems to continue to breastfeed.
6. Staff shall promote the introduction of semi-solid foods at 4-6 months with continued breastfeeding up to 2 years.
7. No feeding bottles and pacifiers shall be allowed in the health facility.
8. No promotional materials about formula, feeding bottles and pacifiers, such as posters, free samples or gift items, shall be allowed in the facility nor shall they be given to the mother.
9. No health care staff shall receive gifts, free samples, donations, free training, etc. from formula manufacturers.
10. Mothers shall be given sufficient education in group classes, individual counseling and/or home visits so that they will be able to explain that :
 - breastfeeding should be started within one hour of delivery after birth because:
 - Colostrum is important for babies and protects them for infection.
 - frequent breastfeeding increases breastmilk production.
 - babies should be fed only mother's milk for the first four to six months because:
 - it is the best food for babies.
 - it prevents infections.
 - bottlefeeding can cause serious illness and death.
 - supplementary foods should be started between four and six months.
 - lactating mothers should eat more food and drink more liquids to maximize their milk supply.

Policy Developed by : National Steering Committee on Breastfeeding

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Lactation Management Training

As part of the government's initiative to promote and support breastfeeding, the NBSC has introduced a plan to train teams of medical personnel at San Diego, California's Wellstart Lactation Management Programme. In 1992 ten teams of pediatricians, obstetricians and nurses from teaching hospitals throughout Pakistan will have been trained.

Upon their return, the teams will train the staffs in their hospitals and establish clinics for treating serious lactation problems. These teams will provide technical support and leadership to the provincial breastfeeding committees. The teams will also assist in provincial-level training to promote breastfeeding education.

Growth Monitoring

Government policy is to provide facilities for growth monitoring and nutrition counselling in all FLCFs throughout the country.

Trained manpower is a requisite to the successful implementation of nutrition programmes. The federal government, in collaboration with provincial governments, has initiated a programme to train medical and paramedical staff in nutrition and nutrition education techniques. This programme has so far undertaken the training of MOs, female MOs and lady health visitors in all of the provinces as well as in Azad Kashmir.

The provincial nutrition cells, in cooperation with provincial health departments, have launched training in the districts prioritized by the provincial governments. The goal is to train personnel to implement and monitor nutrition activities at their centres and in their communities.

Iodine Deficiency Disorders Control Program

Iodine deficiency disorders, IDD, are a major public health problem in Pakistan. The northern areas of the country, Azad Jammu and Kashmir, the Northern Areas and the northern districts of NWFP are recognized as some of the world's most severely endemic areas for IDD. Surveys from these endemic areas show the prevalence of IDD as high as 70%. In other regions of the country, including the plains of NWFP, Punjab Sindh and Balochistan, IDD endemic areas have also been reported. It is estimated that approximately fifteen million people are at risk for the full spectrum of IDD.

Although not all of the consequences of iodine deficiency are reversible once they occur, iodine deficiency can be prevented by iodine supplementation. The government launched a short term iodized oil project in 1987, with the objective of administering iodized oil to the

target population of children from birth to nine years of age, and to women up to 45 years of age in the highly endemic regions of AJK, NAs and the northern districts of NWFP. The target populations in these project areas are currently estimated at 6.8 million. Approximately 1.2 million have received iodine supplementation to date. One oil injection is effective for three to four years, while a single dose of two capsules develops iodine stores that will last from one to two years.

In 1989, the Nutrition Sector of the Planning and Development Division in collaboration with the Utility Stores Corporation developed a plan for producing iodized salt and distributing it to the project areas. The coordination and marketing costs are covered by the government and the salt is sold at the same market price as common rock salt. The iodized salt is available as packaged salt in all Utility Stores and other shops in the endemic area.

MOs should prescribe iodized salt for all people living in the endemic areas. They also should encourage traders and shopkeepers to sell and promote iodized salt. Iodized salt should be stored away from sunlight, but should be displayed in view of the customers.

Iron

One of the major signs of iron deficiency is anemia. Although provincial health departments are distributing iron sulphate tablets through some selected centres a scheme is being prepared to universalize the distribution at the national level. The programme may be launched in early 1992.

WORLD FOOD PROGRAM

In 1975 the government requested WFP assistance in providing a programme of supplementary feeding integrated into basic health services. The objectives of the program are:

- To reduce the high incidence of protein-calorie malnutrition among preschool children, pregnant women and nursing mothers
- To promote better child and family feeding
- To encourage greater attendance at health and welfare centres in order to provide more opportunities for intensive activities in immunization, mother and child health care and sanitation education
- To lay the foundation for an appropriate distribution system for food, particularly among the most needy of Pakistan's population

The groups eligible to receive WFP rations are pregnant and lactating mothers and children between six months and eighteen months of age who are poor and malnourished and weigh less than 80% of the standard weight-for-age.

Recently, the foodbasket has changed from wheat, dried skimmed milk and edible oil to edible oil, tea, sugar, pulses and wheat soyabean flour. The main emphasis of the project will now be on promoting the use of primary health care facilities. Twelve hundred health outlets, which are mainly administered by provincial health departments and supervised by provincial health departments and by DHOs, will register about two hundred beneficiaries.

During emergencies such as the famine in Thurparker, Sindh, or national calamities such as earthquakes and floods, WFP provides food commodities. WFP also has an afforestation project in which workers receive half their pay as food.

OVERVIEW OF MO AND PARAMEDIC TRAINING

Through review of the nutrition content of the MO and paramedic training you will become familiar with the procedures and services they are expected to carry out. You will then be able to observe and assess the quality and quantity of services provided and take necessary steps to assure adequate and appropriate nutrition services to people in the community. This section begins with the roles of the health team and the procedures for determining nutrition needs taught to the MOs and other health workers.

ROLE OF THE MEDICAL OFFICER

The MO will ordinarily undertake the following responsibilities:

- See all patients referred by the LHV/FHT.
- Confirm the clinical assessment of the LHV/FHT and prescribe treatment as indicated.
- Refer patients when required to secondary and tertiary health care facilities.
- Reinforce the counselling points that were discussed with the LHV or FHT.
- Conduct nutrition counselling.
- Solicit the help and participation of volunteers from the community.
- Conduct on-the-job training of staff and volunteers, and provide up-to-date information.
- Supervise the work of LHVs and FHTs.
- Maintain equipment. Scales should be calibrated weekly to ensure proper functioning.
- Periodically observe the LHV's technique of measuring; then take a duplicate measurement and compare the two to assess accuracy.
- Ensure that the LHV has adequate time, space and materials for counselling. Observe her counselling approach and give guidance on any incorrect and missed points, reinforce effective approaches and suggest alternatives when necessary.
- Check that plotting of growth charts, recording of pregnancy weight gain, and filling of registers is performed; and check that the information is reasonable. Help LHVs avoid spending too much time on records rather than on patients.

- Ensure the availability of equipment, growth charts, stationery, teaching aids, iron and folate supplements, etc.
- Encourage home visits and community involvement.
- Educate staff on the importance of nutrition services and the preventive approach.
- Listen to staff concerns and give them the opportunity to provide feedback on difficulties and successes.
- Don't forget to congratulate the staff on a job well done, especially in the face of numerous constraints.

ROLE OF THE LADY HEALTH VISITOR AND FEMALE HEALTH TECHNICIAN

The LHV AND FHT will normally perform nutrition related activities in the following areas:

Paediatric Care

- Assess nutritional risk to children.
- Weigh all children.
- Record weight on the child's health chart and interpret the growth curve.
- Provide preventive nutritional counselling and promote good nutrition.
- Conduct diet histories and food frequencies for those identified as "at risk."
- Conduct clinical assessment and refer patients needing further advice to the MO.
- Provide individualized nutrition counselling and follow up.

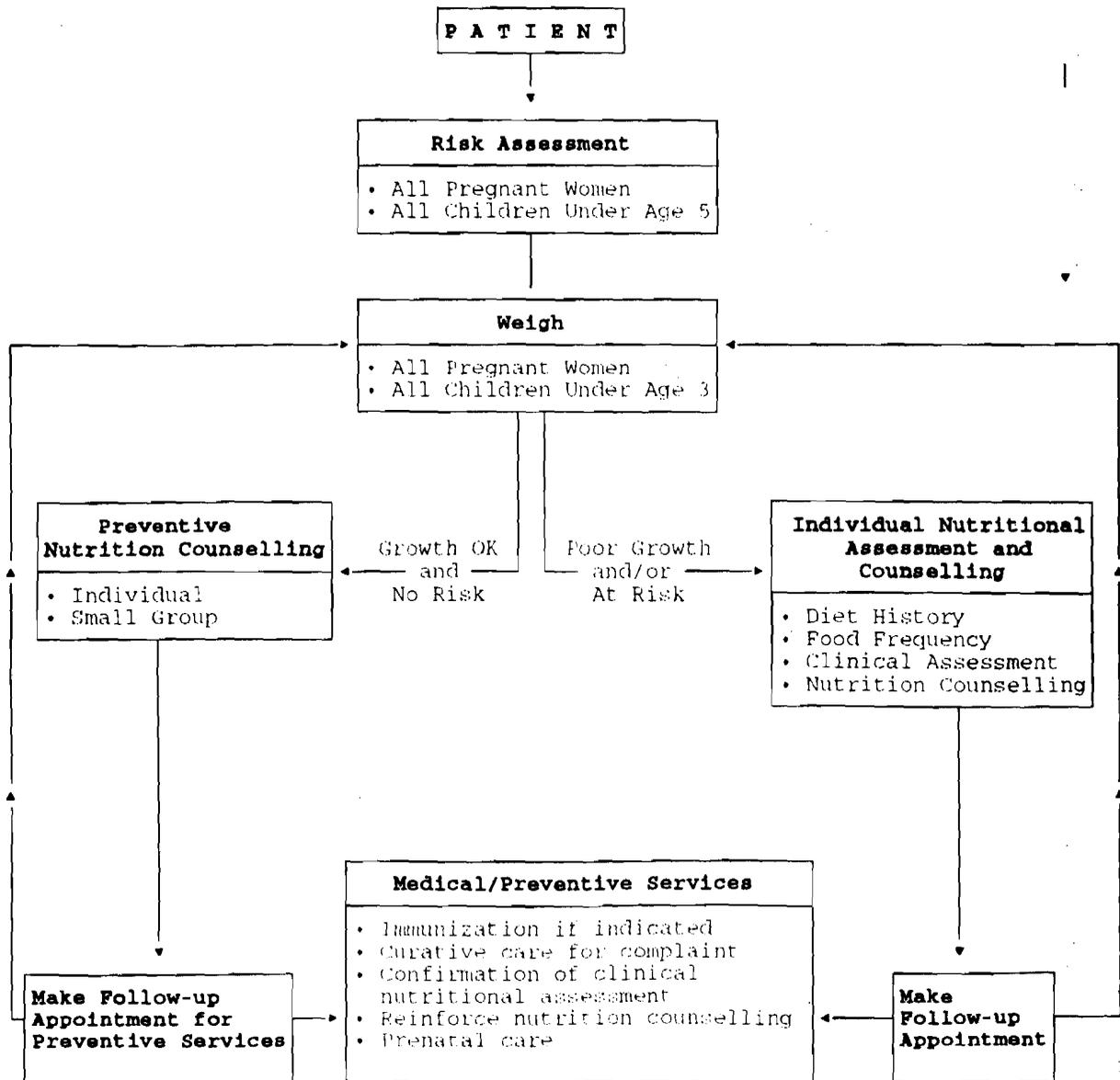
Prenatal Care

- Weigh all pregnant women.
- Record weight and assess weight gain.
- Provide preventive counselling on maternal diet.
- Prescribe iron and folic acid supplements.
- Conduct diet histories and food frequencies when indicated.

INTEGRATION OF NUTRITION SERVICES IN PRIMARY HEALTH CARE

Most patients do not come to the health centre specifically for nutritional problems. Therefore the promotion of good nutrition and care for other health problems needs to be integrated into the roles of health staff. Nutrition services as outlined in the following flow chart are delivered through the primary health care outlets.

NUTRITIONAL SERVICES



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Nutritional services in the health centre

1. Risk Assessment

All children under five years old should be assessed for risk of malnutrition, using a check list of risk factors. All pregnant woman should also have a risk assessment completed. In Pakistan children and women are vulnerable to malnutrition due to the following factors.

- Children
 - Non-exclusive breastfeeding
 - Inadequate and inappropriate weaning practices
 - Recurrent episodes of diarrhoea and ARI
 - Bottle feeding
- Women
 - Chronic undernutrition
 - Lack of knowledge about balanced diet
 - Insufficient dietary intake in closely spaced pregnancies and lactation

2. Malnutrition Risk Factors

Social*	Medical/Nutritional*
* Mother: ill working incompetent	* Low birth weight
* Father: ill unemployed	* Twins
* Parental loss: (death/desertion) (divorce/separation)	* Mixed feeds or bottle feeding
* Inadequate childcare for working women	* Delayed feeding of solid foods
* Drug addiction in family	* Chronic/recurrent diarrhoea
* More than two children under five years of age	* Recurrent respiratory infections
* Previous infant/child death	* Otitis media, measles, TB, pneumonia, whooping cough
	* Incomplete vaccinations
	* Others (congenital anomalies, e.g. cleft lip)

3. Growth Monitoring

All children from birth to 36 months of age who come to the health centre should be weighed, have their growth plotted and have appropriate action initiated.

4. Prenatal Weight

All pregnant women coming to the health centre should be weighed and have their weight gain assessed.

5. Clinical and/or Biochemical Assessment

- Children at risk of developing malnutrition need to be examined for signs of PEM and micronutrient deficiencies.
- Pregnant and lactating women should be examined for signs of anaemia and have an assessment of hemoglobin concentration.
- All patients in areas where iodine deficiency is endemic should be examined for goiter or other symptoms of IDD.

6. High Risk Nutrition Counselling

High risk nutrition counselling should be provided to the following groups:

- Parents of children with growth faltering or parents of those who are at risk of developing a nutrition-related problem.
- Parents of malnourished children
- Pregnant and lactating women
- Patients suffering from micronutrient deficiency, or those at risk of developing it

7. Nutrition Supplementation

- Pregnant women should receive 120 mg iron and 500 mg folic acid daily.
- Low birth weight infants at two months of age should receive iron syrup or tablets at 1 mg/kg body weight per day.
- All patients with iodine deficiency or those who are at risk of developing iodine deficiency should be advised to use iodine salts.
- If malnutrition supplements are not available at the centre they should be prescribed.

8. Preventive Counselling: Promotion of Good Nutrition

Every contact with members of the community should be used as an opportunity to promote good nutrition.

ROLE OF SUPERVISOR

As a district level supervisor you should encourage and assist the health teams at the FLCFs to promote good nutrition and to be on the lookout for cases of children or women who are "at risk." You are to carry out the following activities to assure adequate nutrition services.

1. Pay regular supervisory visits to each health facility in the area; and use the Supervisory Checklist to provide effective supervision of nutrition activities including support, guidance and quality control.
2. Develop a plan for providing nutrition services at the health facilities, including the following activities:
 - Identification of groups at risk for malnutrition
 - Nutrition counselling to prevent malnutrition in a risk group
 - Treatment for patients with malnutrition
 - Promotion of good nutrition practices within the context of population services provided by health facilities
3. Motivate staff to perform better by congratulating them for jobs done well.
4. Assist the health staff in implementing nutrition services by providing additional training, resources or changes in procedures in defective areas.
5. Make arrangements with other hospitals for referral cases.
6. Ensure availability of equipment, growth charts, stationery, training aids, iron, folate, vitamins and micronutrient supplements, etc.
7. Listen to staff concerns and give opportunities to provide feedback on difficulties and successes.
8. See that all sanctioned posts are filled.
9. Maintain proper records at the centre and at the district office.
10. See that adequate space is available for interviewing, weighing and counselling.

DIETARY ASSESSMENT

Food Groupings And Their Functions

FOOD GROUPINGS	FOOD SOURCE	FUNCTIONS	KEY NUTRIENTS
STAPLE:	chapatti rice	energy growth protection	protein, iron, calories
PROTEIN RICH:	legumes eggs milk meat, fish, chicken breastmilk	growth protection	protein, iron, folic acid calories, calcium
VITAMINS & MINERALS:	fruits vegetables	protection growth	Vitamins A and C, iron folic acid
ENERGY:	fats oils sugar	energy	calories

As a guide to nutrition assessment and counselling, the chart on the following page shows the recommended daily allowance of essential nutrients for both males and females according to age and stage of development .

DAILY FOOD GUIDE

FOOD TYPE	WOMAN	PREGNANT WOMAN	LACTATING WOMEN	MAN	FEMALE 10-19	MALE 10-19	CHILD 7-9	CHILD 4-6	CHILD 1-3
STAPLE:									
Rice or Chapatti	5 Roti	6 Roti	6 Roti	8 Roti	5 Roti	6 Roti	5 Roti	4 Roti	2 Roti
VITAMIN & MINERAL:									
Fruit	3	3	3	2	3	3	2	2	2
Vegetables	½ pao	1 pao	1 pao	1 pao	½ pao	1 pao	½ pao	½ pao	½ pao
PROTEIN RICH:									
Legumes	1 pao	1 pao	1 pao	1½ pao	1 pao	1 pao	1 pao	1 pao	½ pao
Meat OR 1 Egg	¼ pao	¼ pao	¼ pao	¼ pao	¼ pao	¼ pao	¼ pao	¼ pao	¼ pao
Milk or Yoghurt	2 pao	2½ pao	4 pao	2 pao	3 pao	2 pao	2 pao	2 pao	2 pao
Breastmilk									On demand until 2 years
ENERGY RICH:									
Oils or Fat	8 teasp.	8 teasp.	8 teasp.	8 teasp.	4 teasp.	6 teasp.	4 teasp.	4 teasp.	2 teasp.
TOTAL CALORIES	2175	2562	2817	2881	2230	2750	2020	1818	1328
RDA	2200	2500	2700	2900	2200	2750	2000	1800	1300

REVISED: DECEMBER, 1991

- * All measures are volume not weight
- * All foods are cooked

EQUIVALENTS-SUBSTITUTES CALORIES

- 1 roti = ½ pao or 1 Roti = 200
- 1 roti = ¼ pao cooked rice 1 Fruit = 40
- 1 small fruit = ½ pao juice ½ pao Vegetable = 35
- ½ pao cooked vegetables = 1 pao raw vegetables = 1 fruit ¼ pao Legumes = 75
- ½ pao cooked dal = ¼ pao of meat = 1 egg = ½ pao milk ¼ pao meat = 75
- 1 teaspoon = 5 ml 1 egg = 70
- 1 pao = 250 ml = 1½ teacups (180 ml) ¼ pao Meat = 75
- 1 pao milk = 1 pao yoghurt = ¼ pao paneer 1 teaspoon Fat = 45

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BEST AVAILABLE COPY

PROTOCOL FOR NUTRITIONAL ASSESSMENT AND COUNSELLING OF CHILDREN

1. Assess nutritional risk for all children under five years, using the Malnutrition Risk Assessment Checklist.
2. Conduct growth monitoring for all children under three years old.
 - Assess the child's age.
 - Zero the scale.
 - Undress the child to light indoor clothes.
 - Measure the child's weight to the nearest 0.1 kilogram.
 - Plot the child's weight on the growth chart.
 - Discuss growth pattern with mother.
3. For children with inadequate growth and/or one or more risk factors, conduct a dietary assessment.
 - Use the Diet History Question Guide and take notes.
 - Conduct an In-Depth Food Frequency and take notes.
 - Compare the current feeding practices with Daily Food Guide.
4. Follow general counselling principles.
 - Use visual aids.
 - Involve the mother or family by asking questions.
 - Reinforce positive behaviours.
 - Use the counselling messages from the curriculum.
 - Check that the patient understands and is able to apply the counselling in daily life.
 - Schedule a follow-up visit.

5A. For children with normal growth, or no identified risk: provide age appropriate preventive nutrition counselling, as follows.

For all infants from birth to two years old:

- Counsel families on optimum breastfeeding practices that are age appropriate.
- Provide information and counselling on breastfeeding problems and diet during lactation.
- Stress the disadvantages of bottle feeding.
- Explain that no special hygiene is required when breastfeeding.
- Advise on the best age to introduce supplementary foods.

5B. For children with inadequate growth and/or one or more risk factors: follow the high risk individual counselling protocol.

- Use information from nutrition assessment tools to identify important dietary changes needed, and discuss with the family how to implement them.
- Provide counselling, following the points described in the preventive section, with additional practical information provided on problem areas.
- Provide additional advice on the management of malnutrition, low birth weight, and nutrition

For all infants three months to one year old:

- Provide information on feeding solid and semi-solid foods and continued breastfeeding.
 - Give practical examples of local and affordable foods.
 - Discuss the consistency and types of foods appropriate for different ages.
 - Demonstrate amounts and discuss frequency of feeding.
 - Discuss proper hygiene.
 - Discuss how and what to feed during illness.

For children over one year old:

- Discuss feeding requirements.
 - Encourage the mother to continue breastfeeding until at least two years of age.
 - Discuss frequency of feeding.
 - Demonstrate types and amounts of food; and hygienic preparation of food.
 - Discuss how and what to feed during illness.

For adolescents:

- Discuss food needs.
 - Relate food needs to future health and having healthier babies.
- With older adolescents, provide general information on the advantages of breastfeeding and the hazards of bottle feeding.

requirements related to illness, as appropriate.

- Schedule follow up appointments for monitoring and counselling as frequently as required.
- Check that families understand and are able to implement counselling advice; and that they return for scheduled follow-up visits.
- Refer children who do not improve or who have severe problems beyond the scope of the BHU to other facilities.

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DETERMINING NUTRITIONAL NEEDS OF CHILDREN AND WOMEN

Nutritional status can be assessed if information is available on growth patterns, past eating practices, and current food intake of the individual. Counselling aimed at maintaining or improving nutritional status is also based on this information. The following methods for obtaining the necessary information are used.

1. Diet history is used to discover information about past eating practices and food beliefs that will be useful in nutrition counselling. (See Overview of MO training.)
2. Diet recall form is used to assess current practices. It is the most accurate way to get information about a person's nutrient intake without sophisticated weighing of actual food items. It is important to list all food and drink taken during the past 24 hours and to get a good estimate of the actual amount of each food item.
3. Food frequency guide provides tips on getting an accurate record of food intake.
 - Start with the most current meal and work backwards. Mention the day of the week and any other special event to help the person remember what was eaten.
 - Try to interview the person who prepared and served the food.
 - Use plates, cups, bowls, glasses, food models or dry food items to estimate the amount eaten. Remember that the amount eaten determines the nutritional value.
 - Ask probing questions.
 - What was added to the food during preparation or when served?
 - How much was served: was it all eaten?
 - What else was eaten outside the home, at tea shops, school or while visiting?
 - What beverages did they drink and what was added to them?
 - Did every one eat the same food? Remember that foods prepared for the family may not be served to all family members.
 - Was this day typical? If not, how was it different? If it was very different you may want to do another recall on a more typical day.

INDEPTH FOOD FREQUENCY GUIDE

How often do you/or your child eat the following foods? (For the past 2 months)

How many times?

How much? (for key foods)

FOOD	DAILY <i>(number of times)</i>	WEEKLY <i>(number of times)</i>	MONTHLY <i>(number of times)</i>	NEVER
roti				
rice				
potato				
corn				
fruits				
leafy green or orange vegetables				
other vegetables				
legumes, dal				
meat, chicken or fish				
egg				
milk				
yoghurt				
paneer				
lassi				
ghee				
oil				
sugar				
biscuits				
soft drinks soda				
fruit juice (frost)				
tea				
samosa				
breastmilk				
weaning foods: khitchri, choori, dalia, kheer, etc.				

ASSESSMENT OF GROWTH IN INFANTS AND YOUNG CHILDREN

By catching and addressing problems early, monitoring growth has great value in promoting health and preventing malnutrition. When correctly used it can be a simple but powerful tool for the nutrition education of mothers and families.

Children under three years of age should be weighed according to the following schedule which, up to the age of 12 months, coincides with the immunization schedule; and then every 6 months up to the age of three:

6 weeks	12 months
10 weeks	18 months
14 weeks	24 months
6 months	30 months
9 months	36 months

Growth Monitoring

- A growing child is a healthy child, and the most sensitive measure of change in growth rate is weight.
- A balanced diet is needed for adequate growth and maintenance of health.
- Many mothers do not recognize the relationship between feeding and growth and do not know the appropriate quantity and quality of diet to feed their child.
- Growth faltering or a slowing down of the rate of growth may be the first sign that dietary intake is inadequate. Malnutrition can be detected long before it becomes clinically apparent by means of repeated weighing and charting (i.e. growth monitoring).
- Growth faltering may also be caused by recurrent illness. Energy requirements increase during illness while the intake of food is often reduced. Growth monitoring records the **pattern** of weight gain and aims for the child's curve to follow the standard curve on the chart, regardless of the colour of the channel. The direction of the growth line is more important than the position of the dots.
- Increase in weight with age is more important than weight on any one occasion. Normal healthy children should be weighed at the times of their immunizations, at three month intervals up to one year of age, and then at six month intervals up to three years of age.
- Lack of weight gain between two weighings indicates a problem that must be addressed by diet assessment and counselling to prevent the development of malnutrition. The child should be weighed again in one month. A follow-up appointment for weighing and counselling should occur within one month.
- It is imperative to clearly understand that the **primary objective of growth monitoring is promotion of growth and prevention of malnutrition - NOT** detection of malnutrition.
- Growth monitoring is only useful if **action** is taken to correct feeding practices when growth faltering is detected.

- If mothers are involved in the process, charting growth can be a way to make growth “visible,” teach mothers about the relationship between health and growth, and reinforce behaviour changes such as improved feeding practices. Mothers should be praised for a growing child. Growth charts are not only a tool for assessing a child’s growth and catching problems early, but also a tool for teaching mothers.
- Weight for Age is the **most sensitive indicator of growth** and an objective assessment that detects even minor changes in the rate of growth. It is the most useful indicator for growth monitoring in children. It does not distinguish between acute or current malnutrition (“wasting”) and chronic or previous malnutrition (“stunting”), but is a composite of both of these conditions.

CHILD WEIGHT SUMMARY PROCEDURE: HANGING SCALE

1. Make sure that the scale is hanging securely in such a position that a child being weighed will not touch the wall, floor, or furniture. It is essential that the dial on the balance is low enough so it can be read at eye level easily. Ask the mother to undress the child.
2. Attach a pair of the empty weighing pants or infant sling to the hook of the scale and adjust the dial to zero, then remove the pants from the scale.
3. Have the mother hold the child. Put your arms through the leg holes of the pants. Grasp the child’s feet and pull the legs through the leg holes. Make certain that one strap is in front of the child so he will hang straight.
4. Attach the strap of the pants to the hook of the scale. **DO NOT CARRY THE CHILD BY THE STRAP ONLY.** Gently lower the child and allow him to hang freely.
5. Check the child’s position. Make sure he is hanging freely and not touching anything. Repeat any steps as necessary.
6. Hold the dial of the scale (do not touch the child or the lower parts of the scale). Read weight to the nearest 0.1 kg. Read the measurement when the child is still and the scale needle is stationary. Even children who are very active, which causes the needle to wobble greatly, will become still long enough to take a reading. **WAIT FOR THE NEEDLE TO STOP MOVING.**
7. Read the weight out loud, and if you have an assistant, have him write it down or help remember it. Otherwise, concentrate on the weight so that you can remember it exactly. You must not walk away from the scale while the child is still hanging.
8. Hold the child in one arm and gently lift the child by the body. **DO NOT LIFT THE CHILD BY THE STRAP OF THE WEIGHING PANTS.** Release the strap from the hook of the scale with your free hand.
9. Write the weight on a piece of paper as soon as you can. Then plot the weight of the chart, explaining the meaning to the child’s mother.

(Adapted from: How to Weight and Measure Children, UN, 1986)

MEASURING CHILD'S WEIGHT WITH A HANGING SCALE



Fig. 14

STAND UP SCALE WITH BEAM AND BALANCE

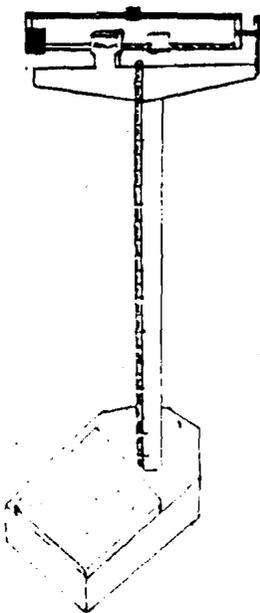


Fig. 15

CHILD WEIGHT SUMMARY PROCEDURE: INFANT BEAM BALANCE

1. Make sure that the scale is on a stable, level surface. Adjust the scale to zero. Ask the mother to undress the child. Place the child, sitting or lying, on the "pan" of the balance.
2. Place the 5 kg. weight on the hook at the end of the beam. If the beam drops, the child weighs less than 5 kg. so remove the weight and use the sliding poise on the beam.
3. Slide the poise toward the end of the beam, gradually, until the beam drops. Adjust the poise back and forth slightly until the beam is "floating" and the pointer at the end of the beam points at zero.
4. Read the weight from the position of the poise and record it. Do not walk away from a child sitting or lying on the scale as it is possible for the child to fall.
5. If the child weighs more than 5 kg. (ie. beam does not drop when 5 kg. weight is attached), leave the weight hanging, and adjust the poise on the beam as described in step #3 above.
6. Read the weight from the position of the poise, add 5 kg. for the hanging weight, and record the total child's weight.
7. If the scale has a capacity of more than 10 kg. it will include additional weights beyond the 5 kg. hanging weight and the 5 kg. poise on the beam. Use the same procedure with the additional weights for heavier children.

WEIGHING SMALL CHILDREN ON AN ADULT SCALE

1. Have an adult stand on the scale.
2. Read the weight and record the weight.
3. Have the same adult hold the undressed infant or child on the scale.
4. Read and record the weight.
5. Subtract the weight of the adult alone from the combined weight of the adult and child. This will give you an approximate weight for the child.
6. Record the child's weight on the chart.

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The MO and the paramedic are to use an Individual Food Needs Assessment Form to obtain information on nutritional intake. This should be followed by weighing and recording on the growth chart which is on the MCH card. The third step of assessment involves comparing nutritional intake with recommended amounts and weights. This will provide specific information on an individual's specific nutritional needs. Nutritional counselling and teaching is based on identified individual needs.

INDIVIDUAL FOOD NEEDS ASSESSMENT

	RECOMMENDED INTAKE	ACTUAL INTAKE	ADDITIONAL NEEDS
<i>Staple:</i> rice			
chapatti			
<i>Vitamin/Mineral:</i> fruits			
vegetables			
<i>Protein Rich:</i> legumes			
meat			
egg			
milk products			
breastmilk			
<i>Energy Rich:</i> oils			
fat			
sugar			

GUIDELINES FOR NUTRITION COUNSELLING AND TEACHING

Nutrition counselling is an important component of nutrition services provided through primary health care outlets. Unless the mothers/caretakers or family understand the relationship between health and appropriate food requirement, the much desired change in attitude towards dietary practices is not possible. Nutrition counselling is the most important single factor to bring about this change leading to proper nutrition of children and pregnant or lactating women.

Who Receives Nutritional Counselling?

- All pregnant women and mothers of children under five years of age should receive some nutritional counselling at each clinic visit, even if the reason for attending the clinic is not related to nutrition.
- Everyone with a nutrition-related problem:
 - High risk patients need individual counselling.
 - Preventive nutritional counselling can be done individually or in small groups.

GENERAL COUNSELLING GUIDELINES

1. Breastfeeding should be continued for at least two years.
2. Breastmilk is a clean, inexpensive source of protein and energy.
3. Breastmilk can be fed even if you are pregnant; breastfeeding during pregnancy won't harm you, your baby, or the unborn child.
4. Children one to two years of age should be fed family foods without spices at least five times a day in addition to breastmilk.
5. Foods should be eaten from the four food groups. Oil or other fats should be mixed in foods every day.
6. Snacks are important for children. They should be nutritious and can be the same foods as those served at meal time.

7. Feeding young children requires your patience and assistance to encourage them to eat an increasing amount of food. They should receive their own plates of food and have adequate time to finish meals.
8. Good hygiene is essential during the preparation and eating of food.
 - Wash hands before preparation and before eating.
 - If you are not serving the food immediately, keep the food cool and covered.
 - Cook it to the boiling point before serving, then quickly cool to the correct feeding temperature.

COUNSELLING MATERIAL AND MESSAGE FOR INFANTS, BIRTH TO 4 MONTHS

1. Initiate breastfeeding as soon as a baby is born--within thirty minutes to one hour.
2. Colostrum should be given from birth until the milk comes in.
3. Prolactal feeds should not be given.
4. Frequent, on-demand feedings should be given.
5. A baby should feed from both breasts at each feeding.
6. Water should **not** be given to a breastfed baby.
7. Supplementary feedings of animal milk or formula should not be given.
8. No foods or interlactal feeds should be given during the first four months.
9. Maternal dietary intake should be increased during lactation.

GUIDELINES FOR NORMAL NUTRITION OF INFANTS

4-6 Months

- Give breastmilk at least 5-6 times per day.
- Feed semisolid foods 3-4 times per day, $\frac{1}{4}$ - $\frac{1}{3}$ pao each feeding.

7-9 Months

- Give breastmilk at least 4 times per day.
- Feed semi-solid foods 3-4 times per day, $\frac{1}{3}$ - $\frac{1}{2}$ pao each feeding.
- Include foods from each food group daily.

10-12 Months

- Give breastmilk at least 4 times per day.
- Feed chopped foods 3-4 times per day, $\frac{1}{2}$ - $\frac{3}{4}$ pao each feeding.
- Include foods from each food group daily.

NUTRITIONAL NEEDS OF INFANTS FOUR TO TWELVE MONTHS OLD

Growth faltering in Pakistani children occurs during the first year due to inadequate caloric intake and repeated infection and diarrhoea. Diarrhoeal diseases can be reduced by breastfeeding. This would also increase caloric intake. Feeding semisolid foods at the age of 4-6 months will prevent malnutrition.

NUTRITIONAL NEEDS OF CHILDREN THIRTEEN TO SIXTY MONTHS

Undernutrition is a continuing problem and a major health hazard for children under five years of age. Breastfeeding should be continued for as long as possible because of its nutritional and protective value. Due to a lack of knowledge, many mothers prolong breastfeeding beyond one year without adding weaning foods to the child's diet. Counselling mothers should improve the nutritional status of children, since nutritious foods are commonly available in the home but are often not fed to the child, or are fed in insufficient amounts. The following chart is a guide for determining the nutritional needs of young children and for counselling.

Daily Food Guide Young Children		
	1 - 3 YEARS	4 - 6 YEARS
Staple	2 rotis	4 rotis
Fruits	2 pieces	2 pieces
Vegetables	½ pao	½ pao
Legumes	¼ pao	1 pao
Meat	⅛ pao	⅛ pao
Milk	2 pao	2 pao
Oils or fat	2 teaspoons	4 teaspoons
<i>Include at least 3 meals and 2 snacks each day.</i>		

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GENERAL GUIDELINES FOR FEEDING CHILDREN 13-60 MONTHS

1. Feed softened foods from the general family diet, but without spices.
2. Food should be served in a separate cup, bowl, or plate.
3. Feed the child three meals and snacks of highly nutritious foods.
4. Add small amounts of oils or ghee to food to increase calorie density without adding bulk.
5. Offer a variety of foods to a child.
6. Foods should be locally available, nutritious, and inexpensive.
7. Avoid expensive, low-nutrient foods such as soda, biscuits, candy, etc.
8. Encourage the child to feed him/herself. Allow adequate time to finish meals.
9. To keep food safe:
 - Prepare fresh food, and give it to the child as soon as possible after cooking.
 - Store food covered in a cool place, reheat to boiling, then cool to the appropriate temperature.
 - Wash hands with soap.
 - Ensure that the child washes his/her hands before eating and after using the toilet.
 - Wash utensils, dishes, and spoons carefully, and keep food protected from dust and flies.
10. Feed a child who is ill more food than usual, and feed him/her extra meals for a few weeks following an illness.

THE EFFECT OF ILLNESS ON NUTRITIONAL STATUS AND THE NEED FOR PROPER FEEDING

Decreased food intake can be due to:

- Nasal obstruction and sore throat
- Loss of appetite or anorexia (all infections)
- Vomiting (Grade I infections, TB, measles, whooping cough)
- Withholding of food by mother
- Respiratory distress in pneumonia, stomatitis-measles, cough in pertussis
- Low nutrient or diluted foods

Decreased absorption of food can be due to:

- Poor digestion (all infections)
- Destruction of absorptive mucosal cells (diarrhoea and measles)
- Mucosal enzyme deficiency (diarrhoea and measles)
- Rapid transit (diarrhoea and measles)

An increased need for nutrition can be due to:

- Increased metabolic rate
- Increased catabolism
- Need to repair damaged cells in gut, respiratory passage
- Need for protein to build immune defenses

Advantages of feeding during and after illness:

- Avoidance of effects of fasting such as ketosis
- Prevents PEM
- Sustains breastfeeding
- Promotes growth
- Improves growth
- Ensures better and faster recovery due to rapid cell repair, cell mobilization, cell growth, better pancreatic and bile secretions, more hormones and increased blood flow

PROTOCOL FOR NUTRITIONAL ASSESSMENT AND COUNSELLING OF PREGNANT WOMEN

1. Assess nutritional risk.
 - Visually assess women for thinness, short stature and paleness.
 - Ask about other risk factors, such as a short birth interval (less than two years) and age younger than seventeen years.
2. Weigh all pregnant women and record the weight.
 - Calculate the weight gain during the second and third trimesters.
3. For pregnant women with identified risk factors or inadequate weight gain, conduct dietary assessments.
 - Use the Diet History Question Guide, and take notes.
 - Conduct an In-Depth Food Frequency, and take notes.
 - Compare current feeding practices with the Daily Food Guide.
4. Follow general counselling principles.
 - Use visual aids.
 - Involve the mother or family by asking questions.
 - Reinforce positive behaviours.
 - Use the counselling messages from the curriculum.
 - Check that the patient understands the counselling and is able to apply it in daily life.
 - Schedule follow-up visits.
- 5A. For pregnant women with no identifiable risk factors:
 - Counsel on dietary needs during pregnancy, following the Daily Food Guide.
 - Prescribe iron and folic acid supplements.
 - Provide information about optimum breastfeeding practices and the disadvantages of bottle feeding.
 - Conduct breast examination.
 - Schedule a follow-up appointment for antenatal care, weight gain monitoring, and counselling.
- 5B. For pregnant women with identified risk factors or inadequate weight gain:
 - Use information from nutrition assessment tools to identify important dietary changes needed, and discuss with the family how to implement them.
 - Provide counselling, following the points described in the preventive section, with additional practical information provided on the problem areas.
 - Check the woman's understanding and ability to implement counselling, and schedule a follow-up visit.
 - Refer women who do not improve or who have severe problems beyond the scope of the BHU to other facilities.

NUTRITION DURING ADOLESCENCE PREGNANCY AND LACTATION

Eating enough food to provide sufficient energy is particularly important for pregnant and lactating women. For ideal dietary intake follow "Daily Food Guide". Observe to see that the counselling material is available and pregnant or lactating women receive the following messages.

What Are The Nutritional Needs Of Pregnant Women?

Daily Food Guide

6 roti
3 fruits
1 pao vegetable
1 pao legumes
1/6 pao meat or 1 egg
2 1/2 pao milk or yoghurt
8 teaspoons oil or fat

- Many women are not eating enough prior to pregnancy.
- **Iron and folic acid** requirements need to be met using daily supplements.
- The daily dosage for **prevention** of anaemia in pregnant women is 120 mg elemental iron and 500 mcg folate (2 tablets/day).

What Are The Nutritional Needs Of Lactating Women?

- Total caloric needs of a lactating woman are 2700 calories:
 - 500 calories more than during pre-pregnancy
 - 200 calories more than during pregnancy

Daily Food Guide

6 roti
3 fruits
1 pao vegetable
1 pao legumes
1/6 pao meat or 1 egg
4 pao milk or yoghurt
8 teaspoons oil or fat

- Milk intake is increased by 1 1/2 pao from pregnancy.
- Increased need for fluids: water or other liquids should be available to satisfy the thirst of the mother.

Why Is Counselling To Improve The Diet Important During Lactation?

- An inadequate diet can start or continue the cycle of malnutrition.
- It is important for a woman to eat and drink enough to satisfy hunger and thirst during lactation.
- Mothers can still produce enough milk if they don't improve their diets, but at the expense of their nutritional status.
- For malnourished or well-nourished mothers the most important factor is producing an adequate milk supply is to breastfeed often and to have feedings of adequate length.
- An adequate diet during lactation:
 - Keeps the mother healthy.
 - Makes her strong to care for and carry a baby.
 - Keeps her strong for all her productive work.
 - Helps her to produce milk.
 - Prevents depletion of the mother's body tissues.
 - Ensures that she enters the next pregnancy well-nourished.
- Malnourished lactating women need to have in-depth diet counselling if the cycle of malnutrition is to be broken.
- Understand the risk factors that are contributing to the malnutrition and counsel accordingly.

SUPPLIES AND EQUIPMENT

- Hanging spring or beam balance for weighing infants
- Standard weights for balances
- Beam balance for adult and older children
- Growth charts and MCH cards
- Posters and health education material
- Calendar of local events
- Standard cups measures
- Furniture such as chairs, table, benches
- Lab service for Hb% estimates

EXERCISES

Supervisory Checklist Exercise

During your visit to the OPD, you will be provided with opportunities to observe MOs and paramedics in providing nutritional service. In conducting nutritional assessment you are to observe the weighing of women and children, filling out of growth charts and the provision of nutrition counselling. During this observation you are to complete the following Work Sheets and the Supervisory Checklist:

1. Individual Case Management Work Sheet #1:

Complete all of Items: 1
2
3
Also complete Items: 4N
5N
6N
7.1 and 7.2
8:1

2. Individual Case Management Work Sheet #2: All Items

3. Individual Case Management Work Sheet #4:

Items for pregnant women: 6.1
7.1 and 7.2
8.1

4. Individual Case Management Work Sheet #6:

Items for postnatal care: 2.1
4.1
8.1

5. Individual Case Management Work Sheet #7:

Complete Items: 2.1 and 2.2
3.4
4.2
5.1
6.1
7.2
8.1

6. Resource Management Work Sheet #5: weighing scale, adult and children

7. Work out the final scores from the Work Sheets and fill in the Supervisory Checklist.

8. Summarize your observations and findings. Meet with the staff to discuss the findings. Complement them on their achievements and jointly plan to correct weak areas.

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Section 1: Individual Case Management Work Sheet 1: Sick Child Under 5	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →				
1. Rapport						
1.1	Was mother greeted?					
1.2	Was mother asked to sit down?					
1.3	Was mother asked reason for coming to the facility?					
2. History						
2.1	Asks for age of child					
2.2	Asks change in eating/drinking pattern					
2.3	Asks change in bowel/urine output					
2.4	Asks for change in activity					
2.5	Asks for other symptoms					
2.I	Asks for child's immunization status					
2.N	Asks for nutrition intake assessment					
3. Examination						
3.1	Looks at general condition (colour, alertness)					
3.2	Looks at condition of eyes, ears					
3.3	Looks at condition of nose, mouth, ear					
3.4	Looks at chest indrawing					
3.5	Counts respiration					
3.6	Takes skin pinch					
3.7	Takes temperature (if indicated)					
3.I	Checks Immunization Card					
3.N	Takes weight (child under 3)					
4. Classification						
	Was child correctly classified?					
4.1	ARI case					
4.2	Diarrhoea case					
4.3	Case with other symptoms					
4.4	Case with no symptoms					
4.I	According to need for vaccines					
4.N	According to nutritional status					

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5a	Management						
5.1	Were child's needs correctly managed? According to WHO protocol for ARI case According to WHO protocol for Diarrhoea case According to acceptable standards for other cases						
5.2	Refers complicated case appropriately						
5.I	Manages correctly immunization needs of the child						
5.N	Manages correctly nutritional needs of child						
6	Advice						
6.1	Explains to parents findings of child's condition						
6.2	Explains need/no need for drugs						
6.3	Explains when to bring back the child						
6.I	Gives appropriate immunization advise						
6.N	Gives appropriate nutritional advise						
7	Follow-up						
7.1	Gives appointment for next visit						
7.2	Checks if mother has well understood treatment/advice given and date of next appointment						
8.	Reporting						
8.1	Completes MCH card						
8.2	Completes OPD Register						
8.3	Uses Referral Forms						
							<u>Total 'Yes'</u> <u>Total 'Yes'+ 'No'</u>
For General Child Care (all cases) <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For ARI Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For Diarrhoea Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For Immunization Management (2.I → 6.I) <i>Write number of 'Yes' scores over total number of 'I' scores</i>		/	/	/	/	/	/
For Nutritional Management (2.N → 6.N) <i>Write number of 'Yes' scores over total number of 'N' scores</i>		/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							
General Child Care:							%
ARI Case:							%
Diarrhoea Case:							%
Immunization Management:							%
Nutritional Management:							%

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Section 1: Individual Case Management Work Sheet 2: Growth Monitoring in Child Under Three	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

	Case 1	Case 2	Case 3	Case 4	Case 5	
Work Area Set: <input type="checkbox"/> Y <input type="checkbox"/> N Name of Staff: → _____						
1. Tares scale to 0 at the beginning of the weighing session						
2. Asks mother for MCH card and if first time, issues an MCH card						
3. Determines age of child as precisely as possible						
4. Undresses the child before weighing						
5. Reads weight correctly						
6. Records age correctly on MCH card						
7. Records weight correctly on MCH card						
8. Explains result to mothers						
9. Talks about need to maintain breast-feeding or good weaning practices						
10. Explains mother if child needs special feeding or other attention						
11. Asks mother if she had any questions about child's status						
12. Gives appropriate appointment for next weighing						
						$\frac{\text{Total 'Yes'}}{\text{Total 'Yes'+ 'No'}}$
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.</i>	/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores over total 'Yes' and 'No' scores:						%

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Section 1: Individual Case Management Work Sheet 4: Pre-Natal Care	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5	
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →					
1. Rapport							
1.1	Friendly attitude						
1.2	Listens carefully						
2. History taking							
2.1	Checks medical/obstetric history on first visit						
2.2	Asks for last menses						
2.3	Probes into complaints						
3. Examination							
3.1	Checks pelvis on first visit						
3.2	Checks BP, weight, oedema, urine						
3.3	Checks fundus height						
3.4	Checks position baby >32 wks						
4. Classification							
4.1	Assesses gestation period						
4.2	Identifies correct risk level						
4.3	Identifies any need for referral						
5. Management							
5.1	Provides routine drugs (FFC)						
5.2	Completes TT vaccination						
5.3	Manages problems by protocol						
6. Advice							
6.1	Advices on feeding and rest						
6.2	Warns for smoking & drugs						
6.3	Advices place of delivery						
6.4	Explains signs of labour						
6.5	Explains how to conduct home delivery						
6.6	Advices emergency action						
7. Follow-up							
7.1	Gives appointment for next check-up						
7.2	Confirms date of next visit						
8. Reporting							
8.1	Completes MCH card						
8.2	Completes Mother Health Register						
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.		/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							

Total 'Yes'
Total 'Yes'+'

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Section 1: Individual Case Management Work Sheet 6: Post Natal Care	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5	
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →					
1. Rapport							
1.1	Friendly attitude						
2. History taking							
2.1	Reviews history using MCH card						
2.2	Determines maternal risk factors						
3. Examination							
3.1	Checks pulse and temp						
3.2	Checks breasts, palpate abdomen						
3.3	Checks perineum/lochia						
3.4	Checks legs for thromboses						
4. Classification							
4.1	Identifies postnatal risk/problem						
4.2	Identifies need for referral						
5. Management							
5.1	Provides routine care (protocol)						
5.2	Manages puerperal pyrexia						
6. Advice							
6.1	Promotes breast-feeding						
6.2	Explains breast and lochia care						
6.3	Counsels for family planning						
7. Follow-up							
7.1	Explains any high risk						
7.2	Confirms date of next visit						
8. Reporting							
8.1	Completes MCH card and Mother Health Register						Total 'Yes' Total 'Yes'+ 'No'
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%

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Section 1: Individual Case Management Work Sheet 7: Neonatal Care	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1. Rapport								
1.1 Shows interest in baby								
1.2 Keeps it on mother lap								
2. History								
2.1 Checks birth weight on MCH card								
2.2 Asks feeding history								
2.3 Asks immunization history								
3. Examination								
3.1 Checks respiration, pulse, temp								
3.2 Checks jaundice								
3.3 Checks umbilical stump								
3.4 Weighs and notes weight change								
4. Classification								
4.1 Identifies neonate's risks								
4.2 Determines weight gain since birth								
4.3 Identifies major problems								
4.4 Identifies need for referral								
5. Management								
5.1 Provides routine care according to protocol								
5.2 Manages respiratory distress								
6. Advice								
6.1 Encourages breast feeding								
6.2 Advises on immunization								
7. Follow-up								
7.1 Explains any high risk								
7.2 Confirms date of next visit								
8. Reporting								
8.1 Completes MCH card and Child Health Register							<u>Total 'Yes'</u> Total 'Yes'+ 'No'	
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%	

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Section 2: Resource Management Work Sheet 5: Physical Resources Management	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

5.1 Are the following equipment/items in good working condition?

Sterilizer

NA Y N

Weighing Scale (adults)

NA Y N

Weighing Scale (children)

NA Y N

First Aid Kit

NA Y N

X-Ray machine

NA Y N

Others? *(Make suggestions)*

5.2 Physical Inventory Equipment/Furniture/Linen (once a year)

Select 10 items as reported in last yearly report.

Does physically verified status correspond with reported status for these 10 items? *If no, discuss results with I/C.*

Y N

5.3 Physical Inventory Drugs/Vaccines/Supplies

Select 10 items as reported in last monthly report.

Does physically verified balance correspond with reported balance for these 10 items? *If no, discuss results with I/C.*

Y N

5.4 Transport (if available)

Verify log book for proper use of vehicle. Discuss results with I/C.

The transport means of the health facility were appropriately used as verified through the log book.

Y N

[Province] Health Department
SUPERVISORY CHECKLIST
For First Level Care Facilities

Institution Name:	Name of Supervisor:
Division:	Year:
District:	Quarter: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Tehsil/Taluka	Date of Visit: <input type="text"/> / <input type="text"/> / <input type="text"/>
Incharge Name:	

Preparation for Supervisory Visit

Date of previous visit: / /

Action taken since previous visit:

Are there special problems from previous visit that need to be followed during the current visit?

List: _____

Any special needs/requirements?

List: _____

Take the following documents with you or make photo copies of relevant parts.

1. Personnel Management Register
2. Last Monthly Report of the Health Institution
3. Last Year Report of the Health Institution (once a year)

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Section 1: Individual Case Management

Make final assessment on case management of the following health care activities using the scores obtained through the worksheets. For health care activities not performed in the supervised health facility, tick the box 'NA' (Not Applicable).

		Quality of Case Management			
		NA	Poor (<50%)	Insufficient (50 - <80%)	Appropriate (≥80%)
1.	Sick Child Under Five				
1.1	General Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2	Diarrhoeal Disease Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3	Acute Respiratory Infection Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4	Management of Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5	Management of Immunization Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Growth Monitoring in Child Under Three	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Immunization Session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Delivery Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Postnatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Neonatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Tuberculosis (follow-up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 2: Resource Management

Make final assessment on the management performance of the health staff for the following resources, using the scores obtained through the worksheets. For resources not available in the supervised health facility, tick the box 'NA' (Not Applicable).

1. Laboratory

1.1 Microscope in good working condition

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

1.2 Laboratory diagnosis of malaria is of acceptable quality.
(Malaria diagnosis correct for $\geq 80\%$ of slides)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

1.3 Laboratory diagnosis of tuberculosis of acceptable quality.
(Tuberculosis diagnosis correct for $\geq 80\%$ of slides)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

2. Community Development Activities

Management of community development activities is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

3. Personnel Management

Personnel Management is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

4. Cold Chain Management

Cold Chain Management is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5. Physical Resources Management

5.1 $\geq 80\%$ of essential equipment is in good working condition

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.2 Physical inventory check for equipment/furniture and linen is satisfactory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.3 Physical inventory check for drugs/vaccines/supplies is satisfactory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.4 Transport means of the health facility were appropriately used

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

6. Record Keeping System Management

The Management of the Record Keeping System is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

Feedback On The Visit

1. Improvements noticed since previous visit:	
2. Problems identified during previous visit that need still further improvement:	
3. Problems identified during this visit:	
4. Recommendations to Health Staff:	
5. Actions to be taken by supervisor:	
6. Problems to be followed at next visit:	
7. Date of next visit: _____	

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MODULE 5

DIARRHOEA & DEHYDRATION

WHO charts and Case Management Guidelines have been used in this module.

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PREVIOUS PAGE BLANK

LEARNING OBJECTIVES

LEARNING OBJECTIVES FOR INCREASED KNOWLEDGE AND UNDERSTANDING

In this module you will receive information which will increase your understanding of the problem of diarrhoea in Pakistan and of the responsibilities of health service providers in controlling this problem. You will receive this information through lectures, reading material and discussion. On completion of the module you will be able to:

1. Define diarrhoea.
2. State the magnitude of the diarrhoea problem in Pakistan.
3. State Government of Pakistan policy for control and treatment of diarrhoea.
4. Describe the role and responsibilities of FLCF staff in implementing government policy.
5. Describe the role and responsibilities of the district level supervisor in assuring implementation of government policy.

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LEARNING OBJECTIVES FOR IMPROVING SUPERVISORY SKILLS

You will be provided with an overview of the MO's and paramedics training on diarrhoea, dehydration and case management; and you will have an opportunity to observe staff. On completion of this module you will be able to:

1. Assess the staff's competency in carrying out the following procedures:
 - Assessment of diarrhoea and degree of dehydration
 - Management of the degree of dehydration
 - Rational use of drugs in diarrhoea
 - Demonstration and preparation of ORS
 - Involvement of the mother as information provider and receiver on care of the child
 - Instruction and counselling of the mother on the proper care of the child.
2. Assess the availability and the use of ORS, naso-gastric tube, IV and drugs recommended for diarrhoea.
3. Assess the quality of record maintenance.
4. Use the Supervisory Checklist in documenting the staff's competency in diarrhoea case management as well as resource management.
5. Help the FLCFs to identify their strengths and constraints in implementing diarrhoea control programme activities.
6. Plan with the staff in maintaining optimum quality diarrhoea case management.

INTRODUCTION

WHAT IS DIARRHOEA?

Diarrhoea is defined as three or more watery stools in 24 hours.

Depending on its duration, diarrhoea can be classified as acute or persistent. In acute diarrhoea the episode lasts for less than two weeks. Persistent diarrhoea lasts for two weeks or longer.

When the loose stools also contain blood, the condition is called dysentery.

Diarrhoea is most common in children between six months and two years of age. It is also common in babies under six months who are not breastfed. Breastfed babies often have soft stools which are not diarrhoea.

EXTENT OF THE PROBLEM

Diarrhoea is the most common presenting symptom in children under five years of age. It accounts for about 40% of all deaths in children of this age group. About 50% of diarrhoea cases under two years are caused by rota virus. Bacterial and protozoal infections are responsible for the rest of the cases.

Diarrhoea remains the number one killer of Pakistani children. Out of the estimated 700,000 children under five years of age who die in Pakistan every year, over 200,000 die of diarrhoea or diarrhoea-related causes. Most of these children die because they are dehydrated as a result of loss of water and electrolytes during diarrhoea. Dehydration combined with malnutrition accounts for most diarrhoea-related deaths. It is possible to reduce this number greatly by using the simple, inexpensive ORT or ORS solutions and continuing to feed the child during illness.

Even though scientific research has proven that ORT is the safest and most effective treatment for most diarrhoea patients, physicians in Pakistan continue to treat diarrhoea patients with intravenous solutions, antibiotics and antimotility drugs. This practice is not only expensive and often ineffective but in the case of antimotility drugs, it is also harmful. Education of physicians, health workers and parents on the proper treatment of diarrhoea will save the lives of many children.

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GOVERNMENT POLICY

The Government of Pakistan planned a National Programme for Control of Diarrhoeal Diseases during the Seventh Development Plan (1988-1993). Each of four provinces also has designated one Deputy Director of Health Services as CDC Project Director. The objectives of this programme are to reduce:

- Morbidity from diarrhoea in children under 3 years by 25%
- Mortality from diarrhoea in children under 5 years by 50%
- Hospital admission rate and hospital case fatality rate each by 50%

The following approaches were adopted to achieve the objectives:

- A massive health education programme directed towards the vital role of fluids and food in determine the prognosis of diarrhoea cases
- ORS available at all health outlets
- Promotion of the use of fluids at home at the onset of diarrhoea to prevent dehydration
- Promotion of proper feeding during and after a diarrhoea episode

TARGETS

- End of June 1989: Health staff responsible for treatment of diarrhoea in major hospitals will be trained in effective case management of diarrhoea. They will further train physicians, paramedics and private practitioners in Diarrhoeal Training Units.
- End of June 1991: Eighty percent of the country's population shall have access to effective case management at health facilities.
- End of June 1992: Diarrhoea case management will be included in the curriculum of all medical and health workers.
- Ninety percent of the parents shall have been educated or informed about:
 - Management of diarrhoea at home
 - Benefits of breastfeeding
 - Personal and domestic hygiene
 - Proper feeding practices

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- End of June 1993: Eighty percent of children under 5 years of age will have access to a trained ORS provider.
- In all health facilities 100% of diarrhoea cases (excepting the severely dehydrated) will be treated by ORT.

In March 1989, the Government of Pakistan launched a nationwide project establishing Diarrhoea Training Units throughout the country in an effort to educate health professionals about simple, scientific, up-to-date approaches to the prevention and treatment of diarrhoea. Between 1989 and 1991 DTUs were established in 10 teaching hospitals. Beginning in January 1992, these DTUs will be converted into Child Survival Training Units, CSTUs. New CSTUs will open in the remaining teaching hospitals and selected District Headquarters Hospitals. The CSTUs will provide training in prevention and management of diarrhoea and acute respiratory infections, as well as in immunization services against the six vaccine-preventable diseases. Counselling on adequate nutrition for children is also an important component of the course.

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PAKISTAN'S NATIONAL DIARRHOEA TREATMENT POLICY

ORAL REHYDRATION THERAPY (ORT):ORS + FOOD

- All diarrhoea cases will drink ORS (or other fluid) prior to leaving.
- All parents will be taught how to mix ORS.
- All parents will be taught how to give ORS (how much, how often, how long). ORS will be given using a cup and spoon or dropper.
- Special care/attention will be given to neonates, especially low birth weight, to avoid excessive use of ORS. Breastfeeding will be encouraged and assisted where needed.
- All parents will be given 1 to 2 ORS packets for home use.

BREASTFEEDING

- Breastfeeding will be encouraged for all infants and continued even during rehydration.

CONTINUED FEEDING

- Feeding appropriate for age will be encouraged to start no later than 4 hours after start of rehydration.
- Milk feeds will not be diluted but may be mixed with cereals and can be offered during maintenance.
- No feeding bottles will be used.

DRUGS

- No anti-diarrhoeal, antiemetic, antispasmodic drugs will be used or prescribed for diarrhoea in children, especially under 5 years.
- Antibiotics will be used only for specified indications to be recorded on the patient record whenever used. This will generally be reserved for bloody dysentery or other systemic infections. Only a single antibiotic will be prescribed.

IV THERAPY

- I.V. will be used only for severe dehydration as demonstrated by objective findings recorded on the patient record form •
I.V. will be used only for rehydration and stopped within 6 hours of initiation.
- Ringer's lactate is preferred but 0.9% Saline with 5% Dextrose is an acceptable alternative. Glucose/Dextrose solution alone will not be used.
- Patients on I.V. will be started on ORS as soon as they can drink.

IMMUNIZATION

- Ensure that no child leaves before its immunization is up-to-date (especially measles). Similarly, the mother should be given TT immunization.

HYGIENE

- Staff will demonstrate commitment to importance of personal hygiene by washing their hands after handling each patient.

PLEASE ENSURE THAT

- Parents leave only after they can explain in their own words the following:
 1. The Need for the Child to Drink More Fluids than Usual:
 - Mix ORS correctly using local measures.
 - Use ORS correctly offering 1/2 to 1 tea cup for each stool or vomit and more if child desires.
 2. The Need for the Child to Continue Eating:
 - Breastfeed, and if 6 months or older, state the food and the approximate amount of food to feed child.
 3. When to Bring the Child Back:
 - Explain signs of dehydration and indications to bring child back.
 4. How to prevent Diarrhoea:
 - Explain the importance of handwashing, breastfeeding and danger of bottle feeding.

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RESPONSIBILITIES OF THE DISTRICT LEVEL SUPERVISOR

1. Technical

- Ensure that the child with diarrhoea is assessed, classified and treated properly at the centre (as per WHO treatment charts).
- Ensure that the mother of the child is counseled adequately by the centre staff regarding prevention and home care treatment of diarrhoea.

2. Administrative

Staff

- Ensure that the staff is available in the ORT corner.
- Fill all sanctioned female posts.
- Ensure that the OPD staff is trained in case management of diarrhoea.
- Determine if the staff is able to manage the workload.

Time

- See that the staff reports for duty on time.
- Ensure that the staff stays at the centre for a full working day.
- Ensure that the facility is staffed for emergencies 24 hours a day.

Space

- Ensure that the diarrhoea related services at the center are placed appropriately.

Material

- Provide the necessary material resources in sufficient quantity. (See page 255.)

Records and reports

- See that the OPD register is filled out adequately.
- Ensure that monthly and immediate reports regarding services delivered are prepared and sent to the concerned headquarters on the scheduled dates.
- Ensure that the case management records of diarrhoea patients are maintained properly.

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OVERVIEW OF MOS AND PARAMEDICS TRAINING

WHO charts are used in training MOs and paramedics in case management guidelines on diarrhoea. The paramedical staff's main responsibilities lie in screening the children for dehydration status and managing children with no dehydration and some dehydration using plans A & B. Those children who are severely dehydrated need to be assessed and managed under plan C by the MO or by a paramedic under his supervision. Only MOs can prescribe medication for diarrhoea. Paramedics need to concentrate on counselling and teaching mothers on appropriate child care during and after diarrhoea to assure optimal growth and development. As supervisors you need to make sure that both MOs and paramedics are carrying out their assigned responsibilities in managing diarrhoea cases.

WHAT IS DIARRHOEA?

The number of stools normally passed in a day varies with the diet and the age of the person. In *diarrhoea*, stools contain more water than normal -- they are often called *loose* or *watery* stools. They may also contain blood, in which case the diarrhoea is called *dysentery*.

Mothers usually know when their children have diarrhoea. When diarrhoea occurs they may say that the stools smell strong or pass noisily, as well as being loose and watery. By talking to mothers you can often find one or more useful local definitions of diarrhoea. In this course we will define diarrhoea as three or more loose or watery stools in a day (24 hours). Frequent passing of normal stools is not diarrhoea.

Diarrhoea is most common in children, especially those between six months and two years of age. It is also common in babies under six months who are drinking cow's milk or infant feeding formulas. Babies who are taking only breast milk often have stools that are soft: this is not diarrhoea.

Diarrhoea can be classified by its duration as acute or persistent. If an episode of diarrhoea lasts less than two weeks, it is *acute* diarrhoea. If it lasts two weeks or longer, it is *persistent* diarrhoea.

Why is Diarrhoea Dangerous?

The two main dangers of diarrhoea are death and malnutrition. Death from acute diarrhoea is most often caused by loss of a large amount of water and salts from the body. This loss is called *dehydration*. Another important cause of death is dysentery.

Diarrhoea is worse in persons with malnutrition. Diarrhoea can also cause malnutrition and can make it worse because:

- Nutrients are lost from the body during diarrhoea.

- Nutrients are used to repair damaged tissue rather than for growth.
- A person with diarrhoea may not be hungry.
- The mothers may not feed the child normally during the diarrhoea; or even for some days after the diarrhoea is better.

To prevent malnutrition food should be given to children with diarrhoea as soon as they will eat.

How Does Diarrhoea Cause Dehydration?

The body normally takes in the water and salts it needs (input) through drinks and food. It normally loses water and salts (output) through the stool, urine, sweat, and breathing.

When the bowel is healthy, water and salts pass from the bowel into the blood. When there is diarrhoea, the bowel does not work normally. Less water and salts pass into the blood, and more pass from the blood into the bowel. Thus, more than the normal amount of water and salts is passed in the stool.

This larger than normal loss of water and salts from the body results in dehydration. Dehydration occurs when the output of water and salts is greater than the input. The more diarrhoea stools a person passes, the more water and salts the person loses. Dehydration can also be caused by a lot of vomiting which often accompanies diarrhoea.

Dehydration occurs faster in infants and young children, in hot, dry climates and when there is fever.

Treating Diarrhoea

The most important aspects of treating of diarrhoea are:

- To prevent dehydration from occurring, if possible
- To treat dehydration quickly and well if it does occur
- To feed the child

Prevention of Dehydration

Dehydration can usually be prevented in the home by drinking extra fluids as soon as the diarrhoea starts. The national programme for control of diarrhoeal diseases is working on identifying several "recommended home fluids" for this purpose. These include ORS solution, food-based fluids, such as yakhnee, rice-water or lassi, and plain water. ORS solution and food-based fluids that contain some salt are most effective. Give one or more of the recommended fluids while continuing to feed the child. The critical action is to **give more fluids than usual**, as soon as diarrhoea starts. If none of the fluids given contains salt, try to give the child food that is salted to taste.

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Treatment of Dehydration

If dehydration occurs, the child should be brought to a community health worker or health centre for treatment. The best treatment for dehydration is oral therapy with a solution made with ORS. ORS solution can be used alone to rehydrate 95% or more of patients with dehydration. Patients with severe dehydration require rehydration with a naso-gastric tube or IV fluids at first, but ORS solution should be used in addition to IV fluids as soon as the patient can drink. ORS solution should be used alone when the signs of severe dehydration are gone.

Feeding

Feeding during the diarrhoea episode provides nutrients the child needs to be strong and grow, and to prevent weight loss. (Fluids given to prevent or treat dehydration, such as ORS solution or other recommended home fluid, do **not** fulfill the need for food.)

Breastfed children should be offered the breast frequently. Other children should receive their usual milk or formula. Children six months or older (or infants who are already taking solid food) should be offered small amounts of nutritious, easily digestible food frequently. After the diarrhoea has stopped, an extra meal each day for two weeks will help the child regain weight lost during the illness.

Other Treatments

There are no drugs which safely and effectively help to stop diarrhoea. Antibiotics are not effective against most diarrhoea-causing organisms. They rarely help and can make some people sicker in the long term. Their indiscriminate use may increase resistance of some disease-causing organisms to antibiotics. In addition, antibiotics are costly, so money is wasted. Therefore, antibiotics should not be used routinely. Their appropriate use for dysentery and for suspected cholera cases with severe dehydration is described later in this module.

Antidiarrheal drugs and antiemetics should **never** be given to children and infants. None has proven value in treating diarrhoea and some can be dangerous. These include: adsorbents (such as kaolin, attapulgate, activated charcoal), antimotility drugs (such as codeine, tincture of opium, diphenoxylate, loperamide), or drugs to treat vomiting (such as chlorpromazine or phenergan). Some of these drugs can cause paralysis of the gut, or they can make the child abnormally sleepy. Some can be fatal if used improperly, especially in infants.

CASE MANAGEMENT OF DIARRHOEA

USE THE APPROPRIATE TREATMENT PLAN

Based on the assessment of the degree of dehydration, you will select one of the treatment plans found on the DIARRHOEA MANAGEMENT CHART.

- Treatment Plan A -- Treat Diarrhoea at Home
- Treatment Plan B -- Treat Dehydration
- Treatment Plan C -- Treat Severe Dehydration Quickly

Follow the treatment plan selected. You will also need to treat any other problems that have been identified. In all cases, first compliment the mother for bringing the child in for care.

Many mothers will expect to be given a medicine to stop the diarrhoea. But it is the dehydration that is the main cause of death. It is necessary to take time to explain to the mother that it is most important to treat dehydration by replacing the fluids lost and to continue feeding the child. Explain that the ORS solution will not stop the diarrhoea, but that it will help keep the child strong until the diarrhoea goes away in a few days.

For cases of dysentery and for suspected cholera cases with severe dehydration, treatment with antibiotics is necessary. In most cases, however, treatment with drugs will not help. In nearly all cases, diarrhoea will stop without special treatment.

Every health worker may not have the skills or the supplies to perform all the steps listed in each plan. The supervisor must determine which procedures can be performed by a health worker in a community setting and which can only be performed in a facility. The supervisor must give each health worker the training, supplies and supervision needed to carry out treatment correctly.

Study the section of the DIARRHOEA MANAGEMENT CHART titled "For Other Problems" to learn what to do about:

- Dysentery (diarrhoea with blood in the stool)
- Persistent diarrhoea (diarrhoea lasting for 14 days or more)
- Severe malnutrition
- Fever

Also read the section of the chart titled "Use of Drugs for Children with Diarrhoea". You will see that drugs are very rarely needed in treatment of diarrhoea. However, antibiotics should be used for dysentery and suspected cholera. A list of suitable antibiotics is listed at the end of this module.

TREATMENT SHOULD END WITH THE MOTHER KNOWING
WHAT TO DO AT HOME AND HOW TO DO IT

ASSESSMENT FOR DEGREE OF DEHYDRATION

FIRST, ASSESS YOUR PATIENT FOR DEHYDRATION

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1. ASK:			
2. LOOK AT: CONDITION EYES TEARS MOUTH and TONGUE THIRST	Well, alert Normal Present Moist Drinks normally, not thirsty	* Restless, irritable* Sunken Absent Dry * Thirsty, drinks eagerly*	* Lethargic or unconscious; floppy* Very sunken and dry Absent Very dry * Drinks poorly or not able to drink*
3. FEEL SKIN PINCH	Goes back quickly	* Goes back slowly*	* Goes back very slowly*
4. DECIDE	The patient has NO SIGNS OF DEHYDRATION	If the patient has 2 or more signs, including at least one *sign,*there is SOME DEHYDRATION	If the patient has two or more signs, including at least one *sign* there is SEVERE DEHYDRATION
5. TREAT	Use Treatment Plan A	Weigh the patient, if possible, and use Treatment Plan B	Weigh the patient and use Treatment Plan C URGENTLY
6. COUNSELLING:			

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TREATMENT PLAN A TO TREAT DIARRHOEA AT HOME

USE THIS PLAN TO TEACH THE MOTHER TO:

- Continue to treat at home her child's current episode of diarrhoea
- Give early treatment for future episodes of diarrhoea

EXPLAIN THE THREE RULES FOR TREATING DIARRHOEA AT HOME:

- 1. GIVE THE CHILD MORE FLUIDS THAN USUAL TO PREVENT DEHYDRATION:**
 - Use a recommended home fluid, such as a cereal gruel. If this is not possible, give plain water. Use ORS solution for children described in the box below.
 - Give as much of these fluids as the child will take. Use the amounts shown below for ORS as a guide.
 - Continue giving these fluids until the diarrhoea stops.
- 2. GIVE THE CHILD PLENTY OF FOOD TO PREVENT UNDERNUTRITION:**
 - Continue to breast-feed frequently.
 - If the child is not breast-fed, give the usual milk. If the child is less than 6 months old and not yet taking solid food, dilute milk or formula with an equal amount of water for 2 days.
 - If the child is 6 months or older, or already taking solid food:
 - Also give cereal or another starchy food mixed, if possible, with pulses, vegetables, and meat or fish. Add 1 or 2 teaspoonfuls of vegetable oil to each serving.
 - Give fresh fruit juice or mashed banana to provide potassium.
 - Give freshly prepared foods. Cook and mash or grind food well.
 - Encourage the child to eat; offer food at least 6 times a day.
 - Give the same foods after diarrhoea stops, and give an extra meal each day for two weeks.
- 3. TAKE THE CHILD TO THE HEALTH WORKER IF THE CHILD DOES NOT GET BETTER IN 3 DAYS OR DEVELOPS ANY OF THE FOLLOWING:**
 - Many watery stools
 - Repeated vomiting
 - Marked thirst
 - Eating or drinking poorly
 - Fever
 - Blood in the stool

CHILDREN SHOULD BE GIVEN ORS SOLUTION AT HOME, IF:

- They have been on Treatment Plan B or C
- They cannot return to the health worker if the diarrhoea gets worse
- It is national policy to give ORS to all children who see a health worker for diarrhoea

IF THE CHILD WILL BE GIVEN ORS SOLUTION AT HOME, SHOW THE MOTHER HOW MUCH ORS TO GIVE AFTER EACH LOOSE STOOL AND GIVE HER ENOUGH PACKETS FOR 2 DAYS:

Age	Amount of ORS to give after each loose stool	Amount of ORS to provide for use at home
Less than 24 months	50-100 ml	500 ml/day
2 up to 10 years	100-200 ml	1000 ml/day
10 years or more	As much as wanted	2000 ml/day

- Describe and show the amount to be given after each stool using a local measure.

SHOW THE MOTHER HOW TO MIX ORS.

SHOW HER HOW TO GIVE ORS:

- Give a teaspoonful every 1-2 minutes for a child under 2 years.
- Give frequent sips from a cup for an older child.
- If the child vomits, wait 10 minutes. Then give the solution more slowly (for example, a spoonful every 2-3 minutes).
- If diarrhoea continues after the ORS packets are used up, tell the mother to give other fluids as described in the first rule above or return for more ORS.

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TREATMENT PLAN B TO TREAT DEHYDRATION

APPROXIMATE AMOUNT OF ORS SOLUTION TO GIVE IN THE FIRST 4 HOURS:

Age: *	Less than 4 months	4 - 11 months	12 - 23 months	2 - 4 years	5 - 14 years	15 years or older
Weight:	Less than 5 kg	5 - 7.9 kg	8 - 10.9 kg	11 - 15.9 kg	16 - 29.9 kg	30 kg or more
in ml	200-400	400-600	600-800	800-1200	1200-2200	2200-4000
in local measure						

* Use the patient's age only when you do not know the weight. The approximate amount of ORS required (in ml) can also be calculated by multiplying the patient's weight (in grams) times 0.075.

- If the child wants more ORS than shown, give more.
- Encourage the mother to continue breast-feeding.
- For infants under 6 months who are not breast-fed, also give 100-200 ml clean water during this period.

OBSERVE THE CHILD CAREFULLY AND HELP THE MOTHER GIVE ORS SOLUTION:

- Show her how much solution to give her child.
- Show her how to give it - a teaspoonful every 1-2 minutes for a child under 2 years, frequent sips from a cup for an older child.
- Check from time to time to see if there are problems.
- If the child vomits, wait 10 minutes and then continue giving ORS, but more slowly, for example, a spoonful every 2-3 minutes.
- If the child's eyelids become puffy, stop ORS and give plain water or breast milk. Give ORS according to Plan A when the puffiness is gone.

AFTER 4 HOURS, REASSESS THE CHILD USING THE ASSESSMENT CHART. THEN SELECT PLAN A, B, OR C TO CONTINUE TREATMENT.

- If there are no signs of dehydration, shift to Plan A. When dehydration has been corrected, the child usually passes urine and may also be tired and fall asleep.
- If signs indicating some dehydration are still present, repeat Plan B, but start to offer food, milk and juice as described in Plan A.
- If signs indicating severe dehydration have appeared, shift to Plan C.

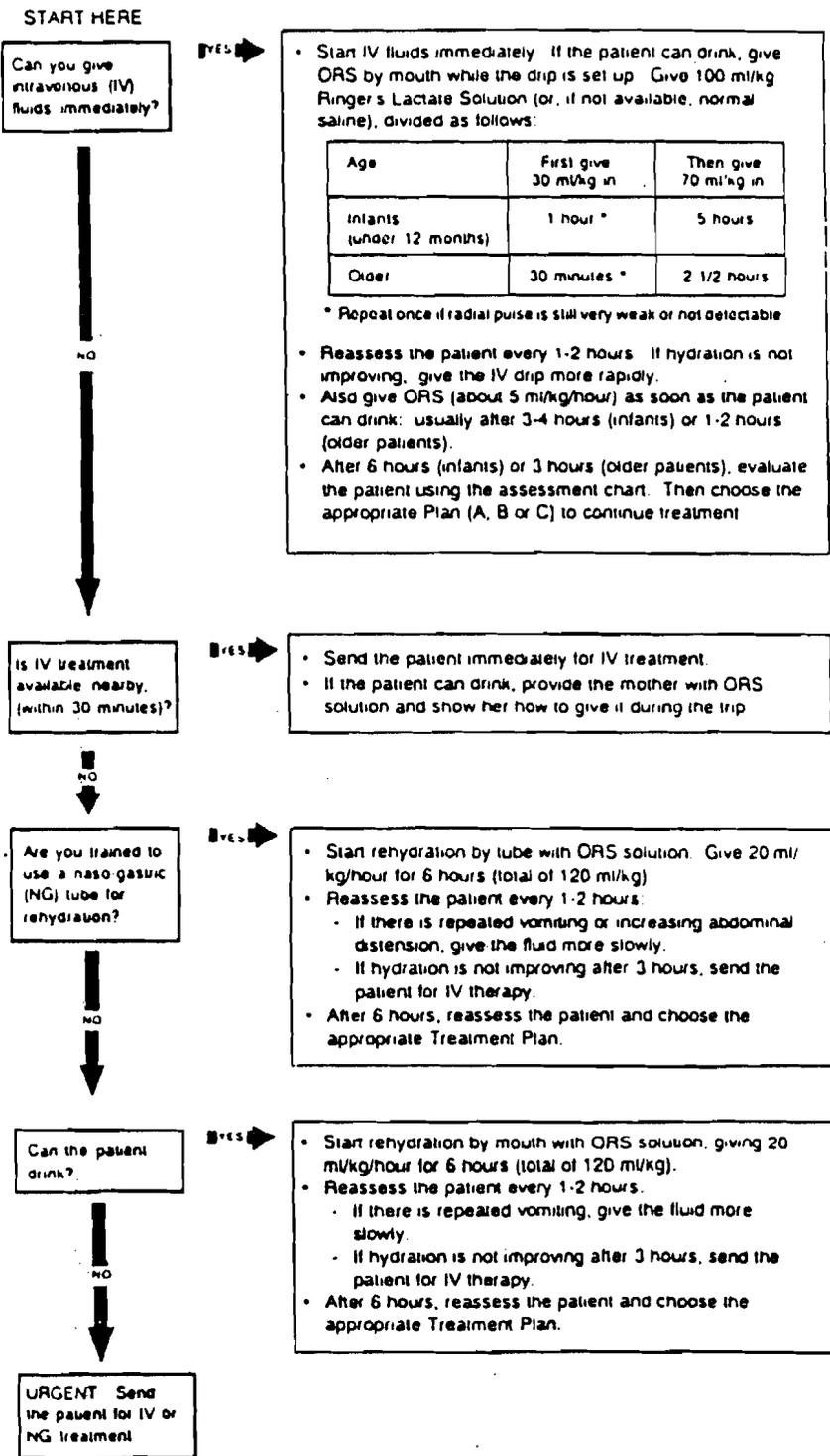
IF THE MOTHER MUST LEAVE BEFORE COMPLETING TREATMENT PLAN B:

- Show her how much ORS to give to finish the 4-hour treatment at home.
- Give her enough ORS packets to complete rehydration, and for 2 more days as shown in Plan A.
- Show her how to prepare ORS solution.
- Explain to her the three rules in Plan A for treating her child at home:
 - to give ORS or other fluids until diarrhoea stops
 - to feed the child
 - to bring the child back to the health worker, if necessary.

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TREATMENT PLAN C TO TREAT SEVERE DEHYDRATION QUICKLY

FOLLOW THE ARROWS. IF ANSWER IS "YES", GO ACROSS. IF "NO", GO DOWN



YES →

- Start IV fluids immediately. If the patient can drink, give ORS by mouth while the drip is set up. Give 100 ml/kg Ringer's Lactate Solution (or, if not available, normal saline), divided as follows:

Age	First give 30 ml/kg in	Then give 70 ml/kg in
Infants (under 12 months)	1 hour *	5 hours
Older	30 minutes *	2 1/2 hours

* Repeat once if radial pulse is still very weak or not detectable

- Reassess the patient every 1-2 hours. If hydration is not improving, give the IV drip more rapidly.
- Also give ORS (about 5 ml/kg/hour) as soon as the patient can drink: usually after 3-4 hours (infants) or 1-2 hours (older patients).
- After 6 hours (infants) or 3 hours (older patients), evaluate the patient using the assessment chart. Then choose the appropriate Plan (A, B or C) to continue treatment.

YES →

- Send the patient immediately for IV treatment.
- If the patient can drink, provide the mother with ORS solution and show her how to give it during the trip.

YES →

- Start rehydration by tube with ORS solution. Give 20 ml/kg/hour for 6 hours (total of 120 ml/kg).
- Reassess the patient every 1-2 hours:
 - If there is repeated vomiting or increasing abdominal distension, give the fluid more slowly.
 - If hydration is not improving after 3 hours, send the patient for IV therapy.
- After 6 hours, reassess the patient and choose the appropriate Treatment Plan.

YES →

- Start rehydration by mouth with ORS solution, giving 20 ml/kg/hour for 6 hours (total of 120 ml/kg).
- Reassess the patient every 1-2 hours:
 - If there is repeated vomiting, give the fluid more slowly.
 - If hydration is not improving after 3 hours, send the patient for IV therapy.
- After 6 hours, reassess the patient and choose the appropriate Treatment Plan.

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THEN, FOR OTHER PROBLEMS

ASK ABOUT BLOOD IN THE STOOL

IF BLOOD IS PRESENT:

- Treat for 5 days with an oral antibiotic recommended for *Shigella* in your area.
- Teach the mother to feed the child as described in Plan A.
- See the child again after 2 days if:
 - under 1 year of age
 - initially dehydrated
 - there is still blood in the stool
 - not getting better
- If the stool is still bloody after 2 days, change to a second oral antibiotic recommended for *Shigella* in your area. Give it for 5 days.

ASK WHEN THIS EPISODE OF DIARRHOEA BEGAN

IF DIARRHOEA HAS LASTED AT LEAST 14 DAYS:

- Refer to hospital if:
 - the child is under 6 months old
 - dehydration is present. (Refer the child after treatment of dehydration.)
- Otherwise, teach the mother to feed her child as in Plan A, except:
 - dilute any animal milk with an equal volume of water or replace it with a fermented milk product, such as yoghurt.
 - Assure full energy intake by giving 6 meals a day of thick cereal and added oil, mixed with vegetables, pulses, meat, or fish.
- Tell the mother to bring the child back after 5 days:
 - if diarrhoea has not stopped, refer to hospital.
 - if diarrhoea has stopped, tell the mother to:
 - use the same foods for the child's regular diet.
 - after 1 more week, gradually resume the usual animal milk.
 - give an extra meal each day for at least 1 month.

LOOK FOR SEVERE UNDERNUTRITION

IF THE CHILD HAS SEVERE UNDERNUTRITION:

- Do not attempt rehydration; refer to hospital for management.
- Provide the mother with ORS solution and show her how to give 5 ml/kg/hr during the trip.

ASK ABOUT FEVER AND TAKE TEMPERATURE

IF TEMPERATURE IS 39° C OR GREATER:

- Give paracetamol.

IF THERE IS FALCIPARUM MALARIA IN THE AREA, and the child has any fever (38° or above) or history of fever in the past 5 days:

- Give an antimalarial (or manage according to your malaria programme recommendation).

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USE OF DRUGS FOR CHILDREN WITH DIARRHOEA

- ANTIBIOTICS should ONLY be used for dysentery and suspected cholera. Otherwise, they are ineffective and should NOT be given.
- ANTIPARASITIC drugs should ONLY be used for:
 - Amoebiasis, after antibiotic treatment of bloody diarrhoea for *Shigella* has failed or trophozoites of *E. histolytica* containing red blood cells are seen in the faeces.
 - Giardiasis, when diarrhoea has lasted at least 14 days *and* cysts or trophozoites of *Giardia* are seen in faeces or small bowel fluid.
- ANTIDIARRHOEAL DRUGS and ANTIEMETICS should NEVER be used. None has proven practical value. Some are dangerous.

RECORD DATA

Record the data on the child in the OPD Register and fill in the following information:

- Name
- Age (or date of birth)
- Date of visit
- Reason for visit
- Diagnosis
- Type of treatment or service provided

WHO RECOMMENDED INSTRUCTIONS

ON

ORS, IV & RATIONAL USE OF DRUGS

ORS SOLUTION

WHAT IS IN ORS SOLUTION?

ORS often comes in packets containing the following ingredients in the stated amounts:

Glucose (a form of sugar)	20.0 grams
Sodium Chloride (ordinary salt)	3.5 grams
Trisodium citrate, dihydrate	2.9 grams
OR	
Sodium Bicarbonate (baking soda)	2.5 grams
Potassium Chloride	1.5 grams

Packets that contain these ingredients in these amounts are made for mixing in **one litre** of drinking water.

Note: Some packets of ORS are made for smaller volumes of water; they have smaller amounts of the same ingredients. It is critical that the correct amount of water be used to mix any packet. If not enough water is used, the solution will be too strong and may be dangerous. If too much water is used, the solution will be too dilute and may not be as effective.

When ORS packets are not available, ORS solution can be made.

STEPS TO MIX ORS SOLUTION

- Wash your hands with soap and water.
- Pour **all** the powder from one packet into a clean container. Use whatever container is available such as a jar, bowl or bottle.
- Measure 1 litre of clean water (or correct amount for packet used). It is best to boil and cool the water, but if this is not possible use the cleanest drinking water available.
- Pour the water into the container. Mix well until the powder is completely dissolved.
- Taste the solution so you know what it tastes like.

Mix fresh ORS solution each day in a clean container. Keep the container covered. The solution can be kept and used for one day (24 hours). Throw away any solution remaining from the day before.

STORE SUPPLIES OF ORS SAFELY

Temperatures should not exceed 30°C (86°F). If ORS is stored a long time above this temperature, it may melt or turn brown. In addition, humidity should not exceed 80%. If ORS is stored a long time in high humidity, the product is likely to cake. If you do not have a storage area which meets these two guidelines, it will be best to stock a small number of packets, such as the number that will be used in three months.

Keep storage areas clear of all types of insects, rats and mice. Arrange cartons so that sharp objects will not make holes in the packets. Arrange cartons of ORS so that identification marks and other labels can be easily seen and so that the oldest ORS (identified by date) will be used first.

Every three months, inspect a few ORS packets, randomly chosen, looking for signs of damage or improper sealing of the packet. Shake the packet to check whether the powder is still free-flowing. If it is hard, lumpy or pasty, open the packet.

- If the powder is white, the product is in perfect condition. (If it is hard but still white, it is all right.)
- If the powder is yellow, the ORS is still effective and safe, but such stocks should be used as soon as possible.
- If the powder is brown or dark brown, the ORS has deteriorated and should not be used. Throw away all such packets.

WHEN PACKETS OF ORAL REHYDRATION SALTS ARE NOT AVAILABLE

The health worker should understand the routine procedures for ordering ORS packets, and the procedure for obtaining emergency supplies quickly.

If ORS packets are not available, and it is necessary to prepare large quantities of *an oral rehydration fluid* and dispense prepared fluid, ingredients can be measured in bulk and mixed thoroughly in an appropriate volume of drinking water. The cleanest available drinking water should be used. Boiled water, cooled before use, or chlorinated water is best. However, the prepared fluid should not be kept for more than 24 hours and should not be dispensed in quantities in excess of the 24 hour volume requirement.

The following table shows an example of making *an oral rehydration fluid* in large quantities (Example is for 5 litres):

The ingredients should be measured precisely using a scale (which may be available in a local pharmacy). This is especially important in measuring potassium chloride because errors in potassium measurements are dangerous.

If a precise measuring scale is not available, prepare the fluid without potassium chloride. In this case, if the child is already taking solid food, advise the mother to give fresh fruit juice or mashed banana to provide potassium.

Do not mix large amounts of salt and sugar in dry form, as it is very difficult to make the mixtures uniform. Rather, prepare only the amount of dry ingredients to be added to a specified amount of water, for example 5, 10 or 20 litres. This assures that the solution will have the correct composition.

ORS SOLUTION PREPARATION

Ingredients	Amount required for 1 litre of an oral rehydration fluid	Amount required for 5 litres of an oral rehydration fluid	Note
Water	1 litre	1 litre X 5 = 5 litres	Use the cleanest available drinking water. Boiled water, cooled before use, or chlorinated water is best.
Sodium chloride (common salt)	3.5 g	3.5 g X 5 = 17.5 g	You must have this to make the solution.
Glucose or -----sucrose (common sugar)	20 g or -----40 g	20 g X 5 = 100 g or -----40 g X 5 = 200 g	You must have one of these to make the solution.
Trisodium citrate, dihydrate or -----sodium bicarbonate	2.9 g or ----- 2.5 g	2.9 g X 5 = 14.5 g or ----- 2.5 g X 5 = 12.5 g	You can make the solution without this, but it is better if you have this ingredient.
Potassium chloride	1.5 g	1.5 g X 5 = 7.5 g	You can make the solution without this, but it is better if you have this ingredient. Do not add potassium chloride if you do not have a precise measuring scale.

If larger volumes of the fluid are prepared, the amount of each ingredient should be increased proportionately.

HOW TO SET UP AN ORT CORNER IN A HEALTH CENTRE

A special area in the health centre should be arranged for oral rehydration therapy. Mothers and their children who need ORS solution will stay at the health centre for several hours. A conveniently located and adequately equipped "ORT corner" will help the staff to manage dehydrated cases more easily.

1. Select the location for the ORT corner. This should be a place:
 - Staff frequently pass, such as near the reception area or examination room (but not in a passage), so the child's progress can be observed and the mother can be encouraged
 - Near a water source
 - Near a toilet and washing facilities
 - Pleasant and well ventilated

2. Arrange furniture in the ORT corner
 - Table for mixing ORS solution and holding supplies
 - Shelves to hold supplies
 - A bench or chairs with a back where the mother can sit comfortably while holding the child
 - A small table where the mother can conveniently rest the cup of solution

3. Organize supplies in the ORT corner. (These amounts are for a health centre that receives 25-30 diarrhoea cases in a week.)
 - ORS packets (a supply of at least 300 packets a month)
 - Six bottles that will hold the correct amount of water for mixing the ORS packet -- including some containers like those that mothers will have at home
 - Six cups
 - Six spoons
 - Two droppers (may be easier to use than a spoon with small infants)
 - Mother's Cards
 - Soap (for handwashing)
 - Wastebasket
 - Tally sheet (optional) -- a tally is kept of diarrhoea cases treated each day in children under five years and in older children.

4. Display posters about diarrhoea and other health messages.

Posters on the walls of the ORT corner about treatment and prevention of diarrhoea and dehydration will be particularly interesting to mothers. Since mothers will sit in the ORT corner for a long time, it is a good opportunity for them to learn about ORT and other important interventions such as breastfeeding, weaning foods, use of clean water, handwashing and use of latrines. Also include posters with information on immunization.

INTRAVENOUS THERAPY FOR SEVERE DEHYDRATION

Technique of Administration

The technique of administration of intravenous fluids can only be taught by practical demonstration by someone with experience. Intravenous therapy should be given only by trained persons. Several general points are made here.

The needles, tubing bottles, and fluid used for intravenous therapy must be **sterile**.

Intravenous therapy can be given into any convenient vein. The most accessible veins are generally those in front of the elbow, on the back of the hand, or, in infants, on the side of the scalp. **USE OF NECK VEINS OR INCISION TO LOCATE A VEIN ARE USUALLY NOT NECESSARY AND SHOULD BE AVOIDED IF POSSIBLE.** In cases requiring rapid resuscitation, a needle may be introduced into the femoral vein where it must be held firmly in place and removed as soon as possible. (The femoral vein is just medial to the femoral artery, which can usually be located by its pulsation.) In some cases of severe dehydration, particularly in adults, infusion into two veins may be necessary; one infusion can be removed once rehydration is well in progress.

It is useful to mark intravenous fluid bottles at various levels to show the times at which the fluid should have fallen to those levels. This allows easier monitoring of the rate of administration.

Solutions For Intravenous Infusion

Although a number of intravenous solutions are available, they all lack some of the electrolytes in the concentration needed by severely dehydrated patients. To ensure adequate electrolyte replacement, some ORS solution should be given as soon as the patient is able to drink, even while IV therapy is being given. The following is a brief discussion of the relative suitability of several intravenous solutions.

Preferred solution

Ringer's Lactate Solution (also called Hartmann's Solution for Injection) is the best commercially available solution. It supplies an adequate concentration of sodium, and sufficient lactate, which is metabolized to bicarbonate, for the correction of acidosis. It can be used in all age groups for dehydration due to acute diarrhoea of all causes. Early provision of ORS solution and early resumption of feeding will provide the required amounts of potassium and glucose.

Acceptable solutions

Normal Saline (also called Isotonic or Physiological Saline). This solution is often readily available. It will not correct the acidosis and will not replace potassium losses. Sodium bicarbonate or sodium lactate and potassium chloride can be given at the same time, but this requires careful calculations of amounts, and monitoring is difficult.

Half-strength Darrow's Solution (also called Lactated Potassic Saline). This solution contains less sodium chloride than is needed to efficiently correct the sodium deficit from severe dehydration.

Half Normal Saline in 5% Dextrose. Like Normal Saline, this will not correct acidosis nor replace potassium losses. It also contains less sodium chloride than is needed for efficient correction of dehydration.

If any of these solutions are used, they should be supplemented by ORS solution given by mouth as soon as the patient can drink. That way the patient will receive potassium, bicarbonate, and sodium, which may not be provided adequately by the above solutions.

Unsuitable solution

Plain Glucose and Dextrose Solutions should not be used as they provide only water and sugar. They do not contain electrolytes and thus they do not correct the electrolyte losses or the acidosis.

Providing IV Therapy For Severe Dehydration

The purpose is to give the patient a large quantity of fluids quickly to replace the very large fluid loss which has resulted in **severe** dehydration.

Begin intravenous therapy quickly in the amount specified on the **DIARRHOEA MANAGEMENT CHART**. If the patient can drink, start giving ORS by mouth until the drip is running. The first portion of the fluid (30 ml/kg) is given very rapidly (within 60 minutes for infants under 12 months, within 30 minutes for older children and adults) to restore the blood volume and prevent death from shock. The rest of the fluid (70 ml/kg) is given more slowly to complete rehydration.

During the course of IV therapy, progress should be assessed every 1-2 hours to determine if the rate of administration is satisfactory or needs to be increased. In particular, attention should be given to:

- The number and volume of stools passed
- The extent of vomiting
- The presence of, and changes in, the signs of dehydration
- Whether the rehydration fluid is being given successfully and in adequate amounts

If the signs of dehydration and the diarrhoea and vomiting have become worse or remain unchanged, **the rate of administration and the amount of fluid given may need to be increased.**

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ANTIBIOTIC TREATMENT OF CHOLERA AND OF DYSENTERY

DISEASE	ORAL ANTIBIOTIC ¹	CHILDREN					ADULTS	
		Dose/frequency/ duration	Estimated dose in tablets, capsules or ml of syrup according to body weight in kg					
			3-5 kg	6-9 kg	10-14 kg	15-19 kg		20-29 kg
CHOLERA ²	Doxycycline³ 300 mg tablet/capsule	Not used for children below 12 years	-	-	-	-	-	300 mg (1 tablet or capsule) Single dose
	Tetracycline 250 mg tablet/capsule	12.5 mg per kg 4 times a day, 3 days	-	½ tablet	1	1	2	500 mg (2 tablets or capsules) 4 times a day, 3 days
	Trimethoprim (TMP) + Sulphamethoxazole (SMX)⁴ Adult tablet (80 mg TMP + 400 mg SMX) Paediatric tablet (20 mg TMP + 100 mg SMX) Syrup (40 mg TMP + 200 mg SMX in 5 ml)	5 mg of TMP + 25 mg of SMX per kg 2 times a day, 3 days	¼	½	1	1	2	160 mg TMP + 800 mg SMX (2 tablets) twice a day, 3 days
	Furazolidone^{5,6} 100 mg tablet	1.25 mg per kg 4 times a day, 3 days	-	-	¼	¼	½	100 mg (1 tablet) 4 times a day, 3 days
DYSENTERY ⁷	Trimethoprim (TMP) + Sulphamethoxazole (SMX) Adult tablet Paediatric tablet Syrup	5 mg of TMP + 25 mg of SMX per kg 2 times a day, 5 days	¼ 1 2.5 ml	½ 2 5 ml	1 3 7.5 ml	1 4 10 ml	2 6 15 ml	160 mg TMP + 800 mg SMX (2 tablets) 4 times a day, 5 days
	Nalidixic Acid 250 mg tablet	15 mg per kg 4 times a day, 5 days	¼	½	1	1	2	1 g (4 tablets) 4 times a day, 5 days
	Ampicillin 250 mg tablet/capsule	25 mg per kg 4 times a day, 5 days	½ tablet	1	1	2	3	1 g (4 tablets or capsules) 4 times a day, 5 days

- ¹Selection of an antimicrobial should be based on sensitivity patterns of strains of *Vibrio cholerae* 01 and *Shigella* isolated in the area.
- ²Antibiotics are recommended for patients older than two years with suspected cholera and severe dehydration.
- ³Doxycycline is the antimicrobial of choice for adults because only one dose is required. See below for treatment of pregnant women.
- ⁴Trimethoprim + Sulfamethoxazole (also named co-trimoxazole) is the antimicrobial of choice for children. Tetracycline is equally effective; however, in some countries it is not recommended for paediatric use.
- ⁵Furazolidone is the antimicrobial of choice for pregnant women.
- ⁶Other choices include erythromycin and chloramphenicol.
- ⁷*Shigella* is the most important cause of dysentery in young children. An antimicrobial to which most *Shigella* in the area are sensitive should be selected. If the stool is still bloody after two days, the antimicrobial should be stopped and a different one used. In many areas trimethoprim-sulfamethoxazole is the drug of choice and nalidixic acid is an alternative. Resistance to ampicillin is frequent.

ANTIMICROBIAL TREATMENT OF PARASITIC DIARRHOEA

DISEASE	ORAL ANTIBIOTIC	CHILDREN					ADULTS	
		Dose/frequency/duration	Estimated dose in tablets according to body weight in kg					
			3-5 kg	6-9 kg	10-14 kg	15-19 kg		20-29 kg
INTESTINAL AMOEBIASIS¹	Metronidazole 250 mg tablet	10 mg per kg 3 times a day, 5 days (10 days for severe disease)	1/4	1/4	1/2	1	1	750 mg (3 tablets) 3 times a day, 5 days (10 days for severe disease)
GIARDIASIS²	Metronidazole 250 mg tablet	5 mg per kg 3 times a day, 5 days	-	1/4	1/4	1/2	1/2	250 mg (1 tablet) 3 times a day, 5 days

¹Amoebiasis is an unusual cause of dysentery in young children. Metronidazole should be given only when trophozoites of *Entamoeba histolytic* containing red blood cells are seen in the faeces or when bloody stools persist after consecutive treatment with two antimicrobials (each given for two days) that are usually effective for *Shigella* in the area.

²Treatment for giardiasis should be given only when diarrhoea is persistent (lasting at least 14 days) and cysts or trophozoites of *Giardia* are seen in faeces or small bowel fluid. Tinidazole and ornidazole are also effective. Tinidazole is given in a single dose of 50 mg per kg, with a maximum dose of 2 grams. Use of ornidazole should follow the manufacturer's recommendations.

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SUPPLIES AND EQUIPMENT

1. Forms

- Diarrhoea Case Record Forms (WHO)

2. Equipment

- Jars marked with volume measurement
- Bed or table with arrangement to suspend bottles for IV fluid
- Scalp vein butterfly
- Baby scale and adult scale
- Plastic cups and spoons
- Cotton gauze
- Droppers
- Syringes
- Thermometers
- Soap
- Garbage/trash bin
- Washbasin
- Bench/chairs for mothers
- Clock
- Water cooler
- Nasogastric tube

3. Drugs

For Rehydration

- ORS packets
- Ringers Lactate with giving set

For Cholera

- Tetracycline
- Doxycycline
- Furazolidone
- Trimethoprim - Sulfamethoxazole

Shigella Dysentery

- Trimethoprim - Sulfamethoxazole
- Nalidixic Acid
- Ampicillin

Intestinal amebiasis

- Metronidazole

Giardiasis

- Metronidazole
- Quinacrine

EXERCISES

Supervisory Checklist Exercise

You will observe a health facility staff managing a child with diarrhoea. Take out the Supervisory Checklist and Work Sheets and complete indicated items.

- Individual Case Management Work Sheet #1:

Items	1.1 - 1.3
	2.1 - 2.N
	3.1 - 3.N
	4.2, 4.3, 4.I and 4.N
	5.1
All Items:	6
	7
	8

- Determine the final assessment score and enter on Resource Management Work Sheet #6, Item 6.1 and on the summary, Individual Case Management page Item 1.2.
- Summarize your findings on case management of diarrhoea and complete Feedback, page 4, on the summary of the Supervisory Checklist.
- Present your findings.
- Ask for staff input.
- Plan together to maintain acceptable standard of diarrhoea case management.
- Give date of next visit.

Section 1: Individual Case Management

Institution Name: _____

Work Sheet 1: Sick Child Under 5

Name of Supervisor: _____
(if different from front page)

Date of Supervision: _____
(if different from front page)

Case 1 Case 2 Case 3 Case 4 Case 5

Work Area Set:		Name of Staff: →				
<input type="checkbox"/> Y <input type="checkbox"/> N						
1.	Rapport					
1.1	Was mother greeted?					
1.2	Was mother asked to sit down?					
1.3	Was mother asked reason for coming to the facility?					
2.	History					
2.1	Asks for age of child					
2.2	Asks change in eating/drinking pattern					
2.3	Asks change in bowel/urine output					
2.4	Asks for change in activity					
2.5	Asks for other symptoms					
2.1	Asks for child's immunization status					
2.N	Asks for nutrition intake assessment					
3.	Examination					
3.1	Looks at general condition (colour, alertness)					
3.2	Looks at condition of eyes, ears					
3.3	Looks at condition of nose, mouth, ear					
3.4	Looks at chest indrawing					
3.5	Counts respiration					
3.6	Takes skin pinch					
3.7	Takes temperature (if indicated)					
3.1	Checks Immunization Card					
3.N	Takes weight (child under 3)					
4.	Classification					
	Was child correctly classified?					
4.1	ARI case					
4.2	Diarrhoea case					
4.3	Case with other symptoms					
4.4	Case with no symptoms					
4.1	According to need for vaccines					
4.N	According to nutritional status					

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	Case 1	Case 2	Case 3	Case 4	Case 5	
5a Management						
5.1 Were child's needs correctly managed? According to WHO protocol for ARI case According to WHO protocol for Diarrhoea case According to acceptable standards for other cases						
5.2 Refers complicated case appropriately						
5.I Manages correctly immunization needs of the child						
5.N Manages correctly nutritional needs of child						
6 Advice						
6.1 Explains to parents findings of child's condition						
6.2 Explains need/no need for drugs						
6.3 Explains when to bring back the child						
6.I Gives appropriate immunization advise						
6.N Gives appropriate nutritional advise						
7 Follow-up						
7.1 Gives appointment for next visit						
7.2 Checks if mother has well understood treatment/advice given and date of next appointment						
8. Reporting						
8.1 Completes MCH card						
8.2 Completes OPD Register						
8.3 Uses Referral Forms						<u>Total 'Yes'</u> <u>Total 'Yes'+ 'No'</u>
For General Child Care (all cases) <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>	/	/	/	/	/	/
For ARI Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>	/	/	/	/	/	/
For Diarrhoea Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>	/	/	/	/	/	/
For Immunization Management (2.I → 6.I) <i>Write number of 'Yes' scores over total number of 'I' scores</i>	/	/	/	/	/	/
For Nutritional Management (2.N → 6.N) <i>Write number of 'Yes' scores over total number of 'N' scores</i>	/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:						
General Child Care:						%
ARI Case:						%
Diarrhoea Case:						%
Immunization Management:						%
Nutritional Management:						%

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Section 2: Resource Management

Institution Name: _____

Work Sheet 6: Record Keeping System

Name of Supervisor: _____
(if different from front page)

Date of Supervision: _____
(if different from front page)

- 6.1 All required registers and patient/client forms are in use according to the HMIS/FLCF Instructions Manual. Y N
- 6.2 Immediate reports for epidemic outbreaks were made up when necessary and duly completed. Y N
- 6.3 Immediate reports were sent out in a timely manner. Y N
- 6.4 Monthly reports were made up correctly from records and registers available in the centre. Y N
- 6.5 Monthly reports were sent out according to time schedule. Y N
- 6.6 Updated graphic representations on priority activities of the health facility are visibly displayed. Y N
- 6.7 All forms and registers are available in sufficient quantity Y N

Number of 'Yes' scores over total number of 'Yes' and 'No' scores

/

Final assessment:

Percentage of 'Yes' scores out of total 'Yes' and 'No' scores

%

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Action 1: Individual Case Management

Make final assessment on case management of the following health care activities using the scores obtained through the worksheets. For health care activities not performed in the supervised health facility, tick the box 'NA' (Not Applicable).

		Quality of Case Management			
		NA	Poor (<50%)	Insufficient (50 - <80%)	Appropriate (≥80%)
Sick Child Under Five					
1.1	General Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2	Diarrhoeal Disease Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3	Acute Respiratory Infection Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4	Management of Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5	Management of Immunization Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Growth Monitoring in Child Under Three	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Immunization Session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Delivery Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Postnatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Neonatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Tuberculosis (follow-up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MODULE 6

ACUTE RESPIRATORY INFECTIONS

WHO material in Management of Acute Respiratory Infections has been used extensively in this module.

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LEARNING OBJECTIVES

LEARNING OBJECTIVES FOR INCREASED KNOWLEDGE AND UNDERSTANDING

During training you will receive the latest information on ARI management through lecture, video and discussions. On completion of this module you will be able to:

1. State the magnitude of acute respiratory problems in children.
2. State the Government of Pakistan's ARI Control Programme's two objectives.
3. Describe the two case management charts on ARI and how to use each.
4. Name three parts to ARI case management.
5. Describe the role of MOs and paramedics in implementing ARI programme guidelines.
6. List district level supervisor's responsibilities in assuring implementation of ARI case management.

LEARNING OBJECTIVES FOR IMPROVING SUPERVISORY SKILLS

During training you will be provided with opportunities to observe children with respiratory infections in the classroom and in the OPD and to assess the competency of the facility in implementation of ARI control program objectives. On completion of this module you will be able to:

1. Observe and assess facility staff competency in assessing and classifying a child with ARI.
2. Assess staff's compliance with the rational use of drugs in ARI case management.
3. Assess staff's compliance in assessment of immunization and nutritional status of children with ARI.
4. Assess availability and utilization of essential resources in ARI case management.
5. Assess staff's competency in counselling and teaching mothers on caring for a child with ARI.
6. Assess quality of record keeping in the OPD register.

7. Identify strengths and constraints in implementing ARI control programme guidelines.
8. Complete the Supervisory Checklist items on ARI and use this information to assess needs.
9. Give feedback to facility staff after completing the Supervisory Checklist.
10. Compliment staff on their achievements.
11. Work out a plan with staff to solve the identified problems in implementing ARI program guidelines.

INTRODUCTION

MAGNITUDE AND TYPES OF ARI PROBLEMS

Children with respiratory infections make up a large portion of patients seen by health workers in health centres and other first level care facilities. Most children 0 to 4 years of age have about four to six acute respiratory infections each year.

Respiratory infections include infections in any area of the respiratory tract including the nose, ears, throat (pharynx), voice box (larynx), windpipe (trachea), air passages (bronchi or bronchioles), or lungs.

Many areas of the respiratory tract can be involved in an illness, and there can be a wide variety of signs and symptoms of infection. These include:

- Cough
- Difficult breathing
- Sore throat
- Runny nose
- Ear problems

Fever is common in acute respiratory infections. Fortunately, most children with respiratory symptoms have only a mild infection, such as a cold or bronchitis. They may cough because the nasal discharge from a cold drips down the back of the throat, or because they have a viral infection of the bronchi (bronchitis). They are not seriously ill and can be treated well at home by their families without antibiotics.

However, some children may develop pneumonia. If this lung infection is not treated with an antibiotic, death may result either by diminishing the intake of oxygen, or by an overwhelming infection from bacteria entering the bloodstream (called sepsis or septicemia). About one-fourth of all children less than five years of age who die in developing countries die of pneumonia. It is, in fact, one of the two most common causes (along with diarrhoea) of death in children. In some areas, pneumonia is the most common cause of death. Many of these deaths are in young infants less than 2 months of age.

The following two figures show the percent of deaths by pneumonia for children under five years of age. The first figure shows that 27% of deaths occur in neonates. The second shows that up to 60% of deaths occur in children under 6 months of age. This signifies that very young infants are more at risk. The third graph reflects admission of OPD patients with ARI. More than one-third of the caseload in OPD is due to ARI. No study has been conducted in Pakistan to collect mortality data.

Therefore, the proper treatment of children under five, especially infants, who have pneumonia can greatly reduce deaths. In order to treat these children, the health worker must be able to

carry out the difficult task of identifying the high risk cases of early pneumonia before they become very serious and end in death.

The WHO ARI programme has accordingly developed case management guidelines for early diagnosis and treatment of infants from birth to 2 months and from 2 months to 5 years of age.

THE PAKISTAN ARI CONTROL PROGRAMME

The Pakistan ARI Control Programme has the following two objectives:

1. To reduce mortality from ARI, in particular pneumonia, in children under five years of age
2. To reduce the inappropriate use of antibiotics and other drugs for the treatment of ARI in children

Percent of Pneumonia Deaths* occurring in the neonatal period

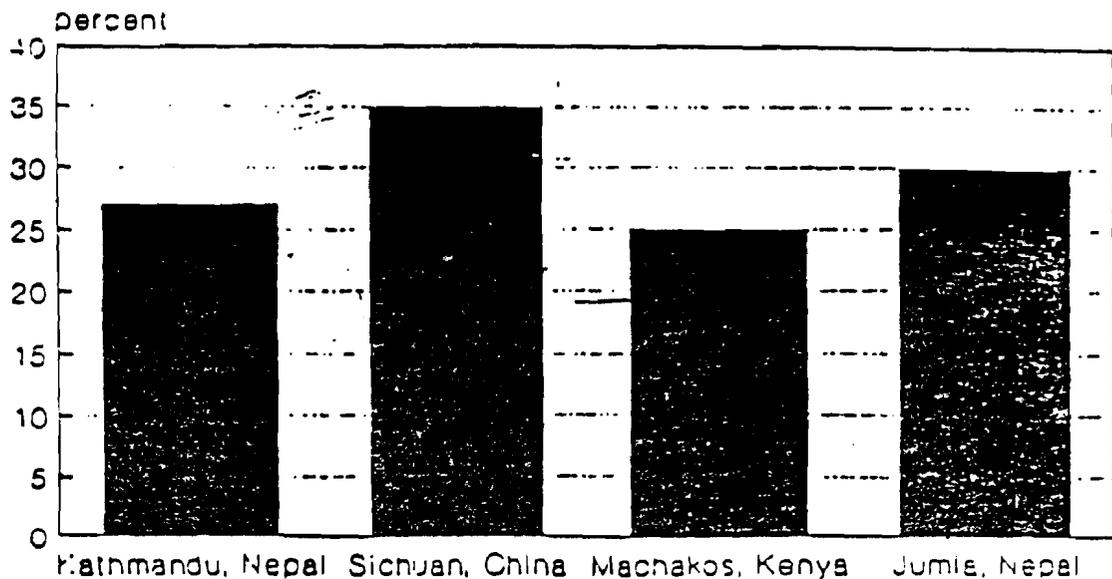
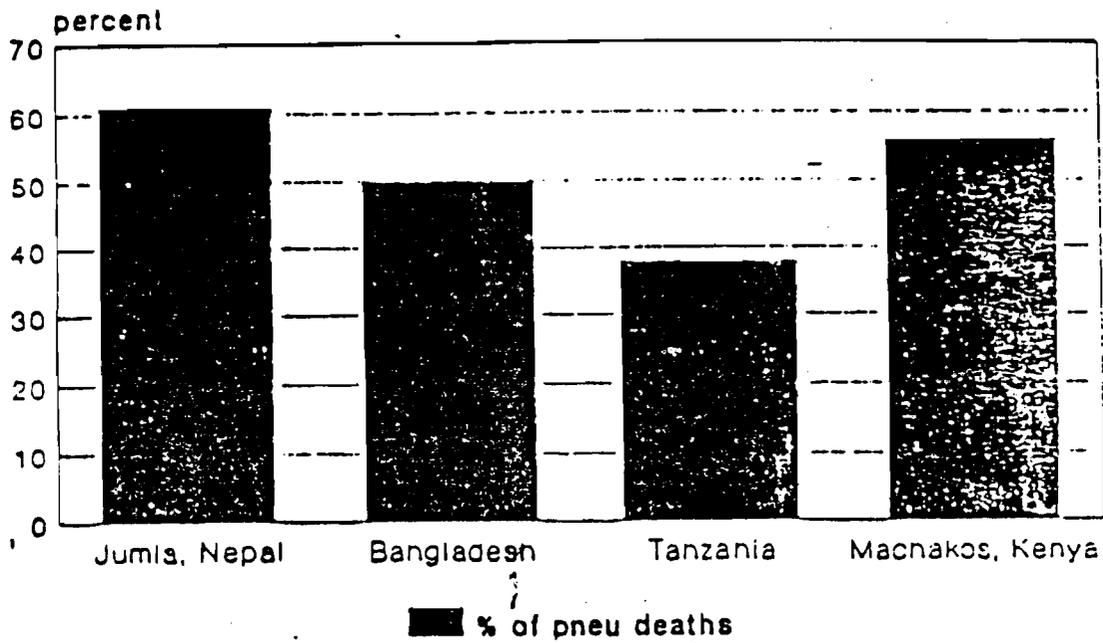


Fig.18 ■ % of pneu deaths

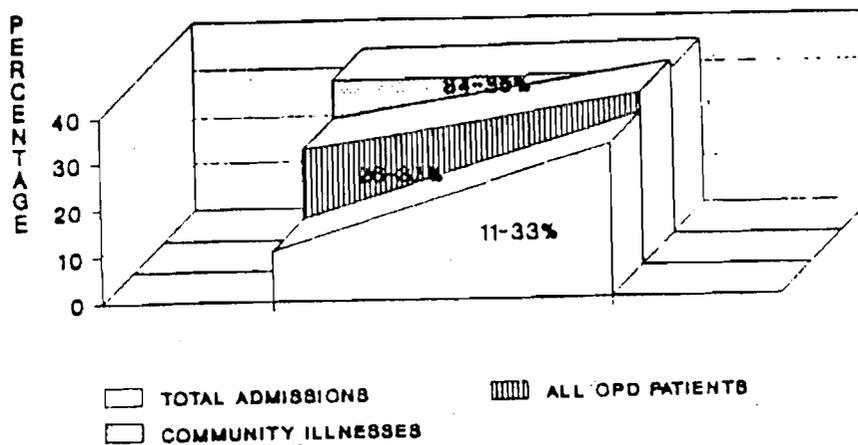
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Percent of Pneumonia Deaths* occurring in infants <6 mos old



Source: WHO ARI Cause of Death in Children 1986

ARI MORBIDITY RANGE IN PAKISTAN (FROM AVAILABLE DATA UPTO 1989)



Source: Khan M.A and Rehman G.N. The ARI in Children's Hospital, Islamabad. First National ARI Workshop Islamabad 1989.

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OVERVIEW OF MO AND PARAMEDIC TRAINING

The acute respiratory infection management training of MO and paramedics includes the following conditions:

- Cough or difficult breathing
- Ear problems or sore throat
- Fever
- Wheezing

In order to provide you with an overview of MO and paramedic training in a very short time, you will be briefed on the ARI Case Management charts so that you can assess whether or not the staff at the facility are implementing these recommended guidelines. You will also be shown a video on assessment of ARI in children.

ARI Case Management charts for assessment classification and treatment are presented in the following sequence. If you want explanations of these charts, please refer to the manual, Management of the Young Child With an Acute Respiratory Infection.

1. Management of a child with cough or difficult breathing

- The young infant less than 2 months
- The child age 2 months to five years
- Home care instructions for children 2 months to 5 years
- Give an antibiotic
- Advise mother to give home care
- Teach mother to give antibiotics at home
- Treat fever
- Treat wheezing.

2. Management of a child with an ear problem

- Dry the ear by wicking
- Give an antibiotic

3. Management of the child with sore throat and infection

Select the appropriate case management chart*

Cough or Difficult Breathing?

If yes

If no

Use the chart:

*Management of the Child with
Cough or Difficult Breathing*

Ear problem or
Sore throat?

If yes

If no

Use the chart:

*Management of the Child
with an Ear Problem or
Sore Throat*

Advise
mother on
home care
and treat
fever, if
present

* A larger scale chart is available in the WHO, ARI Module

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THE YOUNG INFANT (AGE LESS THAN 2 MONTHS)

SIGNS:	<ul style="list-style-type: none"> ● Stopped feeding well, ● Convulsions, ● Abnormally drowsy or difficult to wake, ● Grunting or groaning ● Wheezing, or ● Fever or feels too cold ● Cyanosis 	
CLASSIFY AS:	VERY SEVERE DISEASE	
TREATMENT:	<ul style="list-style-type: none"> ▶ Refer URGENTLY to hospital for antibiotic by injection if any of the above signs. ▶ Give first dose antibiotic (preferably injection) 	

SIGNS:	<ul style="list-style-type: none"> ● Fast breathing (60 per minute or MORE) or ● Severe chest indrawing/ nasal flaring 	<ul style="list-style-type: none"> ● No fast breathing (LESS than 60 per minute) and ● No severe chest indrawing or danger signs.
CLASSIFY AS:	SEVERE PNEUMONIA	NO PNEUMONIA
TREATMENT:	<ul style="list-style-type: none"> ▶ Refer URGENTLY to hospital for antibiotic by injection if any of the above signs. ▶ Give first dose antibiotic, preferably injection <p>(if referral is not feasible, treat with antibiotic and follow closely.</p>	<ul style="list-style-type: none"> ▶ Advise mother to give home care: <ul style="list-style-type: none"> ▶ Keep baby comfortably warm ▶ Breastfeed frequently. ▶ Clear nose if it interferes with feeding. ▶ Watch for signs of illness. ▶ Advise mother to return if: <ul style="list-style-type: none"> ▶ Illness worsens. ▶ Breathing is difficult. ▶ Feeding becomes a problem. ▶ High fever

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THE CHILD

AGE 2 MONTHS UP TO 5 YEARS

SIGNS:	<ul style="list-style-type: none"> ● Not able to drink, ● Convulsions, ● Abnormally sleepy or difficult to wake, ● Stridor in calm child, or ● Clinically severe undernutrition. 	
CLASSIFY AS:	VERY SEVERE DISEASE	
TREATMENT:	<ul style="list-style-type: none"> ▶ Refer URGENTLY to hospital ▶ Give first dose antibiotic. ▶ Treat fever, if present. ▶ Treat wheezing, if present. ▶ If cerebral malaria is possible, give antimalarial. 	

SIGNS:	<ul style="list-style-type: none"> ● Chest indrawing. (esp. subcostal) with or without fast breathing <p style="text-align: center;">[If also recurrent wheezing, go directly to ▶ <i>Treat Wheezing</i>]</p>	<ul style="list-style-type: none"> ● No chest indrawing, and ● Fast breathing (50 per minute or more if child 2 months up to 12 months; 40 per minute or more if child 12 months up to 5 years). 	<ul style="list-style-type: none"> ● No chest indrawing, and ● No fast breathing <p style="text-align: center;">(Less than 50 per minute if child 2 months up to 12 months; Less than 40 per minute if child 12 months up to 5 years).</p>
CLASSIFY AS:	SEVERE PNEUMONIA	PNEUMONIA	NO PNEUMONIA: COUGH OR COLD
TREATMENT:	<ul style="list-style-type: none"> ▶ Refer URGENTLY to hospital. ▶ Give first dose antibiotic. ▶ Treat fever, if present. ▶ Treat wheezing, if present (If referral is not feasible, treat with antibiotic and follow closely. 	<ul style="list-style-type: none"> ▶ Advise mother to give home care ▶ Give antibiotic. ▶ Treat fever, if present. ▶ Treat wheezing, if present. ▶ Advise mother to return with child in 2 days for reassessment, or earlier if the child is getting worse. 	<ul style="list-style-type: none"> ▶ If coughing more than 30 days, refer for assessment ▶ Assess and treat ear problem or sore throat, if present (see chart). ▶ Advise mother to give home care ▶ Treat fever, if present. ▶ Treat wheezing, if present.

Reassesses in 2 days a child who is taking an antibiotic for pneumonia:			
SIGNS:	WORSE	THE SAME	IMPROVING
	<ul style="list-style-type: none"> ● Not able to drink. ● Has chest indrawing. ● Has other danger signs. 		<ul style="list-style-type: none"> ● Breathing slower, ● Less fever. ● Eating better
TREATMENT:	▶ Refer URGENTLY to hospital	▶ Change antibiotic or Refer	▶ Finish 5 days of antibiotic

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HOME CARE INSTRUCTIONS FOR CHILDREN AGE 2 MONTHS UP TO 5 YEARS WITH ACUTE RESPIRATORY INFECTIONS

Feed the Child.

- Feed the child during illness.
- Increase feeding after illness.
- Clear the nose if it interferes with feeding.



Increase Fluids.

- Offer the child extra to drink.
- Increase breast-feeding.



Soothe the throat and relieve the cough with a safe remedy.



**Most important:
Watch for the following signs
and return quickly if they occur:**



- Breathing becomes difficult.
- Breathing becomes fast.
- Child is not able to drink.
- Child becomes sicker.

This child may have pneumonia.

► Give an Antibiotic

- Give first dose of antibiotic in clinic.
- Instruct mother on how to give the antibiotic for five days at home

AGE or WEIGHT	Cotrimoxazole		AMOXYCILLIN		AMPICILLIN	
	trimethoprim + sulphamethoxazole ► Two times daily for 5 days Syrup Adult Tablet single strength (10 mg trimethoprim + 200 mg sulphamethoxazole) (100 mg trimethoprim + 400 mg sulphamethoxazole) per 5 ml		► Three times daily for 5 days Tablet Syrup 250 mg 125 mg in 5 ml		► Four times daily for 5 days Tablet Syrup 250 mg 250 mg in 5 ml	
Less than 2 months (< 5 kg)	1/4*	2.5 ml*	1/4*	2.5 ml	1/2	2.5 ml
2 months up to 12 months (6-9 kg)	1/2	5.0 ml	1/2	5 ml	1	5 ml
12 months up to 5 years (10-19 kg)	1	7.5 ml	1	10.0 ml	1	5 ml

- * If the child is less than 1 month old, give 1.25 ml syrup twice daily.
Avoid cotrimoxazole in infants less than one month of age who are premature or jaundiced.

► Advise Mother to Give Home Care

- Increase fluids.
 - Increase breastfeeding.
 - Offer the child extra to drink.
- Feed the child.
 - Feed the child during illness.
 - Increase feeding after illness.
 - Clear the nose if it interferes with feeding.
- Soothe the throat and relieve the cough with safe, simple remedies.
- Most important: Watch for signs of pneumonia. Bring child back quickly to the health worker if:
 - Breathing becomes difficult.
 - Breathing becomes fast.
 - Child is not able to drink.
 - Child becomes sicker.

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TEACH THE MOTHER TO GIVE THE ANTIBIOTIC AT HOME

1. Explain carefully to the mother how much of the antibiotic to give, how many times daily, and when to give it. Write it down for her. If she cannot read, draw a simple picture.
2. Give the mother enough antibiotic for 5 days. Explain to the mother that she must:
 - Give the child the antibiotic for 5 days, and
 - Finish the five-day treatment, even if the child seems better.
3. Make sure that the mother understands all the instructions and will be able to carry them out. There are several ways to do this:
 - Ask the mother to repeat the instructions (e.g., the dosage). Then, correct any misinformation.
 - Ask the mother to demonstrate what she has heard. Then, if necessary, show her again how to do the step correctly.
 - Help the mother plan how she will give the antibiotic on the dosing schedule.
 - Ask her what problems she might have giving the child the antibiotic. Then, help her to overcome any problems. For example:
 - * If she is working away from home and will have difficulty giving all doses, help her identify someone who could care for the child and give the child the antibiotic when she is away.
4. Advise the mother on how to give home care
5. Ask the mother to bring the child back to be reassessed in 2 days, or sooner if the child worsens. You need to reassess the child to see whether the child is improving with the antibiotic.

Treatment instructions should always end with the mother knowing what to do at home and how to do it.

► Treat Fever

In a falciparum malarious area:

<ul style="list-style-type: none"> ● Fever is high ($\geq 39^{\circ}\text{C}$) 	<ul style="list-style-type: none"> ● Fever is not high ($< 39^{\circ}\text{C}$) 	<ul style="list-style-type: none"> ● Any fever, or ● History of fever 	<ul style="list-style-type: none"> ● Fever for more than five days.
<ul style="list-style-type: none"> ● Give paracetamol. 	<ul style="list-style-type: none"> ● Advise mother to give more fluids. 	<ul style="list-style-type: none"> ● Give an antimalarial (or treat according to your malaria programme recommendations.) 	<ul style="list-style-type: none"> ● Refer for assessment

FEVER ALONE IS NOT A REASON TO GIVE ANTIBIOTIC EXCEPT IN A YOUNG INFANT (LESS THAN 2 MONTHS).

PARACETAMOL doses:

→ Every six hours

Age or Weight	100 mg tablet	500 mg tablet
2 months up to 12 month 6-9 kg	1	0.25
12 months up to 3 month 10-14 kg	1	0.25
3 years up to 5 years 15-19 kg	1.5	0.5

► Treat Wheezing: only for M.O's

Children with First Episode of Wheezing

If in respiratory distress → Give a rapid acting bronchodilator and refer
 If not in respiratory distress → Give oral salbutamol for 5 days

Children with Recurrent Wheezing (Asthma)

Give a rapid acting bronchodilator
 Assess the child's condition 30 minutes later

IF: RESPIRATORY DISTRESS OR ANY DANGER SIGN → THEN: Treat for SEVERE PNEUMONIA or VERY SEVERE DISEASE (Refer)

NO RESPIRATORY DISTRESS AND:
 FAST BREATHING → Treat for PNEUMONIA (include oral salbutamol)

NO FAST BREATHING → Treat for NO PNEUMONIA (include oral salbutamol)

RAPID ACTING BRONCHODILATOR

Nebulized Salbutamol (5 mg/ml)	0.5 ml Salbutamol plus 2.0 ml sterile water
Subcutaneous Epinephrine (adrenaline) (1:1000 - 0.1%)	0.01 ml per kg body weight

ORAL SALBUTAMOL ► Three times daily for five days

AGE or WEIGHT	2 mg tablets	4 mg tablets
2 months up to 12 months (< 10 kg)	1/2	1/4
12 months up to 5 years (10-19 kg)	1	1/2

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EAR PROBLEM

ASSESS

ASK:

- Does the child have ear pain?
- Does the child have pus draining from the ear? For how long?

LOOK, FEEL:

- Look for pus draining from the ear or red, immobile ear drum (by otoscopy).
- Feel for tender swelling behind the ear.

CLASSIFY THE ILLNESS

SIGNS:	<ul style="list-style-type: none"> • Tender swelling behind the ear 	<ul style="list-style-type: none"> • Pus draining from the ear LESS than two weeks or • Ear pain or • Red, immobile ear drum (by otoscopy). 	<ul style="list-style-type: none"> • Pus draining from the ear two weeks or MORE
CLASSIFY AS:	MASTOIDITIS	ACUTE EAR INFECTION	CHRONIC EAR INFECTION
TREATMENT:	<ul style="list-style-type: none"> ▶ Refer URGENTLY to hospital. ▶ Give first dose antibiotic ▶ Treat fever, if present. ▶ Give paracetamol for pain. 	<ul style="list-style-type: none"> ▶ Give an antibiotic for five days, as for pneumonia ▶ Dry the ear by Wicking. ▶ Reassess in five days. ▶ Treat fever, if present. ▶ Give paracetamol for pain. 	<ul style="list-style-type: none"> ▶ Refer for one assessment if possible ▶ Dry the ear by wicking. ▶ Treat fever if present ▶ Give paracetamol for pain

TREATMENT INSTRUCTIONS

▶ Give an Antibiotic

- ▶ Give first dose of antibiotic in clinic.
- ▶ Instruct mother on how to give the antibiotic for five days at home

AGE or WEIGHT	Cotrimoxazole <small>trimethoprim + sulphamethoxazole</small> ▶ Two times daily for 5 days		Amoxicillin ▶ Three times daily for 5 days		Ampicillin ▶ Four times daily for 5 days	
	Adult Tablet 800 mg trimethoprim + 400 mg sulphamethoxazole	Syrup 100 mg trimethoprim + 200 mg sulphamethoxazole per 5 ml	Tablet 250 mg	Syrup 125 mg in 5 ml	Tablet 250 mg	Syrup 250 mg in 5 ml
Less than 2 months (< 5 kg)	1/4*	2.5 ml*	1/4*	2.5 ml	1/2	2.5 ml
2 months up to 12 months (6-9 kg)	1/2	5.0 ml	1/2	5.0 ml	1	5.0 ml
12 months up to 5 years (10-19 kg)	1	7.5 ml	1	10.0 ml	1	5.0 ml

* If the child is less than 1 month old, give 1.25 ml syrup twice daily.
Avoid cotrimoxazole in infants less than one month of age who are premature or jaundiced.

▶ Dry the Ear by Wicking

- ▶ Dry the ear at least 3 times a day:
 - ▶ Roll clean, absorbent cloth into a wick.
 - ▶ Place the wick in the child's ear.
- ▶ Remove the wick when wet.
- ▶ Replace the wick with a clean one until the ear is dry.

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SORE THROAT

ASSESS

ASK:

- Is the child able to drink?
- Does the child have a sore throat?

LOOK, FEEL:

- Feel the front of the neck for nodes
- Look for exudate on the throat

CLASSIFY THE ILLNESS

SIGNS:

- Not able to drink.

- Tender, enlarged lymph node on neck and
- White exudate on throat.

CLASSIFY AS:

THROAT ABSCESS

STREPTOCOCCAL SORE THROAT

TREATMENT:

- ▶ Refer to hospital
- ▶ Give benzathine penicillin or amoxicillin/ampicillin
- ▶ Treat fever, if present.
- ▶ Give paracetamol for pain.

- ▶ Give benzathine penicillin or amoxicillin/ampicillin
- ▶ Give safe, soothing remedy for sore throat.
- ▶ Treat fever, if present.
- ▶ Give paracetamol for pain

▶ Treat Fever

● Fever is high ($\geq 39^{\circ}\text{C}$)	● Fever is not high ($< 39^{\circ}\text{C}$)
● Give paracetamol	● Advise mother to give more fluids.

In a falciparum malarious area:

● Any fever, or ● History of fever	● Fever for more than five days.
● Give an antimalarial (or treat according to your malaria programme recommendations.)	● Refer for assessment

PARACETAMOL doses:

Every six hours

Age or Weight	100 mg tablet	500 mg tablet
2 months upto 12 months 6 - 9 kg	1	0.25
12 months upto 3 years 10 - 14 kg	1	0.25
3 years upto 8 years 16 - 18 kg	1.5	0.5

FEVER ALONE IS NOT A REASON TO GIVE ANTIBIOTIC EXCEPT IN A YOUNG INFANT (LESS THAN 2 MONTHS)

▶ Give Benzathine Penicillin

for suspected streptococcal sore throat:

BENZATHINE PENICILLIN IM

A single injection

< 5 years	600,000 units
≥ 5 years	1,200,000 units

Or amoxicillin, ampicillin, for ten days

▶ Soothe the throat with safe, simple remedies.

▶ Give paracetamol for pain and fever.

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SUPERVISOR'S RESPONSIBILITIES

1. Technical

- Ensure a child brought to the FLCF with ARI is assessed, classified and treated according to WHO guidelines.
- Ensure that the mother of the child with ARI is counselled and taught home care procedures by staff.

2. Administrative

Staff

- Ensure that the staff is regular in attendance.
- Fill all sanctioned posts.
- Properly train the staff in managing ARI cases.
- Determine if the staff is able to handle the work load.
- Resolve any conflict among staff members.
- See that each staff member knows his/her job description.
- Identify staff members needing in-service training.

Time

- See that all staff report for duty on time.
- Ensure that staff remain at the center for full a full working day.
- Ensure that the duty roster of the center is prepared for holidays and after regular working hours.

Space

- Ensure that sufficient space is available for the free flow of patients in the OPD for their assessment and treatment.

Material

- Ensure that the equipment, drugs and supplies for ARI cases are available in sufficient quantities. (See page 289 for list.)

Records and Reports

- Prepare the monthly and immediate reports regarding services delivered and send to the concerned headquarters on the scheduled dates.

Evaluation of Services

- Carry out supervisory visits to FLCFs in order to assess the quality of ARI services delivered by the health center staff and to help improve these services.

Supervisory Visit

- Observe the facility staff and assess the quality of service and management of ARI patients on the basis of the following criteria:

History

Did the staff ask the mother:

- About any change in the child's eating/drinking pattern
- If the child has had fever? If so, for how long
- If the child is coughing? If so, for how long
- If the child is able to drink
- About any change in activity
- If the child has had ear pain
- If the child has had difficulty in breathing
- If the child has puss discharge from the ear
- If the child has a sore throat
- If the young infant (age less than two months) has stopped feeding well
- If the child has had convulsions

Examination

Did the staff:

- Check the temperature
- Count respiratory rate
- Note color of nails
- Examine ears and nose for discharge
- Look and listen for stridor
- Look and listen for wheezing. Is it recurrent?
- Examine throat
- Check for clinically severe undernutrition
- Observe for difficulty in breathing
- See that the child is abnormally sleepy or difficult to wake
- Look for chest indrawing

Classification

Did the staff classify the child according to the WHO protocol as:

- A very severe disease
- Severe pneumonia
- Pneumonia

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- No pneumonia (cough or cold)
- Ear problem
- Sore throat

Treatment

Did the staff:

- Prescribe antibiotics
- Was this antibiotic available?
- Prescribe/give any other medicine
- Enter in the OPD register the administration of antibiotics or the writing of a prescription

Counselling the mother

Did the staff tell the mother:

- To continue giving fluids and food
- To clear the nose if mucous interferes with feeding
- To offer extra fluids to the sick child and to increase breastfeeding to infants
- To keep the child at normal temperature
- How to administer prescribed medicines
- About the importance of completing a drug regimen
- How to watch for cyanosis
- How to watch for chest indrawing
- Did the staff make sure that the mother understood the instructions
- When to return
- To return immediately if:
 - Breathing becomes difficult
 - Breathing becomes fast
 - Child is not able to drink
 - Child becomes sicker

SUPPLIES AND EQUIPMENT

1. Forms/Registers

- Acute Respiratory Infection Case Record forms
- ARI prescribed register for OPD

2. Equipment

- Otoscope
- Torch
- Tongue depressor
- Suction machine
- Nasogastric tube
- Weighing scale
- Nebulizer
- Watch (each trainee should have one for counting respiration)
- Thermometer

3. Drugs

Antibiotics

- Cotrimoxazole Tab. (Trimethoprim + sulphamethoxazole)
- Amoxicillin
- Ampicillin
- Procaine penicillin
- Benzyl penicillin
- Kanamycin, gentamicin (amino-glycoside)
- Chloramphenicol
- Cloxacillin, flucloxacillin, oxacillin

Other drugs

- Aminophylline
- Epinephrine and adrenaline 1/1000
- Salbutamol
- Paracetamol

4. Other supplies

- Cotton

EXERCISES

Classroom Exercise

Problem #1:

As a supervisor you were visiting a BHU and observed the MOIC examine and talk to patients. He seemed to have a very pleasant and easy going personality. He took time to talk to adult patients and parents of children and made them feel at ease. A child was brought in with a cough and fever of 4 days duration. The MO prescribed 1 tablet (250 mg) amoxycyline, three times daily for 5 days. He instructed the mother to crush and mix the medicine with a small amount of food. The mother seemed satisfied when she left the MO's room.

1. Based on the above information, state which parts of a case management was implemented and which part was not visibly implemented.
2. Where would you record this observation? What is your final assessment score on ARI case management?
3. What feedback would you give to the staff on this observation?
4. What additional information would you obtain from the staff? How would you involve them in implementing ARI case management guidelines at the facility?

Problem #2:

In January, you observed an MO at work in the OPD. He was examining children. You wrote down information you gathered on one case.

- Child's age--2 years 3 months
- Respiratory rate 54/min
- Child was coughing and running a fever of 39.2° (for three days, according to the mother)

The MO told mother that the child has fast respiration indicative of pneumonia and needs antibiotics. He crushed a tablet of Cotrimoxazole mixed it with some banana and asked the mother to give it to the child. He gave her 15 tablets for 5 days and told her to return in two days for reassessment. He also advised paracetamol for fever. He encouraged the mother to give the child more fluids and small frequent feedings during the illness and recovery. He concluded the visit by asking the mother to repeat what she was to do in caring for her child.

1. Complete your Work Sheets and Supervisory Checklist and assign a final score for ARI case management.
2. What feedback would you give to your staff based on this case?

Supervisory Checklist Exercise

You will have an opportunity to observe staff in managing a child with ARI. As part of your supervisory visit:

- Complete the following items on the Supervisory Checklist, Individual Case Management Work Sheet #1: Items:
 - 1 through 3.N
 - 4.1
 - 5.1
 - 6.1 - 6.N
 - 7.1 - 7.2
 - 8.1 - 8.3
- Check that appropriate entries on the MCH card and OPD Register are made.
- Summarize findings of your visit:
 - On case management of ARI patients
 - On availability and utilization of resources
 - On record keeping
- Give final assessment score for ARI case management
- Check appropriate boxes in the summary part of the Supervisory Checklist, Individual Case Management page. Items:
 - 1.1
 - 1.3
 - 1.4
 - 1.5
- Meet with the staff in groups and/or as individuals.
 - Identify strengths and constraints in delivery of ARI services.
 - Compliment staff on accomplishments and providing services to ARI patients.
 - Give feedback to the facility staff on your findings during the supervisory visit.
 - Identify training needs for facility staff.
 - Workout a plan with the facility staff to solve identified constraints/problems within a specified time frame.

Section 1: Individual Case Management	Institution Name: _____
Work Sheet 1: Sick Child Under 5	
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →				
1. Rapport						
1.1	Was mother greeted?					
1.2	Was mother asked to sit down?					
1.3	Was mother asked reason for coming to the facility?					
2. History						
2.1	Asks for age of child					
2.2	Asks change in eating/drinking pattern					
2.3	Asks change in bowel/urine output					
2.4	Asks for change in activity					
2.5	Asks for other symptoms					
2.I	Asks for child's immunization status					
2.N	Asks for nutrition intake assessment					
3. Examination						
3.1	Looks at general condition (colour, alertness)					
3.2	Looks at condition of eyes, ears					
3.3	Looks at condition of nose, mouth, ear					
3.4	Looks at chest indrawing					
3.5	Counts respiration					
3.6	Takes skin pinch					
3.7	Takes temperature (if indicated)					
3.I	Checks Immunization Card					
3.N	Takes weight (child under 3)					
4. Classification	Was child correctly classified?					
4.1	ARI case					
4.2	Diarrhoea case					
4.3	Case with other symptoms					
4.4	Case with no symptoms					
4.I	According to need for vaccines					
4.N	According to nutritional status					

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5a	Management						
5.1	Were child's needs correctly managed? According to WHO protocol for ARI case According to WHO protocol for Diarrhoea case According to acceptable standards for other cases						
5.2	Refers complicated case appropriately						
5.I	Manages correctly immunization needs of the child						
5.N	Manages correctly nutritional needs of child						
6	Advice						
6.1	Explains to parents findings of child's condition						
6.2	Explains need/no need for drugs						
6.3	Explains when to bring back the child						
6.I	Gives appropriate immunization advise						
6.N	Gives appropriate nutritional advise						
7	Follow-up						
7.1	Gives appointment for next visit						
7.2	Checks if mother has well understood treatment/advice given and date of next appointment						
8.	Reporting						
8.1	Completes MCH card						
8.2	Completes OPD Register						
8.3	Uses Referral Forms						
							<u>Total 'Yes'</u> <u>Total 'Yes'+ 'No'</u>
For General Child Care (all cases) <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For ARI Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For Diarrhoea Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For Immunization Management (2.I → 6.I) <i>Write number of 'Yes' scores over total number of 'I' scores</i>		/	/	/	/	/	/
For Nutritional Management (2.N → 6.N) <i>Write number of 'Yes' scores over total number of 'N' scores</i>		/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							
General Child Care:						%	
ARI Case:						%	
Diarrhoea Case:						%	
Immunization Management:						%	
Nutritional Management:						%	

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Section 1: Individual Case Management

Make final assessment on case management of the following health care activities using the scores obtained through the worksheets. For health care activities not performed in the supervised health facility, tick the box 'NA' (Not Applicable).

		Quality of Case Management			
		NA	Poor (<50%)	Insufficient (50 - <80%)	Appropriate (≥80%)
1.	Sick Child Under Five				
1.1	General Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2	Diarrhoeal Disease Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3	Acute Respiratory Infection Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4	Management of Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5	Management of Immunization Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Growth Monitoring in Child Under Three	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Immunization Session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Delivery Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Postnatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Neonatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Tuberculosis (follow-up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Feedback On The Visit

1.	Improvements noticed since previous visit:
2.	Problems identified during previous visit that need still further improvement:
3.	Problems identified during this visit:
4.	Recommendations to Health Staff:
5.	Actions to be taken by supervisor:
6.	Problems to be followed at next visit:
7.	Date of next visit: _____

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MODULE 7

INTEGRATED CHILD FOCUSSED CASE MANAGEMENT GUIDELINES

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LEARNING OBJECTIVES

LEARNING OBJECTIVES FOR INCREASED KNOWLEDGE AND UNDERSTANDING

This module is the final phase of your training and reviews the sessions of the previous days to prepare you for providing supportive supervision to your staff in the FLCFs. On completion of this session you will be able to:

1. State the rationale of Integrated Child Survival Training.
2. Describe and discuss the importance of communication among health team members within a facility and between facilities.
3. Describe and discuss the importance of teaching and counselling mothers on appropriate measures to enhance a child's well-being.
4. Describe the need for and method of referral to a District Headquarters Hospital or Teaching Hospital.
5. State the importance of monitoring and providing supportive supervision in implementation of child survival activities.

LEARNING OBJECTIVES FOR IMPROVING SUPERVISORY SKILLS

During this module you will be provided with instructions on the use of The Supervisory Checklist and Work Sheets in monitoring child health services. You will also be provided with opportunities to observe MOs and paramedics in the OPD. On completion of training you will be able to use the Supervisory Checklist and:

1. Assess your staff's competency in assessing, classifying and managing the health and medical needs of children coming to the facility.
2. Assess the availability of essential personnel and material resources in child health services and their use by the staff.
3. Identify the staff's strengths and weaknesses in case and resource management of adequate and appropriate child health services in the four intervention areas.
4. Obtain input from staff on their achievements, problems, needs and concerns.
5. Plan with staff to implement the actions necessary for improving child health services by identifying the responsibilities of the supervisor and of the staff.

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INTRODUCTION

Traditionally, diseases and their treatments have been the focus of medical training. However, the experiences of health service providers all over the world have gradually broadened this thinking. It is now recognized that children's health status is determined by many factors including biological, psychological and social factors. Biological factors are those having to do with growth and development. Psycho-social factors are environmental influences such as family income, size and composition of the family, educational level of parents or caretaker, family customs, habits and home remedies, and available health care services.

The realization that focussing only on the treatment of illness is inadequate and inappropriate has resulted in a change in medical curricula. The focus now is increasingly on the child as a growing and developing person with basic health needs that vary according to age. Health needs can be answered by health promotion services, such as the giving of required vaccines, nutritional counselling or by the diagnosis and treatment of disease. Medical needs refer to those needs arising out of illness whereas health needs cover those needs related to illness prevention and health promotion.

This course began by reviewing the objectives of PCSP training, which is to improve health services to children in four intervention areas through the training of paramedics, MOs and their supervisors. We also emphasized that all levels of health workers must work together as a team to bring about an improvement in health service.

The child survival training package is integrated in two ways. Information from the four intervention areas is put together to affect the growing child; and the efforts of all levels of health personnel are put together to better serve the child.

It is crucial that supervisors and all members of the health team remember the rationale behind the integrated approach to the child survival training.

- **The child mortality rate can be reduced significantly only by considering the total well-being of the developing child.**
- **Health professionals must work together in meeting the child's health needs. One single health professional is not capable of meeting all of a child's health needs.**
- **The involvement of the mother or caretaker is vital to improving a child's health status.**
- **Since new information in paediatrics doubles every ten years, the continuing education of health professionals is essential.**
- **In-service training must be job-specific and provided to personnel at each level of the health care system.**

In the design of this course, there were three reasons for focussing on health promotion and illness prevention. First, these are areas which in the past have received minimal attention. Second, if attention is not given to health promotion and illness prevention activities, the morbidity rate will remain high even if the mortality rate is brought down. Third, if children are visiting a facility regularly for services such as growth monitoring and immunization, their illnesses may be identified at an earlier stage. These visits also provide the opportunity for the health professional to counsel parents about personal hygiene and diet at home.

Staff of FLCFs need to be convinced that every child coming to a facility may have unrecognized health or medical needs, or both. Once the child's needs are identified, the staff must be directed to counsel the parent and to work out a plan for the child's health care with the parent.

The main training objective of this section is to prepare you as a supervisor to provide adequate and appropriate health care to children coming to your facilities. Adequate and appropriate care includes proper diagnosis, treatment, referral and follow up services based on the age and condition of the child. It also means involving the mother or caretaker at each step of the intervention.

This module specifically focusses on the supervisor's role in providing supportive supervision which includes:

- Monitoring and evaluating competency in case management as well as the availability and use of resources
- Giving periodic feedback to staff and obtaining their inputs
- Planning with staff to improve health services in the four intervention areas

During the last four days, the government's policies and programmes in these four intervention areas and the supervisor's responsibilities in each of these areas were discussed separately. In this section your newly-acquired knowledge and skills will be put together so that your supervisory role focusses on assuring adequate and appropriate care to a growing child with medical and health needs coming to a health facility. You are expected to apply this expertise to assess your staff's competency in meeting both the health and the medical needs of children.

INTEGRATED CASE MANAGEMENT GUIDELINES

The Integrated Case Management Guidelines have been developed as part of the government's newly integrated child-focussed approach to training. These guidelines are meant to be used by MOs in assessing all children coming to the facility. Supervisors are to encourage and ensure that all staff implement the guidelines for all children and to discourage them from focussing only on treatment of an identified illness as has been the prevailing practice.

As supervisors you are to help bring about a change in health service practices by assisting the staff to adopt this new approach to assessing a child for health and medical needs and to help the mother by counselling and teaching her on the needs of her child for optimal growth and development.

CASE MANAGEMENT GUIDELINES

1. Inquire of the mother her reasons for coming to the facility. List the reasons.
2. History:

Ask mother

- Age of the child
- Any change in food or fluid intake
- Any change in activity
- His/her immunization status
- Any change in motion
- Any change in urinary output
- Presence of cough or difficult breathing
- Fever

3. Assessment:

Look and Listen

- Look at general condition - colour, alertness and activity
- Cough
- Breathing - rapid, wheezing, stridor
- Runny nose
- Runny ears
- Condition of throat

Carry out the following procedure:

- Count respiration and note quality
- Take weight and record weight on growth chart
- Take temperature if indicated
- Verify immunization status
- Pinch skin to determine skin turgor

4. Classify child as:

- Having no symptoms
- Having symptoms of ARI
- Having symptoms of diarrhoea
- Having a need for immunization
- Weighing less than expected weight for age
- Having other symptoms

Refer to:

- | |
|---|
| Inform of services available from the facility for future use |
| ARI Case Management |
| Diarrhoea Case Management |
| Immunization Schedule |
| Growth Management Chart |
| Manage as per symptoms |

5. Treatment: Treat according to classification and recommendation on treatment chart and government policy.

6. Inform and instruct mother on

- Diagnosis
- Treatment at facility and at home
- Nutrition according to state of illness/health and age
- Fluid intake according to state of illness/health and age
- Symptomatic relief for pain, fever, and difficulty in breathing or eating.
- When to bring child back to facility:
 - for reassessment of present illness
 - for next immunization
 - for growth monitoring
 - when mother feels child is not well

7. For those cases which cannot be managed properly at your facility, make referrals. For the following two situations referral is a must:

- Children requiring investigations not available at the facility
- Severely ill children requiring specialized or intensive care

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A Tool For Supervisors

The Supervisory Checklist was introduced in the module on Management and Supervision. Sections of the checklist were discussed under the subsequent modules as a way to thoroughly familiarize you with this tool. In this final phase of training the checklist will be reviewed so that on completion of this section you will know how to use this tool for effective supervision.

Take out the two sections of the Supervisory Checklist. Let us review the instructions to be clear on how to use this tool.

EXERCISES

Supervisory Checklist Exercises

Take the Supervisory Checklist and the accompanying Work Sheets to the assigned centre. You have three hours for your visit. Complete the following sets of activities:

1. Pre-visit activities
2. On site activities
 - Prepare for observation of staff performance on case and resource management
 - Observation and documentation
 - Intervention
3. Post visit activities
 - Complete checklist
 - Consolidate information with other checklists
 - Make report

Supervisors Activities in Using all Work Sheets on Individual Case and Resource Management

At the beginning of training course, the duties of district level supervisor was discussed. As you have learned, these duties fall under three broad categories: management and coordination, supervision, and monitoring and evaluation. Management and coordination activities move both upward to the divisional and provincial levels as well as downward to the health facility level. Supervision, monitoring and evaluation mainly flow in downward direction to the facility level.

During these six days of training you were instructed to use the Supervisory Check list as a tool in assessing the delivery of child health services. You have been instructed to work with facility team members to verify the identified problems, develop a plan to solve these problems by identifying the responsibilities of individual team members including yourself. Finally, you were asked to develop and discuss a plan for monitoring and evaluation of the agreed upon plan. To fulfill these duties you have worked on assessments according to Individual Case Management Work Sheets #1,2,3 and Resource Management Work Sheet #4 and sections of Resource Management Work Sheets #2,3,5 and 6. This course has concentrated solely on the Child Survival Interventions areas because first, this project is child-focussed; second, your supervisees, MOs and paramedics, have been or will have been trained in Child Survival Intervention case management; and finally, in order to implement these case management guidelines it has been agreed that certain resources are essential and that it is the supervisor's responsibility to provide these resources. The Focus of this training has been mainly on supervision, monitoring and evaluation of the facility staff -- the downward flow of the supervisor's activities.

As you are well aware, not all of the Work Sheets in the Supervisory Checklist have been discussed in this training. You are advised to use complete the checklist to assess the quality and quantity of services and resources in maternal and neonatal care, malaria and tuberculosis just as you have practiced with the Child Survival Interventions. This checklist will also help focus your activities in management and coordination in the upward activity flow from the district.

For example, use the checklist to assess the staff's practice in providing maternal and neonatal care and to determine the available resources at the facility for providing these health services. Once the staff's skill in case management in assessed you can identify those prescribed steps in case management that are being carried out satisfactorily, those being carried out unsatisfactorily and those that are not being carried out at all. For resources, assess their availability and utilization. Summarize what is available or unavailable, and assess whether or not the available resources are being used properly. If resources are not being used properly, instructions on proper use needs to be included in the training.

Community development activities of the facility staff should also be looked at and summarized on the checklist. Those activities that have been suggested and are not being carried out may need to be initiated in the training either at the facility or at district level.

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You should summarize your findings on the needs and problems in all areas in a report to the DG Health on the status of activities and resources, identifying and suggesting steps that need to be taken.

For example, if staff in a facility are not carrying out prescribed activities because of lack of skill, the information should be forwarded to other projects, such as Family Health, so that the information can be used in designing a more meaningful training programme for MO's and paramedics. If the resources necessary for carrying out prescribed activities are not available at the facility, the administrators, such as the DD and DG Health, need to be informed. They can then look at the budgets and decide from where these resources can be obtained and process for approval, procurement and delivery.

In summary, you have been instructed during this week-long training session to use the Supervisory Checklist as a tool to assess the case and resource management skills of facility staff. Once an assessment is made you have been instructed to help solve, with facility staff, the identified problems in Child Survival Intervention areas so that child health services are improved. For services in maternal and neonatal care, tuberculosis and malaria, you have not received instructions. However, you can and should use the checklist to assess and identify existing problems and play an active role in planning, managing or solving the identified problems with administrative officials so that all health services in the district are improved.

APPENDICES

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Appendix 1

Statement of Work For Paramedical Staff (LHV/FHT) in Child Survival Areas

- I. As members of the health team of a RHC, BHU or OPD of a hospital (First Level Care Facility) where the team leader is the medical officer, the paramedical staff will provide mainly health promotive, illness preventive and some treatment services. The paramedical staff will specially focus on following tasks in providing child survival services as part of their total responsibility at the facility.
1. Screen all children under five and lactating women
 2. Enquire the reason for coming to the facility note down need for other than child survival services. For all children coming to the facility follow guide lines listed below. For diarrhea, and ARI follow WHO case management guidelines. For other conditions follow existing facility practices.
 3. Ask
 - Name and age of the child
 - Any change in food or fluid intake
 - Any change in activity
 - Immunization status
 - Cough or difficult breathing
 - Any change in motion or urinary output
 4. Look, and listen for:
 - General condition, color, alertness and level of activity
 - BCG mark (if not verified previously)
 - Cough
 - Breathing - rapid/wheezing/stridor/chest indrawing
 - Runny nose
 - Sore throat
 - Ear discharge

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5. Carry out following procedure:
 - Count respiration and note quality in terms of regularity/presence or absence of other respiratory symptoms.
 - Take weight and record weight on growth chart
 - Verify immunization information with immunization card.
 - Take temperature if indicated

6. Classify child as
 - 6.1 Coming for immunization
 - 6.2 Coming for growth monitoring and nutrition counselling
 - 6.3 Returning as per recommendation of the MO following treatment
 - 6.4 Having symptoms of ARI
 - 6.5 Having symptoms of diarrhea
 - 6.6 Having other symptoms that can be managed at the facility
 - 6.7 Having other symptoms that can not be managed at the facility

7. Manage the child's condition by
 - 7.1 Providing needed immunization and advise for when to return.

 - 7.2 Explain to mother child's weight curve using growth chart and identify his/her nutritional needs after completing diet assessment form and provide nutrition counselling as indicated.

 - 7.3 Obtain reports from mother on progress or lack of progress of the child's condition resulting from prescribed treatment and obtain information on present status of the child. Encourage mother to report to the MO on above points. Reinforce meeting the nutritional and immunization needs of the child.

 - 7.4 For a child suffering from ARI
 - (1) Age less than 2 months and 2 months up to 5 years with a classification of no pneumonia: cough or cold - manage as per WHO case management guidelines starting with assessment.
 - (2) Age 2 months up to 5 years with any classification of pneumonia, severe pneumonia or very severe disease - Have the child examined by a MO; Explain, demonstrate and reinforce MOs advise on case management.
 - (3) Age less than two months with classification of very severe disease and pneumonia have MO examine the child. Explain, demonstrate and reinforce MO's advise on case management.

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7.5 For a child suffering from diarrhoea

- (1) Assess all diarrhea cases and manage children classified as having no sign of dehydration and some dehydration following WHO treatment plan.
- (2) A child with severe dehydration must be seen by a MO and managed under his supervision until the child improves to be classified as having some or no dehydration.
- (3) A child suffering from diarrhea with blood in the stool or diarrhea lasting more than 14 days must be examined and managed by a MO or under his supervision.

7.6 A child suffering from other than diarrhea or ARI and whose treatment needs can be met with facility resources, - paramedics may provide illness preventive and health promotive counselling and other services. However seriously ill children must be seen and treatment prescribed by MO. The paramedic may explain, demonstrate and reinforce, MOs recommendations.

7.7 A child coming to the facility with signs and symptoms that cannot be managed with facility resources should be seen by a MO who needs to write the referral note. The paramedic staff explains reasons for referral, and discusses with parents's how to get to the referred institute, what to take their and whom to approach.

8. **Counsel mothers on:**

- Keeping children healthy by utilizing available services from health outlets and by adopting adequate personal hygiene habits, and by giving adequate amount and type of food.

II. The paramedical staff will also carry out the following support procedures to ensure appropriate, adequate and safe services.

1.

General

- Temperature Taking
- Maintaining a clean and orderly work station; ensuring availability of **drinking** water for patients and their companions.
- Maintaining assigned registers by filling in information daily.

2.

Immunization

- Loading and using the refrigerator. (When vaccinator not available)
- Checking the temperature of the main compartment and keeping a chart.
- Defrosting the refrigerator.
- Cleaning and sterilizing immunization instruments.
- Preparing for an immunization session at the facility.

3.

Nutrition and Growth Monitoring

- Correct weighing of the child and women
- Completing the growth chart and its explanation to the mother
- Diet intake and risk assessment on women and children
- Nutrition counselling specific to woman's and child's identified needs.
- Visit schedules.

4.

ARI

Instruction for giving prescribed medicine

- tablets
- syrup

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Advise mother to give home care

- Keeping the child warm
- Ear wicking
- Home remedies for sore throat and cough
- Increase fluids
- Feeding the child during and after illness
- Clearing the nose if it interferes with feeding
- When to bring child back to the facility

5.

Diarrhoea

- Maintenance of ORT
- Preparation of ORS
- Use of Home fluids when ORS not available
- Feeding during and after diarrhoea

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Appendix 2

Statement of Work For Medical Officers

A Medical Officer's technical responsibilities to children include provision of direct care by himself or through his staff for proper diagnosis, treatment, referral and follow-up, in an out-patient or in-patient Department.

1. In an Out-patient Clinic/Department.
 - 1.1 Each child attending OPD is seen by a MO. A history is taken from the mother in order to identify children who are at risk of developing health problems or who are suffering from illness.
 - 1.2 Children who have not been fully immunized are referred to receive immunization, on this visit if needed, or when it is indicated.
 - 1.3.1 Children whose weight is normal or above normal are seen with the mother and the history of food intake for the child is obtained. The MO compares his/her intake with recommended daily intake for the age group and assesses whether or not nutritional needs are being met. He/she discusses observations and findings with the mother and gives appropriate advice for the immediate or near future to prevent problems of malnutrition.
 - 1.3.2 For children whose weight is below normal for his/her age, the MO obtains nutrition history via diet recall and identifies quantity and quality of food required for recovery and maintenance of proper growth for this child. He/she discusses with the mother how she can meet these needs and advises her to return to the centre monthly until the child catches up with his/her expected weight gain.
 - 1.4 For children suffering from diarrhoea, the MO follows the diarrhoea case management guidelines.
 - 1.5 For children suffering from acute respiratory infection, the MO follows ARI case management guidelines.

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- 1.6 For children who have other diseases or who are suffering from additional symptoms, the MO diagnoses and treats accordingly, using the same process that is used in case management for diarrhoea or ARI.
- 1.7 For children who can not be managed at the facility, the MO makes a referral.

2. In an In-patient Department

- 1.1 The MO makes rounds once or twice a day to assess condition of patient. He/she discusses findings and observations with parents and asks if they have any questions. He/she responds to their queries and provides necessary information.
- 1.2 The MO makes sure that prescribed treatment or medication is administered.
- 1.3 He/she checks on patient's and caretaker's diet and makes suggestions.
- 1.4 When patient is ready for discharge, the MO talks to parents as to what to expect, what steps to take to continue to care for the child in meeting his/her medical, nutritional and immunization needs. He/she informs or suggests when child should return to the facility.

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Appendix 3

Responsibilities of District Supervisors

Statement of Work The District Level Supervisor (DHO/ADHO, FSMO/AHI) is the administrative head of all facilities in his assigned area and works closely with the MO incharge in implementing the primary health care services with a special focus in child survival intervention areas.

The duties of the District Level Supervisor fall under three broad categories: Management and coordination; supervision; and monitoring evaluation.

1. Management and coordination

- 1.1 Coordinates activities with the Director General and the Divisional Director of Health Services and the Medical Superintendent of the District Head Quarter Hospital. Regularly keeps each informed on the activities of his staff of FLC Facilities.
- 1.2 Provides policy and programme guidelines to the medical officers and paramedics of FLCF.
- 1.3 Goes over MOIC and his team members job descriptions with the MOIC and explains his/her responsibilities and limitations.
- 1.4 Receives requests for essential resources required to provide child survival and other services and arranges for their delivery quarterly and as needed.
- 1.5 Coordinates with the MS of DHQH on training of staff and in facilitating referrals to and from DHQH.
- 1.6 Coordinates with Divisional Director and or Director General of Health Services in facilitating implementation of health services from FLC facilities in his area - including planning and releasing of funds, posting of essential staff and provision of essential material resources.
- 1.7 Assures that staff have been provided with all their entitled benefits adequately i.e. housing, utilities, leaves, training etc.

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2. Supervision

- 2.1 Visits each facility at least quarterly, meets with the staff to discuss implementation of the programme and any needs they may have and provides guidance.
- 2.2 Assures provision of adequate health service including child survival services through observation of their practice and filling out of the supervisory check list.
- 2.3 Assesses staff's need for training and plans for scheduling them.
- 2.4 Participates in training at the facility or district level as indicated.

3. Monitoring and Evaluation

- 3.1 Assesses the condition of the building and needed repair and maintenance work and arranges for them.
- 3.2 Assess records/registers on:
 - Status of service provided.
 - Status of supplies, furnishings and drugs.
 - Communication, i.e. telephone, letters, fax, telexes.
 - Training
- 3.3 Submits quarterly reports or encloses the MOICs reports on:
 - Number of patients attending the clinic.
 - o/o receiving adequate care.
 - Status of staff.
 - Status of drugs, vaccines and other essential resources.
 - Number of training events, persons trained.
- 3.4 Reports annually on problems faced by his staff, how they were managed and what problems remain to be solved in the following year.
- 3.5 Submits annually budget for each facility based on current year's expenditure and services provided.

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Supervisory
Checklist

INSTRUCTIONS

September 1, 1992

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GENERAL INSTRUCTIONS

The supervisory checklist is a district level data collection instrument intended to improve quality of patient and facility management in first level care facilities.

1. Purpose

- 1.1. To help supervisors at the district level to assess as objectively as possible quality of case management and of resource management in first level care facilities under their responsibility.
- 1.2. To serve as a tool for continuing education of the staff in first level care facilities.
- 1.3. To provide to divisional, provincial, and national public health managers the necessary data for monitoring quality of care in first level care facilities.

2. Users

The supervisory checklist can be used by all types of district and tehsil/taluka level supervisors, such as District Health Officers (DHOs), Assistant District Health Officers (ADHOs), Taluka Officers, Assistant Health Inspectresses (AHIs), Field Supervisory Medical Officers (FMSOs), etc.

It can be used simultaneously by several supervisors, e.g. ADHO for curative care, AHI for maternal care etc. At the end of each quarter, the checklist should be available to the District Health Officer so that he can draft the Quarterly District Report.

3. Presentation

The Supervisory Checklist for First Level Care Facilities provides summary statements on all activities performed in the first level care facility. It first gives a framework for the preparation of a supervisory visit. It then has a Section 1 on Case Management, and a Section 2 on Resource Management. Finally it gives a framework for the provision of feedback to the health facility staff.

Following are a series of work sheets permitting the supervisor(s) to assess in detail the performance of the health staff for each of the activities in case management and in resource management, so that the statements given in the Supervisory Checklist can be made more objective.

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WORK SHEETS

Section 1: Individual Case Management

Following is a series of work sheets permitting to assess quality of care provided to patients/clients for priority health care activities:

1. Sick Child Under Five
 - 1.1 General Child Care
 - 1.2 Diarrhoeal Disease Case
 - 1.3 Acute Respiratory Infection Case
 - 1.4 Management of Nutritional Status
 - 1.5 Management of Immunization Status
2. Growth Monitoring in Child Under Three
3. Immunization Session
4. Prenatal Care
5. Delivery Care
6. Postnatal Care
7. Neonatal Care
8. Family Planning
9. Tuberculosis (follow-up)

Assessment by the supervisor is performed through **observation of the health care provider in action** (except for tuberculosis). During his supervisory visit, the supervisor selects a number of cases to be observed and uses the work sheets to make a detailed check on the case management. For most of the priority health care activities, standard case management guidelines are available and can be consulted in addition to the work sheets.

For each health care activity, observations on a maximum of five cases can be recorded. For each item, write in the appropriate box, one of the following scores:

- YES: Item was correctly performed by the staff
NO: Item was not or incorrectly performed by the staff
NA: Assessment of this item was not applicable for this particular case

At the end of the work sheet, 'Yes' and 'No' scores are totalled, and the percentage of 'Yes' scores out of the total 'Yes' and 'No' scores is calculated. These percentages can then be transferred to the supervisory checklist.

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Section 1: Individual Case Management Work Sheet 1: Sick Child Under 5	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5
	Work Area Set: <input type="checkbox"/> <input type="checkbox"/> Y N	Name of Staff: →				
1.	Rapport					
1.1	Was mother greeted?					
1.2	Was mother asked to sit down?					
1.3	Was mother asked reason for coming to the facility?					
2.	History					
2.1	Asks for age of child					
2.2	Asks change in eating/drinking pattern					
2.3	Asks change in bowel/urine output					
2.4	Asks for change in activity					
2.5	Asks for other symptoms					
2.I	Asks for child's immunization status					
2.N	Asks for nutrition intake assessment					
3.	Examination					
3.1	Looks at general condition (colour, alertness)					
3.2	Looks at condition of eyes, ears					
3.3	Looks at condition of nose, mouth, ear					
3.4	Looks at chest indrawing					
3.5	Counts respiration					
3.6	Takes skin pinch					
3.7	Takes temperature (if indicated)					
3.I	Checks Immunization Card					
3.N	Takes weight (child under 3)					
4.	Classification					
	Was child correctly classified?					
4.1	ARI case					
4.2	Diarrhoea case					
4.3	Case with other symptoms					
4.4	Case with no symptoms					
4.I	According to need for vaccines					
4.N	According to nutritional status					

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5a	Management						
5.1	Were child's needs correctly managed? According to WHO protocol for ARI case According to WHO protocol for Diarrhoea case According to acceptable standards for other cases						
5.2	Refers complicated case appropriately						
5.I	Manages correctly immunization needs of the child						
5.N	Manages correctly nutritional needs of child						
6	Advice						
6.1	Explains to parents findings of child's condition						
6.2	Explains need/no need for drugs						
6.3	Explains when to bring back the child						
6.I	Gives appropriate immunization advise						
6.N	Gives appropriate nutritional advise						
7	Follow-up						
7.1	Gives appointment for next visit						
7.2	Checks if mother has well understood treatment/advice given and date of next appointment						
8.	Reporting						
8.1	Completes MCH card						
8.2	Completes OPD Register						
8.3	Uses Referral Forms						
							<u>Total 'Yes'</u> <u>Total 'Yes'+ 'No'</u>
For General Child Care (all cases) <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For ARI Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For Diarrhoea Cases <i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/
For Immunization Management (2.I → 6.I) <i>Write number of 'Yes' scores over total number of 'I' scores</i>		/	/	/	/	/	/
For Nutritional Management (2.N → 6.N) <i>Write number of 'Yes' scores over total number of 'N' scores</i>		/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							
General Child Care:						%	
ARI Case:						%	
Diarrhoea Case:						%	
Immunization Management:						%	
Nutritional Management:						%	

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Section 1: Individual Case Management Work Sheet 2: Growth Monitoring in Child Under Three	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5	
Work Area Set: <input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1.	Tares scale to 0 at the beginning of the weighing session						
2.	Asks mother for MCH card and if first time, issues an MCH card						
3.	Determines age of child as precisely as possible						
4.	Undresses the child before weighing						
5.	Reads weight correctly						
6.	Records age correctly on MCH card						
7.	Records weight correctly on MCH card						
8.	Explains result to mothers						
9.	Talks about need to maintain breast-feeding or good weaning practices						
10.	Explains mother if child needs special feeding or other attention						
11.	Asks mother if she had any questions about child's status						
12.	Gives appropriate appointment for next weighing						<u>Total 'Yes'</u> Total 'Yes'+ 'No'
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.</i>		/	/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores over total 'Yes' and 'No' scores:							%

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Section 1: Individual Case Management Work Sheet 3: Immunization Session	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 4		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1.	Uses sterile needle and syringe for each injection							
2.	Uses correct syringe and needle							
3.	Gives injection at the correct place							
4.	Uses the correct route for injection							
5.	Records dates of immunization on appropriate cards and registers							
6.	Informs mother when the child needs to be brought back							
7.	Asks the mother to repeat the instructions to assure that she understood							
8.	Rinses and sterilizes reusable syringes and needles							
9.	Discards disposable syringes and needles							
10.	Discards opened vials of vaccines						<u>Total 'Ye</u> Total 'Yes'+	
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.</i>		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores over total 'Yes' and 'No' scores:								

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Section 1: Individual Case Management Work Sheet 4: Pre-Natal Care	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5	
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →					
1. Rapport							
1.1	Friendly attitude						
1.2	Listens carefully						
2. History taking							
2.1	Checks medical/obstetric history on first visit						
2.2	Asks for last menses						
2.3	Probes into complaints						
3. Examination							
3.1	Checks pelvis on first visit						
3.2	Checks BP, weight, oedema, urine						
3.3	Checks fundus height						
3.4	Checks position baby >32 wks						
4. Classification							
4.1	Assesses gestation period						
4.2	Identifies correct risk level						
4.3	Identifies any need for referral						
5. Management							
5.1	Provides routine drugs (FFC)						
5.2	Completes TT vaccination						
5.3	Manages problems by protocol						
6. Advice							
6.1	Advices on feeding and rest						
6.2	Warns for smoking & drugs						
6.3	Advices place of delivery						
6.4	Explains signs of labour						
6.5	Explains how to conduct home delivery						
6.6	Advices emergency action						
7. Follow-up							
7.1	Gives appointment for next check-up						
7.2	Confirms date of next visit						
8. Reporting							
8.1	Completes MCH card						
8.2	Completes Mother Health Register						
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.		/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:						%	

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Section 1: Individual Case Management

Institution Name: _____

Work Sheet 5: Labour and Delivery

Name of Supervisor: _____
(if different from front page)

Date of Supervision: _____
(if different from front page)

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set: <input type="checkbox"/> Y <input type="checkbox"/> N		Name of Staff: →						
1.	Rapport							
1.1	Helps mother to relax							
1.2	Instructs clearly and calmly							
2.	History taking							
2.1	Uses MCH card to check risks							
2.2	Identifies gestation period							
2.3	Identifies hours of labour							
3.	Examination							
3.1	Takes pulse, bp, temp.							
3.2	Checks pv bleeding, anaemia							
3.3	Counts contractions							
3.4	Checks position foetus							
3.5	Counts foetal heart rate							
3.6	Examines pelvis, cervix by VE							
4.	Classification							
4.1	Checks if labour < 12 hours							
4.2	Identifies foetal distress							
4.3	Identifies presenting part(s)							
4.4	Determines need for referral							
5a	Routine Management Labour							
5.1	Monitors pulse, bp 1/2 hourly							
5.2	Checks bladder/bowel							
5.3	Checks foetal heart 1/4 hourly							
5.4	Checks cervix/descend 2-hourly							
5.5	Gives sugary drinks							
5b	Management Normal Delivery							
5.6	Clean instruments/hands/perineum							
5.7	Controls slow delivery head							
5.8	Checks cord around neck							
5.9	Cleans mouth and nose of baby							
5.10	Checks if placenta complete							
5.11	Checks contraction uterus							
5c	Management complications							
5.12	Gives IV fluid if in shock							
5.13	Refers obstructed labour							
5.14	Resuscitates baby (protocol)							
6	Advice							
6.1	Explains risk of infection							
7	Follow-up							
7.1	Gives date for Postnatal Care visit							
8	Reporting							
8.1	Completes card and Mother Health Register							
Write number of 'Yes' scores over of total number of 'Yes' and 'No' scores		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%	

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Section 1: Individual Case Management Work Sheet 6: Post Natal Care	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1. Rapport								
1.1	Friendly attitude							
2. History taking								
2.1	Reviews history using MCH card							
2.2	Determines maternal risk factors							
3. Examination								
3.1	Checks pulse and temp							
3.2	Checks breasts, palpate abdomen							
3.3	Checks perineum/lochia							
3.4	Checks legs for thromboses							
4. Classification								
4.1	Identifies postnatal risk/problem							
4.2	Identifies need for referral							
5. Management								
5.1	Provides routine care (protocol)							
5.2	Manages puerperal pyrexia							
6. Advice								
6.1	Promotes breast-feeding							
6.2	Explains breast and lochia care							
6.3	Counsels for family planning							
7. Follow-up								
7.1	Explains any high risk							
7.2	Confirms date of next visit							
8. Reporting								
8.1	Completes MCH card and Mother Health Register							
							<u>Total 'Yes'</u> Total 'Yes'+ 'No'	
<i>Write number of 'Yes' scores over total number of 'Yes' and 'No' scores</i>		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%	

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Section 1: Individual Case Management Work Sheet 7: Neonatal Care	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1.	Rapport							
1.1	Shows interest in baby							
1.2	Keeps it on mother lap							
2.	History							
2.1	Checks birth weight on MCH card							
2.2	Asks feeding history							
2.3	Asks immunization history							
3.	Examination							
3.1	Checks respiration, pulse, temp							
3.2	Checks jaundice							
3.3	Checks umbilical stump							
3.4	Weighs and notes weight change							
4.	Classification							
4.1	Identifies neonate's risks							
4.2	Determines weight gain since birth							
4.3	Identifies major problems							
4.4	Identifies need for referral							
5.	Management							
5.1	Provides routine care according to protocol							
5.2	Manages respiratory distress							
6.	Advice							
6.1	Encourages breast feeding							
6.2	Advises on immunization							
7.	Follow-up							
7.1	Explains any high risk							
7.2	Confirms date of next visit							
8.	Reporting							
8.1	Completes MCH card and Child Health Register							
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores		/	/	/	/	/	/	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							9	

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Section 1: Individual Case Management Work Sheet 8: Family Planning	Institution Name: <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

		Case 1	Case 2	Case 3	Case 4	Case 5		
Work Area Set:	<input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →						
1.	Rapport							
1.1	Friendly attitude/approach							
1.2	Effective communication							
2.	History							
2.1	For selection of couple							
2.2	For determination of method							
3.	Examination							
3.1	Blood Pressure							
3.2	Weight / weight change							
3.3	Breasts							
3.4	Genital tract							
3.5	Circulatory system/veins							
4.	Classification							
4.1	Asks for couples preference							
4.2	Agrees on appropriate method							
5	Management							
5.1	Prescribes correct dose(s)							
6	Advice							
6.1	Explains and verifies client's understanding of correct usage of selected method							
6.2	Possible side effects							
6.3	What to do if they occur							
7	Follow-up							
7.1	How often and when to return for follow-up							
7.2	Where to go for re-supplies							
7.3	Confirms date of next visit							
8	Reporting							
8.1	Completes Family Planning portion of MCH Card or Family Planning/EPI Card							
8.2	Completes Family Planning Register							
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores		/	/	/	/	/	<u>Total 'Yes'</u> Total 'Yes'+ 'No'	
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:							%	

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Section 1: Individual Case Management Work Sheet 9: Tuberculosis (follow-up)	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

Verify the Tuberculosis Register and five Tuberculosis Facility Cards presently in use. For each card, answer the following questions by Yes, No or NA

		Case 1	Case 2	Case 3	Case 4	Case 5
	Work Area Set: <input type="checkbox"/> Y <input type="checkbox"/> N	Name of Staff: →				
9.1	Was the patient correctly registered in the Tuberculosis Register?					
9.2	Was address filled in so that patient could be traced?					
9.3	Were default actions taken according to instructions?					
9.4	Were sputum smear controls performed according to instructions?					
9.5	Where appropriate, was the final status of the patient recorded and registered in the Tuberculosis Register?					
Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.		/	/	/	/	/
Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:						

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Section 2: Resource Management

Following is a series of work sheets to assess resource management by the health care staff:

1. **Laboratory**
2. **Community Development Activities**
3. **Personnel Management**
4. **Cold Chain Management**
5. **Physical Resources Management**
6. **Record Keeping System**

These work sheets can help the supervisors to make a final assessment on the management of various resources by the facility staff. The results are transferred to the supervisory checklist.

Section 2: Resource Management Work Sheet 2: Community Development Activities	Institution Name: _____ <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

2.1 Is population chart posted visibly? Y N

2.2 Has it been updated for this year? Y N

2.3 Is a map of the catchment area posted visibly? Y N

2.4 Are the most important villages of the catchment area plotted on the map? Y N

2.5 Does staff actually know the target populations for various activities? Y N

2.6 Is the following health education material displayed in the centre?
 On Oral Rehydration Y N

On Vaccination Program Y N

On Breastfeeding Y N

On Appropriate Weaning Practices Y N

On Family Planning Y N

Verify Meeting Register

2.7 Were meetings with community leaders or with health committees held during the last quarter? Y N

2.8 Were Health Education sessions held in surrounding schools during the last quarter? Y N

In health facilities with female staff (WMO, LIIV, FHT)

2.9 Does the staff maintain regular contacts and supervise the TBAs in the villages of the catchment area? NA Y N

Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.

Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:

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Section 2: Resource Management Work Sheet 3: Personnel Management	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

Verify staffing pattern of the health facility, compare with information available in Personnel Management Register. Update Personnel Management Register where necessary.

3.1 Is a duty roster displayed in the health facility?
Y N

3.2 Are written job descriptions available to the staff?
Y N

3.3 Is the daily attendance register kept up to date?
Y N

Verify meeting register

3.4 Where an adequate number of staff meetings organized in the health facility during the last quarter?
Y N

Write number of 'Yes' scores over total number of 'Yes' and 'No' scores.

/

Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores:

%

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Section 2: Resource Management Work Sheet 4: Cold Chain Management	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

- | | | |
|---|--------------------------|--------------------------|
| 4.1 Is refrigerator placed at correct position? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.2 Is plug secured? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.3 Are door and rubber of the door in order? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.4 Is floor around the refrigerator dry (no leakage)? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.5 Is thermostat working and set correctly? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.6 Is daily temperature sheet displayed and kept up to date? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.7 Are vaccines and dilutes at proper place in the refrigerator? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.8 Are vaccines stored within the limits of the expiry dates? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.9 Are the door shelves empty? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.10 Is there an automatic generator? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.11 Is there a voltage regulator? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |
| 4.12 Are alternate arrangements made in case of power cut? | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N |

Write number of 'Yes' scores over total number of 'Yes' and 'No' scores. /

Final Assessment: Percentage of 'Yes' scores out of total 'Yes' and 'No' scores: %

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Section 2: Resource Management Work Sheet 5: Physical Resources Management	Institution Name: _____ <hr/>
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

5.1 Are the following equipment/items in good working condition?

- | | |
|-----------------------------------|--|
| Sterilizer | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
NA Y N |
| | |
| Weighing Scale (adults) | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
NA Y N |
| | |
| Weighing Scale (children) | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
NA Y N |
| | |
| First Aid Kit | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
NA Y N |
| | |
| X-Ray machine | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
NA Y N |
| | |
| Others? <i>(Make suggestions)</i> | |

5.2 Physical Inventory Equipment/Furniture/Linen (once a year)

Select 10 items as reported in last yearly report.

Does physically verified status correspond with reported status for these 10 items? *If no, discuss results with I/C.*

 Y N

5.3 Physical Inventory Drugs/Vaccines/Supplies

Select 10 items as reported in last monthly report.

Does physically verified balance correspond with reported balance for these 10 items? *If no, discuss results with I/C.*

 Y N

5.4 Transport (if available)

Verify log book for proper use of vehicle. Discuss results with I/C.

The transport means of the health facility were appropriately used as verified through the log book.

 Y N

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Section 2: Resource Management Work Sheet 6: Record Keeping System	Institution Name: _____
Name of Supervisor: _____ <i>(if different from front page)</i>	Date of Supervision: _____ <i>(if different from front page)</i>

- 6.1 All required registers and patient/client forms are in use according to the HMIS/FLCF Instructions Manual. Y N
- 6.2 Immediate reports for epidemic outbreaks were made up when necessary and duly completed. Y N
- 6.3 Immediate reports were sent out in a timely manner. Y N
- 6.4 Monthly reports were made up correctly from records and registers available in the centre. Y N
- 6.5 Monthly reports were sent out according to time schedule. Y N
- 6.6 Updated graphic representations on priority activities of the health facility are visibly displayed. Y N
- 6.7 All forms and registers are available in sufficient quantity Y N

Number of 'Yes' scores over total number of 'Yes' and 'No' scores

Final assessment:

Percentage of 'Yes' scores out of total 'Yes' and 'No' scores

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[Province] Health Department
SUPERVISORY CHECKLIST
For First Level Care Facilities

Institution Name:	Name of Supervisor:
Division:	Year:
District:	Quarter: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Tehsil/Taluka	Date of Visit: <input type="text"/> / <input type="text"/> / <input type="text"/>
Incharge Name:	

Preparation for Supervisory Visit

Date of previous visit: / /

Action taken since previous visit:

Are there special problems from previous visit that need to be followed during the current visit?

List: _____

Any special needs/requirements?

List: _____

Take the following documents with you or make photo copies of relevant parts.

1. Personnel Management Register
2. Last Monthly Report of the Health Institution
3. Last Year Report of the Health Institution (once a year)

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Section 1: Individual Case Management

Make final assessment on case management of the following health care activities using the scores obtained through the worksheets. For health care activities not performed in the supervised health facility, tick the box 'NA' (Not Applicable).

		Quality of Case Management			
		NA	Poor (<50%)	Insufficient (50 - <80%)	Appropriate (≥80%)
1.	Sick Child Under Five				
1.1	General Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.2	Diarrhoeal Disease Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.3	Acute Respiratory Infection Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.4	Management of Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5	Management of Immunization Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Growth Monitoring in Child Under Three	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Immunization Session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Delivery Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Postnatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Neonatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Tuberculosis (follow-up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Section 2: Resource Management

Make final assessment on the management performance of the health staff for the following resources, using the scores obtained through the worksheets. For resources not available in the supervised health facility, tick the box 'NA' (Not Applicable).

1. Laboratory

1.1 Microscope in good working condition

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

1.2 Laboratory diagnosis of malaria is of acceptable quality.
(Malaria diagnosis correct for $\geq 80\%$ of slides)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

1.3 Laboratory diagnosis of tuberculosis of acceptable quality.
(Tuberculosis diagnosis correct for $\geq 80\%$ of slides)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

2. Community Development Activities

Management of community development activities is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

3. Personnel Management

Personel Management is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

4. Cold Chain Management

Cold Chain Management is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5. Physical Resources Management

5.1 $\geq 80\%$ of essential equipment is in good working condition

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.2 Physical inventory check for equipment/furniture and linen is satisfactory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.3 Physical inventory check for drugs/vaccines/supplies is satisfactory

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

5.4 Transport means of the health facility were appropriately used

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

6. Record Keeping System Management

The Management of the Record Keeping System is of acceptable quality.
(A 'Yes' answer was recorded for $\geq 80\%$ of management indicators)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NA	Y	N

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Feedback On The Visit

1.	Improvements noticed since previous visit:
2.	Problems identified during previous visit that need still further improvement:
3.	Problems identified during this visit:
4.	Recommendations to Health Staff:
5.	Actions to be taken by supervisor:
6.	Problems to be followed at next visit:
7.	Date of next visit: _____

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