

PN-ABZ-950

**PAKISTAN NGO INITIATIVE PROJECT
NGO HEALTH
FACILITY-BASED ASSESSMENT**

May 12-30, 1996

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BASICS Technical Directive No.: 000 PK 00 015
USAID Contract No.: HRN-6006-C-00-3031-00

A

TABLE OF CONTENTS

ACKNOWLEDGMENTS

ABBREVIATIONS

EXECUTIVE SUMMARY	1
I. PURPOSE OF VISIT	3
II. BACKGROUND	3
III. DATA COLLECTION INSTRUMENTS	4
IV. TRIP ACTIVITIES	6
A. Briefing with MotherCare Technical Advisor	6
B. Working Meeting, The Asia Foundation	6
D. Debriefing, Presentation of Findings, and Brainstorming Session with TAF	6
V. RESULTS	7
A. SITE Frontier Primary Health Care	7
B. SITE Baltistan Health and Education Foundation	10
C. SITE: Maternal and Child Welfare Association of Pakistan	13
D. SITE Maternity & Child Welfare Association of Pakistan	16
E. SITE Family Planning Association of Pakistan	19
VI. CONCLUSIONS AND RECOMMENDATIONS	21

APPENDICES

- A. The Mandate for Measurement
- B. Instruments for the Health Facility Assessment
 - Structured Observation Checklists
 - 1. Sick Child Visit
 - 2. Equipment and Supplies
 - 3. Antenatal, Postnatal, Family Planning Visit
 - 4. Female Sterilization Procedure
 - Questionnaires
 - 1. Sick Child Exit Interview
 - 2. Health Care Worker Interview
 - 3. Antenatal Visit Exit Interview
 - 4. Postnatal visit Exit Interview
 - 5. Family Planning Exit Interview
- C. Key Indicators
- D. People Contacted
- E. Documentation

ACKNOWLEDGMENTS

"Ride this road to feel genuinely small and vulnerable"

Description of the Skardu road in: King, J. Karakoram Highway. The High Road to China. Berkeley: Lonely Planet Publications, 1993.

Our sincere thanks to The Asia Foundation and MotherCare, who so ably juggled our schedule and managed to keep us on track in the face of unpredictable weather, security concerns and lost questionnaires.

Our deepest appreciation and admiration for the dedicated NGOs who graciously received our whirlwind visit and worked so diligently with us in this mission aimed at assessing and improving the delivery of primary health care for mothers and children.

And finally to the chauffeurs who successfully navigated the Karakoram Highway and the road to Skardu—not once, but twice; we don't know how you did it, but THANKS.

ABBREVIATIONS

BASICS	Basic Support for Institutionalizing Child Survival Project
BHEF	Baltistan Health and Education Fund
CBC	Complete Blood Count
CBO	Community Based Organization
CBR	Crude Birth Rate
CC	Contraception
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
EPI	Expanded Programme on Immunization
FP	Family Planning
FPAP	Family Planning Association of Pakistan
FPHC	Frontier Primary Health Care
HGB	Hemoglobin
IEC	Information, Education and Communication
IM	Intramuscular
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MCWAP	Maternity and Child Welfare Association of Pakistan
MMR	Maternal Mortality Rate
NGO	Nongovernmental Organization
NWFP	Northwest Frontier Province
Ob/Gyn	Obstetrician/Gynecologist
OC	Oral Contraceptive
OPD	Outpatient
ORS	Oral Rehydration Solution (Salts)
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PID	Pelvic Inflammatory Disease
PNI	Pakistan NGO Initiative Project
RCT	Randomized Clinical Trial
TAF	The Asia Foundation
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UA	Urinalysis
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTI	Urinary Tract Infection
WFP	World Food Program
WHO	World Health Organization

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EXECUTIVE SUMMARY

A rapid health facility and capacity-building assessment of five nongovernmental organization participants of the Pakistan NGO Initiative (PNI) was conducted under the auspices of the Asia Foundation (TAF) from May 14-28, 1996. This exercise was designed to collect information on the quality of maternal and child health and reproductive health care delivery; clinic organization and management; availability of drugs, supplies, and materials; knowledge and skills of clinical health care workers; and the identification of possibilities for capacity-building.

The assessment was conducted by a team comprised of Dr. Patrick Kelly, BASICS technical officer, and Dr. Suellen Miller, MotherCare consultant, assisted by The Asia Foundation staff--Nasim Sherin (at Kagan) and Naveda Khawaja (at Lahore), and by the clinical supervisor of each NGO being assessed. After data collection at each location, staff members and the team met to discuss findings and identify areas for capacity-building or development. Kelly and Miller then analyzed and interpreted the data. A report on each facility was presented to the Asia Foundation on the last day of the assignment.

The facilities assessed were diverse as to location (urban, peri-urban, and rural); services provided (primary health care, curative care, MCH only, family planning); number of staff; number and types of clients; and level of funding. These differences and the small number of observations precluded any statistical analysis on aggregated data.

In general, the most basic clinical skills were performed well at most facilities. With a few exceptions, capacity building in the areas of infection prevention, interpersonal communication skills, increased male involvement in MCH and reproductive health care, and development of community participation will be necessary in these NGO facilities to achieve the PNI goal of improving access and delivery of MCH services.

The products of this mission include the survey instruments, a list of key MCH indicators derived from them, individual site assessment reports, and the overall summary report.

Next Steps

This information can serve both TAF and the individual facilities in the PNI. TAF can use these assessments as a database for decisionmaking for funding capacity-building projects within the PNI or it could use the survey instruments and key indicators to provide baseline and/or evaluation data for a country-wide situational analysis of all participating NGOs.

With translation of these tools into local languages and training of surveyors, individual facilities can use the methodology for self assessment, quality assurance, and quality improvement. Finally, the individual facilities we have assessed could use these external evaluations when applying for funding.

I. PURPOSE OF VISIT

The overall purpose of this mission was to assist in the participatory planning process for the nongovernmental organizations (NGOs) supported by the USAID-funded Pakistan NGO Initiative Project of The Asia Foundation.

The specific assistance provided by the two cooperating agencies, MotherCare and BASICS, was to design and implement a health facility situation analysis assessment tool for maternal and child health. Specific tasks included the following:

1. The development of combined situational assessment instruments for maternal and child health.
2. The pre-testing, adaptation, and finalization of the situation analysis assessment instruments in country with TAF.
3. The training of local TAF resource people to learn how to use the instruments.
4. The implementation of the instruments and initial analysis of findings.

II. BACKGROUND

The Pakistan NGO Initiative is a USAID-funded, Asia Foundation project for the support of the Pakistan government's Social Action Program, which addresses critical development issues—education, health and community organization. The overall purpose of the PNI is:

"To strengthen NGO capacity to work with local communities to increase access to social services in maternal health, child survival, female education and family planning."

The PNI strategy can be summarized as follows:

"There are three manifest needs for NGO development in Pakistan: to critique, to support and to enable. NGO performance must be critiqued through applied research and analytical evaluation. Based on the critique, support must be provided strategically to NGO activities and institutions."

The goal of the PNI is to improve knowledge and skills of NGOs and community-based organizations (CBOs) to improve the access and delivery of MCH services within their health programs. This assistance will be in the form of information, training and skills building, and a "package of tools" to use in existing programs, or the identification and the development of appropriate health activities where none exists.

The proposed core areas of appropriate technical assistance that have been identified include:

1. Participatory planning and capacity-building assessment
2. Health management and technical training
3. Development of IEC within community based systems
4. Operations research to improve NGO delivery/effectiveness of health services
5. Monitoring and evaluation for improving access/delivery of health services
6. Information documentation and dissemination.

The first core area is comprised of three activities which are described in the cooperating agency (MotherCare and BASICS) 1996 workplans:

1. autodiagnosis/community needs assessment
2. facility assessment exercises
3. state of the art workshop in November 1996

This mission to examine current practices and the quality of MCH care provided by NGO facilities represented the implementation of core activity no. 2.

The facility assessment was performed by the two consultants, Miller and Kelly, with assistance from TAF staff members at two sites (Nasim Sherin at the Frontier Primary Health Care Center, Kagan, and Naveda Khawaja at the Maternity and Child Welfare Association of Pakistan, Lahore). Due to time constraints, it was not possible to train NGO staff in the facility assessment procedures. It is the suggestion of the consultants, however, that such training would be valuable to enable NGOs to acquire the skills for self-assessment, self-monitoring, and self-evaluation of their programs that will provide the basis for quality assurance and improvement.

III. DATA COLLECTION INSTRUMENTS

Four structured observation checklists and five questionnaires were designed/adapted for this study. They are listed below and included Appendix B. The standard Situation Analysis Questionnaires developed by BASICS for use with children, the MotherCare Situational Analysis

Modules, and the World Health Organization Safe Motherhood Needs Assessment Questionnaires were adapted for use in Pakistan NGOs.

Structured Observation Checklists

1. Sick Child Visit
2. Equipment and Supplies
3. Antenatal, Postnatal, Family Planning Visit
4. Female Sterilization Procedure

Questionnaires

1. Sick Child Exit Interview
2. Health Care Worker Interview
3. Antenatal Visit Exit Interview
4. Postnatal Visit Exit Interview
5. Family Planning Exit Interview

The structured observations of the visits are a method for observing and assessing the health care worker/client interaction. The facility equipment and supply checklist assesses inventory, stockouts, logistics, and record keeping. The health care worker interviews are designed to assess aspects of the worker's training, supervision, and knowledge. The interviews with clients and mothers/caretakers of clients are designed to assess the understanding and interpretation of the visit from the client's perspective.

Key Indicators

The key indicators developed for this assessment were adapted from the BASICS indicators, modified by the addition of maternal, child, and family planning indicators used by MotherCare and WHO (See Appendix C).

IV. TRIP ACTIVITIES

A. Briefing with MotherCare Technical Advisor (May 13)

Kelly and Miller met with Judith Standley, Project Coordinator and other TAF staff. Data collection instruments were presented and modified per Standley's intimate knowledge of the situation in Pakistan. Background information on the health facilities to be visited was given. The consultants also attended a security briefing at the US Embassy with Mr. Ronald Mazer.

B. Working Meeting, The Asia Foundation (May 14)

Present at Meeting

Judith Standley and Nasima Sherin
Suellen Miller
Patrick Kelly
Dr. Emel Khan and Nusrat
Dr. Nasima Frey-Rahman
Dr. Najmi Shamim

The Asia Foundation
MotherCare
BASICS
FPHC
BHEF
FPAP

During this meeting, each NGO's representative introduced her/himself and the organization's goals and purposes in desiring to participate in this facility assessment exercise. Background materials, including the BASICS Pathway to Survival, were discussed (Appendix A), the assessment instruments were distributed, and Dr. Kelly and Dr. Miller described how these instruments would be used.

C. Field Visits for Data Collection (May 15-27)

Kelly and Miller traveled to and assessed five NGO health centers: FPHC (Mardan and Kagan), BHEF (Skardu), MCWAP (Skardu), FPAP (Lahore), and MCWAP (Lahore).

D. Debriefing, Presentation of Findings, and Brainstorming Session with TAF (May 28)

Present at Meeting

Erik Jensen
Judith Standley
Menaz Akbar
Nasim Sherin
Fatimah Afzal

TAF Representative
MotherCare Advisor
Program Officer for PNI
PNI Project Officer
Program Officer for PNI

Naveeda Khawaja
Patrick Kelly
Suellen Miller

In-coming MotherCare Health Advisor
BASICS
MotherCare

V. RESULTS

- A. SITE Frontier Primary Health Care (FPHC)**
Headquarters, Mardan and Kagan Health Center
Northwest Frontier Province
DATE May 15-16, 1996

1. Method

We worked for two days with Dr. Emel Khan and his team at Mardan and Kagan (one of four health centers). Given that the first day was women's and children's day, the center was packed with clients. The formal assessment included observation of the case management of five women (antepartum, postpartum, family planning) and five children (for diarrhea/cough/fever); interviews of two physicians (male and female), three LHVs, two TBAs, and a male CHW; and an equipment and supply inventory of the center. Thanks to the excellent help from Nasim Sherin of TAF, exit interviews were held with five mothers/caretakers (including a 9 year old sister) of children and with four women—two antenatal, one family planning, and one first-day postpartum. Sherin also translated an interview with a TBA. The community outreach program was seen by visits to a village and refugee camp with the LHVs (one-day postpartum check and woman in labor) and to a children's park and craft center. The questionnaires were supplemented by discussion, synthesis of our findings, and exploration of the priority felt needs for the program.

2. Scope of services

Originally created as a model pilot project to serve Afghan refugees, the Kagan center now provides a comprehensive package of curative and preventive services to Pakistani villages as well (13,000 total population covered). MCH activities include ante and postnatal visits, LHV-supervised TBA home deliveries, family planning (started in 1995), an EPI program, nutritional rehabilitation, and IEC extending beyond the center via home visits and a school health program. The nutrition program participates in the WFP distribution of edible oils project and, at the three craft centers, 8-12 year old girls are provided literacy and health training and taught sewing and weaving skills. Of special note is a small, well-functioning laboratory, a kitchen for nutrition demonstrations and nutritional rehabilitation of severely malnourished infants, and an ORT corner for ORS counseling, demonstration and treatment.

A baseline survey has been done for the catchment population with a file established for each family. Home deliveries are encouraged, and LHVs, TBAs, and CHWs are responsible for 25-50

households in their communities to provide basic first aid (TBAs and CHWs have kits), provide counseling and follow-up to families and refer patients to the health center when necessary.

The clinic is open five days a week with a fee of 5 rupees for outpatient curative visits. There is no charge for family planning, preventive MCH visits, immunization and tuberculosis treatment. TBAs are encouraged to charge for their delivery services. Excellent relations exist with the district hospital for referrals, which are monitored with referral forms to provide feedback to the health center.

3. Availability of services

Neither of the two physicians interviewed have had any formal refresher training in the last 12 months and the CHW interviewed claimed that he would like more training. One of the physicians had some hesitancy in remembering the EPI calendar, and the CHW did not know it at all. TBAs are well supervised by the LHVs; the LHVs are supervised by the Lady Doctor on site as well as by a Training Master who makes regularly scheduled visits (she is now on maternity leave). TBAs come to the clinic with the antenatal client, so they observe both the physical care as well as learning important instructions to the clients. LHVs knew all criteria for referral to hospital for antepartum, postpartum, and newborns. TBAs could name some of the danger signs.

The pharmacy is well supplied with all essential medicines for child case management. There is no problem of expired drugs and stock-outs.

4. Quality of services

Perhaps the best indicator of the high quality of services delivered is the remarkable fact that immunization coverage of mothers and children is virtually 100 percent. Systematic screening of all children for nutritional and immunization status is not done and, partly as a result of high case load, the history and physical examination of sick children is essentially limited to the chief complaint(s). On the other hand, the laboratory is systematically used to provide complementary information (stool exams, UA, CBC, HGB, malaria smear, skin scrapings, pregnancy tests) to the clinical impression, resulting in diagnosis and treatment that is specific, includes observation and treatment before release, and avoids the inappropriate use of medication. Instruction for the use of medication is given to clients or to mothers of children clients by the pharmacist, with additional counseling provided by LHVs and TBAs as necessary.

Antenatal and postnatal visits are extremely thorough, with all aspects of an antenatal visit performed well and recorded. Record keeping was excellent. Relationships observed between health care workers and clients (both in the clinic and at home) appeared warm and the clients were responsive. Interpersonal communication skills, especially listening skills and asking open-ended questions, need strengthening. The LHVs do not advise the mothers or the community of danger signs of pregnancy, because they do not want to scare them. All clients are aware of when they should return for follow-up.

TBA kits were in pristine condition with an empty Dettol bottle and a new bar of soap. TBAs knew the three "cleans". TBAs seemed to be more knowledgeable about newborn care and resuscitation than about emergency maternal care.

5. Management capacity

Supervision is frequent, with both oral and written feedback and monthly meetings. Record keeping is generally good, although Kelly observed cases where the road to health cards were not up to date. The first annual report of the NGO for 1995 has been published. Overall statistics are kept by each area, monthly and annually. Results of these records are used for projecting indicators.

6. Effectiveness

The physicians had adequate knowledge of indications for referral to hospital of sick children, pregnant/postpartum women, and newborn infants. Mothers interviewed knew at least one general and one specific aspect of home case management for a sick child, but only one indication of the need for seeking care from a health center. Pregnant women did not know danger signs of pregnancy.

7. Areas of capacity-building for TAF support

- ◆ In its quest for continuing funding, the NGO is attempting to shed its image as an emergency project for Afghan refugees and become known as an organization whose strategic plan is to provide long term PHC and development programs in the NWFP. Doubling outpatient fees from 5-10 rupees is being considered, but financial participation of the community can never be expected to cover more than a maximum of 10 percent of costs.
- ◆ The FPHC has a vision of being a model of PHC service and thus is interested in strengthening communication and collaboration with other programs, both governmental and in the private sector.
- ◆ There is keen interest and desire for training in a variety of areas: improved community mobilization (autodiagnosis, for example), community education, nutrition, family planning, and interpersonal communication skills.
- ◆ Proposals have been developed for two programs (preschool education and mental health) that have not yet received funding.
- ◆ A full scale evaluation of the entire FPHC program is planned for 1997 which will serve as the basis for future strategic planning.

- ◆ This site would be excellent for operations research, such as an iron study, or a feasibility study for reduced number of prenatal visits for normal multiparas.

8. Overall impressions

We give the FPHC our highest recommendations for funding. Set up to be a model of excellence for delivery of primary health care, the organization has the vision to increase not only the quality but also the scope and geographic coverage of its services. As noted, the quality of maternal and child case management and universal vaccination coverage is remarkable, making this organization an excellent candidate for eventual participation in the introduction of integrated management of childhood illness in Pakistan.

B. SITE Baltistan Health and Education Foundation (BHEF)

Rahman Clinic

Skardu, Baltistan

DATE May 18-19, 1996

1. Method

We worked for a day and a half with Dr. Nasima Frey-Rahman and her Skardu team, including Dr. Roomana Fariq, Ob/Gyn, Dr. Hans Frei, political scientist, Dr. Khurshid Shafi, visiting Ob/Gyn specialist from Lahore, and Fasima, a very experienced LHV. The formal assessment included observation of the case management of five children and 11 female clients (dermatology, parasites, joint pain, ulcers, antenatal, reproductive health) and one male adult (infertility); an interview of the two physicians and three CHWs; two surgical procedures; and an equipment and supply inventory of the center. The absence of an interpreter precluded exit interviews with the women. Evaluation of the outreach program consisted of visits to three "community health centers" in Skardu and a school health program in the village of Tinjus, 25 kilometers from Skardu. The questionnaires were supplemented by discussion, synthesis of our findings, and exploration of the priority felt needs for the program.

2. Scope of services

The overall vision of the Foundation is complete community development, health, education, literacy, appropriate technology, and women in development. The clinic provides a broad range of services focused on curative medicine and operates a small laboratory. MCH activities include child, ante and postnatal visits, family planning, and participation in national programs such as polio eradication and distribution of edible oil. Pregnant women receive tetanus toxoid but there is no EPI program for children. One physician runs a medical screening and health education program in about 40 schools and village camps. Clinic fees include 10 rupees for a child (15 with medication), 20 rupees for an antenatal visit (200 with ultrasound), 5 rupees for oral contraceptives, 10 for an IUD, and 200 for tubal ligation. Patients who can't pay are not

denied treatment. Referrals, when necessary, are made to the district hospital. CHWs dispense pills and condoms in the centers and during home visits. One LHV has been trained to do IUD insertions in the clients' homes. Mini-lap sterilizations and other minor surgeries (Miller observed the surgical excision of a vaginal skin tag) are performed in the operating theater.

All CHWs are trained in the BHEF two-year training program which is extensive and consists of daily didactic sessions as well as practical clinical training. Two CHWs assist in the clinic each day, learning by watching and doing, as a means of on-the-job training. All CHWs attend BHEF literacy training.

3. Availability of services

Neither of the two clinicians has received formal training in case management in the last 12 months. Community medical services are delivered in 15 village health centers run by female CHWs, who provide family planning for 5 rupees (pills and injections), see antenatal clients, and assist home deliveries. Other outreach activities include appropriate technology (local construction of school benches, improved kerosene stoves), tree planting, and primary education and functional literacy for girls and women. There were stock-outs of essential medicines and supplies in the last month, including antibiotics, ORS, syringes and X-ray film. When monthly air shipments from Islamabad do not arrive due to the vagaries of the weather, most needed supplies can be purchased locally.

There are seven recovery beds for difficult deliveries, postnatal rest, and surgical recovery. There is only staff for these beds during the day; no cases or deliveries are conducted in the center at night.

4. Quality of services

The assessment and classification of sick children is limited to the chief complaint(s). Thus systematic screening and recording of nutritional and vaccination status is not done and key components of the history and physical necessary for integrated case management are omitted.

Four out of five of the children observed presented with chronic gastrointestinal symptoms and distended abdomens, and were treated for intestinal parasites, without laboratory confirmation of the diagnosis.

One of the clinicians does not speak Balti and communicates with clients through an interpreter, the LHV.

All of the adult clients were seen rapidly and with little attention to IPC or health education. As the focus of the clinic is curative, medical treatment was prescribed for many complaints. In the 12 adult clients seen, one HGB was ordered; no other lab tests were ordered except for ultrasound, which three women received. Many of the patients asked for ultrasound for vague,

non-specific complaints. One client who had had an IUD removed over a year ago and who was still having irregular bleeding was given an ultrasound and then surgical D&C was recommended.

In the two surgeries observed, sterile technique was broken; there was no running water for the surgical hand scrub and bar soap was used. Sterile cloths and drapes were touched with bare, wet hands, instruments were contaminated, and there was heavy traffic in the room during the procedure. Local anesthesia was inadequate for pain control. A "dirty" vaginal case preceded the mini-lap, the theater was not decontaminated between cases.

CHWs were interviewed via double-translation from English to Urdu (provided by Dr. Nasima) to Balti (provided by Fasima, LHV). Answers were accurate, complete, and given without hesitation. All CHWs had UNICEF-distributed birth kits, the contents of which were in pristine condition, soap bars were in original wrappers, "Dettol" containers were empty.

5. Management capacity

Supervision is frequent when the director of the BHEF visits Skardu up to 10 times a year. Feedback may be oral or written. A number of monthly reports are made covering clinic, school health, and community health worker activities. Fasima, the very experienced, bi-lingual LHV, provides the CHWs ongoing supervision and classes. Record keeping by CHWs in the centers consisted of a log record of client name, age, BP, and fee paid. The delivery logs contained the same information plus the gender of the infant, and whether infant died or survived the birth experience.

6. Effectiveness

The clinicians have adequate knowledge of indications for referral to hospital of sick children, pregnant/postpartum women, and newborn infants. Both doctors have good surgical skills.

We had no opportunity to evaluate mothers' knowledge of home case management of a sick child or indications of the need for seeking services from a health center. Pregnant women's knowledge of risk signs or family planning acceptors' knowledge of methods was likewise not evaluated.

Expressed plans, needs, desires—

- Nurse/midwife volunteer for theater training and management coming from Australia
- A mobile clinic with portable ultrasound
- Assist other NGOs in proposal writing
- Expand the clinic to a hospital for women
- Train more village health workers
- Establish more reference centers

- Possible collaboration with EPI, prime minister's PHC and World Bank/UNICEF Northern Area Health Project
- Expansion of female literacy activities
- Computer training for women

6. Areas of capacity building for TAF support

- ◆ Improvement of logistical system to eliminate stock-outs
- ◆ Improvement of quality of clinical services (surgical and non-surgical)
- ◆ Specific training in asepsis, sterile techniques, and theater operations
- ◆ Improvement of supervision and follow-up of CHW activities
- ◆ Strengthening of IPC skills
- ◆ Training in such areas as integrated case management, community mobilization and promoting positive behavior change
- ◆ Operations research—randomized clinical trial (RTC) of exclusive breastfeeding; control group will be given normal care (water to newborns) and experimental group to receive breastmilk only
- ◆ Strengthening record keeping system

C. SITE: Maternal and Child Welfare Association of Pakistan (MCWAP)

Family Health Center

Skardu, Baltistan

DATE May 19, 1996

1. Method

We worked for a half day with Dr. Shazia Arif, Medical Director and her two under-training CHWs, Amna and Hosnia. The formal assessment included observation of the case management of seven women (one for family planning, one hypertensive patient for antenatal care, two with UTIs, one with menorrhagia, one PID and one for generalized pains and malaise), and two children for fever/cough and worms. We also interviewed the physician and conducted an equipment and supply inventory of the center. The absence of an interpreter precluded exit interviews with the women and time was not available to visit the periurban clinic operated by the center. The questionnaires were supplemented by a discussion session during which we

synthesized our findings, and explored areas for capacity building, strengthening, and development.

2. Scope of services

The program provides an integrated package of MCH services (including ante and postnatal visits, family planning, immunizations, nutrition and IEC), reproductive health and curative medical services. Fees include 3 rupees for vaccination, 5 for a child or antenatal visit, 5 for an injectable contraceptive and 10 for an IUD. Those patients who claim inability to pay (around 50 percent) are not denied treatment. Excellent relations exist with the district hospital for referrals and shared training. Dr. Shazia performs surgery and conducts both in-clinic and home deliveries. She also trains *dais* and TBAs and conducts health awareness radio shows.

3. Availability of services

On her own initiative, the physician received one month of training last winter in simplification of the record system, family planning, and EPI management. To increase her knowledge of various aspects of family health/primary care, she spent time learning from a dermatologist. The medical training included both theory and clinical practice; the physician's knowledge of the EPI calendar, danger signs of pregnancy, and family planning methods was correct.

A baseline survey has been done for the catchment population with a file established for each family. Home deliveries are encouraged and LHV's and TBAs have been trained, although direct client/LHV or TBA interactions were not observed. Periodic outreach camps are held in the summer months in Sadpara village.

There were stock-outs of medicines in the last month, especially antibiotics and analgesics. Limited supplies of ORS are present and vaccines present no problem, since they are readily available from the district hospital.

4. Quality of services

The physician speaks Balti, and takes the time to communicate with the clients. In all of the interactions observed, health education was integrated into the visit. The doctor demonstrated good IPC skills and was respectful to each client. Treatment for all female patients was appropriate for the diagnosis, necessary questions of the history asked, and proper screening and diagnostic procedures were performed. In prescribing treatment, those without money were given medications; those who had financial resources (determined by asking about the employment of the husband) were given prescriptions.

Partly as a result of understaffing, the assessment and classification of sick children is limited to the chief complaint(s). Thus systematic noting and recording of nutritional and vaccination

status is not done and key components of the history and physical necessary for integrated case management are omitted.

There may be some over-prescribing, since in one case a child seen for fever/cough was given an antibiotic even though the respiratory rate had not been determined and the diagnosis of pneumonia was not made.

5. Management capacity

Supervision is frequent during the six warmer months of the year, when the Mrs. Khadjija Gauhar visits Skardu from Lahore. Feedback is both oral and written. Record keeping in the clinic presents a major problem for the doctor, as the numerous report forms are mostly in English, thus precluding assistance from any of her staff. In spite of this, the registers are up to date, with annual summaries available in the home office in Lahore.

6. Effectiveness

The physician has excellent knowledge of indications for referral to hospital of sick children, pregnant/postpartum women, and newborn infants.

Without exit interviews, we had no opportunity to evaluate client knowledge of home case management, indications of the need for seeking care from a health center, and understanding of the health education received.

7. Areas of capacity building for TAF support

- ◆ More staff support is needed and difficult to acquire, since it is difficult to find trained people willing to work in Skardu
- ◆ Revision of the information system—simplification and translation of forms into Urdu
- ◆ Improved logistics to eliminate stock-outs of essential supplies
- ◆ Systematic training in such areas as integrated case management, community mobilization, and promotion of positive behavior change
- ◆ Upgrading of the skills (including literacy) of the support staff

8. Overall impressions

Dr. Shazia is an extremely dedicated physician who is running an excellent clinic. She is an exemplar of dedication and devotion, to both her individual clients and to public/primary health in Skardu. It was inspirational to find someone of her caliber willing to live in the isolated,

desolate Baltistan area. Her technical skills, infection prevention techniques, and IPC skills were all excellent. We would highly recommend her and her clinic to any funding agency considering MCWAP, Skardu for grants, donations, or training.

D. SITE Maternity & Child Welfare Association of Pakistan (MCWAP)

20-F, Gulberg II, Lahore

DATE May 26, 1996

1. Method

The team for this assessment was expanded by the addition of Naveeda Khawaja, MotherCare representative for TAF. The team arrived at the clinic and met with clinic administrative staff and executive directors (Dr. Awan, Mrs. Shahid, Mrs. Sami, Dr. Muneer, and Mrs. Gauhar) for a briefing on the purpose of our visit, the tools for the assessment, and some background and history of the MCWAP. The formal assessment included observation of provider/client interactions for three women, two antepartum and one preconceptional, and two children for cough/diarrhea; interviews of two physicians, the nursing supervisor, and one TBA; and an equipment and supply inventory of the center. Exit interviews were conducted with two female clients and with the mother of one sick child. Observation of home visits consisted of visits to two neighborhoods by the LHVs. The questionnaires were supplemented by discussion, synthesis of our findings, and exploration of the priority felt needs for the program.

2. Scope of services

The clinic provides services to conceptional and preconceptional mothers, infants, and under fives in a densely populated, poor urban community. The services are characterized as primary maternal and child care, including family planning, immunizations (TT for childbearing age women and complete immunizations for children), nutrition, health information, and education. An on-site laboratory without microscope performs HGB and UA tests. For every 5,000 population unit in their 25,000 population base, they have one LHV, one trained *dai*, and two under-training *dais*. For the total 25,000 population there is a nursing supervisor and a medical doctor. Besides center-based care, LHVs perform scheduled home visits and follow-up. The record keeping system consists of a baseline survey and comprehensive MCH file for every family in the catchment zone. This information provides the quantitative data necessary for the monitoring and evaluation of progress towards meeting the impact targets of decreasing MMR, IMR and CBR, and increasing CPR. The clinic fee structure ranges from 5-10 rupees for an OPD visit to 50 rupees for an IUD; however, no one is denied services for inability to pay. Home deliveries for all low-risk multigravida are conducted by the *dais* and LHVs; primigravid women and higher risk women are referred to the hospital. All family planning methods available in Pakistan are provided at the clinic; clients desiring sterilization are referred to FPAP or to government clinics. Community and women's development and health education and nutrition

are important aspects of care, as is the training of *dais*. The MCWAP publishes the "Mother and Child" magazine.

3. Availability of services

The center is open six days a week, with scheduled vaccinations on Tuesday and Thursdays, and antenatal clinic scheduled for those two days and Saturday. However, any type of client will be seen on the day they show up. Case management and outreach are basic to this center, so they are on-going. A posted time table of activities includes center and home visiting activities, and the following health education activities: women's development, family planning, health education, and nutrition demonstration and education classes. While the supplies and medications were neat and in order, with no stock-out in the last month, some medications on the shelves were expired. The nutritional demonstration room (for preparation of weaning foods) was well-stocked and clean.

4. Quality of services

Particularly impressive are the systematic screening of all clients and meticulously kept record forms. For example, before being examined by a physician, all children are seen by a LHV, who weighs, records the weight on a growth chart, checks the vaccination status, determines the chief complaint and nature of the illness, and takes the temperature with a thermometer if indicated. Physical examination by the physician was systematic regardless of the chief complaint. There may be a tendency to over prescribe as one afebrile child with cough and diarrhea received an antibiotic (possibly to cover a sore throat) and an anti-diarrheal, in addition to ORS.

Clients are treated with respect and the staff seems well-liked by the clients. They were readily recognized and welcomed during the home visits. There is an abundance of IEC printed materials; health related videos are shown in the waiting area. Health staff interviewed were knowledgeable on the TT schedule for women, immunization schedule for children, and risk signs for referral of pregnancy, delivery, and postnatal women and newborns. The patients referred would also be followed-up at home to assess outcomes and for on-going care. "Mortality and Morbidity" rounds are held, and every family who has experienced a death is visited.

5. Management capacity

This is definitely an area where MCWAP serves as a model for other health care providers. Supervision of non-physician staff is both informal (when supervisors and staff are working together) and formal. There are job descriptions for each position. Records are submitted monthly, quarterly, semi-annually, and annually, and results are used for assessing progress towards targets and epidemiological surveillance.

6. Effectiveness

The statistics of the MCWAP provide evidence of their overall effectiveness in meeting their goals of improved MCH indicators. Two exit interviews found good maternal knowledge. The antenatal patient reported good health education and demonstrated an adequate knowledge of risk signs of pregnancy and birth. Likewise, the mother of a sick child knew general and specific aspects of home case management, how to correctly prepare ORS, and two signs of the child getting worse at home.

7. Expressed needs

MCWAP appears to be at a turning point in their life span. On-going funding is difficult to obtain, and in some ways their effectiveness and quality in their Lahore neighborhoods may work against them in demonstrating need for sustainable funding. They have reached the end of certain funding cycles and alternative donors are being sought. In an effort to solve the especially difficult problem of finding qualified people willing to work in Skardu, the Punjabi health department in Lahore has been requested to reserve two places in the next training cycle for LHVs for women from Skardu. Another need is for the training of motivators in all communities.

8. Areas of capacity-building for TAF support

- ◆ Training support for LHVs and male motivators
- ◆ Operations research to examine necessary number of prenatal visits and streamlining record keeping
- ◆ Technical assistance in grant preparation and seeking new areas of donor participation

9. Overall impressions

We give the MCWAP our highest recommendations for funding. In the context of the rapid urbanization of Pakistan (Lahore and other cities), it is a model of excellence for delivery of primary health care to the urban poor. As noted, we were particularly impressed by the "results orientation" (so beloved by the donor community) of the planning, monitoring and evaluation process. The systematic approach to child case management already being implemented makes this organization an excellent candidate for eventual participation in the introduction of integrated management of childhood illness in Pakistan.

E. SITE Family Planning Association of Pakistan (FPAP)
Model Clinic, Lahore
Lahore, Punjab
DATE May 24-25, 1996

1. Method

We spent 1.5 days with the staff of both the central office and the Lahore Model Clinic. We observed clinical interactions between physicians (see list of names contacted) and one vasectomy client, one child (teething), three tubal ligation clients, and eleven female clients (antenatal, postnatal, postoperative, family planning, menopausal, infertility, and preconceptional). In addition, we observed LHV/client screening and counseling interactions for seven clients. We interviewed one physician and one LHV. The absence of an unbiased translator precluded exit interviews. We supplemented our observations and interviews with a group discussion, synthesis, and exploration of areas for capacity-building, strengthening, and development.

2. Scope of services

This program provides a diverse package of services, including IEC, nutrition, vaccinations, referrals, male and female surgical sterilizations, reproductive health care services, and child care, with an emphasis on family planning and maternal health. Children accompanying their mothers are examined and treated or referred to a nearby hospital if necessary.

Community development activities, such as skills training for girl children, and reproductive health extension services to the deprived "far flung" areas through mobile teams are also provided for surgical contraception, with an average each month of four camps for women and two to three for men. Laboratory tests, including HGB, UA, blood grouping, pregnancy tests, and semen analysis, are performed in the separate laboratory by trained lab technicians. There are separate floors for male and female patients. Fees for services are 5 rupees for antenatal visits, free reproductive health or family planning visits, with a charge for family planning methods ranging from 3 rupees for a cycle of OCs, 5 rupees for 12 condoms, 10 rupees for an IUD, 70 rupees for 20 foaming vaginal tablets, and 100 rupees for Norplant insertion. Antenatal clinics are screened for appropriate delivery site and provider. Those with risk factors are advised to deliver at their nearest hospital (or hospital of their choice); low-risk clients who prefer home delivery are given recommendations for trained TBAs. Counseling and health education are provided at each visit. FPAP collaborates with other NGOs providing training sessions through their Training Division.

3. Availability of services

The Model Clinic operates every day but Friday, and, with two exceptions, all services are available every day. Laparoscopic sterilizations are performed on Mondays only; immunizations

are provided on Tuesdays. Medications, family planning supplies and methods, linens, and record keeping forms were all in stock. Although staff training concentrates on family planning rather than child case management, clinicians have correct knowledge of the EPI calendar. A restricted list of medicines is stocked for children, and when injectable antibiotics are indicated, the children are referred to the hospital. ORS is available and used, although no specific ORT corner is present.

4. Quality of services

Quality of service is the "obsession" of the FPAP, with all family planning clinical procedures being performed according to written IPPF guidelines. FPAP has written country-specific manuals for theater and operations and reproductive health extension services. A quality of care manual was observed, and is currently in the process of being revised. All clients are treated with respect, the "GATHER" approach is used, and counseling and health education are integrated into each visit. IEC materials in the forms of handouts and posters for no/low literate and literate clients are displayed or distributed. In Lahore, these materials were in Urdu and English, in other areas they are in appropriate languages. Aseptic technique was observed in all non-surgical client interactions, while asepsis and sterile techniques were observed in the operating theater which is separated from all other patient and staff activities by a changing room and scrub room. Instruments are cleaned, decontaminated, and sterilized, and linens are sterilized. While surgical patients receive IM analgesia and local anesthesia, both touch and voice "anesthesia" are used for sensitive or nervous clients. Physicians and the LHV were knowledgeable about risks of various FP methods, the TT schedule for pregnant women, signs for newborn referral, and danger signs of pregnancy and delivery.

Guidelines for clinical procedures for child case management are not as formally defined as those for family planning. There is no systematic screening of all children for nutritional and immunization status and the clinic, while providing some child immunizations, does not provide all of the antigens in the national EPI program.

5. Management capacity

Supervision of the LHV was performed on site as she had ready access to all physicians. Rural LHVs receive monthly supervisory visits. In addition to her two-year LHV course, she was trained (by the Training Division) specifically in FPAP family planning training.

All providers are responsible for reports, which are submitted monthly, quarterly, semiannually, and annually. These reports are then used by central office planners to produce performance indicators for the next year.

6. Effectiveness

All observations were positive, clients appeared to understand instructions, follow-up cards were given, and follow-up/home treatment procedures were explained. Statistical records seem to indicate high utilization of clinics, repeat clients, snow ball referrals of clients, and other indicators of satisfied users. However, we could not conduct one-to-one exit interviews to validate these impressions. Clinician knowledge of signs for referral of women and children to hospital was excellent.

7. Areas of capacity building for TAF support

- ◆ Develop capabilities for Pap smear testing in this clinic by training lab technicians in Pap slide reading and classification—this could be a demonstration project/operations research project in one clinic.
- ◆ Utilize the training staff of FPAP to train other NGOs in the PNI in community development, IPC skills, IEC materials development, and asepsis/theater training.
- ◆ Together with the IPPF, the FPAP is in the process of developing a ten-year strategic plan, focusing on decentralization and a multi-sectoral approach.
- ◆ The FPAP has the expertise and interest in including an integrated package of child services in its program. The main constraint is lack of resources, partly due to the fact that IPPF funding is directly correlated to the volume of family planning activities.

8. Overall impressions

We give the FPAP, Lahore Model Clinic, our highest recommendations for funding. In all areas that we assessed, we found this clinic met, and in many cases, exceeded our standards for care and procedures. Every staff member with whom we interacted was knowledgeable in her field, helpful, and respectful to clients and family members. It is unusual to find the combination of well-developed IPC skills *and* well-developed infection prevention and surgical skills in one location. FPAP is that rare clinic where patients are treated well and safely. FPAP staff should be utilized to train other NGOs in management, IPC, IP, and operative theater training.

VI. CONCLUSIONS AND RECOMMENDATIONS

For this type of assessment to be used by the NGOs for self-assessment and diagnosis, the methodology would need to be made more user friendly, i.e., simplify the tools and training and translate the tools into Urdu or other appropriate language. If TAF were to do this as a situation analysis on a global scale, time would be needed to train the workers in each site. Ideally, two clinicians and a social scientist would be needed to do a through and unbiased analysis.

Coalition Building

In areas such as Skardu where the presence of two nominally competitive NGOs has led to parallel and duplicative service delivery, we would recommend better coordination, with the merging of skills and responsibilities where possible. Nearly all of the sites could benefit from training in IPC, and the training team of FPAP seems to be ideal for this purpose.

Presently in the United States coalitions and mergers are taking place among many individuals, organizations and institutions involved in health care services delivery. Cost-effectiveness through economies of scale and decreasing duplication of services have become key words in health care delivery reform.

In our survey of NGOs in Pakistan, we learned that the very survival of the institutions was threatened. Investigating how individual small NGOs could collaborate to decrease costs would be another research project that would benefit all NGOs.

Family Planning

Outreach to the community to develop more family planning acceptors can probably only succeed with the acceptance by the religious leaders and by utilizing male motivators. Again, this is a need for all of the NGOs.

Decreasing Maternal Mortality

WHO, UNFPA, and MotherCare have all stated that one of the most important activities that TBAs can perform to reduce maternal mortality is to know the danger signs/risk signs of pregnancy and labor and to teach them to family and community members. This was not being done in many of the NGO clinics, and we would recommend that all of the TBAs, CHWs, and *dais* be taught these signs and trained how to teach them to their patients and spread this knowledge to the community.

APPENDICES

APPENDIX A
THE MANDATE FOR MEASUREMENT

THE MANDATE FOR MEASUREMENT.

I. The end of the 20th century

A. Much is new

1. World orders
2. Democracies
3. Technologies
4. Development strategies
5. Crises
6. Health problems

B. Child survival

1. Brilliant successes
 - a. EPI, ORS
2. Daunting challenges
 - a. Malnutrition, AIDS
 - b. Resistance to medicines
 - (1) Malaria
 - (2) STD, tuberculosis

C. Two important questions

1. We have funding today, but for how long?
2. If funds are scarce, why use them for surveys?

II. The importance of measurement

A. Since we are assured that the all-wise Creator has observed the most exact proportions of number, weight and measure in the make of all things, the most likely way therefore to get any insight into the nature of those parts of the Creation which come within our observation must in all reason be to number, weigh and measure.

Stephen Hale (1677-1761), English scientist

III. The mandate to measure intensifies

A. International agencies

1. WHO: Progress towards health for all by the year 2000
2. UNICEF: Mid and end of decade goals of the UN child summit in 1992
3. USAID
 - a. Agency goal: Stabilizing world population and protecting human health
 - (1) Strategic Objective 3. Reduce infant and child mortality
 - (a) Definition of Results Packages

B. Specific objectives for the year 2000

1. Reduction of 1990 levels of IMR by 1/3 or to 50/1000 live births
2. Reduction of under fives mortality by 1/3 or to 70/1000 live births
3. Reduction of maternal mortality by 50%

C. The challenge is increasing needs in the face of decreasing budgets

D. There is a need for impact evaluation and the demonstration of trends

E. Indicators of sustainability will serve as a litmus test that will determine whether projects do or do not get funded

IV. The BASICS project (Basic Support for Institutionalizing Child Survival)

A. The continuation of CCCD, PRITECH, REACH and HEALTHCOM

B. The mandate

1. Increase the survival of children under 5 years of age

C. Strategic objectives

1. Conceptual model of the Pathway to Survival

2. Technical agenda

a. Integrating preventive and curative services - ICM

b. Developing sustainable immunization programs

c. Strengthening nutrition in child health programs

d. Promoting positive health behaviors

e. Establishing public-private partnerships

f. Improving monitoring and evaluation

g. Mission statement: Increase the capacity of developing countries to plan, implement and sustain effective public health programs

(1) End of project objective: To have developed, tested and implemented indicators and instruments for child survival program monitoring and evaluation

(2) Conceptual models

(a) Project management system (Cycle)

(b) Project planning and evaluation logic

(c) The evaluation process

(3) Program evaluation approach

(a) Hierarchy of results

i) Process and output

ii) Outcomes

iii) Impact

(b) Indicator spectrum

i) Qualitative and quantitative

(c) Approaches implemented by BASICS

i) Measuring process and output

ii) Measuring outcome and impact

a) Household surveys

b) Community diagnosis

c) Rapid Health Facility Assessment

d) Private sector and social marketing analysis

e) Health status: Mortality and morbidity (PBT)

APPENDIX B

Pakistan NGO Initiative

Instruments

for the

Health Facility Assessment

conducted by

The Asia Foundation

with technical assistance from

MotherCare and BASICS

May 1996

**Health Facility Assessment
Observation Checklist - Sick Children**

Province _____	Date ___/___/___
Facility name _____	Facility type _____
Interviewer no. _____	Childs age (months) _____ ID No. _____

--BEGIN TIMING THE INTERVIEW NOW--TIME: _____

1. What reason does the mother give for bringing the child to the health center? (Tick all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Fever/malaria | <input type="checkbox"/> Difficulty breathing/cough/pneumonia |
| <input type="checkbox"/> Diarrhea/vomiting | <input type="checkbox"/> Other: (specify) _____ |

Screening

Does the health worker determine the child's:

- | | | |
|---------------------------------------|---|---|
| 2. Date of birth | Y | N |
| 3. Age by asking mother | Y | N |
| 4. Weight | Y | N |
| Plot weight on a weight for age chart | Y | N |
| 5. Temperature: By thermometer | Y | N |
| By touch | Y | N |
| 6. Respiratory rate | Y | N |

Does the health worker ask questions about:

- | | | | |
|--|---|---|-----|
| 7. Drinking or eating | Y | N | |
| 8. Breastfeeding | Y | N | N/A |
| 9. Convulsions | Y | N | |
| 10. Vomiting | Y | N | |
| 11. Change in consciousness/lethargic/sleepy | Y | N | |
| 12. Nature of illness | Y | N | |
| 13. Duration of illness | Y | N | |

All key history questions (Q. 7 to Q. 13) asked?	Y	N
--	---	---

- | | | |
|---------------------------------------|---|---|
| 14. History of fever | Y | N |
| 15. History of diarrhea | Y | N |
| 16. Number of stools in past 24 hours | Y | N |
| 17. Blood in the stool | Y | N |
| 18. History of cough | Y | N |
| 19. History of difficulty breathing | Y | N |
| 20. History of measles | Y | N |
| 21. History of home treatment with: | | |
| Herbs/traditional medicine | Y | N |
| Western medicine | Y | N |

22. Does the health worker ask for the child's immunization card? Y N

If NO, go to question 23

If YES, does the child have card Y N

If the child has card: Is the child referred for immunization

Today Another day Not referred Up to date

If child has NO immunization card, does health worker:

Criticize the mother Y N

Ask mother to return with card Y N

Refuse to vaccinate child Y N

Vaccinate child and give another card Y N

Vaccinate child and not give new card Y N

Vaccinate and tell mother to bring card next time Y N

23. Does the health worker ask for the mother's vaccination card Y N

If NO, go to question 24

If YES, does mother have card Y N

If the mother has card: Is the mother referred for vaccination

Today Another day Not referred Up to date

If she does NOT have card does the health worker:

Ask mother number of doses of TT received? Y N

Ask mother to return with card Y N

Refuse to vaccinate mother Y N

Vaccinate mother and give another card Y N

Vaccinate mother and not give new card Y N

Vaccinate and tell mother to bring card next time Y N

Examination

Does the health worker examine the child's

24. Ears Y N

25. Chest:- by counting respiratory rate Y N

- by stethoscope Y N

26. Skin turgor Y N

27. Look for pallor (conjunctival/palmar) Y N

28. Pitting oedema (Kwashiorkor) Y N

All key areas examined?	Y N
-------------------------	-----

Diagnosis and treatment

Does the health worker diagnose the child as having:

29. Diarrhea/gastroenteritis Y N

30. Dehydration Y N

If YES, is it Mild Severe Not Stated

31. Dysentery/bloody diarrhea Y N

32. Cold/allergy	Y	N
33. Pneumonia	Y	N
34. Malaria	Y	N
35. Fever, other cause	Y	N
36. Measles	Y	N
Malnutrition	Y	N
37. Other	Y	N
38. Does not make a diagnosis	Y	N

What does the health worker administer or prescribe for the child
(Circle ALL that apply)

	Administer		Prescribe	
39. Chloroquine injection	Y	N		
40. Chloroquine tablets/syrup	Y	N	Y	N
41. Paracetamol/Aspirin	Y	N	Y	N
42. Tepid bath	Y	N	Y	N
43. Antibiotic injection	Y	N		
44. Antibiotic tablets/syrup	Y	N	Y	N
45. Vitamin A or vitamins	Y	N	Y	N
46. ORS./RHF	Y	N	Y	N
47. Antimotility/antidiarrheal	Y	N	Y	N
48. Metronidazole tablet or syrup	Y	N	Y	N
49. Tablet or syrup, unknown type	Y	N	Y	N
50. Injection, unknown type	Y	N	Y	N
51. None	Y	N	Y	N

Is the treatment appropriate for the diagnosis?	Y	N	
Diarrhea case treated with an antibiotic?	Y	N	N/A
Dysentery case treated with an inappropriate antibiotic?	Y	N	N/A
Malaria case treated with an inappropriate drug?	Y	N	N/A
ARI case treated with an inappropriate drug?	Y	N	N/A

52. Does the health worker explain how to administer oral medications?		Y	N
53. Does the health worker demonstrate how to administer oral medications?		Y	N
54. Does the health worker ask an open-ended question to verify the comprehension of how to administer medications?	Y		N
Does the health worker explain the need for continued home care? (Feeding, fluids, etc.)		Y	N
55. Does the health worker explain when to return for follow-up?	Y		N
56. Did the health worker tell the caretaker to bring the			

child back for the following signs?

Child is not able to drink or drinking poorly	Y	N
Child is not able to breast-feed	Y	N
Child becomes sicker	Y	N
Child develops a fever	Y	N
Child develops fast or difficult breathing	Y	N
Child develops blood in the stool	Y	N

Are at least two of Q. 56 messages checked?	Y	N
---	---	---

57. Does the health worker ask an open-ended question to verify the comprehension of when to return with the child? Y N

If ORS is given or prescribed, does the health worker:

58. Explain how to prepare ORS Y N

59. Demonstrate how to prepare ORS Y N

60. Ask the mother to demonstrate how to prepare ORS Y N

Does the health worker:

61. Ask the mother questions to see if she has understood Y N

62. Ask the mother if she has any questions Y N

63. Criticize mother or show disapproval Y N

64. Send the mother to education class Y N

CHECK THE TIME OF THE INTERVIEW AS THE MOTHER LEAVES:

TIME: _____ DURATION OF INTERVIEW: _____ minutes

END OF HEALTH WORKER OBSERVATION

**Health Facility Assessment
Equipment and supply checklist.**

Province _____	Date ___/___/___
Facility Name _____	Facility type _____
Interviewer No. _____	

Facility type: ___ Public ___ Private
 ___ Mission ___ NGO
 ___ Other: (Specify) _____

Patient and worker accommodation

- | | | | |
|---|---|---|--|
| 1. Is there adequate seating for patients | Y | N | |
| 2. Is there a desk for workers | Y | N | |
| 3. Is there potable water | Y | N | |
| * Is there electricity | Y | N | |
| 4. Is there a toilet or latrine | Y | N | |
| If YES: Is it locked | Y | N | |
| Is it accessible | Y | N | |
| Is it clean | Y | N | |
| Is it working | Y | N | |
| 5. Do workers greet patients as they come in | Y | N | |
| 6. Are health information posters displayed? | | | |
| For child case management | Y | N | |
| * For maternal case management | Y | N | |
| IF YES: Are they written in the local language. | Y | N | |
| 7. Is an ORT corner present and being used | Y | N | |

Equipment and supplies

Are the following equipment and supplies present in the clinic
 If YES, in working order?

- | | | | |
|---------------------------------|---|---|-----|
| * Means of transportation | | | |
| Car | Y | N | Y N |
| Motorcycle | Y | N | Y N |
| Motorbike | Y | N | Y N |
| Bicycle | Y | N | Y N |
| * Sink or basin for handwashing | Y | N | Y N |
| * Soap/product for handwashing | Y | N | |
| * Light | Y | N | Y N |
| 8. Thermometer | | | |
| Child | Y | N | Y N |
| * Adult | Y | N | Y N |
| * Blood pressure cuff | Y | N | Y N |
| * Medical Stethoscope | Y | N | Y N |
| * Fetoscope | Y | N | Y N |
| 9. Otoscope | Y | N | Y N |
| 10. Weighing scale | | | |

- * Adult Y N Y N
- * Baby Y N Y N
- * Table model Y N Y N
- * Salter Y N Y N
- 11. Watch with a second hand or other timing device Y N Y N
- 12. Steam sterilizer Y N Y N
- 13. Cooker or stove Y N Y N
- 14. Measuring and mixing utensils? Y N Y N
- 15. Cups and spoons? Y N Y N
- * Examination table/stirrups Y N Y N
- * Vaginal speculum Y N Y N
- * Gloves Y N Y N
- * Sheets Y N Y N
- * Laboratory supplies
- * Microscope Y N Y N
- * Equipment for hemoglobin Y N Y N
- * Equipment for urinalysis Y N Y N
- * Equipment for pregnancy tests Y N Y N
- 16. Refrigerator Y N Y N
- If NO, go to question 17
- Type: Electric Kerosine Gas Solar
- Condition: Good Fair Poor
- Thermometer inside? Y N Temp: _____
- Temperature chart? Y N
- In last 30 days, temperature recorded up to date? Y N
- Temperature above 8C _____ (number of days)
- Temperature below 0C _____ (number of days)
- 17. Frozen cold packs? Y N
- 18. Cold boxes Y N
- Condition: Good Fair Poor
- 19. Are communications materials available?

Type of material	Quantity	Main topic/message
Flipchart		
Posters		
Counseling cards		
Pamphlets		
Other (Specify) _____		

- * Specific Educational materials available for women
- * Pregnancy nutrition/need for iron Y N
- * Warning signs of complications of pregnancy Y N
- * Breast-feeding Y N

- * Family planning Y N
 - * STD/HIV/AIDS Y N
- Documentation and record keeping

Are the following items present in the clinic?

REGISTERS

- | | | | | | |
|-----|------------------------------------|---|---------------------------|---|---|
| | | | If YES, is it up to date? | | |
| 20. | Immunization register for children | Y | N | Y | N |
| * | Consultant register | Y | N | Y | N |
| * | Referral/transfer register | Y | N | Y | N |
| * | Prenatal visits | Y | N | Y | N |
| * | Maternity visits (Deliveries) | Y | N | Y | N |
| * | Postnatal visits | Y | N | Y | N |
| * | Family planning visits | Y | N | Y | N |

A STOCK OF FORMS

- | | | | |
|-----|--|-------|---|
| 21. | Health cards/vaccination for children | Y | N |
| 22. | Health cards /vaccination for women | Y | N |
| 23. | Notifiable disease report forms | Y | N |
| 25. | Total Number of patient visits in last month | _____ | |
| * | Children under five years of age | _____ | |
| * | Prenatal visits | _____ | |
| * | Deliveries | _____ | |
| * | Postnatal visits | _____ | |
| * | Family planning acceptors | _____ | |
| 26. | Average number. of patients seen per day | _____ | |
| 27. | Are immunization tally sheets kept? | Y | N |
| 28. | Were there any stock-outs in the last month? | Y | N |

IF YES:

Item	Number of stock-outs last 30 days
Vaccines	
Syringes/needles	
ORS	
Drugs	
Cards/forms	

Availability of drugs and other supplies the day of the survey:

Tick all conditions that apply for each item

- | | | | | | |
|-----------------|----------------------|------------------|-----|------------------|-----|
| Supplies | | Available | | Available | |
| ----- | | | | | |
| 29. | Drugs for pneumonia: | _____ | Y N | _____ | Y N |
| 30. | Drugs for Shigella: | _____ | Y N | _____ | Y N |
| 31. | Drugs for cholera: | _____ | Y N | _____ | Y N |
| 32. | Drugs for malaria: | _____ | Y N | _____ | Y N |

33.	Quinine IM	Y	N
34.	Benzympenicillin IM	Y	N
35.	Chloramphenicol IM	Y	N
36.	Paracetamol	Y	N
37.	Tetracycline eye ointment	Y	N
38.	Gentian violet	Y	N
39.	Iron	Y	N
40.	Vitamin A	Y	N
41.	Mebendazole	Y	N
42.	Sterile water for injection	Y	N
43.	ORS	Y	N
44.	IV solution for severe dehydration	Y	N
45.	Needles	Y	N
46.	Syringes	Y	N

Vaccines

Available

47.	BCG	Y	N
48.	OPV	Y	N
49.	DPT	Y	N
50.	Measles	Y	N
51.	TT	Y	N

Maternal Health and Family Planning

*	Contraceptives		
*	Oral		
*	Combined high/standard oestrogen (>35 mcg)	Y	N
*	Combined low oestrogen (<35 mcg)	Y	N
*	Progesterone only "mini pills"	Y	N
*	Injectable		
*	Depoprovera (3 months)	Y	N
*	Norestat (2 months)	Y	N
*	Sub-dermal implants (Norplant)	Y	N
*	IUDs	Y	N
*	Condoms	Y	N
*	Reproductive health		
*	Folic acid or combined ferrous sulfate/folic acid	Y	N
*	Ergometrine	Y	N
*	Antibiotics		
*	Ampicillin	Y	N
*	Erythromycin	Y	N
*	Ceftriaxone	Y	N
*	Gentamycin	Y	N
*	Kanamycin	Y	N
*	Sulfamethoxazole + trimethoprim	Y	N
*	Antihypertensive for preeclampsia	Y	N
*	Anticonvulsant		
*	Diazepam	Y	N
*	Magnesium Sulfate	Y	N
52.	Are expired drugs in the clinic?	Y	N
	IF YES, which ones?		

53. Are expired vaccines in the refrigerator? Y N
IF YES, which ones _____

54. Are frozen vials of DPT or TT in the refrigerator? Y N

Management of drugs and other supplies

55. Are drugs/other supplies stored in a locked cabinet? Y N

56. Are stock cards available for the essential drugs ? Y N

57. Are drugs and ORS packets stored in a cool, dry place? Y N

Organization of clinical tasks: Based on observations, tick all staff who regularly do each task. If other, specify the staff position (eg. Lady health visitor, TBA, etc.)

Tasks	Doctor	Nurse	Other	No-one
58. Registers patients				
59. Manages triage/patient flow				
60. Weighs children				
61. Charts growth				
62. Takes patient temperature				
63. Assesses/classifies illness				
64. Assesses feeding problems				
65. Prescribes drugs				
66. Gives ORS at facility				
67. Completes patient records				
68. Dispenses drugs				
69. Gives first dose of drug				
70. Instructs how to give drugs				
71. Instructs how to give ORS				
72. Advises on feeding/nutrit.				
73. Advises on other home care				
74. Immunizes children				
* MATERNAL CARE	-----	-----	-----	-----
* Takes blood pressure				
* Weighs				
* Measures fundal height				
* Listens to fetal hearts				
* Tests urine				
* Discusses delivery plans				
* Gives vitamins/iron				
* Teaches breast-feeding				
* Counsels family planning				
* Dispenses FP methods				

END OF EQUIPMENT AND SUPPLY CHECKLIST

Location	Y	N
Attendant	Y	N
If planned home delivery, does the health worker discuss backup plans for transportation to health facility?	Y	N
24. Breast-feeding	Y	N
25. Plans for child spacing	Y	N
26. Fetal movement	Y	N

Does the health worker teach the pregnant woman the "danger signs" of pregnancy:

27. Bleeding	Y	N
28. Headache/problems with eyes	Y	N
29. Swelling	Y	N
30. Fits/convulsions	Y	N
31. Fatigue/breathlessness	Y	N
32. Fluid/water from vagina	Y	N
33. Does the health worker ask to see the woman's immunization record?	Y	N
34. Does the health worker give women with low hgb/anemia iron and folate?	Y	N
35. Does the health worker provide pregnant women with malaria prophylaxis or treatment?	Y	N

Part B: Postpartum Visit - Does the health worker determine:

36. Date of delivery or age of child	Y	N
37. If operation or vaginal delivery	Y	N
38. If complications of delivery	Y	N
39. If still bleeding	Y	N
40. If breast-feeding	Y	N
41. Resumption of sexual relations	Y	N
42. Plans for child spacing	Y	N

Does the health worker examine:

43. Weight	Y	N
44. Blood pressure	Y	N
45. Breasts	Y	N
46. Abdomen	Y	N
47. Vaginal exam	Y	N

Does the health worker check laboratory tests for the postpartum woman:

48. Urine	Y	N
49. Hemoglobin	Y	N
50. Does the health worker ask to see the woman's immunization record?	Y	N

Part C: For postpartum family planning and family planning only women

51. Does the health worker talk to the woman about family planning methods: (Tick all that apply)
- | | | |
|-------------------------------------|---|---|
| a. No sex | Y | N |
| b. Traditional method | Y | N |
| c. Natural family planning | Y | N |
| d. Lactational amenorrhea | Y | N |
| e. Withdrawal | Y | N |
| f. Pill | Y | N |
| g. IUD | Y | N |
| h. Injection (Depoprovera/Norestat) | Y | N |
| i. Subdermal implant (Norplant) | Y | N |
| j. Sterilization | Y | N |
| k. Condom | Y | N |
| l. Other | Y | N |
- Specify: _____

52. Does the health worker talk about possible side effects: (Tick all that apply)
- | | | |
|-------------------------------------|---|---|
| a. No sex | Y | N |
| b. Traditional method | Y | N |
| c. Natural family planning | Y | N |
| d. Lactational amenorrhea | Y | N |
| e. Withdrawal | Y | N |
| f. Pill | Y | N |
| g. IUD | Y | N |
| h. Injection (Depoprovera/Norestat) | Y | N |
| i. Subdermal implant (Norplant) | Y | N |
| j. Sterilization | Y | N |
| k. Condom | Y | N |
| l. Other | Y | N |
- Specify: _____

53. Does the health worker talk about how the methods work: (Tick all that apply)
- | | | |
|-------------------------------------|---|---|
| a. No sex | Y | N |
| b. Traditional method | Y | N |
| c. Natural family planning | Y | N |
| d. Lactational amenorrhea | Y | N |
| e. Withdrawal | Y | N |
| f. Pill | Y | N |
| g. IUD | Y | N |
| h. Injection (Depoprovera/Norestat) | Y | N |
| i. Subdermal implant (Norplant) | Y | N |
| j. Sterilization | Y | N |
| k. Condom | Y | N |
| l. Other | Y | N |
- Specify: _____

54. Does the health worker provide the woman with the method or explain to her where she can get it? Y N

55. Does the health worker explain risk/danger signs of a method that would indicate a need for the woman to come back? Y N

FOR ALL ADULT WOMEN PATIENTS

- | | | |
|--|---|---|
| 56. Does the health worker ask open-ended questions to check if the woman has understood what she has been told? | Y | N |
| 57. Does the health worker ask the woman if she has any questions? | Y | N |
| 58. Does the health worker speak to the woman respectfully and treat her kindly? | Y | N |
| 59. Does the health worker explain to the woman when she needs to return for her next appointment? | Y | N |

END OF HEALTH WORKER OBSERVATION

**Health Facility Assessment
Surgical Checklist - Female Sterilization**

Province _____	Date ____ \ ____ \ ____
Facility name _____	Facility type _____
Interviewer no. _____	

- | | | |
|--|---|---|
| 1. Changing room/or changing area/scrub area | | |
| Soap dispenser | Y | N |
| Running water | Y | N |
| Sterile towel | Y | N |
| Scrub brush | Y | N |
| | | |
| 2. Does health worker participating in surgery: | | |
| Know proper surgical scrub technique | Y | N |
| Air dry hands or use sterile towels | Y | N |
| Gown in aseptic manner | Y | N |
| Glove in aseptic manner | Y | N |
| Not contaminate herself, her instruments, or others | Y | N |
| | | |
| 3. Is patient prepped? | Y | N |
| | | |
| 4. Does patient have appropriate level of anesthesia? | Y | N |
| | | |
| 5. Is the patient greeted, fears allayed, reassured of progress? | Y | N |
| | | |
| 6. Is the bedding changed? | Y | N |
| | | |
| 7. Is proper surgical technique utilized? | | |
| Mini-lap | Y | N |
| Laposcopic | Y | N |
| | | |
| 8. Are instruments cleaned, decontaminated between patients? | Y | N |
| | | |
| 9. Are instruments sterilized by boiling autoclave/gas | Y | N |
| | | |
| 10. Is the room decontaminated between patients? | Y | N |
| | | |
| 11. Are gowns and gloves changed between patients? | Y | N |

- Gave ORS / RHF
 Herbs/traditional medicine
 Other treatment: specify _____

If the child is under 6 months, what are you feeding him/her?

9. Have you ever heard of:

- ORS for diarrhea? Y N
 Rehydrating home fluid for diarrhea? Y N
 If NO, go to question 12
 IF YES, why do people give ORS/RHF to children with diarrhea?

- To prevent dehydration
 To stop diarrhea
 Other: specify _____
 Doesn't know

10. Have you ever been shown how to prepare:

- ORS? Y N
 RHF? Y N

11. How do you prepare:

- ORS?
 Correct (mix 1 packet with 1 litre of water)
 Incorrect
 Doesn't know
 RHF?
 Correct (mix 8 tsp. sugar and 1 pinch salt with 1 litre of water)
 Incorrect
 Doesn't know

12. Does the child have FEVER or MALARIA Y N

If NO, go to question 14

If YES:

13. What did you do to treat the fever at home?

(Tick all that apply) SHOW SAMPLE MEDICINES IF NECESSARY

- Nothing
 Gave aspirin/paracetamol Gave chloroquine other antimalarial
 Gave antibiotics Gave herbs traditional medicine
 Gave tepid bath Remove the child's clothing
 Other: specify _____

14. Does the child have:

COUGH or DIFFICULTY BREATHING or PNEUMONIA? Y N

If NO, go to question 16

15. What did you do to treat the child at home?

(Tick all that apply) SHOW SAMPLE MEDICINES IF NECESSARY

- Nothing
 Gave aspirin/paracetamol Gave antibiotics

Gave cough medicine Gave herbs/traditional med
 Applied mentholatum
 Other: specify _____

16. Did the health worker give you any medicines at the clinic today? Y N
 If NO, go to question 17
 If YES, complete the table below:

For any ORAL medicines that the mother mentions, fill in the information in the table below by asking:

HOW MUCH medicine will you give the child EACH TIME?
 HOW MANY TIMES will you give it to the child EACH DAY
 HOW MANY DAYS will you give the medicine to the child?

Medicine	How much each time	Correct Y/N	Times /day	Correct Y/N	Days	Correct Y/N	All Corr Y/N
Chloroquine	_____	_____	_____	_____	_____	_____	_____
Antibiotic	_____	_____	_____	_____	_____	_____	_____
Paracetamol	_____	_____	_____	_____	_____	_____	_____
Aspirin	_____	_____	_____	_____	_____	_____	_____
ORS/RHF	_____	_____	_____	_____	_____	_____	_____
Antidiarrheal	_____	_____	_____	_____	_____	_____	_____
Cough mixture	_____	_____	_____	_____	_____	_____	_____
Vitamins	_____	_____	_____	_____	_____	_____	_____

Caretaker knows correctly (how much, how many times, how many days) for ALL medications prescribed? Y N

Child has: Diarrhea Fever/Malaria ARI

17. What will you do for your child when you return home?
 (Tick all that apply)

Doesn't know

General	Diarrhea	Fever/malaria	ARI
<input type="checkbox"/> Continue feeding/ breast-feeding	<input type="checkbox"/> ORS/RHF <input type="checkbox"/> more fluids	<input type="checkbox"/> Antimalarial <input type="checkbox"/> Paracetamol/ aspirin	<input type="checkbox"/> Antibiot
<input type="checkbox"/> Complete course of medications	<input type="checkbox"/> fluids after each stool/vomit	<input type="checkbox"/> Tepid bath	
<input type="checkbox"/> Bring the child back if he/she doesn't get better or gets worse			

Other: specify _____

Mother knows at least 1 general and 1 specific aspect of home case-management

Y N

18. Has your child ever received an immunization? Y N

19. How did you learn when and where to come for immunization?
(Tick all that apply)

Doctor/nurse/midwife Community health worker
 Community volunteer Radio
 Poster Television
 Neighbor or friend Health education class
 Other: specify _____

20. Where do you normally take your child for immunizations?
(Tick all that apply)

this clinic another clinic
 mobile clinic Never immunized before

21. Which diseases will be prevented by the immunizations you or your child have received?
(Tick all that apply)

Don't know Measles
 Diphtheria Tuberculosis
 Tetanus Polio
 Whooping cough Other: specify _____

22. Do you know what might happen as a side effect after the immunization? Y N
If YES, what were you told? (Tick all that apply)

Fever Pain at injection site
 Irritability Swelling Other: specify _____

23. Have you or your child ever come to this clinic to be vaccinated and been turned away for any reason? Y N
IF YES, what was the reason? (Tick all that apply)

Immunization session canceled
 Immunization session stopped before the mother arrived
 No immunization session the day of the visit
 Child was ill
 Clinic had run out of vaccine or supplies

If the mother has the card, record the dates of ALL VACCINES GIVEN, both today and in the past, and the child's birth date and age.

Birth date: ___/___/___ OR Age: ___ Months

IMMUNIZATION			
Polio-0 (birth)	Received	Y	N
BCG	Received	Y	N
DPT-1	Received	Y	N
Polio-1	Received	Y	N
DPT-2	Received	Y	N
Polio-2	Received	Y	N
DPT-3	Received	Y	N
Polio-3	Received	Y	N
Measles	Received	Y	N

Child is up to date? Y N

Did the child receive a vaccination today Y N N/A (Up to date)

28. Do you have your own vaccination card?

Yes No Lost Never received Left at home

IF YES, copy the mothers tetanus toxoid vaccinations in the table below. If the mother's TT doses are recorded on the child's vaccination card, copy them here also.

IMMUNIZATION			
TT-1	Received	Y	N
TT-2	Received	Y	N
TT-3	Received	Y	N
TT-4	Received	Y	N
TT-5	Received	Y	N

Mother is up to date?

Y N

29. Did you receive a tetanus vaccination:

Today

Referred for vaccination another day

Was not given or referred for tetanus vaccination

30. When do you listen to the radio?

(Tick all that apply) PROMPTED QUESTION

Every day

At least once a week

Every 2 weeks

Every month

Less frequently than every month

Never listen

31. How much did you have to pay today? _____

32. Did you have to borrow money to pay for
the services you received today?

Y N

END OF INTERVIEW

Thank the woman for answering your questions and ask her if she has any questions.

Be sure that she knows how to prepare ORS for a child with diarrhea, when to return for vaccination and how to take the prescribed medications, when to return if the child becomes worse at home.

**Health Facility Assessment
Health Care Worker Interview**

Province _____	Date ____/____/____
Facility name _____	Facility type _____
Interviewer no. _____	HCW Name _____ ID No. _____

Introduce yourself to the health care worker. Tell him/her that you would like to ask him/her some general questions about the clinic followed by some questions about his/her job.

1. What are the hours of operation at this clinic?
 opening _____ closing _____ Total number of hours _____
2. In how many outreach posts/villages does this clinic operate/work? _____
3. How many days per month does each outreach post operate? _____
4. Do you charge fees for any services at this clinic? Y N
 If YES, what are the fees for each service?

Service	Fee
Sick child outpatient clinic	
Well baby clinic	
Antenatal clinic	
Immunization clinic	
Reproductive health/family planning clinic	
Health education	

5. How are supplies received?
 ___ Delivered to facility ___ Picked up from a central store
 * Frequency of supply?
 ___ < 1 month ___ 1-3 months ___ > 3 months
6. What is the **most common** cause of a delay in delivery of supplies?
 ___ Inadequate transport/fuel ___ Difficulty ordering
 ___ Insufficient staff ___ Rupture of stock at central store
 ___ Other: specify _____

7. What is your job title?
- Doctor Registered nurse/Midwife
- Health assistant Lady Health Visitor
- Community Health Worker Male Female
- Other: specify _____
8. Do you have written guidelines for your work? Y N
- If YES, can we see them? Available Unavailable
9. Do you have a supervisor? Y N
- If NO, go to question 15
10. Do you have a schedule for supervisory visits? Y N
11. How many times have you had a visit from a supervisor:
- In the last six months (number of times)
- In the last 12 months (number of times)
- Supervisor works here and sees worker daily
12. What did your supervisor do last time s/he supervised you?
- (Tick all that apply)
- Observed immunization technique
- Observed management of sick children
- * Observed antenatal visit
- * Observed family planning visit
- Reviewed reports prepared by health worker
- Updated health worker on current information
- Discussed problems with supplies and equipment
- Other: specify _____
13. Did you receive feedback from that supervisory session? Y N
- IF YES**, in what form?
- Written report
- Oral report
- Other: specify _____
14. What does your supervisor do to keep your technical skills up to date?
- (Tick all that apply)
- Workshops
- Performance feedback
- Training sessions
- Other: specify _____
15. Do you have to submit any reports such as the number seen, or the number of doses of vaccine administered? Y N
- If NO, go to question 18
- IF YES**, ask the **TYPE** of report. **HOW OFTEN** and if **UP TO DATE?**

Type of report	How often/year	Up to date?	
_____	_____	Y	N
_____	_____	Y	N
_____	_____	Y	N

16. How do you use the information collected in these reports to help you with your job?

- Ordering stock
- Assessing targets
- Epidemic surveillance
- Communication with community/personnel
- Doesn't use info.
- Doesn't know
- Other: specify _____

17. What type of feedback do you get from these reports?

- None
- Oral discussion
- Written report
- Other: specify _____

18. What are the most difficult problems that you face in doing your job? (Tick all that apply)

- Lack of training
- Mothers don't bring children to clinic
- * Women don't come to clinic
- * Negative attitudes of family members to contraception
- Staff shortages
- Lack of supplies and/or stock
- Lack of supervision
- Lack of feedback on performance
- Inadequate transport
- Other: specify _____

19. Have you discussed these problems with your supervisor? Y N

20. In this clinic, at what ages do you give: (age in MONTHS)

	First	Second	Third	Fourth
DPT				****
Polio				
BCG		****	****	****
Measles		****	****	****

EPI vaccination schedule all correct?

Y N

21. To whom do you give tetanus toxoid? (Tick all that apply)

- Only pregnant women
- Women of childbearing age (15-49) who come for care themselves/antenatal clinic
- Women of childbearing age who bring their children for immunizations or treatment
- Don't know

Indications for TT vaccination correct?

Y N

22. What days are immunizations given? (circle days)

Number of immunization days/week

M T W Th F Sa Su _____

23. Do you have an antenatal clinic?

Y N

IF YES, on what days is the clinic held (circle days)

Number of clinic days/week

M T W Th F Sa Su _____

IF NO, why are clinics not held? (Tick all that apply)

- No training
- No space available
- Don't know
- No staff
- No supplies

24. Please tell me the signs that would make you refer a child to a hospital? (Tick all that apply)

- Child is lethargic/abnormally sleepy/unconscious
- Child has had convulsions
- Child is not eating or drinking
- Child has not responded to usual treatment
- Child looks very unwell
- Child has a very high fever
- Child vomits everything
- Child has a severe dehydration
- Child has a severe pneumonia
- Child has a severe malnutrition/anemia
- Other: specify _____

Health worker knows at least 3 signs for referral of child Y N

* Please tell me the signs that would make you refer a pregnant woman to a hospital? (tick all that apply)

- * High blood pressure
- * Swelling of face or hands (oedema)
- * Hemorrhage
- * Malpresentation
- * Water breaks before labor begins
- * Labor pains begin before it is time
- * Previous cesarean section
- * History of complications in previous pregnancy
- * Other: Specify _____

* Health worker knows at least 2 signs for preg. woman ref. Y N

* Please tell me the signs that would make you refer a postpartum woman to a hospital? (tick all that apply)

- * Fever
- * Postpartum hemorrhage
- * Abdominal pain or tenderness
- * Foul smelling vaginal discharge
- * Other: Specify _____

* Health worker knows at least 2 signs for referral of pp woman Y N

* Please tell me the signs that would make you refer a newborn infant to a hospital? (Tick all that apply)

- * Cannot suck
- * Infected umbilicus
- * Does not move much/lethargic
- * Dark blue or very pale color
- * Infant is cold
- * Infant is very small
- * Other: Specify _____

* Health worker knows at least 2 signs for referral of newborn Y N

25. Have you ever wanted to refer a patient to a hospital
but been unable to do so? Y N

If YES, why could you not refer the patient?

(Tick all that apply)

- Hospital too far
- No transport available
- No fuel available
- Husband refused
- Mother refused
- Relatives refused
- Parents didn't have enough money
- Other: Specify _____

26. How many training sessions have you received in the last 12 months? _____
If NO training received, go to Question 29

27. What type of training was it? _____

28. Did your last training involve clinical practice? Y N

29. What do you see as your role in communicating to mothers when
they bring their child to the health facility?

- Giving information on danger signs to watch for
- Giving information on what to do at home
- Giving information on how to give medicine at home
- Finding out what mothers have done at home and what the
symptoms of the child's illness are
- Giving information on how to prevent illness
- Telling mothers when to come back to the health facility
- Ensuring that mothers understand what to do at home
- Giving group talks
- Other: Specify _____

* What do you see as your role in communicating to pregnant or
postpartum women?

- * Giving information on danger signs of pregnancy/postpartum period
- * Giving information on what to do at home
- * Helping mothers determine how to get to the hospital in an
emergency
- * Teaching mothers about breast-feeding
- * Teaching mothers about family planning
- * Telling mothers about newborn care
- * Other: Specify _____

55

30. What prevents you from communicating with mothers when they bring their child to the health facility? :

- It isn't really my role
- Someone else does it
- No time
- I don't know how
- They do not listen/understand what we say
- I don't have any education materials
- It is not important
- Other: specify _____

* What prevents you from communicating with women when they come for their prenatal/postpartum visits?

- * It isn't really my role
- * Someone else does it
- * No time
- * I don't know how
- * They do not listen/understand what we say
- * I don't have any education materials
- * It is not important
- * Other: specify _____

END OF THE HEALTH WORKER INTERVIEW

Thank the health worker for his/her cooperation and answer any questions that he/she may have about the correct recommendations for immunizations or management of sick children and women.

12. I would like to know more about the services that you received during your visit today. Did the staff:

Check your blood pressure	Y	N
Measure your weight	Y	N
Perform an abdominal exam	Y	N
Listen to the baby's heart	Y	N
Take a urine sample	Y	N

13. I would now like you to think about all of your visits during this pregnancy, including today. During any of these visits did the staff:

Take your history	Y	N
Take a blood sample or stick your finger	Y	N
Give you iron pills	Y	N
Give you a tetanus immunization	Y	N
Give you vitamins	Y	N
Give you advice about diet	Y	N
Discuss the place of delivery	Y	N
Discuss family planning	Y	N
Talk about STDs, HIV, AIDS	Y	N
Talk about breast-feeding	Y	N
Advise you what to do if there is a problem like fits or bleeding	Y	N
Give you malaria medicine	Y	N

14. What are some danger or warning signs of a problem with a pregnancy?

Heavy vaginal bleeding/hemorrhage	Y	N
Long labor (more than 12 hrs)	Y	N
Pallor/fatigue/short of breath	Y	N
Foul smelling vaginal discharge	Y	N
Abdominal pain	Y	N
Fever	Y	N
Headache/edema/fits	Y	N
Other	Y	N
If YES, then specify:		

15. Not including the time you spent waiting, how many minutes
did you spend with the health care worker today? _____ min.

16. Did you get a chance to ask questions today? Y N
If YES:

17. Did your questions get answered? Y N
If YES:

18. Did you understand the answers? Y N

19. Did the HCW or staff tell you when to come
back for your next appointment? Y N

Thank you for taking the time to speak with us today. Do you have any
questions that you would like to ask us?

END OF INTERVIEW

9. Did you pay for your last delivery Y N
 If YES, how much did you pay? _____ rupees
10. How soon did you leave the facility? Y N
 Same day? Y N
 Next day? Y N
 More than one day? Y N
11. Did someone at the facility advise you to return
 for a postpartum checkup? Y N
 (Go to 13)
12. Did you deliver at home? Y N
 If NO, where did you deliver? _____
 Who helped you with your delivery?
 Nurse or midwife Y N
 Clinician or doctor Y N
 TBA Y N
 Family member Y N
 No one Y N
 (Go to 15)
- Did you pay for your last delivery Y N
 If YES, how much did you pay? _____ rupees
13. Did the person who helped you with your delivery
 visit you at home after the delivery? Y N
14. Did that person advise you to come to the health facility
 for a postpartum visit? Y N
15. I would now like to know more about the services that you
 received during your visit today. Did the staff:
 Measure your blood pressure Y N
 Perform a vaginal exam Y N
 Ask if you had abnormal bleeding Y N
 Discuss family planning Y N
 If YES, what did you discuss? _____
 Was a family planning method given? Y N
 If YES, which one? _____
- Discuss breast-feeding Y N
16. Are you currently doing anything to prevent
 your next pregnancy? Y N
 If NO, go to 18

17. What are you currently doing to postpone your next pregnancy?

- A. No sex
- B. Traditional method
- C. Natural family planning
- D. Lactational amenorrhea
- E. Withdrawal
- F. Pill
- G. IUD
- H. Injection/Depo
- I. Norplant/subdermal implant
- J. Sterilization
- K. Condom
- L. Other (Specify): _____

18. Not including the time you spent waiting, how many minutes did you spend with the health care worker today? _____ minutes

19. Did you get a chance to ask questions today? Y N

If NO, go to 22

20. Did your questions get answered? Y N

If NO, go to 22

21. Did you understand the answers? Y N

22. Did the Health Care Worker or staff tell you when to come back for your next appointment? Y N

Thank you for taking the time to speak with us today.
Do you have any questions that you would like to ask us?

i _____
j _____
k _____
l _____

8. How old is your youngest child? _____ months
9. Did you breast-feed the youngest? Y N
If NO, go to 11)
10. For how long did you/are you breast feed(ing)? _____ months
11. Are you currently doing anything to prevent your next pregnancy? Y N
If NO, go to 14
12. What are you currently doing to postpone your next pregnancy?
A. No sex
B. Traditional method
C. Natural family planning
D. Lactational amenorrhea
E. Withdrawal
F. Pill
G. IUD
H. Injection/Depo
I. Norplant/subdermal implant
J. Sterilization
K. Condom
L. Other (Specify): _____
13. Did you get this method for the first time today? Y N
14. When you saw the health care worker today did she:
- Ask you about how many babies you had Y N
- Ask you if you wanted to postpone your next pregnancy Y N
- Talk to you about different methods of postponing your next pregnancy? Y N
- talk to you about possible side effects of those methods Y N
15. Not including the time you spent waiting, how many minutes did you spend with the health care worker today? _____ minutes
16. Did you get a chance to ask questions today? Y N
If NO, go to 19

17. Did your questions get answered? Y N
If NO, go to 19
18. Did you understand the answer? Y N
19. Did the HCW or staff tell you when to come back for your
next appointment? Y N

Thank you for taking the time to speak with us today.
Do you have any questions that you would like to ask us?

APPENDIX C
KEY INDICATORS

TAF Capacity Building Assessment
Selected key indicators

I. AVAILABILITY OF SERVICES

1. **Health facility standard case management training**
DEFINITION: Proportion of all health facilities with at least one health worker trained in case management in the last 6 months)
 - a. **Quality of training received**
DEFINITION: Clinical practice during the last training received
 - b. **Knowledge of child immunization and/or immunization for pregnant women/women of reproductive age**
DEFINITION: Correct knowledge of the EPI calendar for infants
2. **Health Facilities with regular community outreach to provide case management, immunizations, and IEC**
DEFINITION: Proportion of facilities that operate at least one outreach post a month
3. **Health facilities where essential medicines are available**
DEFINITION: Proportion of facilities with zero out-of-stock of medicines in the last 30 days
 - a. **ORS availability**
DEFINITION: Proportion of facilities with zero out-of-stock of ORS in the last 30 days
 - b. **Essential medicine availability**
DEFINITION: Proportion of facilities with zero out-of-stock of medicines for ARI, diarrhea and malaria in the last 30 days
 - c. **Family planning methods availability**
DEFINITION: Proportion of facilities with zero out-of-stock of family planning methods in the last 30 days

II. QUALITY OF SERVICES

A. TECHNICAL CAPACITY - SCREENING

4. Evaluation of nutritional status

DEFINITION: Proportion of cases in which the health worker evaluated the child's nutritional status

a. Child weighing

DEFINITION: Proportion of children who were weighed the day of the visit

b. Growth monitoring

DEFINITION: Proportion of children whose weight was recorded on the growth chart the day of the visit

5. Completeness of history

DEFINITION: Proportion of cases in which the health worker asked 5 key questions

a. Verification of child's vaccination status

DEFINITION: Proportion of children whose vaccination status is checked

b. Verification of mother's vaccination status

DEFINITION: Proportion of mothers whose vaccination status is checked

c. Antenatal screening

DEFINITION: Proportion of women whose history includes age, LMP or EDC

B. TECHNICAL CAPACITY - EXAMINATION

6. Completeness of physical examination

a. Completeness of child's physical examination

DEFINITION: Proportion of cases in which the health worker examined 5 key areas

b. Completeness of antenatal physical examination

DEFINITION: Proportion of cases in which the health worker performed 7 basic steps: weight, BP, check for edema and pallor, determine fundal height and EDC and listen to FHT.

C. TECHNICAL CAPACITY - TREATMENT

7. Case Management

DEFINITION: Proportion of children treated appropriately according to the diagnosis made by the health worker

a. Avoidance of missed opportunities for vaccination

DEFINITION: Proportion of children not up-to-date, vaccinated the same day or referred for another day

- b. Adequate aseptic technique for infection prevention
DEFINITION: Health worker performed infection prevention techniques appropriate to the visit: Hand washing before and after touching clients, decontamination and cleaning of instruments, proper surgical hand scrub, gowning and gloving, aseptic technique, surgical technique

- 8. Inappropriate use of antibiotics for ARI
DEFINITION: Proportion of cases diagnosed as simple flu/cold that received antibiotics

- 9. Inappropriate treatment for diarrheal diseases
DEFINITION: Proportion of cases diagnosed as simple diarrhea that received antibiotics and/or anti-diarrheal medicines

- 10. Appropriate treatment for diarrheal diseases
DEFINITION: Proportion of cases diagnosed as simple diarrhea that received ORS or rehydrating home fluids.

D. MANAGEMENT CAPACITY

- 11. Supervision
DEFINITION: Proportion of health facilities that have received at least one supervisory visit in the last 6 months

- a. Frequency of supervision
DEFINITION: Average number of supervisory visits in the last year
- b. Supervision feedback
DEFINITION: Proportion of health workers that received feedback from the last supervision visit

- 12. Immunization records
DEFINITION: Proportion of health facilities with up-to-date immunization registers for children, pregnant women, and/or women of reproductive age

- 13. Outpatient records
DEFINITION: Proportion of health facilities with up-to-date patient registers

III. EFFECTIVENESS

HEALTH WORKER'S KNOWLEDGE

14. Indications for child referral/ pregnant or postnatal woman referral to hospital
DEFINITION: Proportion of health workers with correct knowledge of at least 3 indications for referral to hospital
- a. Constraints to hospital referral
DEFINITION: Proportion of health workers who have experienced difficulties in referring a client to hospital
- b. Knowledge of safe delivery practices
DEFINITION: Proportion of health workers with correct knowledge of the 3 cleans of delivery: clean hands, clean delivery place and clean cord cutting

HEALTH WORKER PRACTICE - INTERPERSONAL COMMUNICATION SKILLS

15. Demonstration of appropriate IPC skills
DEFINITION: Proportion of health workers who
- Greet client
 - Asks questions of the client
 - Speaks to the client in a way she can understand
 - Demonstrates what she wants the client to learn
 - Asks for a demonstration by the mother to see if she has understood

CLIENT KNOWLEDGE

16. Home Case Management of a sick child
DEFINITION: Proportion of mother's who know at least 1 general and 1 specific aspect of home case management
- a. Counseling from the health worker
DEFINITION: Proportion of mothers who received counseling regarding home case management from the health worker
17. Recognition of need for outside care
DEFINITION: Proportion of mothers who know at least 2 danger signs indicating the need to seek care from a health center
18. Knowledge of family planning methods
DEFINITION: Proportion of women who can describe family planning methods currently available at the health facility

19. Knowledge of risk signs/danger signs of pregnancy/birth/postpartum

DEFINITION: Proportion of women who can state at least three risk signs/danger signs.

APPENDIX D
PEOPLE CONTACTED

12

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Secretary General
Assistant Secretary GENERAL
Advisor MCWAP
Skardu Program-Director
Medical Officer
Nursing Supervisor
Nursing Supervisor
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Medical Officer
Medical Officer
Medical Officer
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Skardu

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Nasima Frey-Rahman
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President
Political Scientist
Rahman Clinic - Chief Medical Officer
School Health Program - Director
Obstetrician/Gynecologist
LHV

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**APPENDIX E
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