

**MANNUAL FOR
MNCH
COORDINATORS
PPHI Sindh**

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Abbreviation

Abbreviation

AMTSL	Active management of third stage of labor
ANC	Antenatal Care
BEmONC	Basic emergency obstetric and newborn care
BHU	Basic health unit
BP	Blood pressure
CEmONC	Comprehensive emergency obstetric and newborn care
CHX	Chlorhexidine
CSG	Community support group
CMW	Community midwife
COC	Combined oral contraceptive
DHIS	District health information system
DOH	Department of Health
EmONC	Emergency obstetric and newborn care
EPI	Expanded program on immunization
FANC	Focused antenatal care
FP	Family planning
HBB	Helping Babies Breathe
HLD	High-level disinfection/disinfected
IMNCI	Integrated Management of Newborn and Child Illnesses
IUCD	intrauterine contraceptive device
LHV	Lady Health Visitor
LHW	Lady Health Worker
MBBS	Bachelor of Medicine/ Bachelor of Surgery
MCH	Maternal and child health
PPHI	Maternal and Child Health Integrated Program
MCPC	Management of Complications in Pregnancy and Childbirth
MgSO₄	Magnesium sulfate
MLBC	Midwife-led birthing centers

MNCH	Maternal, newborn, and child health
MOH	Ministry of health
MVA	Manual vacuum aspiration
NGO	Non-government organization
OJC	On the job coaching
OJT	On the job training
OPD	Outpatient department
OSCE	Objective Structured Clinical Examination
PAINS	Period, abdominal pain, infection, not feeling well, strings
PCPNC	Pregnancy, Childbirth, Postpartum and Newborn Care
PNC	Postnatal care
PPFP	Postpartum family planning
PPH	Postpartum hemorrhage
PPHI	People's Primary Health Initiative
PPIUCD	Postpartum intrauterine device
PROM	Premature rupture of membranes
QIPS	Quality improvement and patient safety
QIT	Quality improvement team
RHC	Rural health centre
SBA	Skilled birth attendant
SG	Support group
TAG	Technical advisory group
TIMS	Training Information Management System
TOT	Training of trainers
TT	Tetanus toxoid
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

1. Introduction

1.1 Primary Health Care

Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Essential Components of Primary Health Care

There are eight essential components of Primary Health Care (PHC) approach. These are given below:

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

Following health facilities are mainly working to provide Primary Health Care (PHC)

1.1.1 Basic Health Unit (BHU)

The BHU is located at a Union Council and serves a catchment population of up to 25,000. Services provided at BHU are promotive, preventive, curative and referral. Outreach/community based services are part of package provided by the BHU. BHU provides all PHC services along with integral services that include basic medical and surgical care, CDD, CDC, ARI, malaria and TB control. MCH services are also part of the services package being provided at BHU. BHU provides first level referral to patients referred by LHWs. BHU refers patients to higher level facilities as and when necessary.

The BHU also provides clinical, logistical and managerial support to the LHWs. It also serves as a focal point, where community and the public sector health functionaries may come together to resolve issues concerning health.

1.1.2 Rural Health Centre (RHC)

The RHCs have 10-20 inpatient beds and each serves a catchment population of up to 100,000 people. The RHC provides promotive, preventive, curative, diagnostics and referral services along with inpatient services. The RHC also provides clinical, logistical and managerial support to the BHUs, LHWs, MCH Centers, and Dispensaries that fall within its geographical limits. RHC also provides medico-legal, basic surgical, dental and ambulance services.

1.2 Secondary Health Care

Hospital at the first referral level serving a district or a tehsil. Secondary Health Care is an intermediate level of health care, which is concerned with the provision of specific technical, therapeutic or diagnostic services. Specialist consultation procedures and hospital admissions fall into this category of care. These services are episodic and usually focused on a particular health problem.

Continuity of care is less critical. The role of a district hospital in primary health care has been expanded beyond being dominantly curative and rehabilitative to include promotional, preventive and educational roles as part of a primary health care approach.

Following health facilities are mainly working to provide Primary Health Care (PHC)

1.2.1 Tehsil Head Quarter

Tehsil Head Quarter (THQ) hospital is located at each THQ and serves a population of 0.5 to 1.0 million. At present majority of THQ hospitals have 40 to 60 beds. The THQ hospital provides promotive, preventive, curative, diagnostics, in patients, referral services and also specialist care. THQ hospitals are supposed to provide basic and comprehensive Emergency Obstetric and New born Care (EmONC). THQ hospital provides referral care to the patients including those referred by the Rural Health Centers, Basic Health Units, Lady Health Workers and other primary care facilities.

1.2.2 District Head Quarter

The District Head Quarters (DHQ) Hospital is located at District headquarters level and serves a population of 1 to 3 million, depending upon the category of the hospital. The DHQ hospital provides promotive, preventive, curative, advance diagnostics, inpatient services, advance specialist and referral

services. All DHQ hospitals are supposed to provide basic and comprehensive EmONC. DHQH provides referral care to the patients including those referred by the Basic Health Units, Rural Health Centers, Tehsil Head Quarter hospitals along with Lady Health Workers and other primary care facilities.

1.3 Tertiary Care

Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, some problems which fall in tertiary care are:

- Head and neck oncology
- Perinatology (high-risk pregnancies)
- Neonatology (high-risk newborn care)
- PET scans
- Organ transplantation
- Trauma surgery
- High-dose chemotherapy for cancer cases
- Growth and puberty disorders
- Neurology and neurosurgery

Following two types of hospitals fall in this category A major hospital that usually has a full complement of services including pediatrics, general medicine, various branches of surgery and psychiatry.

A specialty hospital dedicated to specific sub-specialty care (pediatric centers, Oncology centers, psychiatric hospitals). Patients will often be referred from smaller hospitals to a tertiary hospital for major operations, consultations with sub-specialists and when sophisticated intensive care facilities are required.

1. Organizational Structure of Health Systems of Pakistan

According to the constitution of Pakistan, provincial government is mainly responsible for the health of the country except in the federally administered territories. Provincial governments are responsible for implementing targets defined in National Health Policy while Ministry of Health (MoH) at federal level are responsible for developing national policies. The district health departments are responsible for district health planning, budgeting, quality assurance and provision of delivering healthcare services based on their local needs.

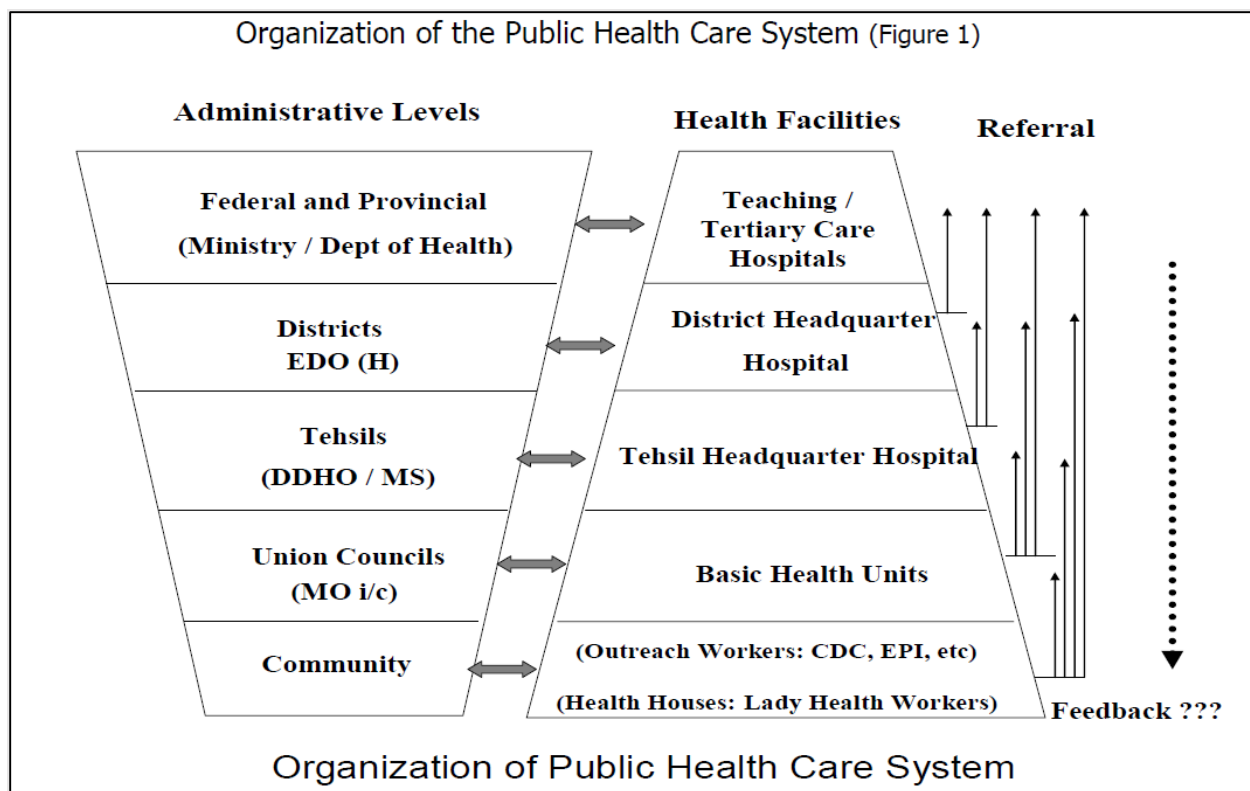
Health systems in Pakistan consist of private and public services. The private sector caters to the health needs of almost 70% of the population of the country, principally a fee for service system and includes broad range of health providers from trained allopathic physicians to spiritual healers. The public health

delivery system is based on three distinct levels of health care delivery system and consists of various national health programmes. Primary Health Care (PHC) units consists of Basic Health Units (BHUs) which covers around 10,000 people and large Rural Health Centers (RHCs) covers around 30000-45000 people.

At the Tehsil Headquarters Hospitals (THQs) secondary care is provided which includes acute, ambulatory and inpatient care while at the District Headquarter Hospitals (DHQs) secondary and tertiary health care facilities are made available to the district. In the major cities of Pakistan around 22 tertiary healthcare facilities are present which also serve as teaching institutions. Maternal and Child Health Centers (MCHCs) are also important part of the health systems and together with BHUs and RHCs provides essential obstetric care through lady health workers by way of community outreach programme. Despite having a vast and broad system of health infrastructure in place, Pakistan's healthcare system is under a huge dilemma.

In 2001, Ministry of Health (MoH) was abolished under the 18th Constitutional Amendment in order to improve accountability at local level and expand service delivery by devolving administrative and financial powers to local authorities. This reform emphasized on decentralization, local autonomy, good governance, intersectoral collaboration, public-private partnership, good quality of care services.

After considerable investment in primary healthcare, the lowest level health facilities in Pakistan, Basic Health Units (BHUs), were still underperforming (Loevinsohn et al 2006). They were the provider of choice in less than 5% of rural visits and 1% of urban visits (PSLM 2006-07). The average number of outpatient visits per BHU per day was 28 in 2003 (World Bank 2005). These facilities were underutilized as quality of services was substandard as there were high rate of absenteeism, shortage of essential medicines, uncooperative staff and inconvenient location. To improve the functioning of BHUs, a pilot program was initiated in 1999 in three BHUs in Lodhran district where the management of the BHUs were contracted out to Punjab Rural Support Program (PRSP). The pilot was later expanded to the district of Rahim Yar Khan in 2003. The perceived success of the expansion resulted in an initiative to further expand the innovation to all four provinces of Pakistan under the President's (now People's) Primary Healthcare Initiative (PPHI). In each province, management of the BHUs was contracted out to the provincial Rural Support Program



Source: Health Systems Profile-Pakistan, Regional Health Systems Observatory, EMRO

2. People's Primary Healthcare Initiative (PPHI) Organizational Information

3.1 Background

After considerable investment in primary healthcare, the lowest level health facilities in Pakistan, Basic Health Units (BHUs), were still underperforming (Loevinsohn et al 2006). They were the provider of choice in less than 5% of rural visits and 1% of urban visits (PSLM 2006-07). The average number of outpatient visits per BHU per day was 28 in 2003 (World Bank 2005). These facilities were underutilized as quality of services was substandard with high rate of absenteeism, shortage of essential medicines, uncooperative staff and inconvenient location. To improve the functioning of BHUs, a pilot program was initiated in 1999 in three BHUs in Lodhran district where the management of the BHUs was contracted out to Punjab Rural Support Program (PRSP). The pilot was later expanded to the district of Rahim Yar Khan in 2003. The perceived success of the expansion resulted in an initiative to further expand the innovation to all four provinces of Pakistan under the President's (now People's) Primary Healthcare Initiative (PPHI).

The PPHI in Sindh is a Public Private Partnership Programme of Government of Sindh. It was initially started under the umbrella of Sindh Rural Support Organisation (SRSO), Sindh- A section 42 Company organized by independent private citizens as a Board of Directors. From 2014, PPHI became a registered not for profit company. The objective of the organization is to revitalize delivery of quality health services in the rural areas of Sindh.

PPHI Sindh manages 1140 primary health care facilities. The organization's main focus is improving health care in the area of maternal, newborn and child health which includes antenatal care, labour and delivery, postnatal care, family planning, immunization, nutrition, BEmONC, CEmONC, diagnostic laboratories, ambulance service etc. Apart from MNCH, the organization also provides services in the area of general OPD, eye clinic, dental clinic, emergency services, vaccines against snake and dog bites etc.

According to Technical Resource Facility (TRF), PPHI model has made important contributions to PHC delivery in Pakistan. DFID and AusAid acknowledged and appreciated the achievements of PPHI in improving quality of health services delivery within the existing health budget in short span of time. World Bank evaluation commented that the success of PPHI largely rests on the ability of PPHI to increase utilization rates without compromising on quality (Heard et al, 2008).

Public Private Partnership model of PPHI is very unique in the sense that it is an independent organization run by 9 Board of Directors and a Chief Executive Officer (CEO), while it is completely funded by government of Sindh. The organization hires staff on merit and promotions are purely based on performance. PPHI has both internal and audit mechanisms to ensure transparency and accountability at all levels.

3.2 Current Activities and Achievements

When PPHI Sindh took the management of BHUs and other primary health care centers, out of 1140 health facilities, 730 were without doctors while the infrastructure of majority of health facilities was in dilapidated condition. The utilization of services by nearby or far flung communities was low, while antenatal care (ANC) visits and deliveries were very low.

PPHI is only given 22% from the entire health budget of the province. Since last seven years a major positive shift in primary healthcare level in Sindh can be observed from the fact that PPHI managed BHUs are now fully functional with doctors, medical equipment, medicines and other essential commodities. PPHI hired **722** Male Doctors, **398** Female Doctors, **630** Dispensers and **579** LHVs/MWs on contract basis. PPHI Sindh deployed **406** lady doctors at rural HFs in the 22 districts of Sindh, which was quite unique for primary health facilities in Pakistan. Taking advantage of the presence of the lady doctors, free

ultrasound services was also introduced for the first time in rural areas. The rate of delivery which was next to none rose to **72000** by the end of year 2016 due to establishing **250** serviceable 24/7 Maternal and Child Health (MNCH) Centers called BHU Plus. Each center has dedicated Female Medical Officer (FMO), LHW/Midwife, labour room, and washroom, as well as infection prevention protocols are being followed thoroughly.

The utilization of health facilities has increased more than 100% over the past years. The outpatient department (OPD) figure has increased from **341,398** in the year 2007-8 to **18,486,474** in 2014-15. This increase is due to the greater availability of doctors and a greater range and quantities of medicine.

In order to strengthen the referral and linkages, these facilities to the higher level health facilities at tehsil and district hospitals, **124** Ambulances were purchased which are readily available at BHU Plus for any emergency.

PPHI's contribution in the area of family planning especially Long Acting Reversible Contraceptives (LARC) can be recognized from the fact that from 2014 to 2016, 46028 implants were inserted by PPHI's health care providers in these health facilities through organizing special family planning campaigns.

For monitoring, PPHI has its very own Smart Phone Monitoring system at health facilities which is used for observing regularity and punctuality of staff, verification of essential equipment, medicine, vaccine and stock out status. While for data collection at the primary health care facilities, mainly District Health Information System (DHIS) is used.

So far the effort has been in building the system and making services available. The focus now will be on making quality services available ensuring the availability of competent staff, commodities coupled with innovative ways for delivering MNCH services.

3.3 PPHI's contribution in the area of maternal, newborn and child health (MNCH)

In order to contribute towards the reduction of maternal, newborn and child health mortality, PPHI Sindh introduced many evidences based practices and trained health care providers of the health facilities. Most of this evidence based practices were introduced for the first time in province of Sindh includes:

- 1) *For reducing the burden of post-partum haemorrhage (PPH):* Advance antenatal distribution of misoprostol was introduced.
- 2) *For decreasing puerperal sepsis:* Implementation of infection prevention protocols was instituted in every facility.

- 3) *For increasing facility based delivery: 24/7 BHU Plus provide MNCH services.*
- 4) *For managing eclampsia: Availability of magnesium sulphate was ensured at all health facilities*
- 5) *For strengthening referrals: Ambulances were placed at all 124 BHU Plus for timely referrals.*
- 6) *For identifying obstructed labour: Availability and utilization of partograph was ensured in all labour rooms.*
- 7) *For decreasing pre-term birth: All BHU Plus were equipped with ultrasound facilities, therefore, pregnant mothers identified with such conditions are counselled during the ANC and referred to tertiary care hospitals. Recently, PPHI also introduced facility based Kangaroo Mother Care (KMC) for saving the lives of premature babies. This intervention will be scaled up to all BHU Plus once the health care providers are trained.*
- 8) *For decreasing birth asphyxia: Helping baby breathe corners are established where trained staff and necessary equipment are available for newborn resuscitation within one golden minute.*
- 9) *For reducing neonatal sepsis: Free of cost supply of Chlorhexidine to BHU Plus for application on umbilical cord just after cutting the cord post-delivery.*
- 10) *For curbing Pneumonia and diarrhoea in under 5: Availability of Amoxicillin, Oral Rehydration Salt (ORS) and Zinc*

3. Role of the MNCH Services wing

- Through the MNCH Services wing will establish the following support systems to enhance quality efficiency and ensure sustainability of the MNCH services
- Regular CSG meetings & health education through mass media and mid-media to create a demand for quality MNCH services, promote best practices, and reinforce key messages
- Pre-hospital transportation systems, tracking promotion of ambulance services, usage, & effectiveness with in BHU plus, other 6/6 centres and comprehensive EmONC
- Systems for continuous technical supportive supervision and mentoring to improve the skills of the health care providers.

4.1 Goal

The MNCH Wing PPHI will have 300 BHU plus running 24/7 in strategic locations throughout its districts. These will include the newly established BHU plus, RHCs & Kausar hospital at Khairpur. The ultimate aim is to ensure that, in every district of Sindh, every woman has access to a facility providing high-quality, and

standardized MNCH services free of cost. The target for Year 2017-18 is 50 more BHU plus in existing list of 250.

4.2 Governing Body of BHU Plus

An MNCH Wing will have all the technical staff of head office (DHS, STA, Director Child health, Deputy Director trainings, Manager DHIS, Manager MNCH, Call center specialist & Assistants). The body will track the progress of all the centers on monthly basis, and will track categorization based on services availability. For year 2017-18 at least 50 will be upgraded as category (A) Health facilities.

4.3 MNCH PPHI Wing Program Approach

4.3.1 MNCH SERVICES FOR BHU Plus & others

BHU Plus is any facility (BHU Type A, B, or MCHC) that is adequately equipped and staffed to provide seven high-quality MNCH services at an affordable cost. These services include:

Family planning (routine and postpartum)

Antenatal care, risk assessment, and birth preparedness

Normal delivery (24/7)

Basic EmONC (24/7)

- Parenteral treatment of infections (antibiotics)
- Parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants)
- Parenteral treatment of hemorrhage (uterotonics)
- Manual removal of the placenta
- Assisted vaginal delivery
- Removal of retained products
- Newborn resuscitation
- Postnatal care for mother and baby
- Child health care and immunization
- Nutrition education and supply of iron folic Acid, Calcium & vitamin D

The Program understands that not all supported facilities are currently providing the same complement of the above services. The goal is that MNCH services will be able to provide most services by the end of the year 2018. In the meantime, facilities will be capacitated to add services in a logical, progressive manner according to the individual facility situation and the needs of the community it serves.

4.3.2 TYPES OF MNCH health facilitie

Table 1: Types of MNCH Health facilities

TYPE	CATEGORIES	TYPE OF SERVICES
Comprehensive MNCH centers	Kausar, Chondko, Tando Jam, & Bhit Shah	All 7, BEmONC & One CEmONC (caesarean section)
BHU Plus	A (Providing CEmONC facilities)	All 7 plus BEmONC & CEmONC services
	Category A Providing BEmONC)	All 7 plus BEmONC services
	B (All basic few BEmONC & referral)	All 7 Basic plus all BEmONC except Assisted vaginal deliveries
	C (Few basic)	FP, ANC, PNC, Nutrition, HBB, & Delivery care
BHUs with MO/FMO for P4P	MNCH & others	Depending upon availability of MO or FMO
BHUs, GD, MCHC & others (with High caseload for MNCH)	A All basic MNCH including LR & referral for BEmONC	FP, ANC, PNC, HBB, Delivery
	B few basic	FP, ANC, General diseases
	C selected	General diseases only

3.3.3 An MNCH health facility may fall into one of four categories:

- **Comprehensive MNCH services units:** These are the units where cesarean section facility is available. It includes Kausar hospital, Chondko, Tando Jam & Bhit Shah & all Rural health facilities when & where cesarean section services are available.
- **All PPHI BHU Plus health facilities: BHU plus facilities are 24/7 health facilities.** will be providing almost all basic & BEmONC services to their A class rated health facilities, which will complete all seven basic & BEmONC services, the aim of the PPHI MNCH is to make all health facilities into (A) class facilities till 2020, the phase wise plan will be developed to upgrade these facilities from C to B & B to A.
- **PPHI other facilities.** The other facilities include facilities with available female care provider for P4P & 6/6 BHU plus, Government Dispensaries, Civil Dispensaries & MCHCs

3.4 Implementation Strategy and steps

The following steps are needed to establish and support participating SBAs and BHU plus in all districts of Sindh:

4. Maintaining tracking sheet of health facilities at all district level to determine the availability of MNCH/FP services.
5. Maintaining tracking sheet of all MNCH checklist of SBA type, shift wise & health facility type Identify and select SBAs as per their clinical skills through multiple approaches. Head office will maintain the checklist of the skills & trainings of MNCH coordinators & MOHQs.
6. Maintain the record of soft and hard copies of on the job coaching & mentoring visits per technical areas to see the quality of coaching visits. Based on specific technical coaching visit development and implementation of site strengthening and capacity building action plans that address infrastructure, supply, equipment, knowledge and skills gaps according to defined standards in each specific area of checklists
7. Coordinate, organize and record CSG meetings (Male & Female) & health education activities and mid- and mass-media activities to enhance the acceptability of SBAs, increasing awareness and use of their services.
8. Provide approved upgrading interventions per site assessments (this may include infrastructural renovations and/or supply and equipment procurements.)
9. Provide continued knowledge and skills development through group-based and on-site coaching, mentoring & supervision of all BHU plus. Target coaching visits for each area based on individual capacity 4-5 per area & if compliance of that particular area is 80% or more then move ahead & if less than 80% then revisit coaching strategy coupled with administrative directions (Exclusive attachment, transfer to other facility or written show causes or explanations).
10. Ensure that facility action plans are properly displayed, reviewed and maintained on regular basis by BHU plus/facility staff, MNCH coordinators & MOHQs.

4.4.1 Technical supportive supervision by MNCH & MOHQs PPHI

It has been observed that supportive supervision and post follow up of training is very important to change the previous practices of health care providers is vital for intensive supportive supervision with experienced and dedicated team of technical peoples who can change the behavior of health care providers to implement evidence based practices and thus achieve quality of care in MNCH resulting in better maternal and newborn health outcome.

4.4.2 What is the role of district and technical team in providing this supportive supervision for PPHI?

PPHI has potential to sustain evidence based interventions in a longer run, this will improve the quality of services. this strategy will make district teams to effectively implement MNCH intervention in the districts. This include daily joint monitoring visits of MNCH coordinators & MOHQs to carry out regular joint supportive supervision of health facilities. The team of MOHQ & MNCH coordinators will travel in same vehicle allocated for technical support by scheduling in a way that MOHQ will work very closely with MO in charge of the health facility for (DHIS, General waste management & IMNCI in particular), while MNCH coordinator will work closely with FMO in charge of MNCH, LHV's & midwives in all shift duties. The MNCH coordinator work with female health care provider while MOHQ will work with in charge MO, Health technician, they can do more than two OJCs same day to most of the facility staff to do more than two OJCs and OJTCs together. The Action plan will be made, if it is already made, would be updated soon after intervention The OJCs done on particular day will also define for the next visit purpose to that facility for next topic of OJC, the one technical area should have maximum of 4 OJCs which will reflect that that particular area will have score more than 80 % in that particular area, if there is any issue with slow learners (5-10%) sometimes needs more visits that need to be documented. But after 4 well prepared visits if the any particular area like ANC do not improved more than 80% that need revision of the strategy which may include, more intensive/ exclusive coaching to the individual, the score would be considered 80% when most of the female staff comply 80 or more. Three kinds of gaps are mostly identified during this process which include Knowledge/practice, Resources & Attitudes. To improve knowledge & practice gaps MNCH coordinators & MOHQs will be evaluated, while for resources gaps DM. When there is gap in availability of resources like equipment, supplies medicines and HR issues respectively. In the office after every visit DM will be informed on job/coaching done for that day or as agreed by DM, weekly or daily After completing three days' visit at facilities. The Friday/Saturday would be full for planning and reporting. The technical staff will work very frequently with 24/7 centers and high caseload facilities while they can visit less frequently at other as they need less support. The technical staff (MNCH & MOHQ) will also support each other in district based group based trainings.

Table 2: What is the plan for the District Level Roll out of supportive supervision?

What to do?	Who is responsible?	What are the resources Needed/available
Joint supportive supervision		
Sharing of joint weekly plan to DM ,PHS & HO. Daily reporting on that plan through online	MNCH & MOHQ	Computer accessibility and internet connectivity for OJCs

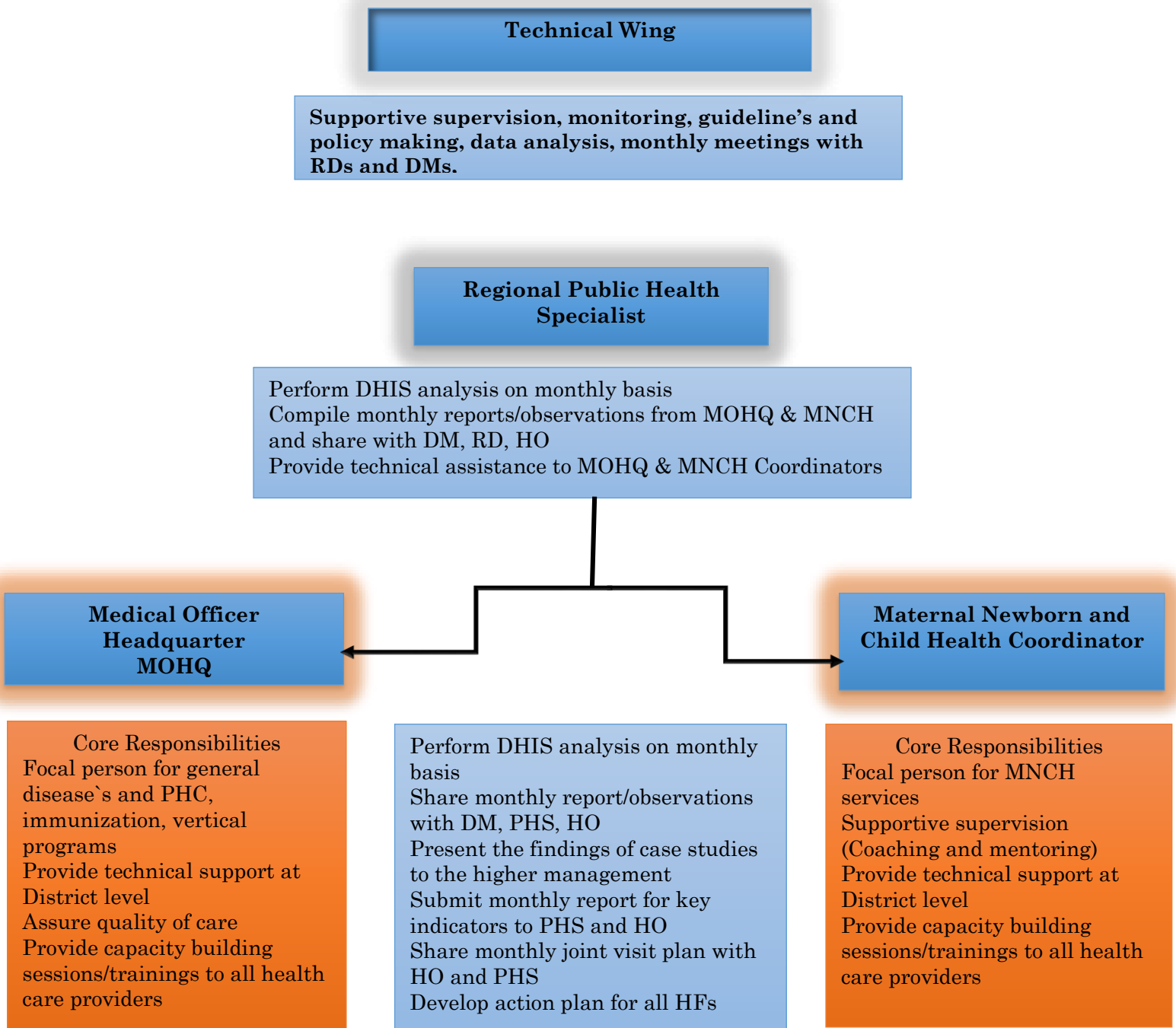
submission of daily report, sheet and letter is already shared.		or Online daily monitoring report
Health facility staff trained on the job trainings and coaching	Technical team (MNCH & MOHQs)	See the training plan (Attachment),and IEC material
Health facility staff receive refresher training and on the job training on a periodic basis	PHS & HO	Available 16 modules, MNCH/other checklists and monitoring on tablets or manual
Facilitate staff monthly DHIS internal meetings to implement and record in DHIS registers, MOHQs will revise the targets of BHU plus, Catchment population chart maintenance, Staff meeting & CSGs meetings.	Health facility staff, MNCH & MOHQs	Skill checklists & monthly register of DHIS
Arrange and conduct trainings for staff who are not yet received any trainings	MNCH & MOHQ	Available 16 modules, Technical checklists and monitoring on tablets or manual
Support facility staff in proper record keeping and data collection from the facilities for MNCH DHIS section # VII, VIII, IX (X & XI when required)	MNCH & MOHQ	Coaching visit formats
Support facility staff in proper record keeping and data collection from the facilities for MNCH DHIS section #	MNCH & MOHQ	Coaching visit formats
Train & coach newly hired staff on the job and during trainings.		Available 16 modules, MNCH checklists and monitoring on tablets or manual
Support technically repair & renovations work for labor room & laboratories etc.	MNCH & MOHQ	Specification for Labor room wash basin, western commode

		in LR & curtains for privacy in LR & KMC ward
Present most common technical gaps & findings in meeting with any technical area & share any one power point presentation in the Monthly review meetings.	MNCH & MOHQ	Observations from the daily reports & Power point presentations from 16 Modules
Cover technical topics if needed or just share common implementation gaps during regular MRMs to improve overall quality of all seven services.	MNCH & MOHQ	OJT modules power point presentations & presentation to address common gaps identified during last month field visits
Support and organize medical camps as well as FP camps when scheduled to refresh knowledge of staff on FP counselling, setting up corners during camps, ensure availability of sterilized kits, gloves and commodity etc.,	MNCH & MOHQs	Assessment plan two week ahead of FP camps
Ensure IEC material relevant to Technical interventions at all health facilities like HBB charts, KMC charts, Misoprostol posters, FP charts, ANC charts & IMNCI charts etc.	MNCH & MOHQs	All relevant posters and IEEC material posters list available in MNCH implementation guide
Role of Managers		
Review & Sign monthly joint visit plan of the MOHQs & MNCH	DM	Share it with PHS/RD/ HO
Review the Observations shared by MOHQs & MNCH coordinator on weekly basis & assign relevant staff for Actions,	DM, Ex M&E & SOs	Weekly basis & action plan to address observations, supply, CSGs, procurement & explanations etc.

like Ex M&E to coordinate with the store manager to provide missing supplies & medicines as per defined timelines, SOs will be assigned to make available those supplies. DM will raise new POs where applicable. SOs will coordinate to reinforce relevant CSGs		Written observations & Action plans of the facilities visited
. DM will review the on monthly basis results of OJTs & OJCs, after every 4-5 coaching visits any particular areas the compliance for that particular area should be 80 or more %	DM,	OJC reports on dashboard and hard copies of action plans
Every Group based training will be monitored	RD/DM/ PHS/HO	Evaluation will be on pre and post test scores
Coordination with DMs for sharing observations related to supplies, IEC material, medicines, equipment's, Record keeping tools & individuals attitude etc., for attitude that could be shared with DM after maximum standard coaching visits (4-5) in same area if the compliance is not made, force DMs to issue explanation letters and maintain in the file of that facility	DMs	Get list from MNCH implementation guide for the Equipment, supplies, drug list while for explanation supported document of OJTs
If staff is absent from duties or late without duties just inform in	DM	Employee personal files for explanation etc.

written to DM to issue explanation etc.		
RD & PHS will review the data of all five districts to see the compliance on technical areas by reviewing number of visits done on any specific area similarly like if 4 or more coaching visits are done compliance is 80 or more or not. Based on findings issue letters to DMs, MNCH & MOHQs for explanation etc.	RD/PHS	OJCs dashboard for coaching visits & compliance
MNCH Coordinators and MOHQ will submit all reports/data (KMC,HBB, P&D, PSBI and other intervention`s) to PHS	PHS	DHIS/ASS/ KMC Register (Collect data manually till online access is provided)

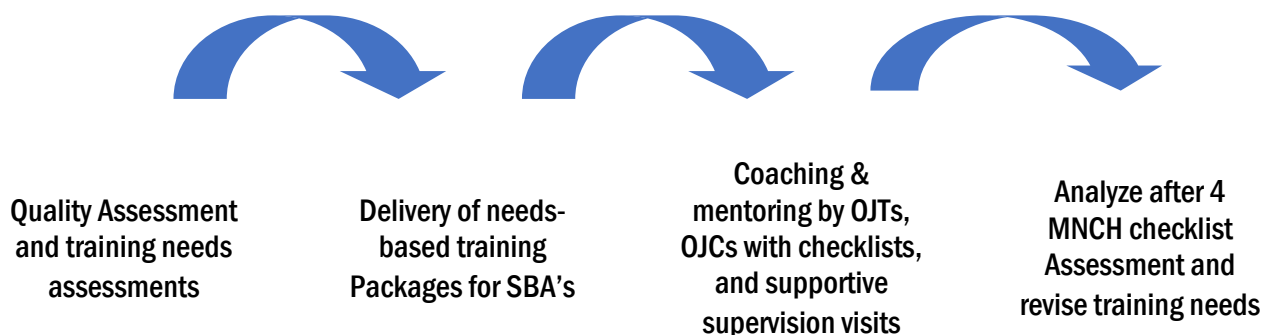
5. Organogram for MNCH Coordinators and MOHQ



6. Technical support for all kind of MNCH Facilities.

MNCH coordinators and MOHQ are hired to support and oversee clinical aspects of MNCH & PHC services at BHU plus and other facilities. MNCH coordinators will support 15-20 BHU plus at priority basis in their assigned districts each, under the technical guidance of PHS, Director Trainings, Director child health & STA. The district & regional technical team will provide supportive supervision and mentorship to MNCH coordinators & MOHQs.

Figure-1



6.1 The BHU Plus Improvement and Capacity Building Cycle

MNCH Centers will receive structured quality assurance plan biannually by either calling central meeting on progress followed by random verification of health facilities. This approach consists of the systematic use of performance standard (MNCH/other Checklists) for training need assessment, gap analysis, action planning (including capacity building interventions) to address gaps, repeat assessment, and recognition of improvement. The quality assurance/ quality improvement process includes four basic steps:

- Revision in performance standards/MNCH checklists in an operational way when & where applicable
- Implementing the checklists through a streamlined and systemic methodology
- Measuring progress to guide the improvement process toward these checklists
- Recognizing the achievement of the standards or pay for performance.

This approach will underpin the delivery of uniform high-quality services at BHU plus and other facilities, guiding the initiation of services as well as recognition of high achievement for pay for performance.

6.3 Training and Need Assessment

6.3.1 Need Assessment as Baseline Assessment

For new BHU plus and new hired staff would be done using MNCH checklists. Technical staff (MNCH coordinator & MOHQ) will work with facility teams to review the findings from the baseline assessment. Then, together, teams will design facility-specific action plans to target gaps. Action plans will address knowledge, skills, and attitude/motivational gaps through tailored capacity building plans. (Detailed checklist and Guide is included as **Annex AN and Annex AO**)

6.3.2 Action Planning and Follow up

MNCH coordinators and MOHQs will support BHU plus and other health facilities to implement action plans with bi-monthly visits to review progress against the action plans as BHU plus cater 80% of MNCH population. They will also support the implementation of on-site capacity building interventions. Similarly, Technical team at head office will compare their own team's assessment with the facility team's assessments, and discuss any areas of divergence. They will engage in one-to-one mentorship with individual team members. Clinical skills assessments will be conducted during regular monthly supportive supervision visits.

6.3.3 Repeat assessment and more focused Action plan

The MNCH coordinators & MOHQs team will re-assess each MNCH Center every 6 months to track progress and identify any new challenges since the previous need assessment and action planning.

6.3.4 Continue to review action plans, follow up, and reward achievement

The quality improvement cycle is an ongoing process of review, refinement, and continual capacity building. Progress is consistently documented and tracked, with appropriate reward mechanisms determined in collaboration with district teams. "High quality" is defined as 80% achievement against MNCH checklists.

7. Training Strategy of PPHI Sindh

7.1 Need- Based Capacity Building For Skilled Birth Attendants

PPHI Sindh will employ mix of capacity building activities to address both provider performance and confidence and help providers achieve quality standards. Trainings may be delivered as:

- Group-based trainings where more than 12 participants gather at an off-site location for a competency-based learning activity, like FP trainings, IMNCI trainings, PCPNC trainings etc.
- On-the –Job (OJT) trainings, where individual providers (or a facility-based team of providers) participate in a structured learning activity at their facility.

Both group-based trainings and OJTs are followed up by continued supportive supervision through facility-based coaching and mentoring.

Before conducting any specific training in a given technical area, all clinical trainers are expected to:

- Complete Training Skills (TS) course – this is only completed once. It is not specific to any technical area.
- Complete a mentored co-training experience
- Attend the TOT of a specific learning resource package. Or, in the absence of a TOT, participate in a group training experience conducted by certified trainers.
- Complete six UNFPA e-learning modules and USAID e-learning modules (accessible at: <http://reprolineplus.org/learning-opportunities>).



Photo credit: PPHI
A midwife practicing on a MamaNatalie model

Details about e-learning process and tracking of technical staff continuing education can be find in Annex

8. GROUP BASED TRAINING

8.1 Training of Trainers

For group-based trainings, the PPHI team will also be responsible for conducting centralized Training of Trainer (TOT) activities and developing district trainers capable of leading subsequent roll-out trainings for health care providers in the districts

Training schedules are finalized quarterly through collaboration between Head Office and the district teams. Following the development and introduction of new Learning Resource Packages for any group-

based training, a Training of Trainers (ToT) is conducted by PPHI head office - preparing Master Trainers. TOTs are regularly monitored by the Head Office assigned team (Dy Director Trainings, Child health & technical advisor) to ensure training consistency and for the provision of additional support as needed.

8.2 Learning Resource Packages

There are globally standardized Learning Resource Packages in accordance with global and national guidelines to build provider knowledge, skills, and attitudes. Training packages (including trainer and learner materials, as well as supplemental job aids and guidance) are provided for use at district-level. These packages are endorsed by the Sindh DOH.

The following training packages are group based will be rolled out during the current year 2017-18

Table 3: Trainings:

Training Name	Training Length	Brief Description
Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC)	6 days	Includes management of all normal and routine evidence-based MNCH care, as well as management of postpartum hemorrhage, and pre-eclampsia/ eclampsia, and sepsis.
Management of Complications in Pregnancy and Childbirth (MCPC)	4 days	Includes Post-Abortion Care (uterine evacuation by manual vacuum aspiration or medical management), and assisted vaginal delivery (vacuum assisted delivery), as well as episiotomy and repair.
Post Abortion Care	4days	
Helping Babies Breathe	2 days OJC Checklists\OSCE A & B (HBB).pdf OJC Checklists\Bag-Mask Ventilation (HBB).docx	Includes neonatal resuscitation.
Competency Base IUCD Doctors	6 days	Includes IUCD and FP overview of all methods for SBAs
Competency Base IUCD CMW/LHVs	10 days	Includes IUCD and FP overview of all methods for SBAs
Advanced family planning: Intrauterine Contraceptive Device	6 days	Includes skills based training on client-centered counseling, and insertion/removal of interval IUCD

Contraceptive Implants (for doctors only) – PWD	2 days	Includes skills based training on client-centered family planning counseling, insertion and removal of implants
Postpartum Intrauterine Contraceptive Device (PPIUCD)	4 days	Includes all aspects of PPIUCD service delivery and technique.
IMNCI training	6 days	Includes diagnosis and management of childhood cough and difficulty breathing & PSBI per new WHO guidelines.
KMC training	2 days	Which includes the concepts, sensitization & practical skill training
Nutrition	2days	Include Mother, infant and young Child nutrition with special focus of breastfeeding skills and counselling.
OJT on Routine Immunization for SBA	1 day	Includes overview of routine immunization for mother, newborn, and child per WHO recommendations
Clinical attachment of newly hired Midwives	4 weeks	One week for the class room (PCPNC) & three weeks attached at high case load facility for hands on practice and certification as per filled log book
Ultrasound training	4 weeks training	One week class room training & three weeks for hands on training at high case load facility under supervision of the certified sonologist.

8.3 Participant Selection for Group-Based Trainings

Selection of participants for training should be based on the following criteria:

For MNCH training, these will be mostly female health care providers, prioritizing staff of BHU plus & female staff providing MNCH services to other than BHU plus health facilities.

Newly hired staff of PPHI should undergo training need assessment for IP, ANC, PNC & FP before deploying at any health facility, either group training or on the job training where applicable. the newly hired staff can be trained by female Medical officer (fulfilling all the pre requisites like pre/posttests, Case studies & checklists etc.)

Has not participated in a training in this service delivery area in the last two years. (If a provider has participated in a similar training in the past two years, the MNCH coordinator will conduct a Training Needs Assessment (TNA) using specific checklists to determine whether the provider should be retrained. If performance on the (TNA) is acceptable (over 75%), MNCH coordinator will make individual plans for

continued coaching and mentoring. But if she scores less than 50 % and that is specifically in knowledge & skills area then organize a training, but score is mostly in communication like greeting, re arrangements & counselling then arrange for on the job Coaching (OJC)

8.3 Documentation Requirements for Group-Based Trainings

For each group -based training, trainers should complete the following:

- Participant's attendance sheet signed & in case training is done by PWD, request for the training report for your own record.
- Administer and grade knowledge pre-assessment for each participant (included in training materials)
- Administer and grade knowledge post-assessment for each participant (included in training materials)
- Complete the analysis of scores of pre/ post-assessments (At the end of all group based trainings, trainees must achieve 80% marks in post-test for certification.) if they do not get 80% or more in scheduled days of training then follow these participants through OJC until they score required & then certify those participants as trained
- Administer and collect the training evaluation form which is completed by all participants.
- Administer and score skills checklists for each new skill area (All participants should pass the Structured Clinical Exam or OSCE – as assessed against a standardized skills checklist - with minimum 80% of score)

8.4 Certification for Group-Based Trainings

Achieving the minimum pass score on the post-training knowledge assessment and the skills assessment is necessary for training certification. All learners who achieve pass marks of 80% or higher on the post-test and post-training OSCEs will receive training certificates. If a learner does not achieve 80% or higher on the post-test and post-training OSCEs, he or she is not eligible for a training certificate, and a follow-up remediation plan should be developed to help him or her achieve certification.

A providers' experience during skills based trainings also informs his or her individual learning plan – these learning plans guide the selection of topics for continued on-the-job training/coaching/and supportive supervision visits. Clinical support staff MNCH coordinators & MOHQs depending upon the district situation, will maintain logbooks for each supported provider at BHU plus & other facilities. These logbooks will contain information about training completed, OJTs completed, OSCE performance, and individual learning needs. The maintenance of these logbooks will be the responsibility of MNCH

coordinators in partnership with the provider. See Annex O for a sample of the Provider Capacity Building Tracking Sheet which forms the basis of the provider logbooks.

Similarly, newly hired & passed midwives from Koochi Goth & other institutions when these are attached for six weeks' time they need to get filled their standard log books developed by MNCH Program Sindh.

9. On the Job Training

PPHI Sindh training wing will be using same modules developed by PPHI 16 OJT modules in key areas of MNCH service delivery. These modules are delivered as a package during PCPNC trainings and singly during OJT sessions. MNCH coordinator should select an OJT module for a supportive supervision visit based on the needs of the specific MNCH Center/provider(s). Decisions about OJT support to BHU plus & others are not arbitrary; they are carefully made based on gaps documented as per MNCH checklists as training need assessments and program capacity building activities. For example, MNCH coordinators may prioritize an OJT session on partograph if a given BHU Plus did not meet partograph-related performance standards in its MNCH checklist of partograph.

In some cases, group-based training content may be delivered in an OJT format if providers are not able to attend a full-time group-based training. In this way, it may be possible to combine staff from more than one BHU plus for a given OJT training session.

9.1 OJT modules:

- 1) Focused Antenatal Care
- 2) Birth Preparedness and Complication Readiness
- 3) Vaginal Bleeding in Pregnancy
- 4) Rapid Initial Assessment and Management of Shock
- 5) Normal Labor and Childbirth
- 6) Partograph
- 7) Active Management of the Third Stage of Labor
- 8) Normal Childbirth: Beneficial Practices
- 9) Prevention and Management of Pre-eclampsia/ Eclampsia
- 10) Postpartum Hemorrhage
- 11) Management of Postpartum Hemorrhage
- 12) Postpartum Care

- 13) Puerperal Sepsis
- 14) Normal Newborn Care
- 15) Breastfeeding
- 16) Infection Prevention and Control

Each OJT module contains a set of materials designed to support on-site learning in that technical area. PPHI has already provided these modules to MNCH coordinators, MOHQs, Public health specialists and district teams with flash drives containing all OJT content. Technical staff can then reproduce hard copies of OJT materials on an as needed basis. Standardized content in each module includes:

1. OJT session objectives and session outline
2. Knowledge assessments (pre and post)
3. PowerPoint presentations with updated, evidence-based didactic content
4. Interactive learning materials – exercises, role plays, case studies, simulations, etc.
5. Job aids and handouts
6. Clinical Skills Checklists

Documentation Requirements for OJT Visits:

1. Coaching format & attendance sheet if group OJT
2. Appropriate skills checklist for that OJT for individual provider
3. Pre and post knowledge assessments
4. Training evaluation form
5. OJT visit data collection form
6. Provider Logbook

9.2 How to Conduct an OJT Session?

Each OJT module will have its own specific supplies/materials requirements, which are outlined in the course materials. However, MNCH coordinator should be prepared with a laptop with OJT content, anatomic models like the Mama Natalie and Neo Natalie simulators, and any other related clinical or demonstration supplies, handouts, etc. MNCH coordinator will need to bring these materials with them to the BHU PLUS receiving the OJT. On the job training activities should be scheduled and planned well in advance with the facility staff and management. As discussed earlier if as per MNCH checklist score decide to do follow up coaching visits & their number, if score is more than 80% then schedule maximum two coaching visits & if less than 80% schedule more than 2 visits depending upon gap nature.

9.3 Post-training Coaching and Mentorship

Acquisition of new knowledge, skills, and attitudes is a process that happens over time, as learners progress from competency to proficiency to mastery. In order to support this learning process, it is essential to reinforce training activities through ongoing mentorship and support. On-site capacity building may take several different forms: routine supportive supervision, or a targeted on the job coaching (OJC) and mentorship visit.

9.4 Supportive Supervision Visits (Regular Facility visits)

Supportive supervision is a term used to describe facility visits to observe, coach, assist in problem-solving, and track progress in providers' clinical capacity. During these follow up visits, staff should discuss the Action plan developed based on MNCH checklists as need assessment tool (the MNCH checklist tool itself can be used to coach and support the SBAs in their daily work) and progress against the facility/ learner action plans. Action plans are further refined with facility teams during supportive supervision visits.

The objectives of supportive supervision visits are:

- To fill the gaps related to knowledge, skills, confidence and current practices of SBA's after training.
- To provide additional coaching in clinical skills.
- To work with supervisors to help ensure that SBAs have the support needed to apply new knowledge and skills at their job sites.
- To collect information about SBAs performance in order to assess the progress of action plan and pay for performance initially for female medical doctors.

The number of supportive supervision visits provided to any single BHU plus/others will vary according to the needs of that facility. For instance, a lower performing BHU plus (B& C category) should receive more support than a higher performing BHU plus. The frequency of supportive supervision visits will also depend upon the range of services available in the BHU plus category wise and the Centers hours of operations (24/7, 6/6). However, MNCH coordinators should visit each MNCH Center for at least two twice per month.

Technical staff members (MNCH coordinators & MOHQs) are advised to make the most of these supportive supervision visits. In other words, staff should try to complete multiple objectives within one

visit to a BHU plus – for example, a MNCH coordinator may review the specific MNCH checklist action plan, conduct an OJT, and provide OJC with that day’s clientele. Technical staff should also be sensitive to the many competing demands on busy SBA’s time. Supportive supervision and on-site training should not interfere with the delivery of high-quality, respectful client care. A flexible approach that allows MNCH coordinators to adapt for BHU plus scheduling is advised. For instance, SBAs may not be able to dedicate the time to an OJT if clients are waiting to be seen. However, high client volume presents an excellent opportunity for learning transfer via coaching and mentorship.

If after several visits, an individual SBA is having difficulty grasping particular knowledge or skills in a given area, additional attention is required. Technical staff should document these findings and notify the district team (including District Manager, PHS, District Health Officer, PPHI District Manager, Child Health Director Coordinator, field manager and Technical Advisors). Some learners may require more intensive mentorship through peer learning, or more frequent contact with technical support.

9.5 Preparing for a Facility Visit:

1. Plan to spend at least 1 hour with each SBA in each scheduled visit for OJC and monitoring.
2. Contact the SBA/facility and agree to a date for the visit. Review the purpose of this follow up visit.
3. Contact the learner’s supervisor/ facility In-charge to confirm your visit. Review the purpose of the follow up visit and make appointment to meet with the supervisor before and after your visit.
4. Prepare the required teaching, learning and documentation materials – including blank copies of the clinical skills checklists and any anatomic model(s) that will be required for the skills to be practiced and evaluated.
5. Review the SBAs performance during the course (test and skills scores achieved), as well as the provider/facility action plan.
6. Meet with the Supervisor/ In-charge at the beginning and end of the visit and share your findings and recommendations with her/them.
7. Encourage SBAs to work with their teams and supervisors to practice skills through role plays and with models and checklists and to reinforce their knowledge with the assistance of knowledge questionnaires and case studies.

9.6 On the Job Coaching (OJC)

OJC and clinical mentorship can be conducted on actual clients, or on anatomical models such as MamaNatalie. OJCs are used to assess competency of specific clinical skills. So, if a provider is seeing a

client for a focused antenatal care visit, the MNCH coordinator should use the FANC skills checklist to guide mentorship. The completion of skills checklists is essential for determination of competency. The skills checklists have been adapted to include steps that are considered most “critical” in determining whether an SBA is competent in providing that skill.

Documentation Requirements for OJC Visits:

- OJC data collection form on mobile (real time) (for each coaching session with an SBA).
- Provider Logbook including all completed skills checklists (include it in online the training data base)

10. Appendix A: MNCH Supply, Equipment, and Medicine List

NO COLOR = supplies provided according to needs identified on assessment

PINK = items provided after training completed

YELLOW = all centers are provided with these items regardless of need

S.no	Items Description
General Items and Furniture	
1.	Office table
2.	Office chair
3.	Exam table
4.	Cabinet, for drugs / instruments
5.	patient stool (Revolving)
6.	waiting bench for high volume facilities
7.	Wall Clock
Medical Equipment	
8.	Screen/curtain for privacy
9.	Instrument Trolley with two trays
10.	Delivery table
11.	IV Infusion Stand,
12.	Autoclave/Boiler for HLD
13.	Emergency standby light
14.	Refrigerator/for facility providing Immunization
15.	Mobile examination light (SMIC China)
16.	BP Apparatus - functional (at least one per service site)
17.	Stethoscope - functional(at least one per service site)
18.	Nelaton catheter/ Foley catheter

S.no	Items Description
19.	Safety Box for used syringes / needles
20.	Adult Weighing scale
21.	Thermometer, clinical, 35-42°C
Medical Supplies	
22.	Patients drape
23.	Vacuum extractor (for assisted delivery)
Documentation	
24.	DHIS Child OPD register
25.	IMNCI case investigation forms for pneumonia and diarrhea
26.	IMNCI Chart for pneumonia and diarrhea
27.	Box file (Partograph, QIPS, OJT etc.)
28.	Antenatal register
29.	Labor Register
30.	Referral record
31.	Immunization
32.	Partographs book or clip file
Examination Kit	
33.	Double-ended, Sims Vaginal medium size/Cusco's Vaginal Speculum medium size
34.	Stainless steel Kidney Basin, 825 ml
35.	Straight Artery Forceps 140 mm
36.	Sponge holder/straight Artery Forceps, 140 mm
37.	Stainless steel Bowl, 600 ml
Implants kit	
38.	Implants Insertion/removal kit
39.	Small straight artery

S.no	Items Description
40.	Small curved artery
41.	Scalpel/Blade holder
42.	Sponge holding forceps
43.	Plain forceps
44.	Kidney tray
45.	Plain Scissor
46.	Tenaculum
47.	Uterine sound
48.	Cuscos speculum medium size
49.	Sponge holding forceps
50.	Plain forceps
51.	Long straight artery forcep
52.	Thread retriever
53.	IUCD Hook
PPIUCD Insertion Kit	
54.	Tenaculum
55.	Sims speculum medium
56.	Sponge holding forceps
57.	Plain forceps
58.	Long kelley forcep
59.	kidney tray
Pneumonia and Diarrhea	
60.	Weighing scale
61.	One Jug (1L), 6 Cups(50), 6 cups (100 ml), 12 Spoon(5ml)
62.	Chair for ORT Corner

S.no	Items Description
63.	ARI Timer
64.	Thermometer
Case Management of newborn Sepsis (CEmONC Hospitals)	
65.	Pulse Oximeter
66.	ARI Timer
67.	Baby weighing scale
68.	Thermometer
69.	Baby stethoscope
Infection Prevention (IP) Set	
70.	Waste bucket with lids (Blue and Black color)
71.	Apron
72.	Plastic /Macintosh Draw Sheet, 90 x 180 cm
73.	Boiler-Sterilizer larger
74.	Brush to clean Instrument
75.	Tub or Bucket with Lid for Chlorine & Detergent Water
76.	Bucket stand for chlorine buckets or tubs
77.	Utility gloves (pair)
78.	Close toed Cut Shoes
79.	Plastic sheets to cover waste bins
80.	Goggles/face shield
81.	Mops
82.	Hand sanitizer
83.	Hamam where tap water is not available
84.	Chlorine solution (3-5L)
85.	Measuring Jug (1L)

S.no	Items Description
Delivery Set	
86.	Instrument Tray 300 x 200 x 30 mm
87.	Fetoscope Aluminum
88.	Stainless steel bowl 600ml
89.	Angular Episiotomy Scissors, 145 mm
90.	Cord clamps stainless steel
91.	Scissors for cutting the cord
92.	Cylindrical Drum, diameter, 150 mm,250 mm
93.	Mayo-Hegar Straight Needle Holder, 180 mm
94.	Standard Straight Tissue Forceps, 145 mm
95.	Sponge holding forceps
96.	Deaver Scissors, 140 mm
97.	Tooth tissue forcep
98.	Plain tissue forcep
99.	Blunt Scissor
100.	Measuring Tape
101.	Stainless steel kidney Basin
Newborn Resuscitation Set	
102.	HBB Resuscitation KIT (Neonatalie, Ambubag, Masks 0 and I size, penguin suction device,
103.	Cord cutting Scissor
104.	Cord ties or clamps
105.	Baby Stethoscope
106.	Ventilation area (table)
107.	ARI Timer
108.	Cotton cloth (2 Pieces) for baby dry

S.no	Items Description
109.	Action Plan Wall Poster
110.	HBB Stickers
	Kangaroo Mother Care
111.	KMC Binder
112.	Feeding cup
113.	Weighing scale
114.	Bed, mattress, pillows
115.	IEC material

11. Appendix B: Facility-based Monitoring Checklist

District _____

Name/Location: _____

Date of visit:

Time of Visit (hh/mm):

-

Name _____

of _____

Health _____

Facility: _____

Visited by:

a)

Name: _____

Designation: _____

b)

Name: _____

Designation: _____

11.1 Staff Availability:

Please write down how many of the following staff are present in the health facility. Here staff availability means those staff present on the day of visit or that staffs not on leave within 7 days or that are not on deputation outside.

Medical Officer	Medical Technician	Dispenser	LHV	Vaccinator	Helper	LHS	Sweeper/Cleaner

11.2 MNCH Services- Record Keeping

S.no	Service Type	Y (Yes)	N (No)
1.	Updated health facility action plan present		
2.	Daily client register/OPD register maintained		
4.	Record of all cases referred maintained in referral register/DHIS register		
5.	Results of last QIPS assessments and action plans are available at facility		
6.	Duty Roster		
7.	All DHIS register maintained		
8.	Results of internal assessment are maintained at facility		
9.	Partographs are available in labor room for every client		

10.3 Availability of Basic Supplies and IEC Materials:

Do you have following materials available in this health facility?

S. no	Description	Y	N
1.	Stethoscope		
2.	BP set		
3.	Examination table		
4.	Functioning examination light		
5.	Functioning Emergency Light		
6.	Emergency Drug Trolley		

7.	Functioning oxygen cylinder		
8.	Protocols for Pakistan pregnancy, Child birth, Postpartum and Newborn care		
9.	Protocols for managing pregnancy complications		
10.	Pregnancy, delivery and post-natal related poster		
11.	FP poster		
12.	Functioning suction machine		
13.	Functioning Bag and Mask		
14.	HBB Poster, timer, cord clamps		
15.	Ventilation table for HBB		
16.	Supplies for preparation of ORS solution (Jug, Cups, Spoons)		
17.	Tongue depressor		
18.	Supplies for functioning EPI center (EPI cards, Syringes, Vaccines for routine EPI)		
19.	Weighing scale		
20.	NG tube		
21.	Availability of KMC unit		
22.	KMC registers, IEC material		
23.	Number of admission and follow cases in KMC according to protocols		
24.	Functioning Operation theatre for Caesarean Section		
25.	Functioning blood transfusion services		

10.4 Infection Prevention Practices:

S.no	Basic requirements	Y	N
I.	Is there a cleaned environment in the health facility		

2.	Are the soiled instruments are decontaminated with 0.5%chlorine sol		
3.	Are the sharps/needles properly disposed after use		
4.	Is the facility has functional autoclave/ sterilizer/boiler		
5.	Are the sterilized equipment used while dressing		
6.	Are the other wastes from HF disposed properly		
7.	Is there adequate water supply to the facility		
8.	Is there electricity and power supply to the facility		

10.5 Availability of MNCH related Essential Drugs:

S.no	Basic Drugs	Y	N
1.	Injection Normal Saline/ Ringer lactate		
2.	Inj. Amoxicillin and Gentamicin		
3.	Inj. Metronidazole		
4.	Inj. Syntocinon (Oxytocin)		
5.	Tab. Misoprostol		
6.	Inj. Magnesium sulphate		
7.	7.1% Chlorhexidine gel		
8.	Low osmolality ORS packets		
9.	Zink syrup/tablet		
10.	Oral Amoxicillin		
11.	Paracetamol (Syp/tablet)		
12.	inhaled bronchodilator/Salbutamol		
13.	Dexamethasone		
14.	Tablet Ferrous Sulphate		
15.	Inj. Calcium Gluconate		
16.	Silver nitrate eye drops		

11.6 Health Facility support groups/QIT teams:

S.no	Questions	Y	N
1.	Does the facility has functional SG/QIT		
2.	Record of SG/QIT meeting conducted in last 2 months course.		
3.	Was an Action Plan developed based on the outcome of the meeting? (observation)		
4.	How many outreach clinics/activities are conducted in last month?	Number ____	

10.6 Referral System:

S.no	Description	Y	N
1.	Referral slips available		
2.	Ambulance services available		
3.	Feedback of referred case recorded		
4.	SOP who need to be referred present		
5.	List of Emergency contact numbers posted		
6.	Total number of cases referred by LHW/CHWs		
7.	Review meetings on referred cases held.		
8.	List of local transporters displayed		

10.7 Capacity Building and management of the facility:

S.no	Description	Y	N
1.	Has the female staff being trained in (MNCH) like EOC update trainings		
2.	Does the facility staff is trained in IMNCI		
3.	Facility staff trained in HBB		
4.	Facility staff trained in KMC		

5.	Is facility staff trained in Misoprostol and chlorhexidine		
6.	Does facility maintain Oxytocin cool chain		
7.	Does facility maintain infection preventions		
8.	Does facility staff trained in FP (Implants , PPIUCD)		

12. Appendix C: Coaching Visit Report District Name/Location:

Name of Facility: _____

Name of the Provider: _____

Day Month Year

Date of Visit:

Name of the Coach: _____

Type of Visit: On Job Training (OJT) Coaching Visit

Topic Covered:

- Focus Antenatal Care (ANC)
- Birth Preparedness and Complication Readiness
- Vaginal Bleeding in Pregnancy
- Rapid Initial Assessment and Management of Shock
- Management of Pre-eclampsia/Eclampsia
- Postpartum Care
- Newborn Care
- Infection Prevention
- Normal Labor Child Birth
- Use of Partograph
- Active Management of Third Stage of Labor
- Normal Child birth: Beneficial Practices
- Postpartum Hemorrhage
- Newborn Sepsis
- Breast Feeding
- Other: _____

12.1 Target performance standards for the current visit: write number only): _____

Intervention during the Current Visit: See below

S.no	Areas using Checklist	Name of health care provider	Standards observed	Gaps identified	Interventions
1					
2					
3					

4					
---	--	--	--	--	--

Take Picture: Record Location:

Reporting Date & Time:

13. Appendix-D Objective Structured Clinical Examination (OSCE)

What is Objective Structured Clinical Examination (OSCE)? The OSCE is a performance-based exam. During the exam, trainees are observed and evaluated as they go through a series of stations where they interview, examine and treat standardized patients presenting with some type of problem.

OSCE Design: An OSCE usually comprises a circuit of short (usual is 5-10 minutes although some use up to 15 minutes) stations, in which each candidate is examined on a one-to-one basis with one or two impartial Trainers /examiner(s) and either real or simulated patients.

Objective: All candidates are assessed using exactly the same stations with the same marking scheme. In an OSCE candidates get marks for each step on the mark scheme that they perform correctly which therefore makes the assessment of clinical skills more objective rather than subjective, where one or two examiners decide whether or not the candidate fails based on their subjective assessment of their skills.

OSCE Marking: Marking in OSCEs is done by the Trainer/Examiner. One of the ways an OSCE is made objective is by having a detailed mark scheme and standard set of questions. Many centers allocate each station an individual pass mark. The sum of the pass marks of all the stations determines the overall pass mark for the OSCE.

Here are some tips for conducting an OSCE before, during and after:

1. Before

- a. Prepare all the stations and supplies, the supplies and materials needed are listed for each station. Ensure you have an assessor for each station that requires direct observation.
- b. Ask if the student has any questions about the skill and is ready to be assessed.

2. During

- a. Observe and assess the student's performance.
- b. Stand where you can see without intruding and let the student perform the skill.
- c. Do not interfere (Dangerous acts can be discussed with student following the OSCE).
- d. Remember, feedback **MUST** be delayed until completion of all stations in OSCE. The station rotation is illustrated on the following page.

3. After

- a. Score the OSCE and document results.
- b. Give students an opportunity to ask you questions about steps they did not understand or they performed incorrectly.
- c. Instruct students to practice the steps that they performed incorrectly.
- d. If many students had trouble with the same stations, either the teaching methods or materials did not adequately cover that learning objective.

14. Appendix E: Participant Capacity Building Logbook

Participant Completion form

Name of Participant _____

Facility _____

Name of Capacity Building Activity	Completion date	Name & Signature of Facilitator
Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC): Group Based Training		
OJT Modules		
Module 1: Focused Antenatal Care		
Module 2: Birth Preparedness and Complication Readiness		
Module 3: Vaginal Bleeding in Pregnancy		
Module 4: Rapid Initial Assessment and Management of Shock		
Module 5: Normal Labour & Child Birth		
Module 6: Use of the Partograph		
Module 7: Active Management of Third Stage of Labor		
Module 8: Normal Child birth and Beneficial Practices		
Module 9: Prevention and Management of Pre-Eclampsia/Eclampsia Module 10: Post-Partum Haemorrhage		
Module 11: Management of Postpartum Haemorrhage		

Name of Capacity Building Activity	Completion date	Name & Signature of Facilitator
Module I2: Post-Partum Care		
Module I3: Puerperal Sepsis		
Module I4: Normal New Born Care		
Module I5: Breast Feeding		
Module I6: Infection Prevention		
Management of Complications in Pregnancy and Childbirth (MCPC): Group Based Training		
Helping Baby Breathe: Group Based Training		
Client-Centered Family Planning and Contraceptive Implants: Group Based Training FOR DOCTORS ONLY		
Advanced Family Planning for Doctors (Including Intrauterine Contraceptive Device: Group Based training		
Client-Centered Family Planning and Intrauterine Contraceptive Device: Group Based training for CMWs AND MIDLEVEL PROVIDERS		
Postpartum Intrauterine Contraceptive Device (PPIUCD): Group Based Training		
IMNCI Training		
Kangaroo Mother Care		
Nutrition: Group Based Training		

15. Appendix F: Technical Staff Development Process and e-Learning Requirements

Purpose:	To provide clinical updates for program staff
Target Audience:	PPHI district technical staff members
Timeline:	
Module Topics:	Managing Post abortion Care Essential Newborn Care Managing Postpartum Hemorrhage Managing Pre-Eclampsia and Eclampsia Managing Prolonged and Obstructed Labor Managing Puerperal Sepsis

Evidence of successful completion of the e-learning modules (screenshot of passed module quiz) will be included in staff files for review by supervisors at the time of performance appraisal. Individual capacity building logbooks should also be filled according to the completion date of the e-learning module package.

- Head Office supervisors will be responsible for supporting Head Office technical staff (Program Officers and Technical Advisors) to complete e-learning modules, and will ensure that documentation is kept in staff human resource files.
- District managers will be responsible to ensure that MNCH Coordinators completes the package of e-learning modules.

Details on the modules follow below:

Six modules target providers who manage pregnancy and labor in their country contexts, including: nurses, midwives and physicians:

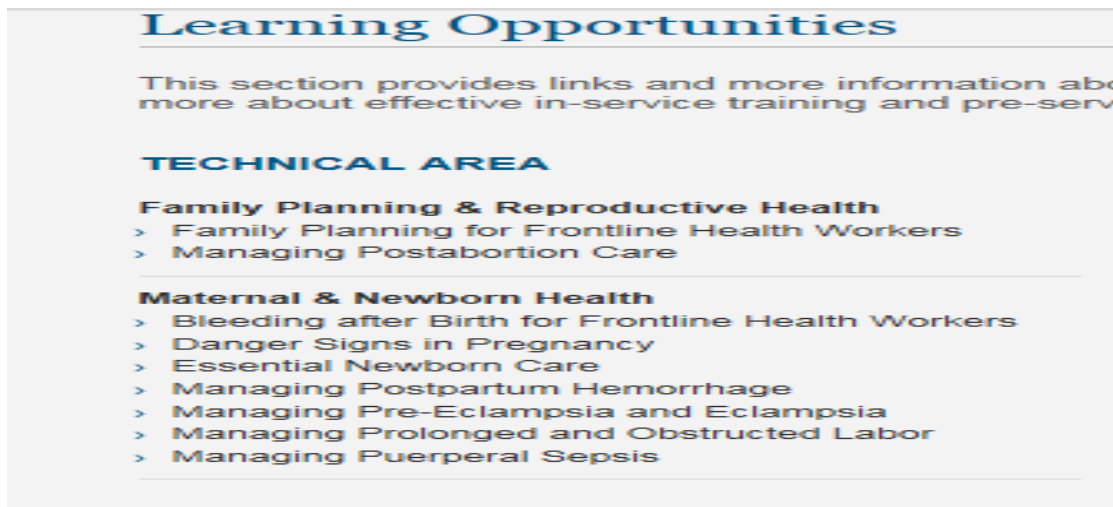
- **Managing Post-abortion Care** <<http://reprolineplus.org/learningopportunities/course/managing-postabortion-care/take-the-course><http://reprolineplus.org/learning-opportunities/course/managing-postabortion-care/take-the-course>>
- **Essential Newborn Care** <<http://reprolineplus.org/learning-opportunities/course/essential-newborn-care>>
- **Managing Postpartum Hemorrhage** <<http://reprolineplus.org/learning-opportunities/course/managing-postpartum-hemorrhage>>
- **Managing Pre-Eclampsia and Eclampsia** <<http://reprolineplus.org/learning-opportunities/course/managing-pre-eclampsia-and-eclampsia>>

- **Managing Prolonged and Obstructed Labor** <<http://reprolineplus.org/learning-opportunities/course/managing-prolonged-and-obstructed-labor>>
- **Managing Puerperal Sepsis** <<http://reprolineplus.org/learningopportunities/course/managing-puerperal-sepsis>>

Staff members are encouraged to also complete the three additional modules targeted to community health workers for refresher, if time allows:

1. Family Planning for Frontline Health Workers
<<http://reprolineplus.org/learningopportunities/course/family-planning-frontline-health-workers>>
2. Bleeding after Birth for Frontline Health Workers
<<http://reprolineplus.org/learningopportunities/course/bleeding-after-birth-frontline-health-workers>>
3. Danger Signs in Pregnancy <<http://reprolineplus.org/learningopportunities/course/danger-signs-pregnancy>>

To complete an e-learning module go to the above link and follow these steps:



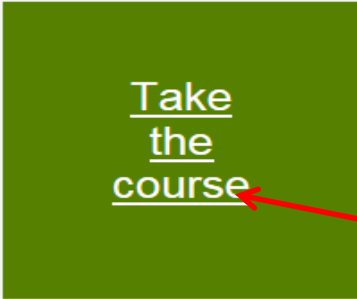
Select the module to take
(such as Essential Newborn Care)

Select "Take the Course"

Essential Newborn Care

Published: January 2014

This module targets midwives, nurses, physicians and other skilled birth attendants who provide essential newborn care. It is created for frontline health workers who are able to provide immediate essential newborn care, newborn resuscitation and recognition of danger signs. It is focused on two general areas: immediate, essential newborn care and early recognition of newborn problems. It includes a video demonstration of newborn resuscitation in using a model. In this module, you will respond to case-study questions for several different women and their newborns.



16. QIPS Guidelines Annexure 1: Action Plan

Standard	Gap	Intervention	Responsible Person	Support Required	Timeline
1.					
2.					
3.					
4.					

17. Appendix 1.1: QUALITY IMPROVEMENT AND PATIENT SAFETY (QIPS) ASSESSMENT TOOL

17.1 Area 1: Focused Antenatal Care (FANC)

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
FANC-01: The provider receives and treats the pregnant woman cordially and respectfully	Verify by direct observation (or role play if no clients) whether the provider:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Greets the woman and her companion (if present) in a cordial manner						
	2. Explains to the woman what she/he is going to do and encourages her to ask questions						
	SCORE						
FANC-02: Pregnant women are attending FANC according to recommended schedule of ANC visits	Check and verify from (Maternal Health Register) record/antenatal cards for documentation of each visit						
	Verify by direct observation or by role play whether the Provider Explains to the women about the following WHO-recommended schedule of ANC visits:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	▪ 1st visit: <16 weeks						
	▪ 2nd visit: 24–28 weeks						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments						
	<ul style="list-style-type: none"> ▪ 3rd visit: 30–32 weeks 												
	<ul style="list-style-type: none"> ▪ 4th visit: 36–38 weeks 												
	SCORE												
FANC-03: The provider takes a FANC history, including screening for danger signs	Verify by direct observation or by role play whether the provider(Annexure 4)	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play											
	1. Asks about and records danger signs that the woman may have, or has had:												
	<ul style="list-style-type: none"> – Vaginal bleeding 												
	<ul style="list-style-type: none"> – Respiratory difficulty 												
	<ul style="list-style-type: none"> – Fever 												
	<ul style="list-style-type: none"> – Severe headache 												
	<ul style="list-style-type: none"> – Blurred vision 												
	<ul style="list-style-type: none"> – Severe abdominal pain 												
	<ul style="list-style-type: none"> – Convulsions/loss of consciousness 												
2. Provider calculates the estimated date of delivery according to her last menstrual period at her first antenatal visit and documents it													
	SCORE												
FANC-04: The provider properly	Verify by direct observation (or if no clients, by role play in Annexure 4) whether the provider:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play											

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
conducts obstetric physical exam of the pregnant woman	1. Measures vital signs (blood pressure, temperature, pulse and respiration)						
	2. Measures fundal height (after 12 weeks)						
	3. Listens to fetal heart sounds (after 20 weeks)						
	4. Determines fetal lie and presentation (after 36 weeks)						
	SCORE						
FANC-05: The provider requests laboratory tests according to the FANC package	Verify by direct observation (or role play if no clients) whether the provider requests or checks the following laboratory tests:						
	1. Routine investigation (blood group and Rh factor, hemoglobin, blood glucose)						
	2. Specific investigation if needed (i.e., hepatitis B, hepatitis C and urine analysis for proteinuria)						
	SCORE						
FANC-06: The provider gives immunization to all pregnant women according to national guidelines	Check immunization record (from Vaccination Register/Maternal Health Register) to verify whether the provider:						
	Verifies tetanus toxoid vaccine provided to all pregnant women (TT2 among pregnant women)						
	SCORE						
	<i>Review five medical records from the last month of cases during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.</i>						

Total of Standards	6
Total Observed	
Total Achieved	

17.2 Area 2: Labor and Delivery

Facility Name: _____

Assessor: _____ Date: _____

PREMATURE RUPTURE OF MEMBRANE (PROM)							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
PROM-1: Medical record documents appropriate management for each woman with rupture of membrane > = 18 hours and women with any early signs of infection	Check the medical record (from Labor Register/Partograph Record) to determine if the provider did the following:						
	1. Administered appropriate prophylactic antibiotics to women with prolonged rupture of membranes: appropriate choice, dose and length of therapy (Annexure 1)						
	2. Administered antibiotics to women with early signs of infection (temp > 38 degrees C or foul-smelling amniotic fluid/vaginal discharge)						
	SCORE						
<i>Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.</i>							
PROM-02: Antibiotics for prevention and treatment of chorioamnionitis are	Observe and verify that the following medicines are available and accessible at facility:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Injection of ampicillin 2g IV every 6 hours PLUS						
	2. Injection of gentamicin 5mg/kg body weight IV every 24 hours (7days) (Annexure 1)						

PREMATURE RUPTURE OF MEMBRANE (PROM)							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
PROM-I: Medical record documents appropriate management for each woman with rupture of membrane > = 18 hours and women with any early signs of infection available in the health facility	Check the medical record (from Labor Register/Partograph Record) to determine if the provider did the following:						
	1. Administered appropriate prophylactic antibiotics to women with prolonged rupture of membranes: appropriate choice, dose and length of therapy (Annexure I)						
	2. Administered antibiotics to women with early signs of infection (temp > 38 degrees C or foul-smelling amniotic fluid/vaginal discharge)						
	SCORE						
	Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.						
SCORE							

PREMATURE RUPTURE OF MEMBRANE (PROM)							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
PROM-I: Medical record documents appropriate management for each woman with rupture of membrane > = 18 hours and women with any early signs of infection	Check the medical record (from Labor Register/Partograph Record) to determine if the provider did the following:						
	1. Administered appropriate prophylactic antibiotics to women with prolonged rupture of membranes: appropriate choice, dose and length of therapy (Annexure I)						
	2. Administered antibiotics to women with early signs of infection (temp > 38 degrees C or foul-smelling amniotic fluid/vaginal discharge)						
	SCORE						
	<i>Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.</i>						
PARTOGRAPH (PG)							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
PG-I: All women in labor are monitored with a partograph that is complete and accurate	Verify by checking record(Partograph Register/Labor Register) that the partograph is filled in completely and in a timely manner:						
	1. Fetal heart rate						
	2. Labor progress: cervical dilatation						
	3. Strength and frequency of contractions						
	4. Oxytocin, when used						

PREMATURE RUPTURE OF MEMBRANE (PROM)								
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments	
PROM-1: Medical record documents appropriate management for each woman with rupture of membrane > = 18 hours and women with any early signs of infection	Check the medical record (from Labor Register/Partograph Record) to determine if the provider did the following:							
	1. Administered appropriate prophylactic antibiotics to women with prolonged rupture of membranes: appropriate choice, dose and length of therapy (Annexure 1)							
	2. Administered antibiotics to women with early signs of infection (temp > 38 degrees C or foul-smelling amniotic fluid/vaginal discharge)							
	SCORE							
	<i>Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.</i>							
	5. Maternal pulse and blood pressure							
	SCORE							
<i>Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.</i>								
PG-2: Every woman has a support person of her choice throughout labor and delivery	Verify by direct observation in the labor room whether:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play						
	1. Women were assisted by a support person of their choice during all stages of labor							
	SCORE							

ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR (AMTSL)							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
AMTSL-I: AMTSL is performed for all women during childbirth	Check medical records(Labor Register/Partograph Register) to see if the following are performed during labor:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Provide uterotonic*within one minute after the baby is born						
	2. If oxytocin is the uterotonic used for AMTSL at this facility, is reliable refrigeration available and used for oxytocin storage?						
	SCORE						
<i>Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.</i> <i>*Uterotonic drugs (oxytocin/misoprostol/ergotamine) (Annexure I)</i>							

IMMEDIATE NEWBORN CARE (INC)							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
INC-01: Routine immediate care of a newborn is properly performed	Check and observe that provider:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Thoroughly dries baby, stimulates baby and covers baby's head immediately						
	2. Places baby on mother's chest in skin-to-skin contact						
	3. Assesses breathing						
	4. Delays cord cutting until pulsation stops (2–3 minutes)						
	5. Applies CHX to the cord stump						
	6. Encourages mother to start breastfeeding within one hour of delivery						
SCORE							

HELPING BABIES BREATHE							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
HBB-01: Equipment and supplies are available at delivery	Check and verify that:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Labor room has resuscitation/ventilation area with all HBB equipment and supplies						
	2. HBB action plan displayed in labor room						

HELPING BABIES BREATHE							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
side and ready to use	SCORE						
HBB-2: Provider has correct knowledge and skills to resuscitate baby	1. Provider successfully performs 7 steps of bag/mask use (Annexure 2)						
	2. Provider successfully performs at least 10 out of 13 OSCE steps (Annexure 3)						
	SCORE						
HBB-3: Provider properly maintains resuscitation record in District Health Information System (DHIS) obstetric register	1. HBB data are available and maintained in DHIS obstetric register						
	SCORE						

HELPING BABIES BREATHE							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
POSTPARTUM HEMORRHAGE (PPH)							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
PPH-01: Provider can appropriately manage women diagnosed with PPH	Check whether medical records contain:						
	1. Notes on IV installation						
	2. Causes of PPH						
	Observe or check and verify that PPH case managed as follows:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Administers oxytocin 20 IU in 1L of saline solution, 60 drops/minute, then 40 drops/minute, up to a maximum of 3L of solution with oxytocin /misoprostol (Annexure 4)						
	2. If bleeding continues after administration of uterotonic drugs, provider manages woman using additional measures to control bleeding (i.e., bimanual compression)						
	3. If bleeding continues despite above management, the provider refers the woman promptly, and documents referral						
	<i>Note for the assessor: Review five medical records from the last month of cases. If it is not possible to review five medical records, please explain the reason in the notes column.</i>						
SCORE							

PRE-ECLAMPSIA AND ECLAMPSIA							
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
PE-01: Medical record documents appropriate management for each woman with severe pre-eclampsia/eclampsia	List of specific observations documented:						
	1. Vital signs (BP, pulse)						
	2. Tendon reflex						
	3. Danger signs						
	4. Urine output						
	5. IV line is attached						
	6. Test for urine proteinuria						
	7. Monitor and evaluate blood pressure						
	8. Any medication for pre-eclampsia/eclampsia administered, dose and timing						
	SCORE						
<i>Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.</i>							
PE-02: Appropriate drugs and equipment are always available and accessible for	The following should be available, accessible and ready for use at the health facility: <input type="checkbox"/> Direct observation <input type="checkbox"/> Role play						
	1. Magnesium sulfate 20%						
	2. IV set						
	3. 10% calcium gluconate						

PRE-ECLAMPSIA AND ECLAMPSIA								
Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments	
management of severe pre-eclampsia/eclampsia	4. Nifedipine or labetalol or atenolol or methyldopa							
	SCORE							
PE-03: The provider correctly manages severe pre-eclampsia/eclampsia	Verify that the provider correctly manages severe pre-eclampsia/eclampsia	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play						
	Loading dose:							
	1. Administers 4g of 20% solution of magnesium sulfate in IV solution (20ml) slowly over a 20-minute period							
	2. Administers 5g of 50% magnesium sulfate solution (20ml), with 1ml of 2% lidocaine IM deep in each buttock (total 10g)							
	In case of convulsion, continue the management of eclampsia/severe pre-eclampsia:							
	3. If convulsions reoccur after 15 minutes, gives 2g (10 ml of 20% magnesium sulfate) slowly in IV over 20 minutes							
	Maintenance dose:							
	4. Plan I: Hydralazine 5mg IV slowly/nifedipine 5mg orally, repeating the dose if the diastolic BP is still more than 110 after 10 minutes							
5. Rapid evaluation of condition and if needed refer								
SCORE								

Total Standards	13
Total Observed	
Total Achieved	

17.3 Area 3: Postnatal Care (PNC)

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PNC-01: The provider conducts a routine physical exam of the postnatal woman within 48 hours of delivery	Observe that the provider performs the following:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Washes hands with soap and water and dries them						
	2. Takes vital signs						
	3. Examines the breasts for establishment of lactation, engorgement and/or tenderness						
	4. Examines abdomen for involution of uterus, tenderness or distension						
	5. Assesses amount of bleeding and healing of laceration/episiotomy (if needed)						
	SCORE						
PNC-02: The provider properly counsels the postpartum mother and manages care	Determine by observation whether the provider counsels on the following areas:						
	1. Family planning						
	2. Nutrition/iron folic supplementation						
	3. Explains to the mother AND her husband or another family member the need to report to the health facility when the following danger signs are observed:						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
according to the assessment findings	- Excessive vaginal bleeding						
	- Severe headache						
	- Severe abdominal pains						
	- Offensive vaginal discharge						
	- Fever						
	- Convulsions						
	- Blurred vision						
	- Extreme fatigue						
	SCORE						
Verify by direct observation or by role play (Annexure 4) that the provider correctly manages the situation.							
CARE FOR THE NEWBORN							
Instructions to the assessor: Observe one or more providers giving care to newborn in the postpartum ward.							
PNC-03: The provider properly conducts a newborn exam	Observe and verify or by role play for the situation	<input type="checkbox"/>	<input type="checkbox"/>				
	I. Whether the provider conducts a thorough physical exam of the newborn:						
	- Washes hands before and after drying them, puts on gloves						
	- Weighs the baby						
	- Counts respiration (normal 30 to 50 per minute)						
	- Measures axillary temperature (36.5–37.2)						
- Performs head-to-toe examination of baby							

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
	- Checks application of chlorhexidine on umbilical stump						
	SCORE						
PNC-04: The provider properly counsels and demonstrates to mother the importance of newborn care	Observe whether the provider:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Demonstrates how to keep the baby warm and dry (proper wrapping)						
	2. Encourages the mother to breastfeed exclusively						
	3. Counsels the mother and family member on the importance of completing child immunizations according to schedule						
	SCORE						
PNC-05: The provider advises the mother about danger signs	Observe whether the provider advises the mother and other family member about the following danger signs and in case any of the danger signs is present, immediately seeks help:	<input type="checkbox"/>	<input type="checkbox"/>				
	1. The infant has convulsions						
	2. The infant vomits everything or is not able to feed or is sucking or feeding poorly						
	3. The infant is not able to feed or is sucking or feeding poorly						
	4. Any problems with breathing						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
	5. The infant is lethargic or unconscious						
	6. Any oozing from the umbilical stump (pus, clear or blood)						
	7. The infant feels hot to touch or very cold to touch						
	SCORE						
	Note for assessor: Verify by direct observation or by using model and role play.(Annexure 4)						

17.4 Area 4: Cough & Difficult breathing ANd Diarrhea

Facility Name: _____

Assessor: _____ Date: _____

COUGH OR DIFFICULT BREATHING AND DIARRHEA							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
Pneumonia and diarrhea (PD)-01: The provider assesses, classifies, treats and counsels caregiver on home care for a child who has a cough or difficulty breathing	Observe and verify from medical record (by using IMNCI chart in the manual) whether the provider:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Assesses, classifies and refers child with general danger signs						
	2. Assesses child presenting with cough and/or difficult breathing						
	3. Recognizes main clinical signs						
	4. Classifies the child as per protocol						
	5. Treats/refers the child as per protocol						
	6. Provides counseling on medication and home care						
SCORE							
PD-02: The provider assesses, classifies, treats and counsels caregiver	Observe and verify from medical record (by using IMNCI chart in the manual) whether the provider:	<input type="checkbox"/>	<input type="checkbox"/>				
	1. Assesses diarrhea and dehydration in sick child.						
	2. Classifies diarrhea and dehydration in sick child						

on home care for a child who has diarrhea	3. Treats diarrhea as per protocol		[REDACTED]	
	4. Counsels caregiver on four rules of home treatment			
	SCORE			

PD-03: Facility has an adequate stock of essential commodities for management of cough or for difficulty breathing and diarrhea	1. Checks and verifies commodities available for management of cough and/or difficulty breathing:			
	- Oral amoxicillin			
	- Inhaled bronchodilator/salbutamol			
	- Injectable antibiotics (for comprehensive and basic emergency obstetric care [CEmONC and BEmONC])			
	- Oxygen (for CEmONC and BEmONC)			
	2. Checks and verifies commodities for management of diarrhea:			
	- Low osmolality ORS packets			
	- Zinc syrup/tablets			
	- IV fluids preferably Ringer's lactate solution/Nasogastric (NG) tube			
	- Jug, cups, spoon			
- Scale				
SCORE				
Total of Standards		8		
Total Observed				
Total Achieved				

17.5 Area 5: Postpartum Family Planning (PPFP)

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PPFP-01: Statistical data are recorded	Verify that the following reports have been completed accurately and sent to the District Health Officer (OR record maintained in cases of a private clinic/hospital):	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Daily registry of services						
	2. If public hospital, CLR6 form is available and in use						
	SCORE						
PPFP-02: The provider gives information about long-acting contraceptive methods available in the clinic and confirms client's choice	Observe whether the provider explains:	<input type="checkbox"/>			<input type="checkbox"/>		
	1. All long-acting contraceptive methods available at facility						
	2. The contraceptive method that client wants to use or helps the client to choose an appropriate method						
	3. Provider informs the client of the effectiveness of IUCD/implant						
	SCORE						
	Verify by direct observation or by role play. (Annexure 4)						
	Observe that the provider performs the following:	<input type="checkbox"/>			<input type="checkbox"/>		

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PPFP-03: The provider performs the insertion using the sterile technique PPIUCD/implant	1. Ensures that she has been appropriately counseled on immediate PPIUCD insertion and still wants an IUCD						
	2. Confirms that correct sterile instruments, IUCD supplies and light source are available in the labor room for immediate post-placental insertion						
	3. Palpates the uterus to evaluate the height of the fundus and the size and degree of contraction of the uterus						
	4. Observes that PPIUCD inserted by using the placental forceps or the ring forceps, following the non-touch technique						
	5. Ensures that the IUCD is placed at the uterine fundus and visually examines the cervix following insertion						
	6. Removes all instruments used and places them (they should be open) in 0.5% chlorine solution and ensures that they are totally submerged						
	SCORE						
PPFP-4: The provider performs the IUCD insertion using sterile technique	Observe that the provider performs the following: <input type="checkbox"/>						
	Performs pre-insertion tasks:						
	1. Asks the client to empty her bladder						
	2. Performs bimanual examination with HLD, sterile or disposable gloves						
	Performs insertion task by using “no-touch” technique:						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
	1. Gently applies antiseptic solution two times to cervix and grasps the cervix with tenaculum/vulsellum						
	2. Sounds the uterus using “no-touch” technique						
	3. Inserts the Copper T 380A using the “withdraw” technique after setting depth gauge						
	4. Removes the tenaculum and speculum and places them in 0.5% chlorine solution for 10 minutes for decontamination						
	Performs post-insertion tasks:						
	1. Explains PAINS signs to clients						
	2. Completes her record						
	SCORE						
IMPLANT							
Assessor needs to check the skills of the service provider for all long-acting contraceptive methods.							
PPFP-5: The provider assesses client’s eligibility for use of Implants		<input type="checkbox"/>					
		<input type="checkbox"/>					
	1. Severe liver disease, infection or tumor						
	2. Breastfeeding a baby less than 6 weeks old after delivery						
	3. Currently has blood clot in legs or lungs						
4. Unexplained vaginal bleeding							

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
	5. Had breast cancer more than 5 years ago, and it has not returned						
	SCORE						
PPFP-6: The provider performs the pre-insertion task	Observe that the provider performs the following steps:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play					
	1. Checks that the client has washed her arm before procedure						
	2. Checks that the instrument tray is ready						
	SCORE						
PPFP-7: The provider correctly inserts the implant	1. Drapes the autoclave sheet over the arm and ensures that the hole in sheet is over the insertion site						
	2. Administers an injection of local anesthetic under the skin of the insertion site to prevent pain while the implants are being inserted						
	3. Inserts the implants just under the skin using an inserter, Closes the incision with an adhesive bandage.						
	SCORE						
PPFP-8: The provider gives instructions about the return and/or follow-up visits	Verify by direct observation or by role play that the provider:						
	1. Discusses return visits and follow-up according to the selected method (after 7 days)						
	SCORE						

Total of Standards	8
Total Observed	
Total Achieved	

17.6 Area 6: Infection Prevention (IP)

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments	
IP-01: Hospital or other health facilities look clean	Check that the following areas are clean (<i>no dust, blood, trash, used needles and syringes, or spider webs</i>):	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play						
	1. Observation/examination room for the first stage of labor							
	2. Delivery room							
	3. Postpartum room							
	4. Washing area for used instruments/sterilization and HLD processing area							
SCORE								
IP-02: Ensure availability and use of personnel protective equipment	Observe that the following equipment is available, accessible and ready for use:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play						
	1. Personal protective equipment available during procedure (delivery and in instrument processing):							
	- Gloves/utility gloves							
	- Eye protection, mask, goggles							
	- Apron and closed shoes							
SCORE								
	Verify by observation whether the following is performed:	<input type="checkbox"/> Direct observation <input type="checkbox"/> Role play						

Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
IP-03: Instruments processing for decontamination and other articles (immediately after use)	1. Decontamination of instruments immediately after procedure (delivery/IUCD insertion and implant insertion) with 0.5% chlorine solution for 10 minutes						
	2. Cleaning of instruments with brush and soapy water after decontamination						
	3. High level disinfection (HLD): instruments are boiled for 20 minutes starting from the time a rolling boil begins OR using autoclave						
	4. HLD/sterilized packs stored properly with expiration dates on them						
	SCORE						
IP-04: Waste is collected and disposed of properly to avoid injuries and contamination	Observe and verify whether:	<input checked="" type="checkbox"/>		<input type="checkbox"/>			
	1. Containers with sharps are incinerated						
	2. Solid waste (used dressings and other materials contaminated with blood and organic matter) are incinerated/buried in incineration pit						
	3. Contaminated liquid waste (blood, urine and other body fluids) are disposed into a toilet or sink and sink is rinsed with water						
	4. Placenta is disposed in placenta pit						
SCORE							

Total of Standards	4
Total Observed	
Total Achieved	

17.7 Area 7: Linkages and Referrals

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Comments
Linkages and referrals: Effective systems of linking and referring clients for higher level care is in place, and effectively used.	Check and verify by record (from referral register) or by staff interview:						
	1. MCH facility has a system in place for referring women/child in case of complication						
	2. Facility has linkage for provision of emergency blood supply						
	SCORE						

Total of Standards	1
Total Observed	

Total Achieved	
----------------	--

Total of Standards	40
Total Observed	
Total Achieved	

18. QIPS ASSESSMENT TOOL APPENDIX 1.2: Use of Uterotonic Drugs

Drug	Dose and Administration	Further Dose	Maximum Dose	Caution and Contraindication
Oxytocin	IV: 20 IU IV in 1 liter of fluid with 60 drips/minutes IM: 10 U	IV: 20 U IV in 1 liter of fluid with 40 drips/minute	Not more than 3 liters of IV solution containing oxytocin	Do not give in IV bolus
Ergometrin/methyl-ergometrin	IM or IV (slow drip) 0.2 mg	Repeated 0.2 IM after 15 minutes If necessary, give 0.2 mg IM or IV (slow drip) every 4 hours	5 doses (total of 1.0 mg)	Hypertension, pre-eclampsia, cardiac diseases

Adapted from: World Health Organization. 2008. *Managing complications in pregnancy and childbirth: A guide for midwives and doctors (IMPAC)*.

First-Line Antibiotics Therapy Regimen for Severe Infection/Maternal Sepsis

Reference	Severe Infection	Sepsis
WHO. 2003. <i>IMPAC</i> .	Ampicillin 2 g IV every 6 hours + gentamycin 5 mg/kgbw IV every 24 hours + metronidazole 500 mg IV every 8 hours until 48 hours fever free	Penicillin G 2 mil. unit or ampicillin 2 g IV every 6 hours + gentamycin 5 mg/kgbw IV every 24 hours + metronidazole 500 mg IV every 8 hours until 48 hours fever free

WHO. 2006. <i>IMPAC</i> .	Ampicillin 2 g IV/IM continued by 1 g IV/IM every 8 hours + metronidazole 500 mg IV every 8 hours until 48 hours fever free	
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19. QIPS Assessment Tool Appendix 1.3: Bag and Mask Ventilation—Skills Check

Name of trainee/provider _____ Date _____

Complete this evaluation with learners before they attempt the OSCE evaluations. Use the comments below the numbered steps to score the performance. Note the number of steps done correctly on the first attempt. Give feedback to the learner.

Repeat the evaluation until all steps are done correctly.

	DONE	NOT DONE
1. Check equipment and select the correct mask Test function of bag and mask. Make sure mask fits the baby's face.	<input type="checkbox"/>	<input type="checkbox"/>
2. Apply the mask to make a firm seal Extend the head, place mask on the chin, then over the mouth and nose. A firm seal permits chest movement when the bag is squeezed.	<input type="checkbox"/>	<input type="checkbox"/>
3. Ventilate at 40 breaths per minute The rate should not be less than 30 or more than 50 breaths per minute.	<input type="checkbox"/>	<input type="checkbox"/>
4. Look for chest movement Check that every ventilation breath produces chest movement.	<input type="checkbox"/>	<input type="checkbox"/>
5. Improve ventilation if the chest does not move a. Head—reapply mask and reposition head b. Mouth—clear secretions and open the mouth c. Bag—squeeze the bag harder	<input type="checkbox"/>	<input type="checkbox"/>

Score on first attempt _____ of 7

All steps done correctly _____ (facilitator name and initials)

20. QIPS Assessment Tool Appendix 1.4: Helping Babies Breathe

OSCE – Station A

Instructions to the facilitator:

Read aloud to the learner the following instructions and the case. Provide prompts where shown in **red**. As you observe the learner, tick the boxes "Done" or "Not Done" for each activity. Indicate the baby's response to the learner's actions using the neonatal simulator or words if using a mannequin. For example, when the learners evaluate crying, show or say that the baby is not crying.

"I am going to read a role play case. Please listen carefully, and then show me the actions you would take. I will indicate the baby's response with the simulator (OR in words), but I will provide no other feedback until the end of the case."

"You are called to assist the delivery of a term baby. There are no complications in the pregnancy. The baby will be born in less than 10 minutes. Introduce yourself and prepare for the birth and care of the baby."

	Done	Not Done
Prepares for birth		
Identifies a helper and makes an emergency plan.....	<input type="checkbox"/>	<input type="checkbox"/>
Prepares the area for delivery.....	<input type="checkbox"/>	<input type="checkbox"/>
Cleans hands and maintains clean technique throughout.....	<input type="checkbox"/>	<input type="checkbox"/>
Prepares an area for ventilation and checks equipment.....	<input type="checkbox"/>	<input type="checkbox"/>
 <i>Prompt: After 5-7 minutes give baby to learner and say, "The amniotic fluid is clear. Show how you will care for the baby."</i>		
DRIES THOROUGHLY	<input type="checkbox"/> *	<input type="checkbox"/>
Removes wet cloth.....	<input type="checkbox"/>	<input type="checkbox"/>
Evaluates crying		
<i>Prompt: Show or say the baby is not crying.</i>		
RECOGNIZES BABY IS NOT CRYING	<input type="checkbox"/> *	<input type="checkbox"/>
Clears airway and stimulates breathing		
Keeps warm.....	<input type="checkbox"/>	<input type="checkbox"/>
POSITIONS HEAD AND CLEARS AIRWAY	<input type="checkbox"/> *	<input type="checkbox"/>
Stimulates breathing by rubbing the back.....	<input type="checkbox"/>	<input type="checkbox"/>
Evaluates breathing		
<i>Prompt: Show or say the baby is breathing well.</i>		
Recognizes baby is breathing well.....	<input type="checkbox"/>	<input type="checkbox"/>
Clamps or ties and cuts the cord.....	<input type="checkbox"/>	<input type="checkbox"/>
Positions skin-to-skin on mother's chest and communicates with mother.....	<input type="checkbox"/>	<input type="checkbox"/>

SCORING:

Successful completion requires a total score of 10 correct of 13 and "Done" must be ticked for **DRIES THOROUGHLY, RECOGNIZES BABY IS NOT CRYING, AND POSITIONS HEAD AND CLEARS AIRWAY** (boxes indicated by *).

Number Done Correctly Facilitator initials

21. Appendix F: Management of Possible Serious Bacterial Infection (PSBI) in Sindh

Management of Possible Serious Bacterial Infection (PSBI) in Young Infant Age up to 2 Months OJC CHECK LIST

Name of Health Facility _____ Date: _____

Name of Health Care Provider _____

Name of Mentor _____

		<i>Mark appropriately</i>		
		Y	N	NA
Section 1: Establishing rapport and child identification				
a	Greets care-giver			
b	Correctly filled details of patient (name, age, sex)			
Section 2: Problem Identification				
#1	Did the provider classify accordingly			
	• Critical illness			
a	Unconscious/ drowsy			
b	Convulsions or history of convulsions			
c	Unable to feed			
d	Persistent vomiting			
e	Bulging of fontanelle			
f	Central cyanosis			
g	Birth weight <1500 grams			
	• Severe Clinical illness			
a	Severe chest in drawing			
b	Hypothermia (<35.0 °C or (95.0 °F)			
c	Raised temperature (>37 °C or 99.50 °F)			
d	Not feeding well			
e	Less moment than normal			
	• Fast breathing as single sign of illness			
a	Fast breathing (respiratory rate 60/min or more)			
	• Local bacterial infection			
a	Umbilical redness or drainage puss			
b	Skin pustules			
	Others please specify			
#3	Classification			
a	Correctly classifies PSBI in young infant (0-59)			
b	Records the classification in the under 5 OPD Register			

#4	Decision Making			
a	Correct decision made (Circle: refer, treat, no treatment) *			
#5	Treatment			
a	Prescribed correct drug			
b	Mention correct dosage and duration			
c	Give advice on home care			
d	Check caregivers understanding			
e	Advises when to return for follow -up care			
Section 3: Respiratory Rate Assessment				
a	Count respiratory rate within +/- 2 from standard			
Section 4: DHIS Figures		Number Cases		
a	No of young infants with critical illness			
b	No of young infants with severe Clinical illness			
c	No of young infants (fast breathing as sign of illness)			
d	No of young infants with local bacterial infection			
e	No of young infants received first dose of antibiotic and referred			
f	No of young infants didn't accept referral and received antibiotics (7 days)			
g	No of successfully treated cases			
h	No of deaths due to PSBI			
Section 5: Availability of medicines /supplies (On day of visit)		Quantity available		
1	Oral amoxicillin syrup/tablets			
2	Gentamycin			
3	Gentian violet (0.5%)			
4	Low Osmolality ORS packets			
5	Zinc syrup/tablets			
6	IV fluids (Ringer lactate, N/Saline)			
7	Functional weighing scale (baby scale)	Yes	No	
8	Functional weighing scale (bathroom scale)	Yes	No	
9	Thermometer (functional)	Yes	No	
10	NG tube	Yes	No	
11	Functional Timer	Yes	No	
12	Pulse Oximeter	Yes	No	

22. Appendix G: CHECKLIST FOR SKIN-TO-SKIN CARE OF THE LOW BIRTH WEIGHT /PREMATURE BABY

SKILLS CHECKLIST FOR SKIN-TO-SKIN CARE OF THE LOW BIRTH WEIGHT /PREMATURE BABY		
Steps	Observation	
	1. Competently performed	2. Need Improvement
<p>Evaluator: <i>Read the following case situation and instructions to the participant:</i> “You are caring for a mother and her baby 3 hours after a normal birth. The baby was put skin-to-skin with the mother immediately after birth. The baby breastfed and received eye care and vitamin K during the first hour after birth. The mother did not receive any KMC counseling during pregnancy, but she is interested in KMC. You are ready to help the mother start skin-to-skin care for her baby.”</p> <p>“Please explain the information you will give the mother and family about the reasons for skin-</p>		
1. Explain/review that skin-to-skin is the best way to care for babies, starting as soon as possible after birth.		
2. Explain/review that skin-to-skin care: <input type="checkbox"/> Helps stabilize the baby’s temperature <ul style="list-style-type: none"> • Keeps the baby near the mother’s breasts for feeding on demand • Promotes the mother’s milk let-down reflex and helps breastfeeding succeed • Promotes faster weight gain in the newborn 		
3. Explain/review that the mother is the best person to provide skin-to-skin care because her breast milk helps the baby resist infections they are exposed to. No one else can give the baby this specific protection from infections.		
<p>Evaluator: Now say this to the participant: “Please demonstrate teaching to mother to give skin-to-skin care to her baby.”</p> <p>Participant can use a combination of methods to teach the mother such as pictures, use of a doll and demonstration with the mother’s baby.</p>		
4. Explain that he or she will teach (or review with) the mother how to give KMC so that the mother can do it herself.		

<p>5. Wash hands and dry them on a clean towel, or air-dry them. Explain to the mother that she should also wash her hands before handling the baby; have mother wash her hands.</p>		
<p>6. Demonstrate the next steps with a doll or the actual baby:</p> <ul style="list-style-type: none"> • Explain that the baby should be naked except for a diaper (nappy), hat and socks. • Undress the baby except for a nappy and hat (and socks if desired). 		
<p>7. Explain that the baby will be carried next to the mother's skin, inside her warm clothing.</p>		
<p>8. Help the mother position the baby upright between her breasts, with the baby's feet below her breasts and hands above.</p>		
<p>9. Help the mother position the baby so that she and the baby is chest-to-chest, with the baby's head turned to one side.</p>		
<p>10. Show the mother how to snugly wrap the baby to her body:</p> <ul style="list-style-type: none"> • Place the center of a long cloth or wrapper over the back of the baby on the mother's chest. • Cross the ends of the cloth behind the mother's back, bring them back around, and tie them in the front underneath the baby. 		
<p>11. Show the mother how to tie the cloth or wrapper tightly enough to maintain skin-to-skin contact, loose enough so the baby can breathe easily. (Note: The baby should not slip out when the mother stands up or moves around.)</p>		
<p>12. Show the mother how to support the baby's head by pulling the cloth or wrapper up to just under the baby's outside ear.</p>		
<p>13. Help the mother put her own clothing (a loose dress, blouse or shirt) over the baby. It should be open enough to allow easy breastfeeding, and the baby's face should not be covered.</p>		
<p>Evaluator: Now say to the participant: "Please explain what other information about KMC you will give to the mother and family."</p>		
<p>14. Advise the mother to go about her normal activities with the baby attached to her body in this way.</p>		
<p>15. Explain how the mother can sleep comfortably with the baby in the KMC position. Show her pictures of sleeping positions.</p>		

16. Show the mother how to loosen the cloth or wrapper to breastfeed on demand, at least every 2–3 hours.		
17. Explain the importance of delaying bathing; show the mother how to give the baby a sponge bath.		
18. Explain that other family members should supply whatever the mother and baby need without separating them, when possible. Explain that the mother will need a lot of support.		
19. Explain when and how another family member may replace the mother briefly to provide skin-to-skin care when needed.		
20. Explain that the mother and family should provide skin-to- skin care continuously, 24 hours a day (day and night), until the baby no longer tolerates KMC. Explain signs that the baby no longer desires skin-to-skin contact (baby is restless in KMC position, fidgets/tries to get out of the KMC position, etc.)		
21 Explain what the mother should do if she or family members become sick with a minor illness (such as a cold).		
22. Encourage the mother to ask questions throughout the demonstration; address her questions and concerns.		
23. Review danger signs of all newborns and what to do if there are danger signs; be sure the woman demonstrates her understanding of danger signs and what to do.		
Add up all of the “ones” (1) and write the total number in this box:		
Date and signature of the person who scored the performance:		

23. Appendix H: Recommendations for Healthcare Waste Management at Maternity Units in Sindh

PPHI/PPHI is responsible for establishing an effective healthcare waste management system at all these facilities to ensure that patients, providers, and community members are not exposed to any increased risk of infections due to improper waste management.

Studies have shown that in Pakistan on an average 2 kg of waste is generated per day per bed. Incineration is the most common final waste disposal method but is not carried out properly and sometimes the waste is burned incompletely in the open.

An effective healthcare waste management system consists of following steps.

1. Minimize waste
2. Segregation of waste the point of care.
3. Proper storage and transportation at the final disposal site.
4. Proper final disposal.

23.1 Final Waste Treatment Options

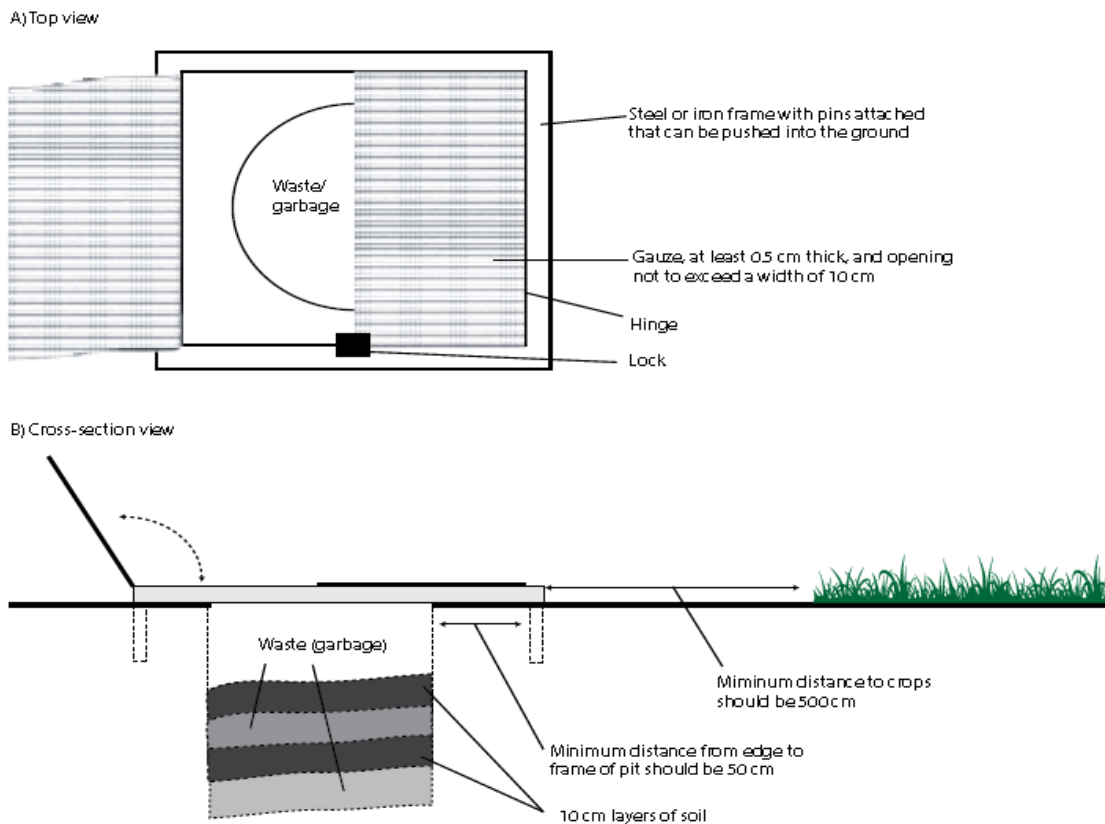
23.1.1 Safe burial on hospital premises

Minimal approaches to health-care waste management need to be used in remote health-care facilities and underdeveloped areas. In addition, minimal practices may also be necessary in temporary refugee encampments and areas experiencing exceptional hardship. Consequently, the safe burial of waste on hospital premises may be the only viable option available at that time. Even in these difficult circumstances, the hospital management can establish the following basic principles:

- Access to the disposal site should be restricted to authorized personnel only.
- The burial site should be lined with a material of low permeability, such as clay, dung and river silt, if available, to prevent pollution of shallow groundwater and nearby wells.
- New water wells should not be dug near the disposal pit.
- Only infectious health-care waste should be buried (if general hospital waste were also buried on the premises, available space would be quickly filled).
- Larger quantities (<1 kg) of chemical wastes should not be buried at one time; however, burying small quantities occasionally is less likely to create adverse pollution.

- The burial site should be managed as a landfill, with each layer of waste covered by a layer of soil to prevent odors and contact with the decomposing waste, and to deter rodents and insects.

The design and use of a burial pit is illustrated in Figure 8.7. Once the pit is constructed, the safe burial of waste in minimal circumstances depends critically on staff following sensible operational practices. This must be insisted upon, and the local health-care manager must realize their responsibility for making an organized waste-disposal system work properly.



Source: COSsen Zuid-Holland (2006)

Safe onsite burial is practicable only for relatively limited periods (i.e. 1–2 years), and for relatively small quantities of waste (i.e. 5–10 tonnes in total). Where these conditions are exceeded, a longer term solution, probably involving disposal at a land-disposal site away from the health-care facility, should be found.

23.1.2 Key points to remember

Many health-care waste-treatment systems are commercially available today. The choice of technology depends on the characteristics of the waste of the health-care facility, the capabilities and requirements of the technology, environment and safety factors, and costs. Treatment technologies employ thermal,

chemical, irradiative, biological or mechanical processes. The common types of treatment technologies are:

- autoclaves
- integrated or hybrid steam-based treatment systems
- microwave treatment technologies
- dry-heat treatment technologies
- chemical treatment technologies
- incinerators

These technologies could be supplemented by post-treatment shredders, grinders and compactors. For most technologies, except incinerators, validation testing is needed to ensure that a minimum level of disinfection can be achieved. Autoclaves come in a wide range of sizes and can be classified according to the method of air removal. Integrated steam-based treatment technologies incorporate various mechanical processes to improve the treatment efficiency. Incinerators can range from small batch units to large complex treatment plants. Incinerators should have flue gas cleaning systems to minimize pollutant releases and meet national or international emission limits. Small-scale incineration is a transitional means of disposal for healthcare waste. When investing in new technologies, priority consideration should be given to technologies that do not produce dioxins or furans. Regardless of the technology, the healthcare facility should have an annual budget for periodic maintenance and repair.

Health-care facilities can work with municipal authorities and other stakeholders to gradually improve the disposal of waste in landfills. Among the desirable features of a landfill are:

- restricted access to prevent scavenging
- daily soil cover to prevent odor, and regular compaction
- organized deposit of wastes in small work areas
- isolation of waste to prevent contamination of groundwater and surrounding areas
- trained staff

In circumstances where sanitary or engineered landfills are not available, various options are possible to minimize the transmission of infections and adverse impacts on the environment from hazardous health-care waste.

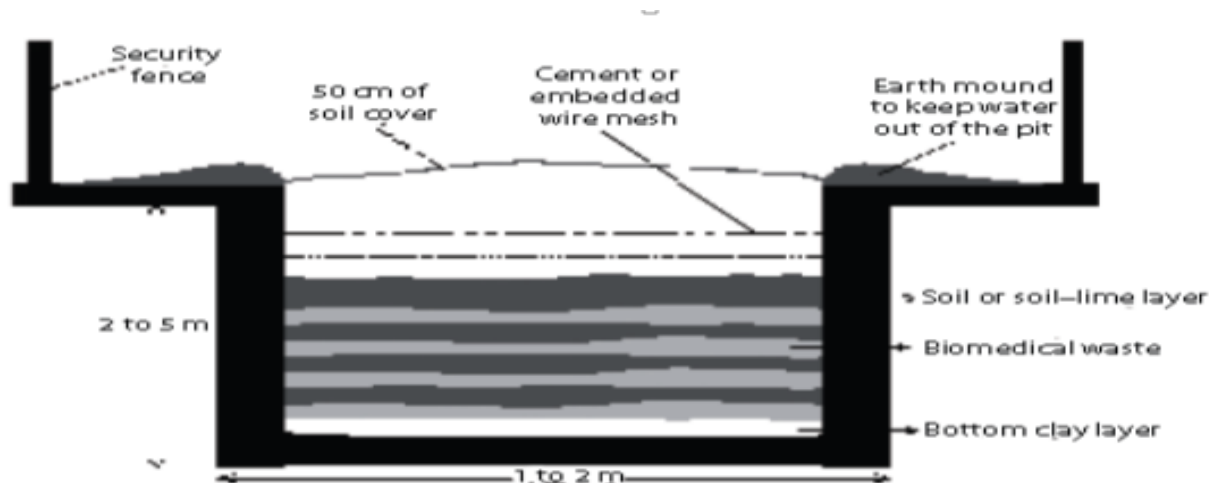
The following waste categories should not be incinerated:

- mercury thermometers (preferably collect for mercury recovery);

- pressurized containers (safe burial in pits);
- polyvinyl chloride (PVC) plastics such as intravenous sets, catheters and PVC containers for sharps (safe burial in pits);
- vials of vaccines (safe burial in pits);
- Anatomical wastes or body parts (safe burial in pits).

23.1.3 Onsite burial in pits

Dig a pit 1–2 m wide and 2–3 m deep. The bottom of the pit should be at least 2 m above the groundwater. Line the bottom of the pit with clay or permeable material. Construct an earth mound around the mouth of the pit to prevent water from entering. Construct a fence around the area to prevent unauthorized entry. Inside the pit, place alternating layers of waste, covered with 10 cm of soil (if it is not possible to layer with soil, alternate the waste layers with lime). When the pit is within about 50 cm of the ground surface, cover the waste with soil and permanently seal it with cement and embedded wire mesh (Figure 14.1).



Source: Medecins Sans Frontieres (2010).

23.1.4 Disposal of Placenta and other pathological waste

Treating and disposing of biodegradable pathological waste is a critical problem for many health-care facilities. The general approach for managing this type of waste is outlined in Chapter 8. This annex describes some alternative approaches, which may be relevant if incineration, cremation and advanced non-incineration technologies applicable to pathological waste (such as alkaline digestion and hybrid steam treatment systems with internal shredding) are not available, and if the pathological waste must be treated or disposed of within the compound of the health-care facility. Under no circumstances should live cultures be treated in this manner. Instead, live cultures should be disinfected in the laboratory before being sent for disposal.

Organic waste often contains too many liquids to be suitable for incineration with volume reducers or batch auto combustion incinerators. The temperature reduction due to the evaporation of the liquids will result in formation of more toxic gases, survival of potential thermos resistant pathogens or even bringing the combustion to a halt.

Much research has focused on the elimination of enteric or waterborne pathogens in various types of composting system, both aerobic and anaerobic. As yet, there has been no comparable research for blood borne pathogens or pathogens involved in hospital-acquired infections; however, the risk appears to be lower than that for enteric infections. Firstly, the likelihood of bloodborne or hospital-acquired pathogens surviving composting is lower than that for waterborne infectious agents. Viruses and bacteria that cannot form spores are likely to be inactivated in a short period, although bacterial spores are more resistant. Bio digestion processes with higher temperatures and longer residence times are considered to be the best at eliminating pathogens.

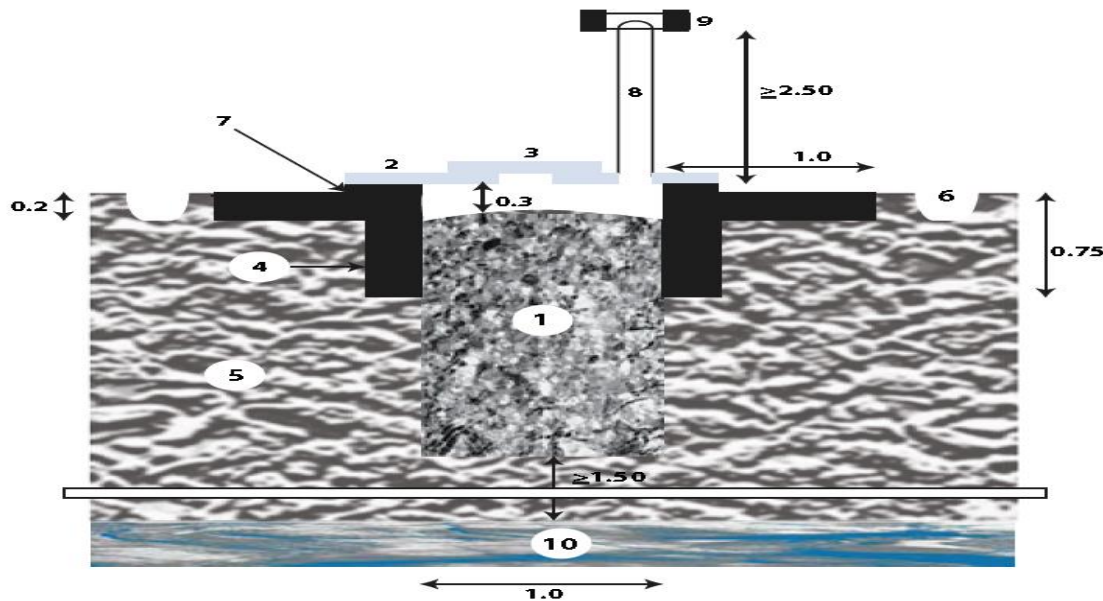
In any waste-disposal approach, care should be taken to prevent contact with untreated waste, such as through skin contact or splashes during collection and placement of the waste into pits, composters, digesters, and so on. Enteric pathogens can cause infection through the usual cycle of infection – for example, someone handling compost from a digestion process may get material on their hands and then spread it to their mouth. Conversely, blood borne pathogens are unlikely to be spread via this usual cycle of infection; it is very unlikely that someone would pick up any blood borne pathogen by handling compost or bio digester slurry unless the worker has cuts or breaks in the skin, or there are sharps in the waste causing injury to the workers.

23.1.5 Placenta Pit

In many communities, burying placentas is an important ritual and one option for disposal. If it is done safely, burial can protect the community from pathogens while respecting cultural norms and religious traditions.

One disposal option is to dispose of placentas in concrete pits. The site of the pits should be as far away as possible from publicly accessible areas and from hygienically critically areas (e.g. water wells, kitchens). Placenta pits should not be built too close to buildings due to possible odors. The dimensions of the pit will be context specific, and will depend on the average number of births and infiltration rate of the soil. In principle, allow 0.5 litres of soil infiltration per placenta, and a maximum of 5 litres of total space per placenta if all the bloody liquids are collected and no infiltration is occurring.

The liquid proportion of placentas can leach into the soil through the unsealed sides of the pit. However, the pit should be designed to prevent the waste from contaminating the surrounding groundwater. A safety distance of at least 1.5 m from the bottom of the pit to the groundwater level is recommended. Placenta pits are not recommended in sites where the water table is near the surface or in areas prone to flooding.



Source: Medecins Sans Frontieres (2010)

The top 50 cm (or more) of the pit should be reinforced with concrete to prevent surface water infiltration. The base of the pit should be made from concrete to stabilize the structure and to slow the downward movement of liquid towards the water table. Placenta pits can be also constructed from a standard concrete ring with a diameter of about 1 m. The top slab should be above ground level and made from watertight concrete to prevent surface water infiltration. The top should be closed by a lockable hatch and a vent pipe installed to ensure that the generated gases can escape and air can get in. Where soil is particularly sandy,

Extra precautions may need to be taken to protect the water table and to prevent the pit from collapsing: the sides may be reinforced with bricks, laid with gaps between them so that the liquids can still escape.

1. Pit: string line, sticks and measuring tape
2. Slab: shovel, hoe, pick axe, miner's bar
3. Lid: fired bricks or cement blocks
4. Base or lining: sand, cement, gravel and clean water
5. Permeable soil: reinforcement bars (diameter 8 mm)
6. Drainage channel: tools to prepare and cast concrete; masons' tools
7. Mortar layer (at least 10 mm thick): jute sacking or plastic sheeting
8. Ventilation pipe: prefabricated slab with lid, 9. Tee with mosquito netting; protective clothing for operators

10. Water table: polyvinyl chloride (PVC) pipe (preferably diameter 150 mm), piece of stainless steel or nylon mosquito net

Dimensions are indicated in meters; labor requirements are for an experienced mason and one or two laborers

It is recommended that two placenta pits are built so that the second one is available as soon as the first is filled. Once a pit is filled up, it should be closed. Any sealed pits should be marked and their locations recorded. However, it may be possible to reopen pits after enough time has passed and the material has been degraded. When pits are reopened, it may be necessary to remove some of the degraded material. In this case, the concrete bottom of the pit has the added advantage that it will prevent workers digging too deeply and either destabilizing the pit or getting too close to the water table.

The process of biodegradation in the pit can destroy pathogenic microorganisms as the waste is subjected to changes in temperature, pH and a complex series of chemical and biological reactions. The degradation processes in a pit are anaerobic, with some aerobic decomposition in the upper layers where oxygen is available for aerobic bacteria. The waste should not be treated with chemical disinfectants such as chlorine before being disposed of, because these chemicals destroy the microorganisms that are important for biological decomposition.

At present, few data are available on how long it will take for all pathogens and eggs to die – particularly because the decomposition process depends on the local conditions (e.g. surrounding temperatures). Therefore, it is recommended that placenta pits should remain for at least two years before reopening. More research is needed on this subject.

Ash or charcoal helps reduce odours without adversely affecting the decomposition. Although adding lime will help to reduce odours, it will increase the pH of the soil and thereby slow the rate of decomposition, and therefore is not recommended. Adding ash will also reduce odours and decrease soil pH. It will also correct the carbon to nitrogen (C:N) ratio and speed up decomposition.

The operation of a placenta pit is based on the following steps and principles (MSF, Technical Brief 6.08):

- Dispose of the organic waste into the pit immediately when it arrives at the waste zone. Use only one pit at the time. Make sure that the pits are always closed with the slab's lid.

- Disinfect the empty organic waste bins with a 0.1% chlorine solution, rinse them with clean water, and finally clean them with water and soap. Never mix chlorine and soap together.
- Close the pit down when the level of the organic waste is about 0.5 m underneath the slab. Put a thick layer of wood ash on top of the organic waste and top up with compacted soil if the pit is closed permanently. Do not use ash from burnt soft waste for this purpose. Most organic waste will decompose into harmless matter, so it is normally possible to empty a pit that has been closed down for at least two years. However, be aware that bones of amputated limbs will still be intact. The general public may find the removal of these remainders offensive.
- Take particular care to avoid injuries with sharps that have accidentally been discarded in the organic waste pit. A new permanent burial place should be found for the organic waste remainders, potentially a controlled tip or a sanitary landfill.

24. Job Description

24.1 Job Title: MNCH Coordinator

24.2 Job Summary

The primary focus of this position is to provide training and support for the work of primary care staff team at PPHI health facilities. The MNCH Coordinator is responsible for ensuring the provision of high-quality primary care services in keeping with principles of client-centered collaborative care. The MNCH Coordinator will lead and coordinate quality improvement activities in the area of maternal, newborn and child health.

The MNCH Coordinator will provide supervision for the primary health care staff team, currently comprised of: Female Medical Officers and LHW/Midwives.

24.3 Responsibilities

24.3.1 Service Delivery and Planning

1. Coordinate the service delivery activities of the primary care staff team, ensuring an integrated, collaborative client-centered approach.
2. Collaborate with District Manager to facilitate optimal communication between primary care and admin staff and to ensure an effective, coordinated work flow.
3. Provide training to health care providers in the form of group based or On the Job Coaching
4. Visit health facilities regularly and share observations and action plans with district office team
5. Carry out DHIS analysis on MNCH indicators on regular basis and report to district, regional and head office.
6. Coordinate the planning process for new programs and service initiatives, in collaboration with the staff team, District Managers, Regional Directors and Head office team as appropriate
7. Reporting on training and visits on monthly basis and as when needed to district, regional and head office.

8. Develop a monthly work plan for trainings and field visit, in collaboration with MO HQ, District Manager and Regional PHS.
9. Conduct health awareness sessions in community.
10. Conduct informative session at MRM

24.3.2 Quality Assurance and Improvement

1. Regularly review and analyze MNCH service delivery and other relevant data. Provide interpretive information to staff and management.
 2. Provide supportive supervision in the development and implementation of quality improvement initiatives related to MNCH services.
 3. Ensure Helping Babies Breathe corners are well established in all MNCH centers
 4. Ensure Kangaroo mother care units are established in all MNCH Centre's
 5. Ensure maternal death audit forms, still birth audit forms are implemented and filled at health facilities
 6. Coordinate quality audits and other quality assurance activities.
 7. Participate in Centre-wide quality assurance and improvement initiatives.
 8. Responsible to conduct knowledge assessments on quarterly basis for pay for performance of medical officer and female medical officers in all health facilities
-
1. Support, coach and supervise assigned staff, including the development and monitoring of goals and individual work plans.
 2. Complete performance appraisals for all direct reports.
 3. Develop and review staff performance to ensure maximization of MNCH service delivery.
 4. In collaboration with the District Manager, coordinate the orientation and training of new primary care staff

24.3.4 Other tasks

1. Participate in team and staff meetings and other meetings as appropriate to support both service delivery and organizational goals
2. Collect, analyze and report on data and relevant information and participate in research as determined by organization
3. Work from a Social Determinants of Health perspective to improve health outcomes for individual clients and/or for the development of community health and well-being
4. Work in a manner that preserves confidentiality
5. Work in a manner that ensures client safety and minimizes risk to clients, especially mother and the newborn.
6. Work in a manner consistent with the PPHI Sindh's Vision, Mission and Guiding Principles
7. Work in a manner that demonstrates self-reflection and personal accountability for work performance

8. Adhere to all PPHI Sindh's policies

24.3.5 Accountability

This position is accountable to the District Manager and for technical support to Regional PHS, Technical wing Head office

25. Job Description

25.1 Job Title: Medical Officer Head Quarter PPHI

25.2 Job Summary

The primary focus of this position is to provide training and support for the work of primary care staff team at PPHI health facilities. The MO HQ is responsible for ensuring the provision of high-quality primary care services in keeping with principles of client-centered collaborative care. The MOHQ will lead and coordinate quality improvement activities in the area of maternal, newborn and child health. The MOHQ will provide supervision for the primary health care staff team, currently comprised of: Medical officer, paramedic staff and others.

25.3 Responsibilities

25.3.1 Service Delivery and Planning

11. Coordinate the service delivery activities of the primary care staff team, ensuring an integrated, collaborative client-centered approach.
12. Collaborate with District Manager to facilitate optimal communication between primary care and admin staff and to ensure an effective, coordinated work flow.
13. Provide training to health care providers in the form of group based, On the Job trainings or On the Job Coaching's
14. Visit health facilities regularly and share observations and action plans with district office team
15. Carry out DHIS analysis on regular basis and report to district, regional and head office.
16. Coordinate the planning process for new programs and service initiatives, in collaboration with the staff team, District Managers, Regional Directors and Head office team as appropriate
17. Reporting on training and visits on monthly basis and as when needed to district, regional and head office.
18. Develop a monthly work plan for trainings and field visit, in collaboration with MNCH Coordinator, District Manager and Regional PHS and share with head office
19. Conduct health awareness sessions in community.
20. Conduct informative session at MRM

25.3.2 Quality Assurance and Improvement

9. Focal person for primary health care and vertical programs
10. Regularly review and analyze health indicators, service delivery and other relevant data. Provide interpretive information to staff and management.
11. Ensure disease surveillance (DEWS and VPD)
12. Monitor and expand quality of clinical care (DHIS priority diseases)
13. Ensure IMNCI protocols are being followed along with functional ORT corners
14. Ensure Pneumonia, Diarrhea and PSBI cases are classified, reported and treated according to protocols
15. Ensure proper disposal of waste management according to protocols
16. Ensure medicine storage and dispensary protocols are being followed
17. Provide supportive supervision in the development and implementation of quality improvement initiatives related to health services.
18. Coordinate quality clinical audits and other quality assurance activities.
19. Participate in Centre-wide quality assurance and improvement initiatives.

25.3.3 Other tasks

1. Participate in team and staff meetings and other meetings as appropriate to support both service delivery and organizational goals
2. Collect, analyze and report on data and relevant information and participate in research as determined by organization
3. Work from a Social Determinants of Health perspective to improve health outcomes for individual clients and/or for the development of community health and well-being
4. Work in a manner that preserves confidentiality
5. Work in a manner that ensures client safety and minimizes risk to clients, especially mother and the newborn.
6. Work in a manner consistent with the PPHI Sindh's Vision, Mission and Guiding Principles
7. Work in a manner that demonstrates self-reflection and personal accountability for work performance
8. Adhere to all PPHI Sindh's policies

25.3.4 Accountability

This position is accountable to the District Manager and for technical support to Regional PHS, Senior Technical Advisor and Senior Director Health Services.