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**PAKISTAN CHILD SURVIVAL PROJECT EXTENSION**  
**Contract No. 391-0496-C-00-3866**

**WORKPLAN**  
**October 1, 1993 - May 31, 1994**

**Submitted to**  
**The Basic Health Services Cell, Ministry of Health of Pakistan**  
**The United States Agency for International Development**

**by the Technical Assistance Team of**  
**Harvard Institute for International Development**

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# **PAKISTAN CHILD SURVIVAL PROJECT EXTENSION**

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### **INTRODUCTION**

The Pakistan Child Survival Project (PCSP) is a bilateral cooperative programme between the Ministry of Health, Government of Pakistan, and the United States Agency for International Development. The overall goal of the Project is to expand and institutionalize child survival programs, in order to decrease infant and child mortality.

Between July 1990 and September 1993, the Project was implemented through six project components which have been identified as having particular importance for the strengthening of child survival programs: planning and management, health management information systems (HMIS), integrated child survival training (ICST), communications, drugs and logistics, and research.

Technical assistance was provided through a consortium of three nonprofit international consulting agencies: Management Sciences for Health (MSH), Harvard Institute for International Development (HIID), and the Academy for Educational Development (AED). In addition, a local subcontractor, Jaffer Brothers Limited, was utilized for administrative and logistical support.

In 1991, due to the Pressler Amendment, severe budget cuts and time restrictions have been imposed on the PCSP. They have limited to a great extent the initially planned activities. USAID therefore decided, at the request of the Government of Pakistan, to provide limited additional funds to extend the HMIS and ICST components for an additional eight months until May 1994. Technical assistance for this additional period was contracted out to Harvard Institute for International Development.

In the following chapters, the planned activities under the PCSP extension for both the HMIS and the ICST components are outlined in detail and accompanied by a time line. Finally, organization and management under the PCSP extension is further clarified.

# HEALTH MANAGEMENT INFORMATION SYSTEM

## I. BACKGROUND

The improvement of existing health information systems is a major national strategy for the development of primary health care based service delivery systems in Pakistan. It was therefore one of the main components of the Pakistan Child Survival Project (PCSP) that started its activities in June 1990.

The Health Information System team of the PCSP undertook a comprehensive assessment study and published a report, describing in detail the shortcomings of the existing health information system. Recommendations for eventual restructuring of the system were provided.

Based on this study, a National Workshop on Health Management Information Systems was held in Islamabad in May 1991. One of the outcomes of the workshop was an agreement between the federal and provincial health officials to transform the existing routine reporting system for government managed First Level Care Facilities (FLCFs) into a comprehensive and integrated Health Management Information System (HMIS). Priority was given to first level care facilities because these are the principal level for the delivery of child survival related services.

The Basic Health Services Cell of the Federal Ministry of Health (MOH), assisted by the Health Information System team from PCSP, received the mandate to coordinate the restructuring process of this **Health Management Information System for First Level Care Facilities (HMIS/FLCF)**.

Between June 1991 and July 1992, the HMIS/FLCF design was finalized with active involvement of the future users of the system. National Programme managers, Provincial Directors, District Health Officers, Medical Officers in Charge, and representatives of the paramedical staff were consulted by organizing workshops and meetings.

Based on the actual functions of the first level care facilities, indicators were chosen for inclusion in the HMIS/FLCF. Data collection procedures, information flows, and data processing mechanisms were defined. In place of outdated data collection instruments, new instruments were designed and field tested. The new information system, although comprehensive, has a particular focus on maternal and child health. It also provides information on quality of care delivered in first level care facilities. For the latter, a supervisory checklist and other district level data collection instruments have been developed as management tools for supportive supervision.

Data processing for the new system has been computerized at appropriate levels in the health system. Computers were installed and data processing staff of 31 computer centers has been trained in using a customized data processing system for HMIS/FLCF data (see table 1).

In October 1992, a nationwide training program started to familiarize an estimated 15,000 medical officers and paramedics employed in government managed first level care facilities with the data collection procedures for the newly designed HMIS/FLCF. The training programme is implemented district wise. As soon as health personnel of a district has been trained, use of outdated registers and forms is discontinued and the new system is adopted.

Unfortunately, the implementation of the Pressler Amendment induced severe budget cuts and time restrictions on the Pakistan Child Survival Project, so that within its scope neither the time nor the funding were sufficient to complete HMIS/FLCF implementation. Indeed, by the end of September 1993, only approximately 40 % of FLCF staff has been trained in the new system (see table 2). The district level data collection instruments have not been put into general use. Computer centers have developed limited experience in data processing, and training of health facility staff and their supervisors in the use of HMIS/FLCF data for decision making are in an early stage.

At the request of the Government of Pakistan, USAID has provided limited funds to extend the HMIS component of PCSP for an additional eight months. Most of these funds will be used to support further the Basic Health Services Cell (BHSC) in the Federal Ministry of Health and to maintain the presence of the PCSP/HMIS Technical Assistance Team.

Hectic efforts are also underway to ensure both government funds and funding from other donors to complete HMIS/FLCF implementation and to institutionalize the system in the federal Ministry of Health and in each of the provincial/state Departments of Health.

TABLE 1

**STATUS OF COMPUTERIZATION**  
(as of September 30, 1993)

PROVINCES/REGIONS	COMPUTERS PROVIDED				PEOPLE TRAINED	
	BY PCSP	BY UNICEF	TOTAL	Installed & Functional	Generic	Specific
AJK	1	1	2	2	2	5
BALUCHISTAN	1	2	3	3	11	13
FEDERAL (Bio.Stat & Nat.programs)	-	-	-	-	-	7
FEDERAL (CHE)	-	1	1	1	2	2
NAs	1	-	1	1	2	2
NWFP	1	5	6	6	11	9
PUNJAB	8	3	11	10	30	21
SINDH	4	3	7	7	13	14
<b>TOTAL:</b>	16	15	31	30	71	73

**TABLE 2: SUMMARY OF DISTRICT LEVEL WORKSHOPS**  
as of September 30, 1993

Province/ Region	Workshops			# of Trainees Trained	FLCF's Trained
	Target	Completed	% Compl.		
AJK	18	8	44%	380	260
Balochistan	43	17	40%	594	383
Federal	3	2	67%	56	48
NAs	9	5	56%	215	150
NWFP	67	26	39%	1,256	756
Punjab	174	44	25%	1,977	1,216
Sindh	31	21	68%	1,078	626
<b>TOTAL</b>	345	123	36%	5,556	3,439

## II. OBJECTIVES

1. To assist the Federal Ministry of Health (MOH) and the Provincial Departments of Health (DOHs) (including AJK and NA) in institutionalization of the HMIS/FLCF as initiated under PCSP;
2. To strengthen the GOP's capability in using the restructured HMIS/FLCF for decision making;
3. To provide technical assistance for transfer of technology in HMIS management and in computerized data processing nationwide;
4. To strengthen the HMIS/FLCF as a tool for planners and supervisors to monitor the progress and impact specifically of child survival interventions;
5. To assist BHSC in the implementation of the WHO funded project on District Level Management.

## III. PLANNED ACTIVITIES

(see HMIS Extension Activities Timeline at the end of this chapter)

*NOTE: In the following paragraphs the term "federal HMIS team" stands for the staff of the Basic Health Services Cell, of the Biostatistics Cell, and of the PCSP/HMIS TA Team. The TA team also includes one HMIS coordinator in Lahore for the province of Punjab.*

The extension does not provide funding for a set of activities, but mainly for operational support to the BHSC and for the continued presence of the PCSP/HMIS technical assistance team. In order to ensure implementation of planned activities, close collaboration of the federal HMIS team with the provincial/state DOHs and relevant donor-funded projects will be crucial. The completion of certain activities described here under (1.a., 1.e., 2.a.) will be contingent on the availability of funds from the Government, or from other donors.

### 1. Completion of HMIS/FLCF implementation

We will assist the federal MOH and the provincial/state DOHs in the organization of the necessary training activities and logistic operations for completion of HMIS/FLCF implementation:

a. Assistance to and monitoring of district level HMIS/FLCF training workshops

More than 200 workshops for FLCF staff still need to be organized and an initial stock of printed supplies provided to the trained FLCFs. Funding sources will vary from province to province, but will be mainly through the Family Health Projects or UNICEF. We will assist federal and provincial managers in organization of training workshops and monitor the quality of the training. Members of the federal HMIS team will therefore travel to the provinces and attend one or more days of the district workshops.

This includes initially maintaining the HMIS/FLCF training database. Towards the end of the extension relevant data sets of this database will be transferred to the provincial/state computer centers (see also under ICS training monitoring).

At the request of the provinces we will also assist in the training of additional master trainers.

b. Pilot-testing of HMIS/FLCF training and implementation in OPDs of major hospitals

OPDs of major hospitals present particular problems for HMIS/FLCF implementation such as more specialized staff in performing FLCF activities, or the patient overload in these departments, or the purchase of printed supplies. We therefore will first pilot-test both training of the staff and HMIS/FLCF implementation in one hospital. At the end of September we had initial contacts with the M.S. of the Federal Government Services Hospital who had volunteered for this project.

We project this pilot-testing to take at least until end of 1993. Based on this pilot experience, appropriate decisions will be taken for further HMIS/FLCF implementation in major hospitals.

c. Distribution of printed supplies and training materials under order

Presently printed supplies and training materials for more than 2,500 health facilities are on order with different printers. Their distribution to each of the provinces, AJK and Northern Areas will be ensured in the coming months.

It also seems likely that in the coming months we will be requested to assist in the monitoring of additional orders placed by donors such as UNICEF or WHO.

- d. Provincial visits to discuss final formats of district level data collection instruments.

Four district level data collection instruments have been designed and field tested in the last year: i) the Supervisory Checklist for FLCFs; ii) the Personnel Management Register; iii) the Training Register; iv) the Quarterly District Report

During the VIIIth National HMIS Team Meeting results of the field testing have been discussed and consensus was reached on formats for each of these data collection instruments. These formats together with instructions for filling in have been sent to the provinces in September requesting final approval in the coming months. We have therefore planned for visits to the provinces, AJK and NAs during the month of November to facilitate the approval process.

- e. Assistance to training workshops for district supervisors

Contingent upon the availability of funds, we will assist federal and provincial managers in training supervisory staff in the use of district level data collection instruments in their final format. These training workshops could be implemented under the WHO Project on District Level Management starting in January 1994.

In the mean time our colleagues in the ICS component of the BHSC will further follow-up supervisors who were trained in the use of a provisional format of the supervisory checklist. They will use the checklist also for pre- and post-assessment of the ICS training.

- f. Launching of the HMIS/FLCF Yearly Report

The printing of the Yearly HMIS/FLCF Report will be finished around November 15. We will ensure the distribution of Yearly Reports through the provincial/state health departments to all FLCFs. These reports will be filled in by the FLCF staff in the first week of 1994 and sent to the computer centers for data entry.

## **2. Use of HMIS/FLCF information for decision making in planning and management**

- a. HMIS/FLCF Feedback Training

Based on actual data sets and more particularly through computerized feedback reports produced through HMIS/FLCF software, decision makers will be guided in the use of the information in their respective planning and management functions. We will provide this training through two possible mechanisms:

i) Through on-the-job contacts

During follow-up meetings in districts where HMIS/FLCF training has been completed (see 3.b.), we will organize a full morning meeting with the district staff and show them computerized feedback reports based on data from the preceding months. These reports will be the starting point for discussions on how to use the generated information in planning and management at the district level.

ii) Through structured workshops

Before December 1994, we will prepare a standard curriculum for a structured workshop on the use of HMIS/FLCF information in planning and management of the government health services. Contingent upon the availability of funding, we will assist the provincial/state health departments in organizing such workshops. More particularly, in the provinces where the Family Health Projects have started activities, training could take place in the Provincial or District Health Development Centers (PHDC, DHDC). Priority staff to be trained are the provincial managers and the district level supervisors.

As for the content of the curriculum, training materials will be based mainly on actual data sets. One way of presenting the data will be through **computerized feedback reports**. But total reliance on the computerized feedback system would not be very realistic, given the limited resources for computer supplies and stationary and the expected hard- and software problems. Supervisors will therefore also be trained in using the data from the HMIS/FLCF reports on an **immediate basis**, while they in turn will train the peripheral health facility staff. Finally, supervisors will be trained in using the newly developed supervisory checklist to improve quality of care delivered in the first level care facilities.

b. Further development of a computerized feedback system

We will further fine tune the computerized feedback tables that have been developed so far, and adapt them as much as possible to the information needs at each level of the health services: health facility level, line managers, planning and programming offices. Particularly, feedback will focus on monitoring quality of care of child survival interventions and their impact on the health status of children.

i) Meetings with National Program Managers

Initially, in October and November, we will have meetings with national program managers to gather more input on how to structure feedback reports focused on priority health problems such as diarrheal diseases, acute respiratory infections, EPI diseases, malnutrition, malaria, and tuberculosis.

## ii) Monthly/Quarterly Feedback Reports

Based on the comments and inputs from decision makers and supervisors on earlier developed feedback formats, the design of sets of monthly and quarterly feedback reports based on the HMIS/FLCF monthly reports will be finalized before the end of 1994. Different sets will be available to federal, provincial, divisional and district level managers.

## iii) Yearly Feedback Reports

Between February and April 1994, other sets of feedback report formats will be designed to help in yearly analysis of data both from the Monthly and the Yearly HMIS/FLCF Reports. These sets could ultimately be used in the production of "Annual Statistical Yearbooks" at the federal or at provincial levels.

## c. Technical Assistance to other health projects in using HMIS/FLCF generated information

Conditional upon the availability of time and staff, we also will respond to requests from the health and other governmental departments, or from other projects, to lecture or to facilitate in workshops and/or meetings related to the use of HMIS/FLCF generated information.

## 3. HMIS/FLCF Institutionalization

### a. Strengthening overall HMIS/FLCF management capability at federal and provincial levels

Through meetings and follow-up visits to the provinces, we will provide guidance to the Federal MOH and the Provincial Health Departments in building up and/or strengthening the infrastructure necessary for overall health information system management.

Our most important advice will be to create a single agency for health information system management at the Federal level and in each Provincial Health Department. This agency should, under the leadership of an epidemiologist/health planner, provide all necessary functions of information system management: (1) supervising the quality of data collection in the periphery; (2) monitoring regular data transmission from the periphery; (3) ensuring (computerized) data processing and filing; (4) managing the distribution system for printed supplies; (5) performing data analysis; (6) and disseminating information in useful manner to decision makers at all levels.

We will also assist in drafting PC-s and/or SNEs to ensure the creation of sanctioned posts for epidemiologist/health planners and computer operators, and to ensure the

required recurrent funds for printed supplies, computer maintenance, and computer supplies. Indeed, without this budgetary support, HMIS/FLCF implementation will very soon come to a complete standstill.

Specifically at the federal level, administrative restructuring will be necessary to ensure overall HMIS/FLCF coordination throughout the country. Until now, HMIS/FLCF design and monitoring have been coordinated by the Basic Health Services Cell, while data processing in future will be mainly done by the Biostatistics Cell under Deputy Director of Public Health. The latter agency needs to be reinforced both in staff and in equipment. An epidemiologist/health planner and a computer programmer need to be appointed as soon as possible. Hardware and printing capability needs to be upgraded in order to handle national databases.

Another warranty for future institutionalization will be to organize pre-service training in HMIS to all doctors and paramedics. In this way, students, prior to their appointments in the government services, will have been exposed to the conceptual relationship between information and management. Whenever and wherever possible, we will facilitate contacts between the health authorities and the teaching institutions, and provide guidance and training materials in setting up these courses if appropriate.

b. Follow-up meetings with district staff

By the end of September, the health facility staff of up to 40% of districts will have started using the modified HMIS/FLCF data collection instruments. Although they have been trained through a standard four day course, it is obvious and confirmed through actual monitoring, that this staff will need further supervision and guidance to become totally familiar with the different patient/client record forms, registers, aggregation and reporting procedures. Under PCSP, a standard checklist for monitoring quality of data collection, and a logbook to monitor regularity of reporting have been developed and have been extensively used by district supervisors.

We will make regular visits to support the supervisors in institutionalizing these new data collection procedures, and assist newly trained supervisors in monitoring the quality of the data collected, and the regularity of reporting. As outlined before, these visits can be combined with meetings where the use of HMIS/FLCF information will be discussed.

c. Follow-up and trouble shooting visits to computer centers

In October 1993, more than 20 established computer centers will receive on a regular basis monthly reports from all the trained FLCFs for data entry and analysis, using software developed under PCSP. Routine procedures for data quality checking, report filing, production of feedback reports, and data transmission to provincial and federal

centers need to be institutionalized. The capability for software trouble- shooting and hardware maintenance need to be increased.

Our team will provide assistance to all centers mostly through a system of regular follow-up visits, and through further training-on-the-job of computer supervisors in each province, so that they in turn can train computer operators of the more peripheral centers.

Particular attention will be given to the Biostatistics Cell in the Federal Ministry of Health, where capability for systems development and computer programming will need to be developed in the coming months. Indeed, after June 1994 no further technical assistance in computer technology has been planned.

d. Follow-up visits to assist in organization of printed supplies distribution system

The HMIS/FLCF includes a set of data collection instruments necessary for data collection and reporting, consisting of 11 record cards, 19 registers, and 3 report forms. An initial stock for approximately 1 year of most of these instruments is provided to the FLCFs as soon as the staff has been trained. At the end of this HMIS extension, a substantial number of FLCFs will run out of supplies.

Through regular follow-up visits we will assist the Health Departments preparing for appropriate budgets, getting appropriate storage of supplies, and setting up a distribution system that ensures regular supplies to FLCFs.

#### **4. Monitoring and evaluation of HMIS/FLCF**

Throughout the extension period, careful monitoring of all the aspects of HMIS/FLCF development will be ensured. The results of this monitoring will be translated into recommendations for further improvement of the system.

a. VIIIth National HMIS Team Meeting

Around mid-December a VIIIth National HMIS Team Meeting will be called together to critically review the process of HMIS/FLCF implementation and institutionalization. This permits the PCSP/TA team to further assist the federal MOH and the provincial DOHs in implementing the actions decided upon during the last five months.

b. External evaluation

We strongly suggest to plan for an external evaluation shortly before the end of the Project, so that solid based recommendations can be made to the Government on further institutionalization and improvement of HMIS/FLCF.

c. Operations Research

Monitoring will also be complemented if possible, by operations research type of studies. In collaboration with the Family Health Projects, or through other funding sources, we will advise on the design and implementation of such studies, related to the use of HMIS/FLCF in improving the quality of care delivered in government basic health services. For example, how can HMIS/FLCF improve continuity of care provided to tuberculosis patients; or how can HMIS/FLCF help in running efficient growth monitoring clinics; or how can HMIS/FLCF be linked to an information system to monitor community health worker activities.

d. HMIS/FLCF international dissemination of results

We also envision to look for opportunities to present the HMIS/FLCF and its first results at an international gathering. In addition to disseminating some of the particular features of HMIS/FLCF in Pakistan, this will also expose our HMIS team to constructive criticism on the system and to similar experiences in other countries.

## H.M.I.S. ACTIVITIES TIME LINE

ACTIVITIES	1993			1994				
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
<b>1. Completion of HMIS/FLCF implementation</b>								
a. Assistance to and monitoring of district level HMIS/FLCF training workshops*	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
b. Pilot-testing of HMIS/FLCF training and implementation in OPDs of major hospitals	■■■■	■■■■	■■■■					
c. Distribution of printed supplies under order	■■■■	■■■■						
d. Provincial visits to discuss final formats of district level data collection instruments		■■						
e. Assistance to training workshops for district supervisors*				■■■■	■■■■	■■■■	■■■■	■■■■
f. Launching of the Yearly HMIS/FLCF Report		■■	■■■■	■■				
<b>2. Use of HMIS/FLCF information for decision making in planning and management</b>								
a. HMIS/FLCF Feedback Workshops*		■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
b. Further development of computerized feedback system								
Meetings with National Program Managers	■■■■							
Monthly/Quarterly Feedback Reports		■■■■	■■■■					
Yearly Feedback Reports					■■■■	■■■■	■■■■	
c. Technical assistance to other health projects in using HMIS/FLCF generated information	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
<b>3. HMIS/FLCF Institutionalization</b>								
a. Strengthening of overall HMIS/FLCF management capability at federal and provincial levels		■■	■■	■■■■	■■■■	■■■■	■■■■	■■■■
b. Follow-up meetings with district staff	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
c. Follow-up and trouble shooting visits to computer centers	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
d. Follow-up visits to assist in organization of printed supplies distribution system	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
<b>4. HMIS/FLCF Monitoring and Evaluation</b>								
a. VIIIth National HMIS Team Meeting			X					
b. External evaluation (based on availability of funds)							■■■■	

October 1, 1993 \* = Conditional upon funding through other sources

# INTEGRATED CHILD SURVIVAL TRAINING

## I. BACKGROUND

One of the main components of PCSP is the Integrated Child Survival Training Component (ICST). Until September 1993, this component was coordinated by a training team based at the Federal Basic Services cell. The team was made up by the staff of the BHS cell and by a technical assistance team (TAT) under the direction of Dr. Tara Upreti (training advisor). In the provinces the team was further assisted by four Provincial Training Coordinators and their counterparts, working under the four Provincial Project Directors. It has not been easy to introduce the concept and implement the training course in Integrated Child Case Management. A great deal of effort from Pakistani government officials and TAT was put in to arriving at an understanding and a consensus on Integrated Child Survival Training. The Secretaries of Health and Director Generals of Health Services from all four Provinces had all shown keen interest in the integrated approach to the delivery of child health services and the integrated Child Survival Training Course and have provided all necessary support.

After a process of consensus building, a training curriculum was developed using available W.H.O. training materials for immunization, ARI and diarrhoea. For nutrition, interpersonal communications, and integrated child case management new materials were drafted. After approval of these materials by National Programme Coordinators and by the Provincial Health Departments, ten training manuals were printed to teach the concept of integrated case management of children under 5 years of age. The training programme focussed mainly on health staff of first level care facilities (FLCFs). Four different types of workshops have been developed:

1.	Trainers	13 days
2.	Medical Officers	12 days
3.	Paramedics	09 days
4.	Supervisors	06 days

After assessing 18 teaching hospitals and 15 District Hospitals, a total of 25 sites for CSTUs were selected. In other teaching hospitals, it was not feasible to establish training units due to lack of adequate space/facilities. At the conclusion of the MSH contract in September 1993, 26 CSTUs had been established (one additional site was selected later): 15 at the teaching hospitals and 11 at District/Divisional Hospitals).

After completion of Medical Officers Training manuals, the training activities for Medical Officers were initiated in December 1991 with a test workshop in Faisalabad. This was followed by a workshop for Master Trainers from all the Provinces. From May 1992, the Provinces began training of trainers for their CSTUs and soon after, initiated medical officers training first

at teaching hospitals and then at the DHQs. The federal training team ensured continuous supervision and monitoring of the training activities. In the mean time, manuals for paramedics and the supervisors were developed. Training for supervisors and paramedics was started in February and April 1993 respectively.

Till August 1993, a total of 107 workshops were held, at which 1340 persons were trained. The training target was 1400, so the project fell short of its target by 60. However, this number has been made up in September 1993, with UNICEF supported training initiated in Azad Kashmir and Punjab.

Table 1 provides target numbers and types of personnel to be trained and project achievements. Trainers consisted mostly of Pediatricians, Medical Officers and 25 Health Education Officers. Table 2 provides break up of the total number of Personnel trained at Federal and Provincial Level.

**TABLE 1**  
**TARGET AND ACHIEVEMENTS IN THE NUMBER OF PERSONS TRAINED**  
**IN TEACHING HOSPITALS AND**  
**DISTRICT HEADQUARTER HOSPITAL CSTUs**  
**BETWEEN JANUARY 1992 TO SEPTEMBER 1993**

<b>PERSONNEL</b>	<b>EXPECTED NUMBER TO BE TRAINED</b>	<b>NUMBER TRAINED</b>
<b>Medical Officers</b>	<b>600</b>	<b>619</b>
<b>Paramedics</b>	<b>400</b>	<b>326</b>
<b>Supervisors</b>	<b>100</b>	<b>92</b>
<b>Trainers</b>	<b>280</b>	<b>303</b>

**TABLE 2**  
**SUMMARY OF PERSONAL TRAINED IN INTEGRATED CHILD SURVIVAL**  
**COURSE AT FEDERAL AND PROVINCIAL LEVEL**  
**FROM JANUARY TO SEPT 1993**

LOCATION	TRAINERS	MO/ WMO	PARA- MEDICS	SUPERVI- SORS	TOTAL
FEDERAL LEVEL	70*	21	-	18	109
BALOCHISTAN	28	85	56	20	189
NWFP	34	109	90	17	250
PUNJAB	76	143	98	17	363
SINDH	95	222	70	20	407
AJ & K	-	10	12	-	22
<b>TOTAL</b>	<b>303</b>	<b>619</b>	<b>326</b>	<b>92</b>	<b>1340</b>

In July 1993, the Integrated Child Survival Activities were assessed by an external evaluation team consisting of USAID and a WHO expert. The team appreciated the work on integrated approach done by PCSP. According to them the ICST curricula developed by GOP and PCSP are consistent with the curricula being developed by WHO and should be given a "fair trial" of at least 2 years (or used as the starting point for any new efforts).

After September 1993, USAID funding for ICST training activities will be limited to operational support of Basic Health Services Cell in Ministry of Health. Fortunately since the beginning of 1993, UNICEF has joined USAID in supporting ICST training activities and has committed to do so in the coming years. It is hoped that other donors will join in this effort so as to gradually cover the whole country.

## II. OBJECTIVES

1. To assist in the establishment and/or strengthening of Continuing Education Cells in Federal and Provincial Health Departments as initiated under PCSP.
2. To continue integrated child survival training through the established CSTUs in 15 teaching hospitals and 11 District/Divisional Hospitals.
3. To expand training activities through establishment of new CSTUs in other districts of the Provinces.
4. To assist Provincial Health Departments to strengthen the supervisory System.

## III. PLANNED ACTIVITIES

(See ICST Extension Activities Time Line at the end of this chapter)

*NOTE: In the following paragraphs the "federal ICST team" includes the staff of the Basic Health Services Cell, of the PCSP/TA Team, and the two UNICEF funded education specialists.*

### 1. ICST Planning

The federal ICST team will assist the Provinces in the planning and coordination of all ICST related activities. Mostly communications will be maintained through the ICST coordinator who has been appointed in each Province/State.

#### a) Provincial visits

The federal ICST team will regularly visit the Provinces to discuss/review the status of ICST implementation and to explore funding for continuation of training activities beyond December, 1993. Specially in the Provinces where the Family Health Projects (FHPs) have started activities, further linkage needs to be built up between the ICST coordinator and the Provincial Health Development Centre (PHDC). In fact, the establishment of district level training units is a common objective both of the FHPs and of the ICST.

Whenever possible, a member of the Federal ICST team can also assist the quarterly Provincial Training Committee Meetings.

b) **Federal Training Committee Meeting**

It is planned that around February 1994, a national meeting will be held to discuss the implementation status and future expansion of the ICST Programme. Participants to this meeting will be members of the federal ICST team, national programme coordinators, and delegates from the provincial training committees. It will be an ideal opportunity to share experiences between different states/provinces and to plan for future activities.

**2. Establishment of new CSTUs**

a) **At District Headquarters Hospitals.**

During the last months of 1993, the federal ICST team will assist the Provinces in establishing CSTUs in approximately 10 districts. In NWFP, Charsadda district has been planned, in Punjab Faisalabad, in Sindh Larkana and Nawabshah, and in AJK Muzaffarabad. For the other districts further discussions will be needed with the provinces and with the donor agencies.

b) **At Teaching Hospitals.**

According to the target of establishing CSTUs at 18 teaching hospitals, 15 CSTUs have been opened and are functioning so far. In 1994, CSTUs will be established in these remaining three teaching hospitals. Although it will be the responsibility of the provinces, the federal ICST team will provide technical advice in this respect.

**3. ICST Implementation**

a) **ICST workshops**

In the last three months of 1993, a total of 47 training workshops are planned to be held in the provinces according to the following distribution:

	<b>AJK</b>	<b>Baloch.</b>	<b>NAs</b>	<b>NWFP</b>	<b>Punjab</b>	<b>Sindh</b>
<b>T.O.T</b>	2	1	-	2	-	
<b>Supervisors</b>	1	-	-	-	-	
<b>MOs</b>	1	1	-	3	6	
<b>Paramedics</b>	2	-	-	4	8	

Approximate 120 workshops will be organized for ICST in 1994 to complete the districts already started, and to expand the training activities in near districts. CSTUs will be advised to maintain an implementation pace of one workshop per month, alternating workshops for medical officers (MOs) and paramedics.

Prior to the establishment of new CSTUs, a Training of Trainers (TOT) workshop will be held to train a staff of approximately ten trainers per CSTU.

It is also foreseen to organize in coordination with the federal HMIS team more workshops for supervisors in districts where ICST activities have been newly implemented (see also activity 1.e. under the HMIS component). The training team will more particularly teach the technical aspects of integrated child case management, while the HMIS team will present the different district level data collection instruments.

**b) Supply of training materials**

Presently 4000 paramedic training manuals are stored in the Basic Health Services Cell. 1500 sets of manuals for medical officers and 500 manuals for supervisors are being printed with UNICEF funds. The distribution to each of the Province, AJK and Northern Area will be ensured in coming months. These supplies should be sufficient for the whole ICST programme in 1994.

#### **4. ICST Monitoring and Evaluation**

Through out the extension period, careful monitoring of all aspects of ICST activities will be ensured.

**a. Follow-up visits to training workshops**

The federal ICST team will assist Provincial coordinators in organization of training workshops and will monitor the quality of the training. Members of the team will therefore travel to the Provinces and attend one and more days of District Workshops. During TOT workshops and in the first workshop of a newly established CSTU, a member of the federal ICST team will be present throughout the workshop, to monitor uniformity and quality of the training.

**b. ICST training assessment in FLCFs**

In order to measure impact of ICST on the quality of the services provided to children under five, pre-assessment of the FLCF staff will be done in the FLCFs of the districts where training in ICST is planned, followed by post-assessment two to three months after the training is completed. These assessments are performed through a supervisory check list, newly designed and field-tested under HMIS/FLCF. They will be done by the district supervisory staff, attended whenever possible by the provincial ICST coordinator or by a member of the federal ICST team.

These assessments will be an on-going activity throughout this extension period. In April-May 1994, analysis will be done on the collected checklists. The results of this assessment will be translated into recommendations for further improvements of the training workshops and, where necessary, of the curriculum.

## I.C.S.T. ACTIVITIES TIME LINE

ACTIVITIES	1993			1994				
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
<b>1. ICST Planning</b>								
a. Visits to provinces to assist in planning ICST activities (combined with quarterly provincial training committee meetings)	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
b. Federal ICST Planning Workshop					■			
<b>2. Establishments of new CSTUs</b>								
a. At District Headquarter Hospitals	■■■■	■■■■	■■■■					
b. At Teaching Hospitals					■■	■■	■■	
<b>3. ICST Implementation</b>								
a. ICST Workshops								
TOT	■			■				
MOs	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
Paramedics	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
Supervisors				■■■■	■■■■			
b. Supply of Training Materials								
Printing	■■■■	■■■■						
Distribution			■■■■	■■■■				
<b>4. ICST Monitoring and Evaluation</b>								
a. Follow-up visits to training workshops	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
b. ICST Training Assessment in FLCFs								
Pre-Test	■■■■	■■■■	■■■■					
Post-Test	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■	■■■■
Analysis							■■■■	■■■■

November 1, 1993

# **ORGANIZATION AND MANAGEMENT**

## **1. PCSP/TA team**

To implement the previously outlined activities, USAID has contracted with Harvard Institute for International Development (HIID), Cambridge, USA, to implement the Pakistan Child Survival Project Extension. Jaffer Brothers Limited (JBL) is subcontractor to HIID, mostly for personnel management of the national staff.

HIID will maintain Dr. Lippeveld in place as Chief of Party. With him a selected number of national professional and administrative staff, all of them except one already in place under the MSH contract, will continue their activities. The professional HMIS staff will include two HMIS training coordinators, one in Islamabad, and one in Lahore, a computer specialist, and a HMIS logistics and supplies manager. UNICEF has committed to continue the services of the two previously employed training specialists until December 1993. After this date, USAID has proposed to fund further technical assistance to the Basic Health Services Cell at their request. The professional staff will be supported by administrative staff and other support staff (see full staff list in annex).

This technical assistance team (TAT) will work in close collaboration with the Basic Health Services Cell of the Federal MOH. They will assist the Provincial Health Departments including AJK and NA particularly in ensuring coordination of all donor projects involved in HMIS and ICST development (see figure 1).

## **2. Government Counterparts**

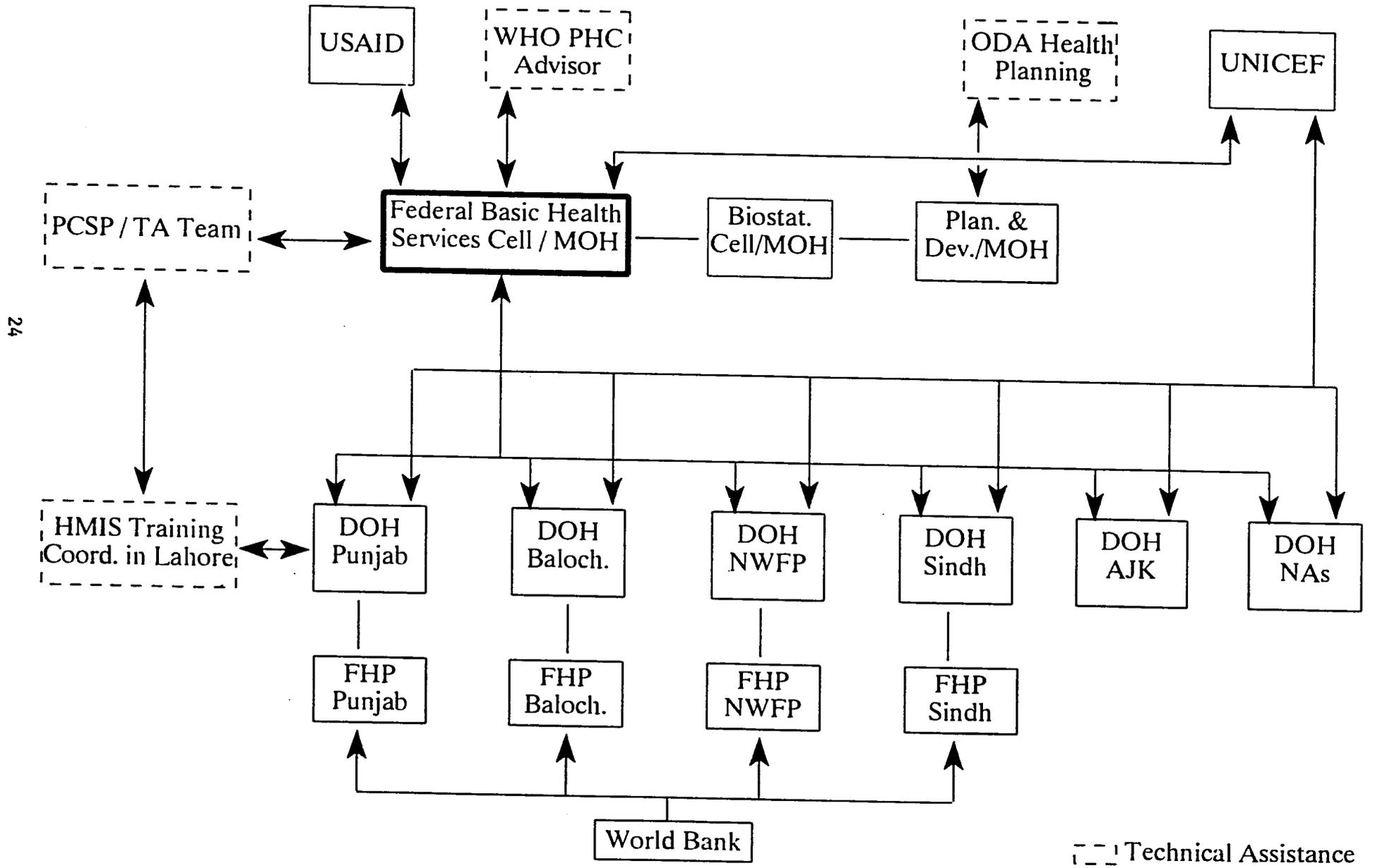
### **a) Federal level**

The PCSP/HMIS team will, as before, operate in close collaboration with the staff of Federal Basic Health Services Cell (BHS) of the MOH in Islamabad. The BHS cell is headed by Dr. Malik Manzoor A. Khan, Deputy Director General, who is overall coordinator of all PCSP extended activities and of all PHC related activities. Dr. Riaz A. Malik is Assistant Director General (Operations) and is more particularly involved in the HMIS component. Dr. Talat Rizvi is Assistant Director General (Training) and is more particularly involved in the ICST component.

Through this Cell all necessary coordination will be ensured with other agencies in the MOH: the National Programme Offices, the Biostatistics Cell, the Planning Cell, etc. Also through BHS, continuous involvement will be sought from the Provincial Health Departments including AJK and NA.

Figure: 1

# PCSP Extension ORGANIZATION CHART



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--- Technical Assistance

## b) Provincial level

As always, the main site for coordination and implementation of the PCSP activities are the provincial Departments of Health (DOH). After September 1993, most provinces/states have maintained continuity in the implementation of PCSP activities through the presence of a PCSP Director, or of HMIS and ICST coordinators. Table 1 gives an overview of PCSP coordination responsibilities in the provinces.

**TABLE 1**                      **PROVINCIAL PCSP COORDINATORS**

	<b>PCSP Director</b>	<b>HMIS Coordinator</b>	<b>ICST Coordinator</b>
AJK		Mr. Chaudhry Sharif	Dr. Gardezi
Balochistan		Dr. Noshervani	Dr. Akhlaque
Northern Areas		Dr. Sher Wali Khan	Dr. Sher Wali Khan
NWFP	Dr. Sharif A. Khan	Dr. Sharif A. Khan	Dr. Nasir Idres
Punjab	Dr. Yaqoob Jaffer	Dr. Naeem Ud-Din	Dr. Mobeen Aslam
Sindh	Dr. Mangnejo	Dr. M. Bux Burghari	Dr. Mangnejo

### 3. PCSP collaboration with other Basic Health Services Projects

#### a) Family Health Projects

Under PCSP, extensive discussions have taken place with the Project staff of the Family Health Projects (FHPs) in the four provinces. The FHPs, mostly operating with World Bank loans, all have a common objective of improving the management environment of the health services in their respective provinces, particularly focusing on safe motherhood activities.

It was therefore agreed that these projects would pick up HMIS/FLCF implementation where PCSP had to end its activities. It therefore will be of crucial importance to the BHS/PCSP team to work side by side with the FHP managers on planning and implementing of HMIS related activities.

The PCSP evaluation team advocated that these projects should also pick up ICST activities. At this stage most FHPs are still in an initial phase of establishing Provincial Health development Centers (PHDCs) and District Health Development Centers (DHDCs). Although tight collaboration will be necessary and has been mostly initiated, it is unlikely that in an initial phase the FHPs would ensure funding of ICST activities.

b) UNICEF

Already since 1992 UNICEF has been closely involved in the development of PCSP activities, both in the HMIS and the ICST activities, and has committed to do so in the future. During the extension period, the PCSP teams will ensure close collaboration with the federal and provincial UNICEF teams.

UNICEF has been extremely helpful in providing conceptual and financial support where necessary in HMIS/FLCF design and implementation. In fact, by the end of September 1993, UNICEF will have donated more than \$ 400,000 to the HMIS/FLCF effort. Under the HMIS extension, UNICEF will continue to provide financial assistance, particularly to the AJK and NAs Health Departments, where no FHPs are operational. They will also further ensure printing MCH cards.

As for the ICST component, UNICEF has taken a leading role in promoting the concept of integrated child case management training throughout the country. Before September 1993, UNICEF has funded workshops in the Hyderabad district in Sindh and in printing of training materials. Its involvement in ICST is growing every day. UNICEF is funding the services of two training specialists in the BHS Cell and has committed to fund workshops in all four provinces, AJK and NAs.

c) WHO District Level Management Project

Similarly, we will work closely together with the WHO funded District Level Management Project. This will be facilitated by the fact that this project is based in the BHS Cell. Dr. Bile is the WHO technical advisor.

It is proposed that under this project training of supervisors in the newly developed district level data collection instruments will take place in early 1994.

d) ODA Health Planning

Funded through ODA, a technical assistance team of Leeds University under the direction of Prof. Colin Thurnhurst is providing assistance to the Federal MOH and the Provincial DOHs in streamlining the health planning process. Emphasis is put on decentralizing the planning and management capability to the district level. Obviously, the development of HMIS/FLCF will be of crucial importance to this process, since one of the main features of the system is to stimulate use of the information at peripheral levels.

Initial contacts with the team have been established under PCSP. We hope to continue this relationship, and particularly work together on the establishment of a feedback system, able to provide the necessary information for district level health services planning.

## **ANNEX; PCSP TECHNICAL ASSISTANCE TEAM**

### **HARVARD INSTITUTE FOR INTERNATIONAL DEVELOPMENT**

1. Dr. Theo Lippeveld, COP/HIS Advisor

### **UNICEF**

1. Dr. Mohammad Ayub Salariya, Training Education Specialist
2. Dr. Zahida Sultana Mir, Training Education Specialist

### **JAFFER BROTHERS (PRIVATE) LIMITED**

#### **Technical Team**

1. Dr. Nasim Haque, HMIS National Coordinator
2. Dr. S.M. Mursalin, HMIS Provincial Coordinator [Lahore]
3. Mr. Shafat Sharif, Computer Specialist
4. Mr. Gohar Latif Khilji, Logistics Manager/Software Specialist

#### **Administrative Team**

5. Maj. [Retd.] Javade Khwaja, Project Manager [JBL-Islamabad]
6. Mr. Khalid Mahmood Butt, Financial & Administrative Specialist
7. Mr. Mohammad Naseem Khan, Operations & Admin Supervisor
8. Mr. Kamran Mumtaz, Project Accountant [JBL-Karachi]
9. Mrs. Shahnaz Farooq, Executive Secretary
10. Mr. Mohammad Sakhi, Secretary [Lahore]
11. Mr. Arif Ullah, Logistics Assistant
12. Mr. Amjad Bhatti, Receptionist
13. Mr. Iftikhar Abbasi, Driver
14. Mr. Saqlain Akhtar, Driver
15. Mr. Amin Khan, Driver [Lahore]
16. Mr. Mohammad Younas, Office Aide