ANC/PNC training report

Safe Motherhood Promotion Project
Ministry of Health and Family welfare
Supported by JICA

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1. Background

In order to reduce maternal and neonatal mortality/morbidity, the Government of Bangladesh (GoB) and JICA jointly launched the Safe Motherhood Promotion Project (SMPP) in 2006 at Narsingdi district for a four-year period. The project is aimed at establishing an effective safe delivery service system, as well as improving the quality of MNH (Maternal and Neonatal Health) services at primary and secondary care facilities in the target area.

Concerning the provision of MNH services at community level, the fifty-eight H&FWCs (Health and Family Welfare Centres) are the governmental primary care facility to provide basic MNH services such as ANC (Ante-Natal Care), delivery assistance, PNC (Post-Natal Care) and FP (Family Planning). At community level, FWV (Family Welfare Visitor) and CSBA (Community Skilled Birth Attendant: either qualified FWA or HA) are defined as SBA (Skilled Birth Attendant) in Bangladesh health sector. While the number of delivery assistance by these SBAs is still limited, they are the main service providers in ANC and PNC in the community. Developing the capacity of these community care providers is crucial to ensure basic MNH services at below union level.

2. Identified areas need to be improved

As a part of facility assessment, SMPP conducted an interview study with FWV and CSBA in 9 model Unions. The interview result indicated that ANC and PNC procedures among the respondents were not quite standardised and some important components are missing from their practices.

As for ANC check-up, all FWVs answered that they always check blood pressure and body weight, but no one measures fundal height with a measuring tape. Many of them determine gestational age based on LMP and hand measured fundal height, thus determined gestational age is often inaccurate. Urine and blood tests as well as STIs screening are not available at any union level facility due to the shortage of reagent/logistics. Instead of haemoglobin test, anaemia cases are detected by observing the colour of conjunctiva, but iron-folic acid is often not provided due to the lack of procurement.

Culturally, post-partum women in rural Bangladesh do not go out during post-partum period. Thus puerperal women usually do not access health facilities unless they develop serious complications. Compared to ANC, PNC/Newborn check-ups are not quite taken root among community people. In the interview, several SBAs mentioned that they do not always conduct physical examination for PNC/Newborn check-ups, but they just verbally confirm clients' condition. Since maternal and neonatal check-ups are provided separately (women usually do not bring their infants), practical advice on breastfeeding cannot be given in PNC consultation.

In addition, ANC/PNC check-up room at many H&FWCs is not well organised. Some H&FWCs do not have examination table at the check-up room, thus the FWV has to bring ANC/PNC clients to IUD insertion room for abdominal palpation. Many H&FWCs do not have enough screen or curtain for maintaining privacy for physical examination. Moreover, face to face consultation is not quite adequate and often does not include health education.

According to the above findings, it was concluded that the currently provided check-ups do not function enough as an opportunity either for early detection of risk signs or for providing health related information. Therefore, SMPP took initiative to organise a specific training on ANC/PNC for SBA for ensuring basic but quality MNH service at union level.

3. Objectives

The overall objective of the training is to improve the quality of ANC and PNC/Newborn Care provided by FWV and C-SBA in target area.

The specific objectives are:

1) To provide basic Ante-natal check-up effectively
2) To provide a package check-up service for Post-partum women and neonates
3) To organise enable environment for effective check-up services at FWC

4. Organisation of training

2 kinds of training, namely ANC and PNC/Newborn check-ups, were organised separately. At the beginning, ANC training was organised as an interactive session with each FWV at H&FWC in the selected 5 model unions. The facilitators visited each of the targeted facilities to conduct the training. The session spent half-day, and started 11 am in order to avoid hampering the service provision at the facility. As the session focused on facility-based ANC service, FWV was the main target and CSBA was invited as observer. ANC training included a discussion on effective logistic arrangement of ANC consultation room. Based on the service flow, the room arrangement as well as missing logistics was re-assessed together with FWV in the session.

Considering the time constraint, 2nd batch of ANC training was organised as a group session at SMPP Narsingdi office. The main participants of 2nd batch ANC training were the FWVs and CSBAs in new model unions. It was assumed that the staff in new model unions would not have an opportunity to receive Infection Prevention Practices (IPP) training in the remaining Project's period. Therefore, some basic IPP components (decontamination, cleaning, sterilisation, waste disposal etc.) were added to the 2nd batch of ANC training.

As for PNC part, 2 batches of PNC/Newborn check-up training were organised as group session. The training was 1 day session held at the training centre in MCWC, Narsingdi.

5. Date, Venue and Participant

In total, 33 FWVs and CSBAs in 14 model unions in Narsingdi attended the training. Table 1 shows the details.

Table 1 Date, Venue, and Participant

Date	Training	Venue	# of FWV	# of CSBA
17/Aug/09	ANC	Mitzanagar, Raipura H&FWC	1	1
09/Sep/09	ANC	Drautpur, Monoholdi H&FWC	1	2
12/Sep/09	ANC	Danga, Polsh H&FWC	1	1
13/Sep/09	ANC	Draulpur, Shibpur H&FWC	1	0
08/Oct/09	ANC	Charakchar, Monoholdi H&FWC	1	1
27/Oct/09	PNC 1st batch	MCWC	10	10
24/Dec/09	PNC 2nd batch	SMPP office	5	7
26/Dec/09	ANC 2nd batch	MCWC	11	12

6. Module development

SMPP developed original modules for both ANC and PNC/Newborn check-up training (see Annex 2, 4 for detail).

In order to make the training practical, the modules consisted of not only theoretical sessions but also demonstrations and skill practices using actual patients or a torso dummy. In addition, some case studies are also included in both of the modules.

7. Facilitator

The training was facilitated by SMPP technical officer and the expert in community health.

8. Time table and implementation

The time tables of both training are shown below.

8.1 ANC check-up training

As previously mentioned, the 2nd batch of ANC training was a group session which combined with IPP training. The training started with self introduction, pre and post-test was excluded since most of the participants were familiar with the theory and the training very much focused on skill practice.

All the sessions were done with participatory manner. At the beginning of the session, the current ANC practice was discussed with the participants. Based on the discussion, the facilitator introduced an efficient ANC check-up flow with locally available logistics.

The pre-assessment pointed out the determined gestational age by the participants is often inaccurate, because it presumed by hand measured fundal height and vaguely remembered LMP. The way of measurement fundal height with a measuring tape and determination of gestational age based on the measured fundal height was introduced in the session. A correspondence table (Annex 7) of fundal height with gestational age was distributed to the participants. The physical examination part including fundal height measurement was demonstrated using actual patients in the facility.

In face-to-face training at 5 selected H&FWCs (1st batch of ANC training), the room arrangement and missing logistics were discussed with the FWV on site. Based on the discussion, the consultation room was re-arranged in the training follow-up visit later.

In the case study session, some complicated fictional cases, such as pre-eclampsia, previous c-section, and APH were shown to the participants. The management skill for these cases in the actual setting was discussed and explained in the session.

Table 2 ANC training (group session)

Time	Topic
10:00	Opening • Introduction • Objectives
10:15	Ante-natal check-up • Discussion about current practice • Demonstration of suggested check-up practice and flow
11:30	Demonstration: measurement fundal height with a measuring tape
12:30	Tea break

12:45	Discussion about logistic arrangement
13:15	Case study
14:15	Lunch
15:00	Infection Prevention Practices (option) • Decontamination • Equipment cleaning • Sterilisation • House keeping • Waste and sharps disposal
16:30	Feedback session Closing

8.2 PNC/Newborn check-up training

PNC/Newborn check-up training started with pre and post-test. Similar to ANC training, the participants' current practice was discussed at the beginning. Most of the participants provide maternal check-up but do not include newborn examination and breastfeeding practice in their PNC check-up procedure.

While the participants told that they provide physical examination for post-partum women, no one assesses the recovery of uterus with fundal height measurement. A correspondence table (Annex 7) of fundal height and lochia during post-partum period was distributed in the session and the fundal height measurement skill was reviewed using a torso dummy.

Following maternal check-up part, newborn physical examination skill was introduced. Along with describing the observation points, an efficient examination flow from head to toe was demonstrated using a baby dummy. In breastfeeding practice, several positions and important observation points were described with a poster and dummy used demonstration.

Some fictional complicated cases, such as puerperal sepsis and neonatal jaundice were discussed in the case study session. Based on the posed information (symptoms and data), the participants were required to find the possible diagnosis and consider the management procedure.

Table 3 PNC/Newborn check-up training

Time	Topic
9:30	Opening • Introduction • Objectives
9:45	Pre-test
10:15	Post-partum check-up • Discussion about current practice • Demonstration of suggested check-up practice and flow
11:00	Newborn check-up • Discussion about current practice • Demonstration of suggested check-up practice and flow
12:00	Tea break
12:30	Breastfeeding practice
13:30	Lunch

14:30	Case study
15:30	Post-test
16:00	Feedback session Closing

9. Evaluation

As for PNC/Newborn check-up training, the participants were evaluated with pre and post-test. Table 4 shows the result. The average score for pre-test was 16.9 (61.8% of the total score), and post-test was 21.9 (80.1% of total score).

The training feedback was also given by the participants in the end of the each session. The participants assessed that the training was very much practical and related to their daily activities. Particularly, they mentioned that it was useful to learn how to measure fundal height with a measuring tape and estimate gestational age with the measured fundal height. They realised that they can get more accurate gestational age using the tape measuring method.

In PNC/Newborn check-up training, the participants told that neonatal examination part was new for them and very much helpful to improve their service. Some participants recognised that this newborn examination part was tough and they requested the facilitators to provide follow-up technical support on site.

Additionally, the participants recommended extending ANC/PNC training to all FWVs and CSBAs in Narsingdi.

Table 4 Pre and post test score of PNC/Newborn check-up training

1st batch		2nd batch	
Pre-test	**Post-test**	**Pre-test**	**Post-test**
23	22	15	25
22	23	14	23
20	22	15	23
19	22	22	26
19	20	16	26
18	20	16	22
18	21	13	22
18	22	16	22
18	21	16	24
18	24	14	24
18	20	17	23
17	19	17	21
17	22		
16	22		
16	22		
15	24		
15	19		
15	19		
14	17		
14	20		

10. Follow-up

As the training follow-up activity, the facilitators (SMPP technical officer and expert in community health) visited each H&FWC in 5 selected model unions (targeted facilities for 1st batch of ANC training) in November, 2009. AFPO attended in some follow-up visits.

The purposes of the follow-up visit were:

- To assess to what extent the participants' knowledge and skills learnt in the training are retained and being applied in actual practice
- To assist re-arrangement of the ANC/PNC consultation rooms based on the discussion in the training

In the follow-up visit, the facilitators assessed the trainees' (only FWVs) knowledge and skills through interview and on-site observation. A particular check-list developed by SMPP (Annex 8) was used for the assessment. As table 5 shows, the findings indicated that the majority of trainees are still weak in neonatal examination and breastfeeding practice. Similarly, the skill of fundal height measurement with a measuring tape is not well acquired with the single training. Supplemental technical input as well as on-site supervision is necessary for the trainees to apply these newly introduced knowledge and skills in their daily practice.

In addition to the technical assessment, the consultation room in each of the 5 H&FWCs was re-arranged in terms of the efficient ANC flow. The pre-identified missing logistics such as bedside screen, step, and examination table were additionally supplied for these H&FWCs.

Table 5 Follow-up findings with check list

Knowledge/Skill		Trainee1	Trainee 2	Trainee 3	Trainee 4	Trainee 5
ANC						
Consultation procedure		74.4%	15.4%	84.6%	44.9%	48.8%
Skill	**Fundal height measurement**	n/a	Not satisfactory	Satisfactory	Not satisfactory	Not satisfactory
	Estimate gestational age	n/a	Not satisfactory	Satisfactory	Not satisfactory	Not satisfactory
Knowledge on complications		66.7%	66.7%	100%	100%	66.7%
PNC						
Maternal Consultation procedure		85.7%	57.1%	85.7%	78.6%	78.6%
Knowledge on complications		87.5%	75%	87.5%	50%	100%
Neonatal examination		50%	42.9%	42.5%	50%	46.4%
Breastfeeding		80%	0%	0%	20%	20%

11. Recommendation

- Complete the follow-up visit for the rest of facilities, particularly for new model unions.
- Neonatal examination, breastfeeding practice, and fundal height measurement skill are new for the most of participants. Thus, repeated on-site follow-up and constant supervision is necessary by the GoB technical managers and SMPP staff.
- Organise similar ANC/PNC training for the rest of FWVs and CSBAs in Narsingdi using the developed tools (module, table, check list etc.).

Annex1: List of participants

Training on ANC check-up
Participant list

Sl No	Name	Designation	Model Union	Upazila
1st batch				
1.	Ms. Renuka Afroz	FWV	Mitzanagar	Raipura
2.	Ms. Jesmin Begum	FWA	Mitzanagar	Raipura
3.	Ms. Salina Islam	FWV	Daulatpur	Monoholdi
4.	Ms. Shakera A Toha	FWA	Daulatpur	Monoholdi
5.	Ms. Rowhanara Begum	FWA	Daulatpur	Monoholdi
6.	Ms. Mobashera Begum	FWV	Danga	Polash
7.	Ms. Rabeya Ahmed	FWA	Danga	Polash
8.	Ms. Shahanaz Pervin	FWV	Dulalpur	Shibpur
9.	Ms. Shamsun Nahar	FWV	Chalakchar	Monoholdi
10.	Ms. Monoara Begum	FWA	Chalakchar	Monoholdi
2nd batch (group session)				
1.	Ms. Rashida Begum	FWV	Shilmandi	Narsingdi Sadar
2.	Ms. Kusum Madhu	FWV	Zinardi	Palash
3.	Ms. Naeid Parvin	FWV	Joynagar	Shibpur
4.	Ms. Bidyut Rani Sarker	FWV	Musapur	Raipura
5.	Ms. Gita Rani Das	FWV	Patuli	Belabo
6.	Ms. Farida Yesmin	FWV	Bashgari	Raipura
7.	Ms. Dilruba Momotaz	FWV	Panchdona	Narsingdi Sadar
8.	Ms. Hamida Khatun	FWV	Ghorashal	Palash
9.	Ms. Nur Akter Begum	FWA	Ghorashal	Palash
10.	Ms. Sabina Yesmin	FWA	Ghorashal	Palash
11.	Ms. Ratna Begum	HA	Ghorashal	Palash
12.	Ms. Nurun Nahar Khanum	HA	Ghorashal	Palash
13.	Ms. Farida Begum	HA	Narayanpur	Belabo
14.	Ms. Salima Jahan	FWV	Narayanpur	Belabo
15.	Ms. Kanan Bala Das	FWA	Zinardi	Palash
16.	Ms. Anima Rani Debnath	FWA	Zinardi	Palash
17.	Ms. Momotaz Nahar	HA	Joynagar	Shibpur
18.	Ms. Afruza Parvin	FWA	Joynagar	Shibpur
19.	Ms. Morium Akter	FWA	Patuli	Belabo
20.	Ms. Rashida Sultana	HA	Patuli	Belabo
21.	Ms. Momotaz Begum	FWV	MCWC	Narsingdi
22.	Ms. Nazmun Nahar	FWV	MCWC	Narsingdi
23.	Ms. Meherun Nessa	FWV	MCWC	Narsingdi

Annex1: List of participants

Training on PNC/Newborn check-up
Participant list

Sl No	Name	Designation	Model union	Upazila
1st batch				
1.	Ms. Monoara Begum	FWA	Chalakchar	Monoholdi
2.	Ms. Shamsun Nahar	FWV	Chalakchar	Monoholdi
3.	Ms. Shakera A Toha	FWA	Daulatpur	Monoholdi
4.	Ms. Shahanaz Pervin	FWV	Dulalpur	Shibpur
5.	Ms. Farida Yasmin	FWV	Bashgali	Raipura
6.	Ms. Salima Jahan	FWA	Narayapur	Belabo
7.	Ms. Farida Begum	HA	Narayapur	Belabo
8.	Ms. Narsin Akter Haque	HA	Panchdona	Narsingdi Sadar
9.	Ms. Sabina Yasmin	FWA	Gorashal	Polash
10.	Ms. Hamida Khatun	FWV	Gorashal	Polash
11.	Ms. Jesmin Begum	FWA	Mitzanagar	Raipura
12.	Ms. Diluba Momotaj	FWV	Panchdona	Narsingdi Sadar
13.	Ms. Renuka Afroz	FWV	Mitzanagar	Raipura
14.	Ms. Nurun Nahar Khanam	HA	Gorashal	Polash
15.	Ms. Ratna Begum	FWV	Gorashal	Polash
16.	Ms. Mobashera Begum	FWV	Danga	Polash
17.	Ms. Rowhanara Begum	FWA	Daulatpur	Monoholdi
18.	Ms. Jhuni Rani Roy	FWV	Narayanpur	Belabo
19.	Ms. Salina Islam	FWV	Daulatpur	Monoholdi
20.	Ms. Rabeya Ahmed	FWA	Danga	Polash
2nd batch				
1.	Ms. Rashida Begum	FWV	Shilmandi	Narsingdi Sadar
2.	Ms. Kusum Madhu	FWV	Zinardi	Palash
3.	Ms. Naeid Pervin	FWV	Joynagar	Shibpur
4.	Ms. Bidyut Rani Sarker	FWV	Musapur	Raipura
5.	Ms. Gita Rani Das	FWV	Patuli	Belabo
6.	Ms. Kanan Bala Das	FWA	Zinardi	Palash
7.	Ms. Anima Rani Debnath	FWA	Zinardi	Palash
8.	Ms. Nelufar Yeasmin	HA	Zinardi	Palash
9.	Ms. Momotaj Nahar	HA	Joynagar	Shibpur
10.	Ms. Afruza Pervin	FWA	Joynagar	Shibpur
11.	Ms. Morium Akter	FWA	Patuli	Belabo
12.	Ms. Rashida Sultana	HA	Patuli	Belabo

Topic	Necessary materials
1. Identify available check-up content for Ante-natal consultation Discuss what the feasible check-up at the H&FWC with the FWV. 1) Ask FWV, what the current practice of Ante-natal check-up at the H&FWC is. - Content - Flow - Utilised logistics 2) Itemise all ANC component which can be available at the H&FWC.	✓ Paper (large) ✓ Pen ✓ Tape ✓ Component check list
2. ANC flow Discuss the **efficient check-up flow** based on the identified content above. The following is the suggested flow. **1) Registration** **First consultation* (1) *Register new clients in the ANC registration book* (2) *Ask to the women about history:* *a) Previous pregnancy (abortion, still birth)* *b) Previous delivery (mode of delivery, cause of previous C/sections, any complications developed)* *c) Neonatal outcome(size of infant, neonatal death)* *d) Medical surgical history, any chronic illness and treatment* *e) TT status* (3) *Record all obtained information in the ANC card* (4) *Identify risk factors according to obstetric and medical history* • *previous still birth or neonatal death* • *history of 3 or more than 3 times spontaneous abortion* • *Birth weight of last baby was <2500g or >4500g* • *Severe pre-eclampsia or eclampsia in last pregnancy* • *Previous surgery on reproductive tract (uterus, cervix)* • *Diabetes, renal disease, cardiac disease* (5) Try to accurately determine EDD/week of pregnancy based on all available information (if the case is 1st trimester, identify EDD based on a), b)) a) LMP b) Timing of first signs of this pregnancy: amenorrhea, morning sickness, tiredness, headache etc. c) Timing of first foetal movement confirm: usually around 20 weeks d) Fundul height: see table e) FHB: all case can be detected with fetoscope or state scope by 24 weeks, normal FHB is 110-160/min (6) Ask to the women about: a) Current foetal movement b) Vaginal discharge c) Any other concerns **2) Measurement** (7) BP: normal BP is <140/90mmHg (8) Temperature (if any sign of infection found) (9) Weight/height **3) Observation**	✓ ANC card ✓ Table of gestational age with Fundal height

Topic	Necessary materials
The principal of physical examination flow is top to bottom, and clean area to dirty area. Thus observation should be done in the following order. *Face→neck→chest→abdomen→legs→feet→genital area (pv)* (10) Check the conjunctival and tongue colour to diagnose anaemia, jaundice (11) Goiter (12) Breast (particularly nipple): at least once during pregnancy period (13) Abdominal palpation a) Measure fundus height b) Identify multiple foetus, foetal presentation, descent, amniotic fluid c) Listen to FHB (after 24 weeks, all FHB must be osculated) (14) Oedema on abdomen, legs/foot, hands, and face (15) Vaginal examination: (a) If women complaint abnormal vaginal discharge, bleeding (b) If possible, better to check birth canal before delivery **4) Consultation** (16) Interpret obtained information/data and diagnose any problems, and assess for referral (17) Give advice to women based on check-up outcome a) Explain any detected risk sign and how to manage it b) Advice about rest, nutrition, activities according to need c) Advice suitable place of delivery according to the risk factors d) Advice emergency referral (available facilities, necessary preparation) e) Give the date of next visit according to history (18) IEC a) Danger sign during pregnancy/ delivery b) Birth planning c) PNC/Newborn Care d) Breastfeeding e) Family planning **5) Supplementation (iron-folic acid)** **6) TT vaccination** **7) Recording** Record all data in ANC card and registration book	
3. Logistic arrangement Discuss about the necessary logistics and room arrangement for effective Ante-natal check-up at H&FWC. a) BP machine b) State scope c) Weight scale (at least 1 small scale for outreach service) d) Height scale (just draw a line on wall for detecting short height < 145 cm) e) Table for recording f) 3 chairs at least (1 for FWV, 2 for client and accompany) g) Examination table for abdominal palpation h) Screen, curtain i) Education materials (danger sign poster/BP poster and card, EPI schedule, FP methods, etc.) Based on above discussion, room and logistics will be re-arranged with FWV.	

Topic	Necessary materials
Identify absence items (make a list).	
4. Skill practice 1) Abdominal palpation : how to measure fundul height with measurement tape 2) Case study for determine gestational age • Amenorrhea: Client does not remember LMP. Client realised amenorrhea 3 month ago. • Morning sickness: started around 3 month ago. • Fundul height: 20 cm • Foetal movement: First recognised last month but cannot specify the date • FHB: cannot be osculated with state scope Q: Determine current gestational age and EDD based on the above information. A: 21-23 weeks, EDD: 17-19 weeks after the date 3) Case study for management of complication • 2nd visit (no abnormal sign at 1st visit), 32 weeks pregnancy of prima gravida, cephalic position, BP 140/90mmHg, oedema+1 on foots, no urine test available, total weight gain +7kg up to the date Q 1: What do you assess this case? A 1: Pre-eclampsia Q 2: What kind of advice do you give this pregnant women and her family? A 2: - Explain the risk of eclampsia - Explain sign of severe pre-eclampsia: headache, sudden oedema on hands and face, visual disturbance, epigastric pain (upper abdominal pain), less amount of urine (< 400ml for 24hours) - Take additional rest (> 15min complete lying down every couple of hours. If possible, take nap) - No need to restrict salt and water intake - Recommend taking urine test at a higher health facility to detect protein urea - Ask women to come back to ANC the following week with the urine test result - If BP will elevate, better to deliver at hospital Case study for management of previous C/S • 1st visit of ANC, 28weeks of pregnancy, 3 gravida 1 para (1 spontaneous abortion), No abnormal sign in ANC check-up, C-section 2 years ago due to prolonged labour Q 1: What kind of risk previous C-section case has? A 1: Prolonged labour, Rapture of uterus Q 2: What is the contraindication of this case? Why? A 2: Induction or augmentation with oxytocin increases the risk of uterine rapture. Q 3: What kind of advice do you give this pregnant women and her family? A 3: - Explain the risk of obstructed labour and rupture of uterus - Explain the risk of using oxytocin for VBAC - Recommend institutional delivery	✓ Abdominal model (or actual client) ✓ Measurement tape ✓ Table of gestational age with Fundul height

Topic	Necessary materials
5) Case study for management of APH • 2nd visit of ANC, 34 weeks of pregnancy, 3 gravida 2 para (normal delivery), Cephalic position, FHB 120, BP 120/60, oedema + 1on feet Main complaint: Client had small amount of vaginal bleeding twice, 1st one occurred 2 weeks ago and last one was a couple of days ago, bleeding started suddenly without any pain Q1: What do you assess this case? A1: APH (suspect alarm bleeding of placenta previa) Q2: What kind of advice do you give this pregnant women and their family? A2: - Explain what placenta previa is (anatomy) - Recommend having ultrasound examination to check the location of placenta - Explain the risk of placenta previa: ▪ possibility of foetal distress (still birth) ▪ massive bleeding in delivery period ▪ high possibility of placenta accreta (abnormally firm attachment of placenta to uterine wall) - Explain the mode of delivery would be judged based on ultrasound findings (A placental edge less than 2 cm from the internal os may need delivery by c-section). However, placenta previa is the main risk factor of placenta accreta (adhesive placenta), and placenta accreta is difficult to diagnose. Thus, placenta previa case should be managed as if she has placenta accreta until proven otherwise (c-section would be recommended)	

Topic	Remark	Necessary materials
1. Post-partum check-up (post-partum women) **1.1 Identify available check-up content for Post-partum consultation** Discuss what the feasible check-up in the setting. 1) What is the current practice of Post-natal check-up (content, flow, and utilised logistics)? 2) Which component can be included in Post-natal/Newborn check-up?	Ask participants about their current practice	✓ White board or large paper & pen
1.2 Post-partum check-up flow Discuss the efficient check-up flow based on the identified content above. The following is the suggested flow. **8) Registration** (19) Register new clients in the ANC registration book (20) Obtain the information of delivery and neonatal condition at birth (21) Record all data in the ANC card (22) Ask mothers about : d) Current vaginal discharge e) Any perineum tear and painful part f) Any other concerns: e.g. problem on urination, fever, abdominal pain **9) Measurement** (23) BP (24) Temperature (if any sign of infection found) (25) Weight	Recommend information collection based on last page of ANC card	✓ Registration book ✓ ANC card ✓ BP machine ✓ State scope ✓ Weight scale ✓ Examination table ✓ Fundal height table ✓ Torso dummy ✓ Measurement tape

Topic	Remark	Necessary materials
10) Observation The principal of physical examination flow is top to bottom, and clean area to dirty area. Thus observation should be done in the following order. *Face→neck→chest→abdomen→legs→feet→genital area (pv)* (26) Check the conjunctival and tongue colour to diagnose anaemia, jaundice (27) Breast: any sore, redness, abscess on nipple and breast (28) Abdomen palpation: (a) checking recovery of uterine based on fundul height and tenderness (b) If c/section, check recovery of surgical scare (29) Oedema on abdomen, legs/foot, hands, and face (30) Any signs of superficial thrombophlebitis: red inframed area over vein, vein feels firm on palpation from clot lying within it, pain, may have fever (31) Vaginal examination (a) If episiotomy or perineum tear case, check recovery of suturing part (b) If mother complains abnormal vaginal discharge, check the discharge	Introduce fundal height table Explain change of lochia	
2. Neonatal check-up **2.1 Identify available content for neonatal check-up** Discuss what is the current practice of Post-natal check-up (content, flow, and utilised logistics)?		
2.2 Neonatal check-up flow Demonstrate the efficient check-up flow. The following is the suggested flow. **1) Observation (Newborn)** The principal of physical examination flow is top to bottom, and clean area to dirty area. Thus observation should be done in the following order. *Head→chest→abdomen →limbs→back→genital area* Remove baby's cloth and let baby lie down on back		✓ State scope ✓ Watch ✓ Thermometer ✓ Infant dummy

Topic	Remark	Necessary materials
(1) Overall examination: Check overall status of neonates first by information collection from care giver (usually mother) and direct observation. Ask care giver the following points. • Is the baby feeding well? • Is the baby sleeping well (sleeping as usual)? • Is the baby in good mood (smiling well, moving well)? Usually, if small children (including neonates) meet above three, you can assume that child is not in serious condition though if he/she has developed any problem such as fever, vomiting, and diarrhoea. **Note: do not ignore care giver's feeling "not doing well" or "not as usual". This often indicates signal symptoms of serious illness.* (a) Assess general condition of newborn by checking the following points. • Size (weight) is normal? • The baby is normally active (muscle tone)? • Any abnormal movement (irregular, jerky movement of body, limbs, face i.e. presence of convulsion or spasm)? • Any obvious malformations (e.g. funny-looking face with Down syndrome)? • Skin colour (pallor, cyanosis, jaundice) is OK? (b) Posture: Normal posture of neonates is bending arms and legs lightly (arms shape W and legs shape M). (c) Body temperature: normal axillary temperature of neonates is 36.5~37.5℃ (If temperature is less than 36.0℃, suspect hypothermia. If temperature is more than 38.0℃, suspect occurrence of fever). Low birth weight neonates go into hypothermia easily (need to special attention). (2) Head: a) Anterior fontanelle: 1~2 cm space between the bones of skull. It bulges when brain pressure increases (e.g. cerebral meningitis, hydrocephalus etc) and a sunken fontanelle is a sign of dehydration. Fontanelle usually closes by 18 months old. b) Cyanosis on lips or nails is important sign of respiratory or cardiovascular disorder. Particularly, if a neonate has blue tongue and lips (central cyanosis), need to be give oxygen immediately.		

Topic	Remark	Necessary materials
(3) Chest: a) Movement of chest: Typical abnormal breathing is nasal alar breathing (movement of nose wing) and restrictive breathing (sunken chest). b) Respiratory rate: normal respiratory rate of neonates is 30~60/min. When you count respiratory rate, listen breath sound as well. c) Heart rate: normal range of heart rate of neonates is 100~160/min. Heart rate can be increased by fever, respiratory difficulty, and bleeding. (4) Abdomen: a) Distension: Need to check any other clinical abnormal signs and assess the condition, e.g. vomiting? /fever? /feeding well? /bowl movement (listen abdominal sound with state scope)? /move actively? (Baby looks sick?) /respiratory distress? /any abnormal tumour palpated? →If the baby appears to be seriously sick (floppy or lethargic) or small (<2500g) or Pre-term, need to immediate refer for further management (insert gastric tube, IV line, medication etc.). b) Umbilicus: any sign of infection (redness extends surrounding skin, draining pass, bleeding). Do not apply any substance or medicine to umbilical cord. If cord gets dirty with stool, wash it with warm water and just expose the cord in the air without covering and applying nothing. (5) Limbs: a) Abnormal posture and movement of limbs (basically neonates' arms and legs move symmetrically): arm palsy (no spontaneous movement on one side), and fracture are common birth injury. Difficult birth, breach delivery, large baby can cause these birth injury. b) Congenital dislocation of hips (often found with restriction of flog leg position, and asymmetric length of legs), Club foot (heel is tuned outward from the midline of the leg), and Extra finger or toe, are common birth defect. <u>Turn the baby on belly</u> (6) Back: a) Check any abnormality and birth injury		

Topic	Remark	Necessary materials
b) Lanugo (body hair): Lanugo usually disappears around 38weeks gestation (Sometimes mature neonate's upper back covered with lanugo, but this is normal). (7) Genital part: a) Male: undescended testicle is the most common abnormally in male neonate. If a neonate's testicle has not descended on its own within the first 6 months of life, he should be evaluated by a paediatrician. b) Female: sometimes female neonate has slight vaginal bleeding and discharge, this is the effect of hormone transferred from mother. c) Anus: if a neonate has not passed meconium within 24hours, check for imperforate anus. (8) Other: (a) Vernix (white fatty product applied neonates' body): usually localized attaches armpit and groin. Pre-term neonate's body is widely covered with vernix. No need to take off vernix. Vernix protects neonates from germs and prevents hypothermia.		
3. Consultation: <u>During consultation, encourage mother to breastfeed and observe the practice</u> (1) Interpret obtained information/data and diagnose any problems, and assess for referral (2) Give advice to women based on check-up outcome f) Explain any detected risk sign and how to manage it g) Advice about rest, nutrition, activities according to need h) Explain about danger sign during post-partum period i) Advice emergency referral (available facilities, necessary preparation) j) Give the date of next visit according to need (3) Give advice to women about Family Planning (4) Give practical advice to women about breastfeeding according to the observation result (positioning, latching, sucking) (5) Explain about EPI schedule for newborn (6) IEC f) Danger sign during post-partum period : high fever, severe abdominal pain, convulsion, severe		✓ EPI schedule poster

Topic	Remark	Necessary materials
headache/visual disturbance, foul smelling vaginal discharge/ large amount of vaginal bleeding (more than 2nd day of menstruation) g) Danger sign of neonates: respiratory distress, conversion, fever, umbilicus infection, feeding difficulty **4. Supplementation (iron-folic acid and Vit A) for post-partum women** **5. Recording** Record all data in ANC card and registration book		✓ Neonatal danger sign poster ✓ Post-partum danger sign poster
6. Breast feeding <u>Explain positioning and steps of breastfeeding with demonstration.</u> (1) Positioning 1) Principle of positioning a) Baby's mouth has to be straight in front of nipple b) Baby's body should be in a straight line from her ear to her shoulder and to her hip. 2) Introducing some positions with pictures or photos: a) Curdle/cross curdle: most common position b) Football (mother): good for mothers had c-section, small babies, mothers with large breast. (2) Steps of breastfeeding 1) Position baby in mother's arms with baby's mouth directly in line with nipple 2) Gently squeeze areola (the darker area around the nipple) with hand (palm and fingers underneath and thumb on top) to make it the same size as baby's mouth. Keep fingers clean of the areola so that baby can take a big mouthful of breast. 3) Slowly bring baby's mouth towards breast and touch baby's lower lip with nipple to encourage her to open her mouth wide. Mother may need to stimulate baby's lip several times or wait patiently for baby to open her mouth wide. 4) Guide breast into baby's mouth and make sure she takes in the whole areola and not just the nipple, and her tongue is always just below nipple. When baby cries, her tongue roles up and difficult place nipple on her tongue. ❖ Rooting reflex/sucking reflex: Both reflexes are primitive reflex which assist breast feeding. Rooting reflex is a baby turns his head toward anything that taps his cheek or mouth, searching for the object by moving his head until the object is found. Sucking		✓ Infant dummy ✓ Breast model ✓ Breast feeding positioning poster

Topic	Remark	Necessary materials
reflex is linked with the rooting reflex and breastfeeding, and causes the child to instinctively suck at anything that touches the roof of their mouth. Sucking reflex does not present when a baby is full and sleeping. 5) Make sure baby is compressing breast rather than just sucking. Only sucking makes nipple sore and baby cannot get enough amount of milk (because the milk tank (lactiferous sinus) is located under areola). Main signs of a compressing baby are a wide open mouth and distinct movement in her ears, temples, and jaw. 6) Basically, mother should wait until baby stop sucking (feed on demand). If mother has to finish lactating, press areola for letting air go into baby's mouth. Slide breast and baby's mouth to different direction (don't pull apart breast and baby's mouth, it causes sore nipple). 7) Try to feed both breasts equally for prevention of mastitis. If baby would suck only one side of breast, start feeding form the other side of breast for next time. 8) Summary of observation points a) Is baby's mouth straight in front of nipple? b) Is baby's body in a straight line from her ear to her shoulder and to her hip? c) Is baby's mouth widely open? d) Is baby's tongue cupped around nipple (mother's nipple is on baby's tongue)? e) Is baby sucking slowly and deeply (observe baby's ears, temple and jaw)? If you hear any smacking or clicking sound, that is the sign of shallow sucking.		

Case studies for PNC/Newborn check-up training

Case 1. Puerperal sepsis (Uterine infection)

Current condition: 6 days post-partum woman, Fever since 2 days ago (no thermometer available), fundul height is 10cm, small amount of bloody lochia continued (mother's remark), slight lower abdominal pain and it increases with applying pressure

Additional information from client/ANC card:
1 gravida 1 para, delivery was assisted by TBA, rapture of membrane occurred 2days before delivery, developed grade 2 perineum tear during delivery and sutured by FWV soon after delivery

Q: What do you suspect first, based on the above mentioned information?
A: Post-partum infection (uterine infection or perineum infection or mastitis or urinary tract infection)

Q: What kind of additional information you need to collect to get a diagnosis?
A:

- Observe perineum part to rule out perineum infection as well as checking lochia (lochia or light bleeding? presence of foul smelling?)
- Observe breast to rule out mastitis (presence of any sign of inflammation, mass, abscess, on breast)
- Ask woman about urination (presence of burning sensation, pain in urination, back pain), and urine specimen test is necessary to rule out urinary tract infection

Note: Definition of puerperal sepsis is...
An infection of the genital tract (uterus, cervix, vagina, and perineum) which occurs after delivery, usually after the 24 hours.

Q: What are the common signs of post-partum uterine infection?
A:

- Fever
- Chills
- Purulent, foul smelling discharge
- Lower abdominal pain
- Soft and bulky uterus on palpation

Q: What are the risks of puerperal sepsis?
A:

- PPH
- Premature rapture of membrane
- Prolonged labour
- C-section
- Unskilled birth attendant
- Unclean delivery equipment
- Frequent vaginal examination (PV) or insertion of any non-disinfected substance
- Presence of any STIs during pregnancy

Q: How do you manage this case?
A: Referrer a higher health facility which can provide the following measures with referral Slip (write down all obtained information)

- Take specimens (urine, vaginal discharge, blood) to identify the causative organisms and confirm diagnosis
- Start appropriate antibiotic treatment
- Remove retained products from uterus if necessary

Case 2. Feeding difficulty and lethargy cause of jaundice

Current condition: 10 days old baby, Mother complains the baby has become less active since a couple days ago, and has not sucked breast milk well since then. No history of fever. Respiratory rate is 40/min and no signs of respiratory disorder (chestindrawing or grunting on expiration etc.).

Additional information from mother/ANC card:
BW around 2.5kg, delivered by c-section cause of prelabour rapture of membrane at 36weeks of pregnancy, 2nd child (2gravida 2para), No specific complication during pregnancy

Q: What do you assess first this case based on above information?
A: Feeding difficulty, and lethargy

Q: What kind of risks this baby has?
A:
- BW less than 2.5 kg, born before 37weeks gestation are risks of severe jaundice
- LBW is the biggest risk of hypothermia
- Feeding difficulty is cause of hypoglycaemia

Q: What kind of additional information you need to collect to get diagnosis?
A:
- Obtain the following information: any history of convulsion, vomiting, abdominal distension, colour of stool and urine.
- Check respiratory status (chest movement, respiratory rate, breath sound) to rule out respiratory disorder
- Check body temperature to rule out hypothermia
- (Measure blood glucose to rule out hypoglycaemia (if blood sugar is less 45mg/dl, treat as hypoglycaemia))
- (Measure serum bilirubin to diagnose jaundice)

Q: How do you manage this case?
A: Referrer a higher health facility which can provide the following measures with referral Slip (write down all obtained information)
- Take blood sample to measure glucose and bilirubin level
- Insert IV line (in case of hypoglycaemia)
- Start phototherapy (in case of serious jaundice)

Note:
- Physiological jaundice occurs in more than 50% of neonates
- Physiological jaundice usually starts 24-72 hours after birth, and it peaks 4-5 days after birth
- Jaundice starts on face first and followed by a downward progression (Face→Upper trunk→Lower trunk&thighs→Arms&lower legs→Palm&soles)
- Visible jaundice seen in the first 24hours of birth or on limbs/palm&soles on day 2nd should be assumed to be serious. The causes of early appeared jaundice are: Rh factor or ABO blood group incompatibility, Intrauterine infection, and G6PD deficiency

- Visible jaundice stars appearing after 72hours or jaundice prolongs more than 15days of birth should be assumed to be abnormal. The causes of late-onset or prolonged jaundice are: Noonatal sepsis, neonatal hepatitis, biliary atresia, breast milk jaundice, and metabolic disorders.

Note:

If you find any neonate suspected jaundice, you have to check the following 4 points.

- What is the birth weight?
- What is the gestation?
- What is post-natal age in hour?
- Is the jaundice physiological or pathological?

If you find a jaundice baby with lethargy and feeding difficulty, you should suspect bilirubin encephalopacy (kernicterus). The common symptoms of kernicterus are lethargy, poor feeding, poor or absence of Moro's reflex*, and opisthotonus convulsions.

> * *Moro's reflex: peaks in the first month of life and begins to disappear around 2 months of age (up-to 6 months). Reflex occurs if a neonate's head suddenly shifts position, the temperature changes abruptly, or he is surprised by a sudden noise. The legs and head extend while the arms jerk up and out with the palms up and thumbs flexed. Shortly afterward the arms are brought together. Bilateral absence of the reflex may indicate* ***damage to the neonate's central nervous system*** *while a unilateral absence could mean an injury due to birth injury such as a clavicle fracture or upper arm paralysis also sometimes present in such cases.*

Pre-Post test
Training on Post-partum and Newborn Check-up

1. **Which of the following are correct?** (Tick all which apply)

☐ Most of maternal death occur during post-partum period
☐ Only who develop complication need to have PNC check-up
☐ PNC/Newborn check-up includes family planning consultation
☐ Post-partum women and neonates should have separate check-up

2. **Which of the following are the common signs of puerperal sepsis?** (Tick all which apply)

☐ Fever
☐ Foul smelling vaginal discharge
☐ Lower abdominal pain
☐ Soft and bulky uterus on palpation

3. **Which of the following are the risks of puerperal sepsis?** (Tick all which apply)

☐ PPH
☐ Prelabour rapture of membrane
☐ Diabetes
☐ Frequent vaginal examination

4. **Which of the following are correct?** (Tick all which apply)

☐ Post-partum hemorrhage (PPH) can be occurred during 6 weeks of after delivery
☐ Cervical tear can be cause of PPH
☐ Common cause of PPH is uterine atony
☐ Oxytocin injection should be given for all delivery cases to prevent PPH

5. **Which of the following are correct?** (Tick all which apply)

☐ Sunken fontanel is a sign of dehydration
☐ Prolonged cyanosis on lip and tongue is a serious sign of cardiovascular disorder
☐ Neonatal heart rate can be increased by fever, respiratory difficulty, and bleeding
☐ Usually neonates pass meconium within 24 hours after birth

6. **Which of the following are correct?** (Tick alls which apply)

☐ Initiation of breast feeding needs to wait after delivery of placenta
☐ Exclusive breastfeeding should be continued by 6 months after birth
☐ Smacking or clicking sound is good sign of sucking breast milk
☐ Baby's mouth always should be in line with mother's nipple

7. **Which of the following are correct?** (Tick alls which apply)

☐ Low birth weight and pre-term delivery are the risks of severe jaundice
☐ Severe jaundice can be cause of feeding difficulty and lethargy
☐ Physiological jaundice usually starts in 24hours of birth
☐ Physiological jaundice usually ends after 2 weeks of birth

Name: _____

Designation/Designated union: _____

Gestational age with Fundal height

Month of pregnancy	Weeks	Fundal height
1st month	4 ~ 8 weeks	Uterus like an egg
2nd month	9 ~ 12 weeks	Uterus like a fist= 11 weeks
3rd month	13 ~ 16 weeks	12 cm=13 weeks
		13cm=14 weeks
		14cm=15 weeks ~16 weeks
4th month	17 ~ 20 weeks	15cm=17 weeks
		16cm=18weeks
		17cm=19weeks
		18cm=20weeks
5th month	21 ~ 24 weeks	19 cm=21weeks
		20cm=21 ~ 23 weeks
		21 cm=24weeks
6th month	25 ~ 28 weeks	22cm=25weeks
		23cm=26weeks
		24cm=27weeks
		25cm=28weeks
7th month	29 ~ 32 weeks	26cm=29weeks
		27cm=30weeks
		28cm=31 ~ 32 weeks
8th month	33 ~ 36 weeks	29cm=33weeks
		30cm=34weeks
		31cm=35 ~ 36 weeks
9th month	37 ~ 40 weeks	32cm=37weeks
		33cm=38weeks
		34cm=39week
		35cm=40 ~ 41weekss

Uterine recovery (Post-partum period)

After delivery	Fundal height	Lochia
Immediate after delivery	10 ~ 12 cm	Bloody
12 hours after delivery	15 cm	
1 ~ 2 days after delivery	11 ~ 17 cm	
3 days	9~13cm	
4 days	9~10cm	
5days	8~11cm	Brownish
6days	7.5~8cm	
7~9 days	6~9cm	
10 days or more	not palpable	Yellow → White
6 weeks	recover as non-pregnant size	

Check list for follow-up of ANC/PNC training

Date: .....

Name of FWV/CSBA: .....

Designated union: .....

Follow-up by: .....

1. ANC practice

	Practice	Result	Remark
ANC procedure (ask or observe ANC procedure)			
1.	**Registration**		
2.	**Taking obstetric and medical history** ***What kind of obstetric and medical history needs to be taken?***		
	f) Previous pregnancy (abortion, still birth)		
	• Previous delivery (mode of delivery, cause of C/section, any complications developed)		
	g) Neonatal outcome (size of infant, neonatal death)		
	h) Medical surgical history, any chronic illness and treatment		
	• TT status		
3.	**Identify risk factors according to history** ***What kind of risk factors can be identified from history?***		
	• Previous still birth or neonatal death		
	• History of 3 or more spontaneous abortions		
	• Birth weight of last baby was <2500g or >4500g		
	• Severe pre-eclampsia or eclampsia in last pregnancy		
	• Previous surgery on reproductive tract (uterus, cervix)		
	• Diabetes, renal disease, cardiac disease		
4.	**Estimate gestational age** ***Based on which information you estimate gestational age?***		
	f) LMP		
	g) Timing of first signs of this pregnancy: amenorrhea, morning sickness, tiredness, headache etc.		
	h) Timing of first foetal movement: usually around 20 weeks		
	i) Fundal height		
	• FHB (foetal heart beat): all case can be detected with fetoscope or stethoscope by 24 weeks		
5.	**Ask client about current concern**		
6.	**BP checking**		
7.	**Temperature checking (if any sign of infection found)**		
8.	**Weight/height checking**		
9.	**Physical examination/observation**		
	• Anaemia and Jaundice		

	Practice	Result	Remark
	• Fundal height		
	• FHB (all case can be osculated after 24 weeks)		
	d) Identify multiple foetus, foetal presentation, descent, amniotic fluid		
	e) Vaginal examination/observation (if women complain abnormal discharge, bleeding)		
10.	**Consultation** ***What kind of advice you provide during consultation?***		
	k) Explain any detected risk factor and how to manage it		
	l) Advice about rest, nutrition, activities according to needs		
	m) Advice suitable place of delivery according to the risk factors		
	n) Advice emergency referral (available facilities, necessary preparation)		
	• Give the date of next visit according to history/checking outcome		
11.	**IEC** ***What kind of information do you provide in IEC?***		
	h) Danger sign during pregnancy/ delivery		
	i) Birth planning		
	j) PNC/Newborn Care		
	k) Breastfeeding		
	• Family planning		
12.	**Iron-folic acid given**		
13.	**Advice of TT vaccination**		
14.	**Recording**		
Skills			
1.	Measurement of fundal height with a measuring tape		
2.	Estimate gestational age using fundal height table		
Knowledge			
1.	2 possible complications for APH		
2.	Risk of previous C-section in delivery		
3.	Definition of pre-eclampsia		

✓ : answered or observed satisfactory, ×: not satisfactory, n/a: not asked or observed

2. PNC/NC practice

	Practice	Result	Remark
PNC procedure (ask or observe PNC procedure)			
1.	**Registration**		
2.	**Taking obstetric and medical history**		
3.	**Ask client about current concern**		
	• Current vaginal discharge		
	• Any perineum tear and painful part		
	• Other: problem of urination, fever, abdominal pain		
4.	**BP checking**		
5.	**Temperature checking (if any sign of infection found)**		
6.	**Weight/height checking**		
7.	**Physical examination/observation**		
	• Anaemia and Jaundice		
	• Breast (engorgement, tenderness, redness, abscess)		
	• Fundal height		
	• Vaginal examination (perineum tear, discharge)		
8.	**Iron-folic acid/Vit A given**		
9.	**Recording**		
Knowledge			
1.	**What are the causes of puerperal sepsis?**		
	• Uterine infection		
	• Perineum infection		
	• Mastitis		
	• Urinary tract infection		
2.	**What are the common symptoms of uterine infection?**		
	• Fever		
	• Lower abdominal pain		
	• Foul smelling discharge		
	• Tender, soft and bulky uterus on palpation		
Neonatal Care procedure (ask or observe NC procedure)			
1.	**Assess general condition** ***What are the 3 points you need to ask care giver?***		
	o) Is the baby feeding well?		
	p) Is the baby sleeping well (sleeping as usual)?		
	• Is the baby smiling well (in good mood, moving well)?		
	Additional information for general assessment		
	l) Size (weight) is normal?		
	m) Posture (arms shape W, legs shape M)		
	n) Muscle tone		
	o) Any abnormal movement (presence of convulsion or spasm)		
	p) Any obvious malformations		
	• Skin colour		

Annex 8: Follow-up checklist

	Practice	Result	Remark
	Body temperature: normal 36.5C-37.5 C		
2.	**Head/Face**		
	• Anterior fontanel (what does sunken/bulging fontanel indicate?)		
	• Cyanosis of lips and tongue (sign of cardiovascular disorder)		
3.	**Chest**		
	• Movement (nasal alar breathing, sunken chest)		
	• Respiratory rate: normal 30-60/min		
	• Hart rate: normal 100-160/min		
4.	**Abdomen**		
	• Distension		
	• Umbilicus		
5.	**Limbs**		
	• Birth injury		
	• Congenital malformation (dislocation of hip, club feet, synpolydactyly)		
6.	**Genital part**		
	• Undescended testicle		
	• Imperforate anus		
7.	**Consultation**		
	q) Explain any detected danger sign and how to manage it		
	r) Advice about rest, nutrition, activities according to needs		
	s) Advice emergency referral (available facilities, necessary preparation)		
	• Give the date of next visit according to need		
8.	**IEC**		
	• Danger sign of post-partum women		
	• Danger sign of post-partum neonates		
	• Family Planning		
	• EPI schedule		
Breast feeding			
1.	**What are the observation points of breast feeding?**		
	• Is baby's mouth straight in front of nipple?		
	• Is baby's body in a straight line from her ear to her shoulder and hip?		
	• Is baby's mouth widely open?		
	• Is baby's tongue cupped around nipple (mother's nipple is on baby's tongue)?		
	• Is baby sucking slowly and deeply (observe baby's ears, temple and jaw, no clicking or smacking sound)?		

✓ : answered or observed satisfactory, ×: not satisfactory, n/a: not asked or observed

別添資料4

Private Community Based Skilled Birth Attendant in Char area of Narsingdi

Safe Motherhood Promotion Project (SMPP)
JICA Bangladesh
June 2011

3. Private Community based Skilled Birth Attendant initiative in Char

3.1 Who is a Private Community based Skilled Birth Attendant (P-CSBA) in Char?

A P-CSBA in Char area is a woman who is trained for assisting delivery at home and providing essential MNH services in the community. She fulfills minimum requirements to be a CSBA, can assist safe normal delivery in the community, and identify emergency cases to be referred to the facility. P-CSBAs are selected by the community and approved by local UHFPO and UFPO based on the criteria set such as:

- Candidates must be a female and married
- Age less than 35 years
- At least SSC pass (or equivalent)
- Residing at the specific unions of the char area
- Motivated to work in the union with agreed upon terms and conditions
- Having family support for the training and services

3.2 Responsibility of P-CSBAs

P-CSBAs are expected to provide the following basic maternal and child care services and conduct related activities through home visits:

- Collect information on Pregnant Women and report to FWAs or FWV
- Provide ANC, PNC and ENC
- Assist normal delivery at home
- Identify pregnancy complications and immediately refer to the facility
- Maintain relationship with private service providers, e.g. TBA & village doctor
- Report to/be supervised by FWV at the union level and by MO-MCH at the Upazila level
- Have a regular meeting with FWV and UP (at least monthly)
- Provide Health Education on Maternal and Neonatal Health in the community

P-CSBAs report their activities to FWV, their immediate supervisor, and to Union Parishad monthly using a reporting format and seek for necessary support from them if necessary.

3.3 Responsibility of Community and P-CSBA Support Mechanism

The communities willing to have P-CSBAs should be involved in the selection of P-CSBAs and create a P-CSBA supporting system. The P-CSBA support system includes establishment of P-CSBA support committee or any other responsible bodies to be nominated and provides supports needed for P-CSBAs to deliver the services at the community especially ensuring monetary incentive or earning against the P-CSBA provided services. In the experiences of this pilot, Union Parishad basically became a supporting body and had a contract with an individual P-CSBA who works in the area. Other mechanisms such as performance monitoring and skill development of P-CSBA are the same as the National CSBA program.

For the sustainability of P-CSBA program, the Union authority decides how to ensure the regular income of P-CSBAs, e.g. P-CSBAs can earn nominal service fees from their clients if the Union authority approves such a practice; P-CSBAs could be hired by the Union authority with minimum salary. In our pilot, all P-CSBAs were allowed by the Union Parishads to charge

the fixed service fee from the clients.

In addition, the community should ensure the transportation for emergency referral and emergency fund for poor pregnant women.

3.4 Responsibility of GoB

Ministry of Health and Family Welfare is the line ministry of National SBA program. P-CSBAs are accredited by the Nursing Counsel and monitored and supported by the MoHFW staff and the community and technically assisted by GoB supervisors namely FWV and MO-MCH. P-CSBAs are also reportable to respective FWVs, assist the regular work of FWV, FWA and HA and collaborate with them in their daily activity especially in case of emergency referral. Since this is the pilot program, it is a responsibility of MoHFW to make sure lessons learnt from this program is incorporated into the designing of national program in Char area.

3.5 Responsibility of JICA

JICA financially contributes to the provision of CSBA training and refresher training and support for their regular activities after completion of the initial training. JICA also facilitates development of linkages among the Government health system, the community and P-CSBAs.

4. Activities

P-CSBA initiative in Char started from June 2008 targeting eight unions of Narsingdi Char area. The first batch of the CSBA Training was organized from December 2008 to June 2009 with 11 trainees and the second batch was held from April to November 2010 with 9 trainees.

To achieve the project objective and outputs, following step wise activities were implemented.

4.1 Approval of the MoHFW for piloting

JICA, in consultation with concerned DGHS/DGFP officials, developed a pilot proposal on Private CSBA initiative in Char and submitted it to the MoHFW for its approval. The proposal was approved accordingly (annex 1).

4.2 Discussion meeting for piloting in the char communities

A discussion meeting was organized involving the Health/FP managers, the Union Parishad members, community representatives, local NGOs and JICA with an objective to get an understanding and agreement of initiating P-CSBA initiative in their community. In this meeting all the stakeholders discussed over the formation of P-CSBA support system and selection of P-CSBA, e.g. the process and criteria of selection, and responsibilities of each stakeholder, were clarified and agreed.

JICA facilitated the organization of this discussion meeting.

4.3 Selection of private CSBAs

The selection of P-CSBA was done based on the GoB guideline. In total 19 P-CSBAs attended CSBA training organized by MoHFW. The following selection process was taken place:

- Written circular for recruitment of P-CSBAs, signed by the respective UP Chairman, was promulgated at all the educational institutions and other suitable sites for information to the

community. The interested candidates directly applied to the UP Chairman to attend the CSBA training.

- The interested potential candidates were also identified in the community and their CVs were collected from the designated unions with the support from CARE-Bangladesh, other NGOs and JICA.
- All the applications should be submitted to the UP Chairman for initial screening and recommendations sent to the existing Upazila CSBA Scrutiny Committee for final selection. The selection was done through the procedure set by the national CSBA program (written and interview of the candidates).

4.4 CSBA training institutes

It was expected that the candidates would not have any previous formal exposure/experience in health and family planning related issues and field activities. Moreover, the project also did not have any previous experience in training such people to be CSBAs. It was therefore very important to ensure that the trainees are competent enough to work in the community independently after the training. Considering all these issues, MoHFW and SMPP decided to place them at a training institute where they would receive quality training with necessary support and institutional facilities for accommodation and food. Two private hospitals which were also the CSBA training institutions accredited by the government, **LAMB Hospital and Kumudini Hospital** were selected for this purpose. Besides, 5 day long basic health care training was added before the initiation of 6 month CSBA training considering the background of trainees who lack the basic knowledge on health (see annex 2). The first batch of CSBA training was taken place in LAMB hospital from December 2008 to June 2009. The SMPP had a contract with OGSB to conduct CSBA training at LAMB hospital. Here, the OGSB role was coordination and monitoring & supervision of the training program. The second batch was organized in Kumudini Hospital from April to November 2010. This time the SMPP had a direct contract with the training institute without support of the OGSB as coordinator. For both batches, the SMPP covered the costs of CSBA training, however, the payment was made through OGSB for the first batch and was directly paid to the training institute for the second batch as per the contracts state.

4.5 Development of reporting & monitoring system of P-CSBA

JICA provided necessary technical assistance to ensure regular reporting & monitoring of P-CSBAs (see annex 3). The P-CSBA reporting and monitoring included the monthly performance of P-CSBAs and regular meeting with FWV/FWA and Union Parishad, which was crucial to ensure the quality of services provided by P-CSBA and enhanced linkages between P-CSBAs and MoHFW. In this respect, P-CSBAs received an orientation on reporting, monitoring, and GoB health delivery structure and system after the 6 month CSBA training.

4.6 MoU between Union Parishad and P-CSBA

MoU was signed between Union Parishad and individual P-CSBA after the completion of CSBA training (see annex 4). The MoU clearly states that P-CSBAs have to reside their community in the Char and regularly provide the services. The P-CSBAs can charge the service fees determined by the UP (e.g., for ANC/PNC 30-50 Tk and for normal delivery assistance 300-500 Tk). However, if the clients are poor, the service fee should be exempted. The UP has to ensure enable environment and necessary supports for P-CSBA. There was signing ceremony organized by the UP and promotion of use of P-CSBA services in the community. The P-CSBAs were also encouraged to work closely with Community Support System (CmSS) if available.

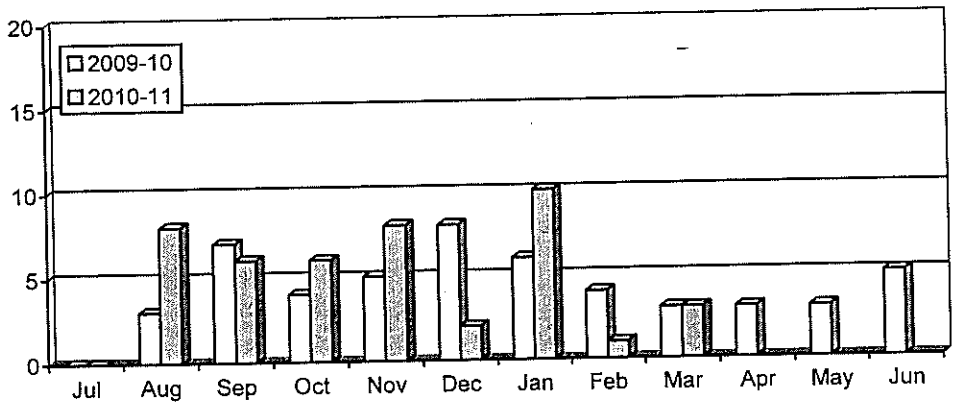
4.7 Implementation of private CSBA activities in Char

P-CSBAs started their activities in the community immediately after completion of CSBA training. Around 6 months later after the training, formal certificates of CSBA were issued by Bangladesh Nursing Council to all P-CSBAs. In order to provide necessary technical support, the SMPP hired one midwife as a Technical Officer in July 2009. She visited all P-CSBAs every month during the first three months and observed their service delivery and provided on the spot technical advices. She also provided telephonic technical assistance whenever P-CSBAs faced difficulties. Those supports were recorded and compiled as a monthly report along with P-CSBA performance reports. Since the initiation of services, P-CSBA' activities were hampered due to not being part of Demand Side Financing (DSF) program. However, after continuous requests and discussions with GoB managers, finally the decision was made to include the P-CSBAs in the DSF program from September 2010. Since then, the performance of P-CSBA has been increased noticeably. The implementation of this pilot continued for three years and a half year refresher and review sessions were organized to provide additional technical sessions, discuss their common problems in the field, and compile the experiences of the initiative. There were awareness raising sessions on P-CSBA combined with ANC/PNC campaign organized by Union Parishads in December 2010. In this occasion, any problems encountered in the community were discussed and necessary actions were decided.

5. Performance of P-CSBA

The performance of the P-CSBAs as a whole shows a rising trend as shown in the following figures. It is evident from the figures (Fig 1-5) that utilization of P-CSBAs for ANC, PNC and normal delivery services have substantially increased. In 2010, the P-CSBAs provided more than 2,600 ANC, and 775 PNC to the pregnant and post-partum women, which is almost three times of the previous six-month period (Fig 1). Total number of deliveries assisted from January to March 2011 is 256, which is almost equal (262) to the total number of deliveries assisted from January to December 2010 and three times compared to the previous six months (Fig 1).

Fig 6. No. of women refered by PCSBAs by month (Batch 1)



However, it should be noted that the number of P-CSBA has been increased from 11 to 19 since November 2010 due to the second batch P-CSBA joining in the field. The significant performance increase of 2011 demonstrated in the graph 1 is also attributed to the increase in the number of P-CSBA itself.

Fig 2. No. of ANC, delivery and PNC conducted by PCSBAs (Batch 1)

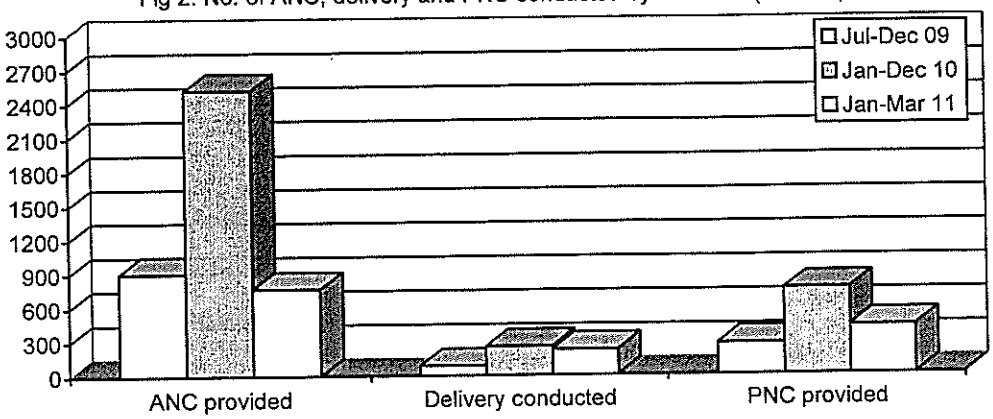


Fig 3. No. of ANC provided by PCSBAs by month (Batch 1)

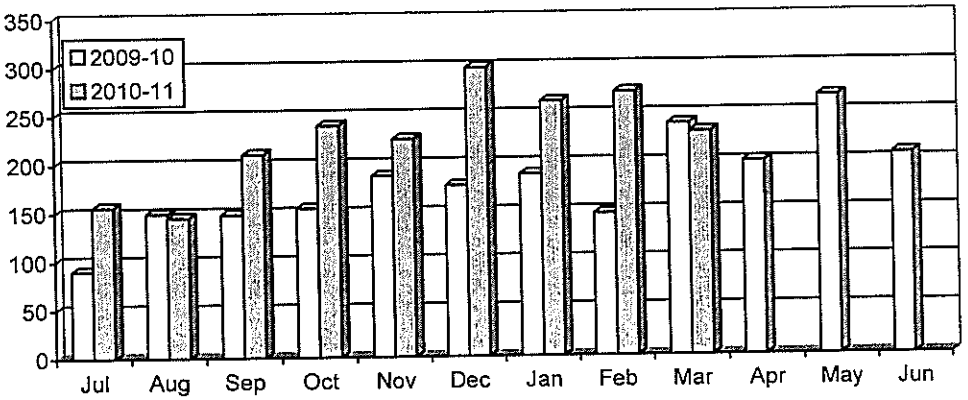


Fig 4. No. of PNC provided by PCSBAs by month (Batch 1)

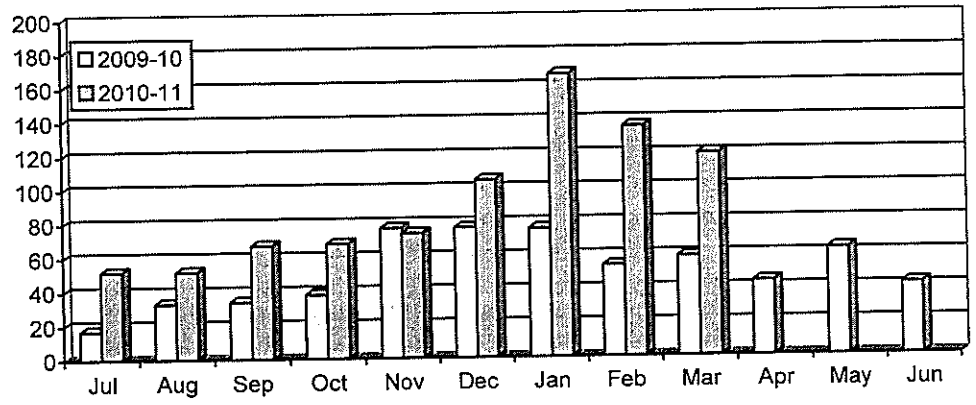


Fig 5. No. of deliveries assisted by PCSBAs by month (Batch 1)

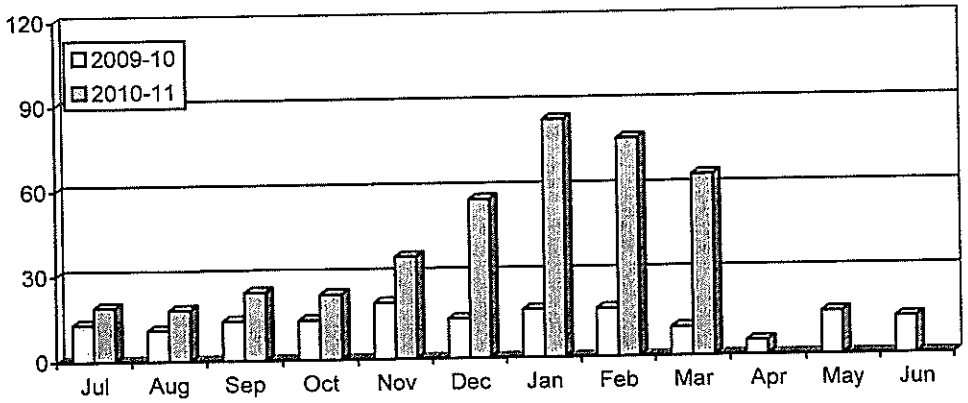
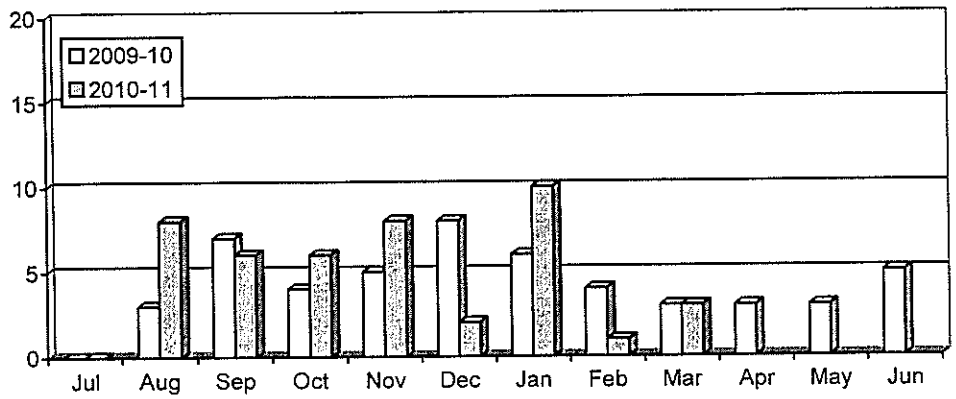


Fig 6. No. of women refered by PCSBAs by month (Batch 1)



6. Comparison between P-CSBA and GoB CSBA

SMPP attempted to compare the performance and knowledge level of two types of CSBA: GoB CSBAs and P-CSBAs. For this purpose, Evaluation of the Community Skilled Birth Attendant Programme Bangladesh (October 2010) financed by UNFPA was utilized to understand the GoB CSBA part and the information collected through interviews by SMPP was used for P-CSBA.

Performance:
According to UNFPA report, the average numbers of ANC, delivery, PNC, and referral provided by GoB CSBA during April 2009 to March 2010 are: 137, 23, 39, and 5, respectively. Similarly, the average numbers of ANC, delivery and PNC provided by P-CSBA in Narsingdi during January to December 2010 are: 229, 23, and 69, respectively.

The weak areas in knowledge:
Both types of CSBA showed weakness of knowledge in the areas of PNC and neonatal care including emergency care. This is mainly because the 6 month CSBA training curriculum does not cover these topics adequately. The GoB organizes the additional training to fill up this gap. However, the number of the CSBA received this additional training is still low. SMPP organized refresher session for P-CSBA giving the focus on PNC, essential neonatal care and newborn resuscitation. The UNFPA report found that the skill of partgraph is not satisfactory. GoB CSBA showed insufficient knowledge on 5 danger signs and referral (how and where to refer) while P-CSBA demonstrated satisfactory level of knowledge on the same topics.

7. Constraints of P-CSBA

The P-CSBAs have faced some problems while working in the community. The following constraints need to be solved if the performance of P-CSBAs is expected to be improved.

- Many of the community people think that the P-CSBAs are government staffs, and they will provide home service free of charges. It is also believed that the P-CSBAs are obligated to attend any delivery anywhere any time. In fact, the clients are reluctant to pay for most ANC/PNC services provided by P-CSBAs. Without proper remuneration it will bc difficult to ensure services of the P-CSBAs in the community.

- The P-CSBAs were supplied some instruments (BP machine, Stethoscope, thermometer, baby weighing scale, rubber sheet, mackintosh etc.) and drugs (inj. oxytocin, inj. magnesium sulphate, I/V fluid, etc) after the 6 month training by the SMPP. However, there will be no additional supply of necessary drugs or replacement of out of order instruments.
- The P-CSBAs were instructed to submit report to FWV of the respective union, but there had been a lot of problems in complying with the instruction. Recently, in meeting with the UFPO and MO-MCH all the P-CSBAs were given instructions to submit the reports to the statistician for a smooth compilation and avoid any dispute.
- A number of the P-CSBAs are unmarried and not well accepted by the community.
- One of the barriers for performances of P-CSBAs was the DSF program in the area. As the clients were not entitled to get benefits from DSF unless they took services from the enlisted service providers, client turnover was low. However, the first batch of P-CSBAs has been included in the DSF project since September 2010 and the performance has sharply increased after that. The second batch will be included in the DSF from July 2011.
- TBAs played a rival role because of conflict of interest.
- Providing services, especially at night, is not always easy for P-CSBAs because of security and lack of permission from the family members.

7. Lessons learned

The P-CSBAs were selected from the community in a participatory way involving the Local Government (LG) and Ministry of Health and Family Welfare (DGHS and DGFP). All the potential candidates were informed, before being selected for the training, about their responsibility, placement after training and benefits. They were also informed that, neither the project nor Government or LG would provide any monthly remuneration to them. They will have to earn their wages through providing services and satisfying the clients. The LG, however, fixed the fees for services to the community. All these activities helped the P-CSBAs motivate for the training and subsequent retention in the project.

Initially, the project was skeptical about effectively training the candidates as CSBA as they did not have any previous work experience either in the health or other sector. As such, a one-week orientation on PHC was designed and implemented by the project (before the actual CSBA training) to make them understand the health service system and field activities of health and family planning sides. Such orientation also acquainted them with some of the medical terminologies used in the CSBA training and was helpful to the trainees and trainers in building their confidence.

Not significant differences are identified between the GoB CSBA trainees and private trainees by the trainers. The GoB trainees have more knowledge on the health issue in general and are more familiar with medical terms compared to the private ones. However, this difference was minimized after the training progressed and the private trainees were found to have a relative advantage of being better educated and younger.

The project appointed a technical officer to closely monitor and support the P-CSBAs during training as well as in the field, in addition to the monitoring by the OGSB. Close monitoring and

support (24-hour support through cell phone) particularly in the field was very much helpful to the P-CSBAs in confidence building and providing services in the community.

The project provided all the P-CSBAs with a register and reporting format. P-CSBAs submit their reports to SMPP, government as well as to the LG. The project periodically (quarterly) compiles the report and gives feedback to the trainees. This helps them to compare their own performance over time as well as performance compared to their other colleagues, and was helpful in encouraging them to improve their performance.

The P-CSBA initiative was well taken by both the DGHS and DGFP officials. It was recognized as an effective strategy to address needs of remote areas like Char where the GoB field workers are hardly available. There are two kinds of P-CSBAs exist in Bangladesh: one is the SMPP model, which the P-CSBAs are from the community and supported by the Union Parishads, and the other model is P-CSBAs who are staffs of local NGOs (e.g., BRAC and ICDDR,B). The former P-CSBAs are permitted to charge the service fees from the clients while the later P-CSBAs get fixed monthly salary from the employed NGOs instead of charging for services. Both arrangements have advantages and disadvantages. It is worth analyzing both types to draw the recommendations.

Among 11 first batch P-CSBAs, one applied to FWV recruitment and got the job June in 2011. Another got married and moved to Dhaka so that she stopped practicing. Two set up their own shops to provide static MNH services to their clients.

Joint UN MNH Initiative started to train community health volunteers as CSBAs from April 2011. Those volunteers are similar to the P-CSBA of SMPP in terms of their background. This case tells us that the P-CSBA of SMPP was recognized by the UN as a good practice. It can be regarded as an impact of P-CSBA of SMPP.

8. Recommendations

- The P-CSBAs need close monitoring and support in the field. This is being provided by the technical officer appointed by the project. As the project will close in June 2010, monitoring responsibility should be handed over to the government.

- UP and CmSS can be involved to promote further utilization of P-CSBAs by the community. The UP and CmSS should play the role of problem solving if the P-CSBAs face any non-technical problem in the community, such as negative propaganda by the TBAs, security issue etc.

- Mechanism needs to be developed so the P-CSBAs are automatically enrolled in the DSF program after getting registration from the BNS. This would require negotiation and advocacy at central level.

- The P-CSBA performance data should be integrated with the government CSBA data for reporting to the district and central level.

9. Conclusion

The P-CSBA initiative has gathered attentions of GoB officers and project managers in Bangladesh. It was in general regarded as a good practice to address the needs of MNCH care in the remote areas. However, it should also be recognized as a transitional measure to respond immediate needs of the people in the remote areas and should not be a long term solution. As the GoB decided to develop internationally qualified midwives, we should support this policy direction, not producing another cadre of service providers in where there is not enough justification to do that.

Attachment1

Proposal on the Refresher Course for Master Trainer Training

Community Clinic Project in Bangladesh

2011/06/27

Safe Motherhood Promotion Project (SMPP)
Satoko Kurata-Kinugawa, Short-term Expert on Training, JICA

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1. Structure of the Training Program for the Refresher Course of Master Trainer Training

1.1 Training Needs

The "Training of Trainers" course for Community Group Trainers was conducted on August 22, 2010. The participants (both GoB and NGOs such as CARE, Plan, BRAC, etc.) in this training are called "Master Trainers," and received 1-day orientation mainly on Community Group Management Guidelines.

However, it was found that the training needs regarding practical issues such as "how to develop, and facilitate Community Groups (CGs)" and "methodologies of resource mobilization" were not sufficiently met. Therefore, the Refresher Course was planned to provide mainly practical knowledge and skills relating to the development of CGs. It also aims to take advantage of established Community Support Groups (CmSGs) in Narsingdi District of SMPP as a hands-on learning resource.

It is also necessary to support the Master Trainer's role in developing many field trainers. Master Trainers are expected to train/ give orientation to not only local authorities at District and Upazilla level, but also train field trainers who will develop CGs. It is very necessary to train enough numbers of field trainers to serve 13,500 CGs that manage 13,500 Community Clinics (CCs) nationwide.

1.2 Flow of the Training Program

An NGO meeting is going to be held in the first week of July 2011. The following issues, for example, need to be discussed for better implementation of the Refresher Course (hereafter " the Course").

- Finalization of the training program including the Course
- Criteria and process of participant selection
- Framework of course assignment (Work Plan, non-theoretical facilitation tools)
- Process and methodologies of evaluation

The "Refresher Course" will be conducted for three days: 2 days in Dhaka, 1 day in the field in Narsingdi. In-class evaluation is going to be implemented.

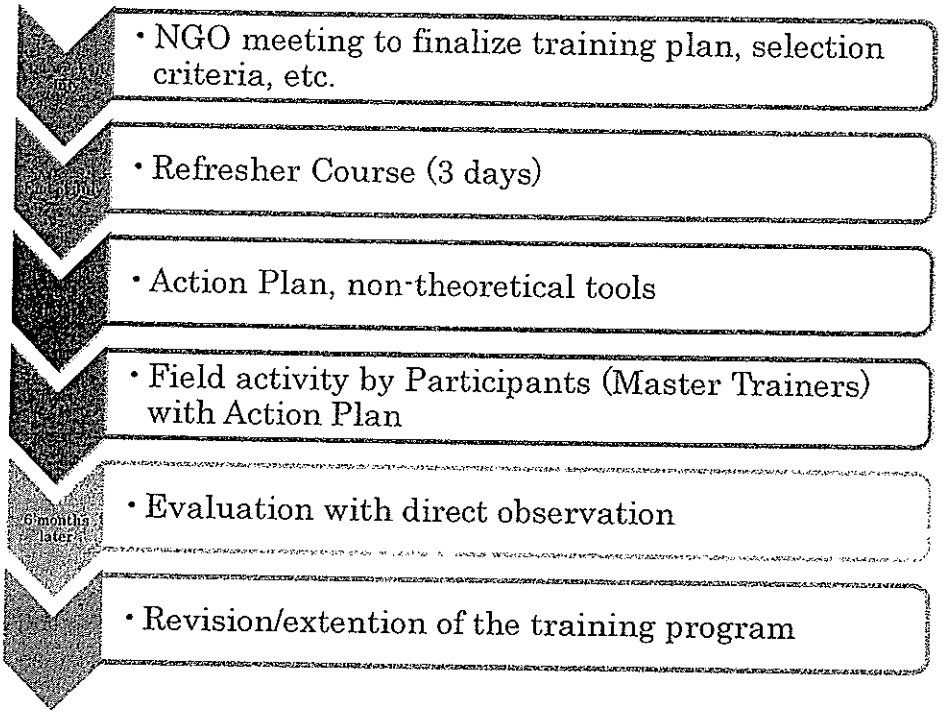
The participants (Master Trainers) submit their "Action Plan" and any non-theoretical tool (graphics, charts, objects, short story, etci.) for the easy tools for community facilitation, for two to four weeks after the training (the deadline will be discussed later.). The SMPP, the trainers of the Course, the Community Clinic Project (CCP) officer, will evaluate and give comments/advice. The Master Trainers will start their field activities based on their Action Plan.

All the output of the course (energizers, analysis, findings, non-theoretical tools), produced by the experienced-Master Trainers, can be compiled in a handbook. It will be the rich resource for community facilitators.

About 6 months later, the evaluators (needed to be identified: from the SMPP, the trainers of the Course, the CCP) of the Course would assess the participants' performance, by interview and by direct observation of the ex-participants' in the field. It may be either facilitation of the CG members, or training of field trainers in their respective organizations. The evaluators will provide useful feedback for further improvement.

The Refresher Course, along with Training of Trainers will be revised based on the findings of the evaluations. It also will contribute some suggestions for further improvement of all of the training programs / capacity development processes of the CCP.

Chart 1 Flow of the Training Program for the Master Trainer Refresher Course



2. Special Attention for Designing the Course

2.1 Initial Focus on Capacity for Community Facilitation

The Master Trainers who participate in the course are required to develop CGs directly as well as to develop numbers of field trainers in their organizations who follow to develop CGs nationwide. However, as the course is planned for only three days, it is better to focus on building the capacity for community facilitation. Next, after accumulating field experience of CG development, some learning opportunities to provide necessary skills for developing field trainers for CGs should be organized.

2.2 Practical Skill Training Components

The Course contains several components for the practice of facilitation skills. The participants are given the chance to be the facilitators in front of the fellow participants. Exchange of energizers is also planned. In this process, the participants will learn from each other, as they are rather skilled facilitators.

A field visit to Narsingdi District where the SMPP developed a Community Support System (CmSS) with CmSGs is part of the course.

2.3 Capacity for Community Group Development

It is necessary to strengthen the participants' capacity of facilitation in general as well as to strengthen their capacity of meeting specific facilitation needs for CGs.

Rich field experience of the development of numerous CmSGs in Narsingdi District is a model to apply. However, the CGs have some differences in terms of:

Formation Process
Members
Roles
Activities

Probably, the largest difference between CmSGs and CGs is that

a) CGs need to manage the facility (CC),

b) CGs consist of a wide range of members with designated social roles/titles.

Therefore, the course needs to provide the participants with the chance of clarification: what specific roles and strategies would be effective to develop CGs?

3. Outline of the Course

3.1. Goals, objectives, target of the Course (participants), expected outcomes.

Goals, objectives, target of the Course (participants), expected outcomes, etc. are shown in the following table.

Table 1 Outline of the Refresher Course for Master Trainers

Category	
Organizer/ Fund	SMPP II
Target	Participants are:
Number	25 – 30 participants (for the first batch)
Expected role of participants after the Course	-Trainer for Training at Union level: CG members, -Trainer of field trainers for CG members capacity development , and possibly, -Trainer for Orientation at District level: training for DGH/DGFP + NGOs, UH/FPO -Trainer for Orientation at Upazilla level: UNO, Upazilla Chairman, all Union Chairmen
Organizational	-Mainly NGOs

background	and possibly, -Government trainers (DGHS/FP), -Retired government trainers, who would have field experience of community mobilization and are willing to commit to the Community Clinic (CC) project.
Required background	Experience in adult learning. Experience in working with community people (length should be fixed). Participation in Master Trainer Training (1-day orientation) in August 2010, or have enough knowledge on CG management guideline. (Some new participants who did not attend last August may be included.)
Trainers	SMPP Master Trainers (JICA, CARE), SMPP District Manager/Officer of Narsingdi District, PLAN, PSTC(NGO), CCP officer, NIPORT officer
Duration	3 days: 1st day, 3rd day—seminar, 2nd day—field visit to Narsingdi
Program	Course plan is shown on the attached sheets.
Goal	Strengthen capacity to facilitate formation of Community Groups (CGs) by sharing the practical know-how of developing Community Support Groups (CmSGs) in SMPP. By understanding the process of CmSG development, as well as by comparison of CG and CmSG, the participants will learn what capacity they should develop with CG members who are expected to develop CmSGs.
Objective	See the following pages.
Plan of execution	● First batch: the end of July 2011. ● Need follow-up meeting/workshop to share experience after this course. ● Additional batch of the Course or further revision of the Master Trainer Training including Refresher Course would be made based on evaluation. (see "4. Evaluation" chapter).
Output required	Action Plans, non-verbal tools for community facilitation to develop CGs. Required to submit to CCP within 2 – 4 weeks of the Course completion. (fixed later)
Venue	1st day & 3rd Day seminar: CC Project meeting room 2nd day field visit: SMPP office in Narsingdi, CmSG, CC in Narsingdi
Evaluation	A short-term and long-term evaluation of the training results is going to be implemented. See more details in "4. Evaluation" chapter.

The structure of the goals and objectives are shown in the following charts:

Chart 2 Structure of the Training Goals

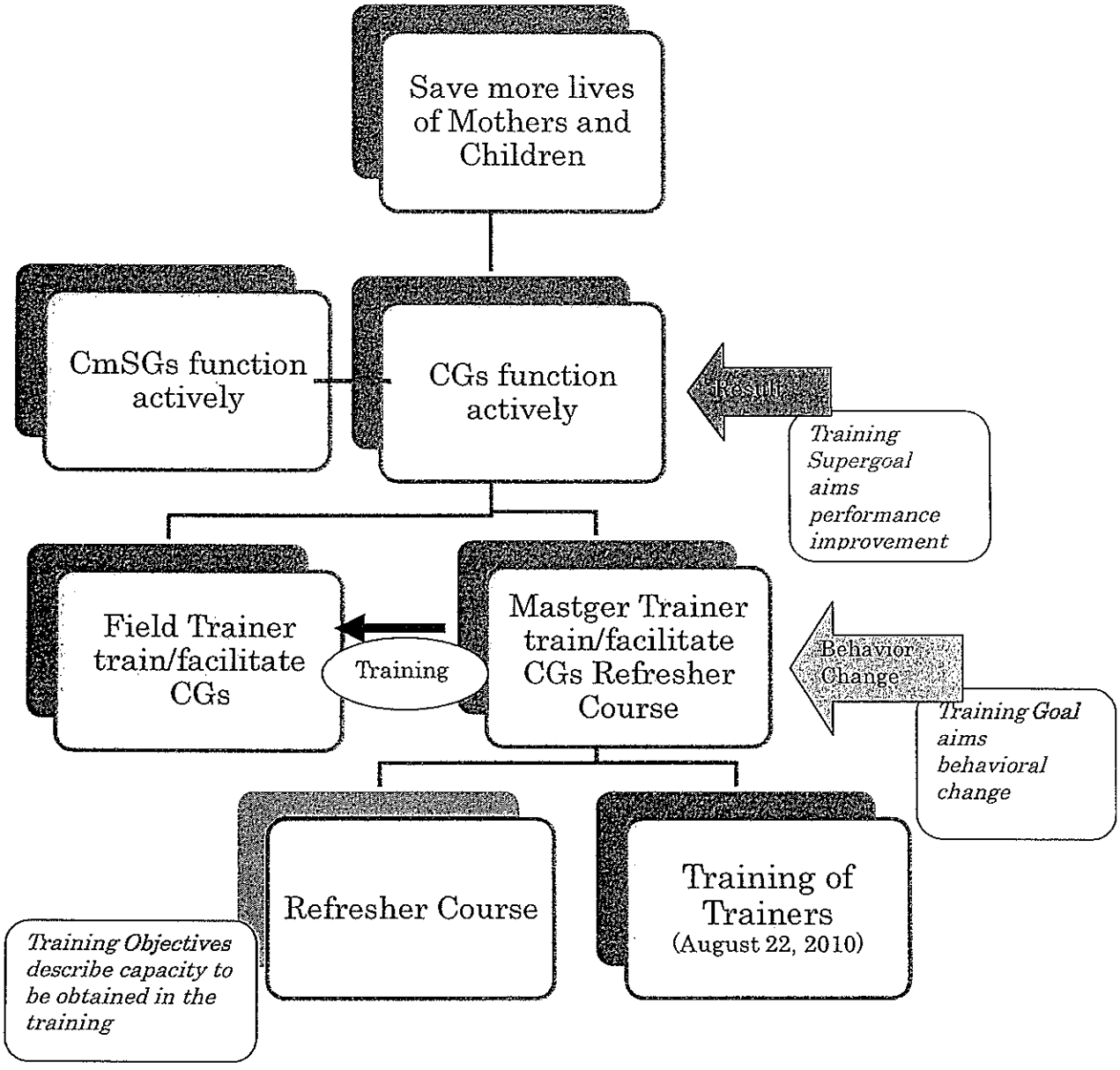
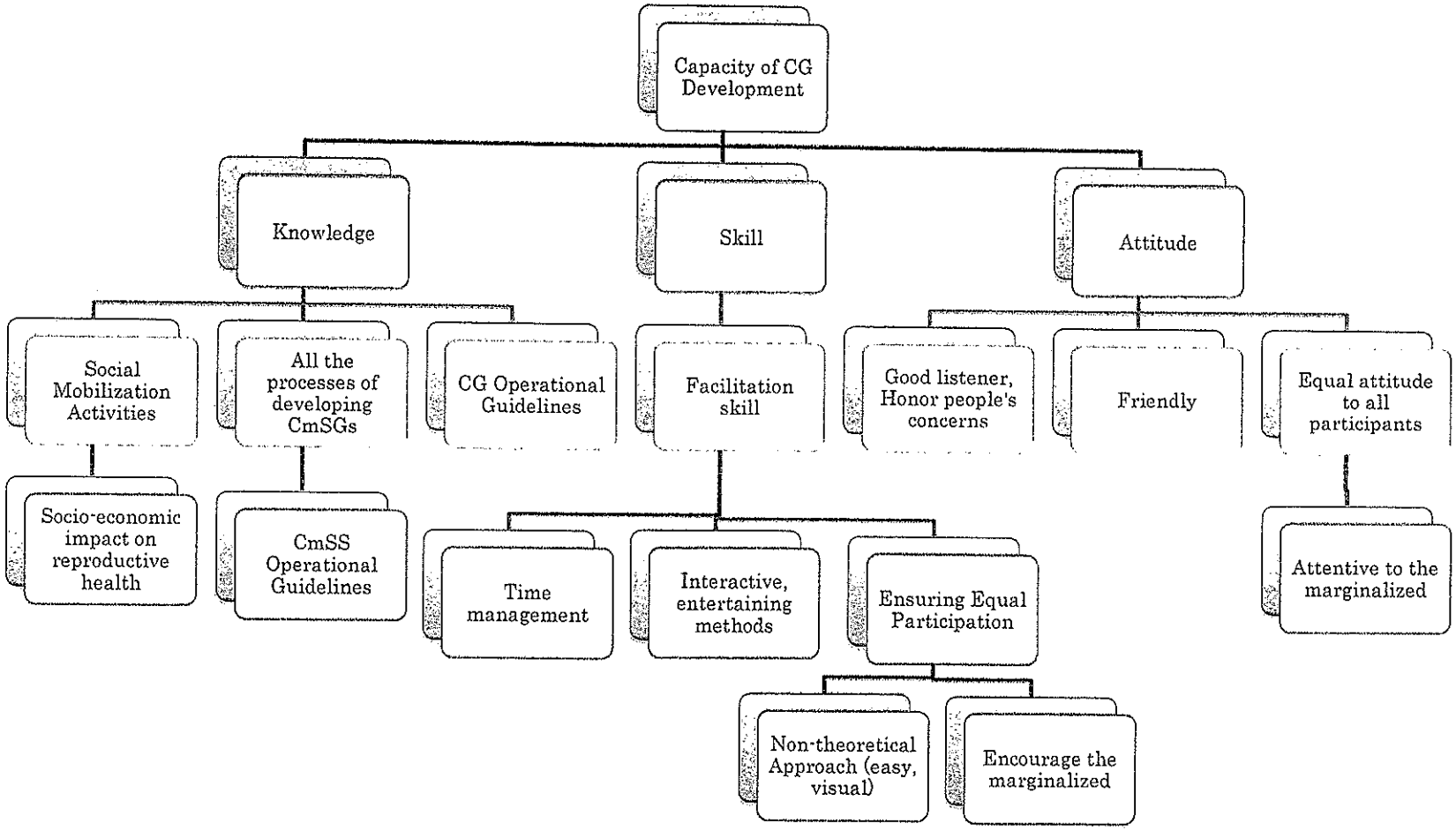


Chart 3 Structure of the Objectives: Capacity of Training & Facilitating CGs



Course Plan

See the attached sheets.

4. Evaluation of the Course

The evaluation for this Refresher Course can be implemented as follows:

The findings can be useful to revise the Course, as well as improve other training components of the Community Clinic Project. Particularly the findings would contribute to designing the training for the CGs.

- In-class evaluation to measure "reaction" of the participants.
- In-class evaluation to measure "learning" of the participants.
- Action Plan, and Non-theoretical tools for facilitation can also be a part of the evaluation. They are submitted two to four weeks after the Course. They can also be a source of information to assess the "learning" of the participants.
- Six months later, evaluation to measure "behavior change" of the participants can be done by interviews and direct observation of the participants' performance in the community. Comparison of the progress and plan of action is to be discussed.
- It is recommended that the organizers/trainers of the Course hold a workshop to share experience of the participants/evaluation findings. The output of the workshop can be utilized to plan supplementary support to the participants as well as to revise the Course.
- Later than the workshop, about 1 – 1.5 years[1] after they have started activity based on the Action Plan, the performance of the CGs that the participants (Master Trainers) have been developing would be evaluated. However, 1.5 years may not be enough to see the result: CGs are required to develop two or three CmSGs in addition to their functions. This is the difference between CGs and CmSGs. The findings would give feedback to see the training program's contribution in CC projects.

[1] In most of the cases of CmSGs in Narsingdi, it was found that the community-based group would be functioning after 1.5 years of establishment.

Table 2 Framework of evaluations of the Refresher Course based on Kirkpatrick's Model

	Level	What to evaluate	Example of Indicators
1	Reaction	Satisfaction, Understanding	-Level of satisfaction regarding training contents, methodology, learning materials -Level of understanding on the process of developing CmSGs/CGs. -Level of understanding on social mobilization -Level of understanding about necessary skills and attitude for the Master Trainer for CGs -Level of sympathy to necessary attitude
2	Learning	Knowledge, Skill	-Level of knowledge about CG guidelines, CmSG operational guidelines -Level of facilitation skill -Quality of Action Plans, non-theoretical facilitation tools -Willingness to apply learning in the field
3	Behavior	Change of action, Application of skills[2], Motivation	-Level of knowledge about various process of developing CGs/Costs in reality -Actions (intervention, facilitation) for the CGs -Level of facilitation skill -Level of accountability -Attitude toward CG/CmSG members -Degree of motivation -Number of field trainers the participants trained, and their performance
4	Result	Change in organizational performance	-Number of established CGs/CmSGs -Performance of CGs such as: -Output of CGs/CmSGs (situation analysis, map, annual plans, funding,

[2]Minor modification included based on Jack J. Phillip's Model.

			birth planning sessions, etc.) -Operational efficiency of CCs -Establishment of liaison with local stakeholders, etc.

5 Suggestions

5.1 Learner-oriented Approach for Trainers' Training

5.1.1 Training methodology

Training courses can be designed with various participatory methodologies so that the participants can enjoy them and learn effectively. As NGOs in Bangladesh have rich field experience of facilitating people at the grass-roots level, non-theoretical methodologies such as energizers, simulations, role-plays, mapping, non-theoretical facilitating tools can be utilized in trainers' training too. Trainers' training would be more beneficial when such hands-on skills are incorporated with sufficient time allocation.

5.1.2 Learning material

Learning material such as the trainers' guide for the "Community Group Training Module", published in December 2010, available both in Bengali (printed hard copy, attachment) and in English (digital document soft copy), can be more user-friendly with a table of contents, more graphics/photos/illustrations and a more visually attractive layout (including use of bold or italic fonts, various types and sizes of fonts, borders, highlights, and an index).

Particularly graphics are the powerful tool to understand complicated issues and concepts at a glance. In addition to a few graphics in the above "Community Group Training Module", flow charts (for the description of processes), Venn diagrams (for the description of organizations/stakeholders), or illustrations of CG members or CC users will make the learning material more attractive.

5.2 Capacity Development for Development of Field Trainers

After accumulation of CG development experience by Master Trainers after

the course, it is recommended to share the results to help other field trainers to develop more CGs nationwide.

To increase competency of the field trainers who support CGs to become functional and sustainable, mentoring by the Master Trainers would be very effective. The Master Trainers in each NGO can develop, and share, the mentoring system for field trainers.

5.3 Strengthening Learning Processes in CC Projects

Workshops or forums can be held from time to time to share the field experience of CG development and examine lessons learned. Facilitator's handbook with compiled outputs of the Refresher Course with participants' non-theoretical facilitation tools, case stories, can be published as the products of this learning process.

In this process, the evaluation output, particularly the "results" perspective needs to be incorporated and discussed. It would improve the CC project itself.

Course Plan of the Master Trainer Refreshers'Course for the Community Clinic Project

Time	Day 1	Resource person/ Facilitator	Day 2	Resource person/ Facilitator	Day 3	Resource person/ Facilitator	Time
9:30	Opening, Course Orientation (including Self-Assessment*)		Move to Narsingdi District. Team A and Team B visit to the different Community Support Groups(CmSGs).	Course Facilitators and SMPP officers in charge of the respective CmSGs, CGs	Fishbowl (4): Review of the Field Trip	2 participant-facilitators	9:30
9:45							9:45
10:00	Energizer for introduction of participants, Ground rules of this course, "What is a good facilitator?"	Course Facilitator (C.F)	Observation of CmSG-Monthly Meeting		What are the factors for successful (functional) CmSG? How the field trainer facilitated? Implications for facilitating/developing Community Groups (CGs)?	C.F.	10:00
10:15							10:15
10:30			Interview to field trainers, CmSG members				10:30
10:45			Monitoring Practice in CmSG -Team A				10:45
11:00			Mapping Practice in CmSG - Team B		*Tea Break*		11:00
11:15	*Tea Break*		Move to Upazilla/Union office, or SMPP Narsingdi Office				11:15
11:30					Case Study (1): Development of a CG in a union where CmSGs are established	C.F.	11:30
11:45	Fishbowl (1) (2): "What is the CG like?"	C.F.	Discussion on the effective liaison with CmSG and the UP, UH/FPO, HA/FWA, HV/FWV, etc.				11:45
12:00							12:00
12:15							12:15
12:30					Presentation and Discussion	2 participant-facilitators	12:30
12:45	Review of CG guideline	C.F.					12:45
13:00	*Lunch*		*Lunch*		*Lunch*		13:00
13:15							13:15
13:30							13:30
13:45							13:45

14:00	Group discussion + sharing: "What are the Field Trainer's roles and strategies to develop CGs?"	C.F.	Observation of Community Clinics (CCs) with CG If possible, separate Team A/B. Interview to field trainers, CG members. Discussion with CG members.
14:15			
14:30			
14:45			
15:00	Sharing the Experience of CmSS	C.F., SMPP officer	Leave Narsingdi District to Dhaka
15:15			
15:30			
15:45	Orientation of Field Trip	C.F., SMPP officer	
16:00			
16:15	Fishbowl (3) What to find in the field trip?	2 participant-facilitators	activity :field trip
16:30			

Case Study (2): Development of CG in a union where there is no CmSG	C.F.	14:00 14:15 14:30 14:45
Presentation and Discussion	2 participant-facilitators	15:00 15:15
Break		15:30
Orientation for Assignment	C.F.	15:45
Course Evaluation, Self-Assessment		16:00
Closing		16:15 16:30

[Remarks]

1.Prerequisite of the participation of the Refresher Course: (to be fixed)

a) Participated in the August 2010 Orientation (T o T) for the CG management Guideline

b) or, Have enough knowledge about the CG guidelines

c) Community facilitation experience for more than 3 years (=or, adjusted by SMPP.)

2. Self-Assessment: provide a chance to evaluate the participants' competency in developing CGs. Acquire some ideas for further improvement.

3. Energizer exercise

A short energizer can be done by any participant, at the beginning of a session. Compile them later as a rich resource for facilitation.

4. Assignment: 2 - 4 weeks after the Course (deadline to be fixed)

a) Action Plan for developing the CG(s) in the assigned area. The goal should be discussed beforehand: e.g. "until the CG become more or less independent"

b) Produce any non-theoretical tool (any graphics, charts, objects (e.g. dolls), short story, etc.) to use for development of CG.

5. Product of the Course

Compile all the output of the Refreshers' Course including duplication of good non-theoretical tools and make a handbook for the Master Trainers.

Process	Title	Purpose	Contents/Activities	Material
1	Course orientation	Orient the participants for training goals, objectives, contents, assignments.	Refreshers' course program with training goals, objectives, contents, assignments (action plan submission), follow-up activities.	Handout, Self-Assessment Sheet
2	Introduction	Getting to know each other	Energizer for getting to know each other	Name tag, any necessary materials for the energizer
	Ground Rules	Creating comfortable learning environment	Listing ground rules proposed from participants.	Flip chart, markers, masking tape
		Tools to ensure participation	(Participants will contribute one or two ideas for ground rules during the course.)	
	What is a good facilitator?	Have a clear idea of "facilitation".	Course Facilitator draws a mind-map with "what is a good facilitator" in the center. Ask the participants, then write their responses, relating to the center, like a web.	Flip chart, markers, masking tape
3	Fishbowl (1) (2)	Facilitation Practice	*see the [Fishbowl] page.	Flip chart, markers, masking tape
		Understand the features of CG	Course Facilitators prepare the flipchart paper with the *table 1	Flip chart papers (on the board) with table 1 written
			C.F. also fill the table based on the discussions of "Fishbowl."	markers, masking tapes, timer or bell
4	Roles and strategies of Field Trainers to develop CG	Identify specific Field Trainers' (=Master Trainers') competency to develop CGs	Group discussion (2 groups, 30 min.) and sharing (30min.) on "What are the roles of Field Trainers to develop CGs?" "What are the effective strategy to develop CGs?"	Table 1 flipchart, cards(adhesive or with masking tape/glue), markers
			Work in Team A/B. Brainstorm writing one issue on one card. Compile in the team. Categorize the similar cards.	
			At the presentation, the presenter put the produced cards on the Table 1 on the board, responding to the proper items on Table 1.	
5	Sharing CmSS Experience	Understand the features of CG in the perspective of similar community mobilization program CmSS	Information of the CmSS: outline of the system and the result	Video of CmSS, Operational Guidelines on CmSS
			Understand the CG in comparison with CmSS. C.Fs show the table 2 (prepared beforehand) side by side of Table 1.	Flip chart papers (on the board) with table 2 written , masking tape.
			Inform the participants that they will revise the Table 1 after the field trip.	
6	Orientation of Field Trip	Orient the participants for field trip objectives and program		Flip chart, markers, masking tape
		Facilitation practice	*see the [Fishbowl] page.	
		Orient the participants to objectives and contents of the field trip	Information about Field Trip: objectives and program, etc.	

Process	Title	Purpose	Contents/Activities	Material
7	Fishbowl (3)	Orient the participants what to learn from field trip	Participants will list up and share perspectives, questions for getting clues, necessary visitors' manner by brainstorming. *see the [fishbowl] page. Mind-set for making a rapport with the community people.	Flip chart papers on the board, markers, masking tape

Process	Title	Purpose	Contents/Activities	Material
8	Visit to CmSG	Understand CmSG by direct observation & interaction	30 minutes of observation and interview.	C.F., or note taker takes photo and notes
		Practice facilitation with CmSG members	2 participant-facilitators (main and sub facilitators) become play the role of the field trainer. Facilitate their meeting, for example, on monitoring and evaluation, or briefing of CG .formation,etc.	
			The CmSG members give evaluative comments to the participant facilitators	
9	Discussion with stakeholders	Understand the relation of CmSG and stakeholders in the Upazilla/Union	Briefing on how to support, coordinate the CmSG, CG, CC.	C.F., or note taker takes photo and notes
		Find an efficient/effective way to work with local stakeholders	Interview & discussion on the local stakeholders' view on coordination, expectation to the Field Trainers.	C.F., or note taker takes photo and notes
10	Visit to CC, CG	Understand CC, CG by direct observation and interaction	30 minutes of observation and interview.	
			2 participant-facilitators (main and sub facilitators) become play the role of the field trainer. Facilitate their meeting, for example, on monitoring and evaluation using the "Community Monitoring Score Board (the typical format)	
11	Fishbowl (4)	Reorganize the field trip findings	Participants will review the findings from the field trip. *see the [Fishbowl] page.	Flip chart, markers, masking tape
		Facilitation practice		
12	What are the factors for successful CmSG? How the field trainer facilitated? Implications for facilitating/dev	Have a clearer idea what roles and strategies are effective to develop CGs	Display the Table 1 with cards of CG-Field Trainers' roles and strategies. The C.F. can encourage the participants supply additional cards with useful strategy to develop CG, based on the findings from the field trip.	Table 1 flip chart with roles/strategy cards.Additional cards (adhesive or with masking tape/glue) to add.
		Motivate the participants to make commitment		
13	Case Study (1)	Make simulation of the process of CG development	C.F. distributes and read the story of the case (with CmSG)	Handout with case story information
		Preparation for Action Plan Making		
14	Case Study (2)	Make simulation of the process of CG development	C.F. distributes and read the story of the case (without CmSG)	Handout with case story information
		Preparation for Action Plan Making		
15	Orientation for Assignments	Orient the participants to expected assignment	Explain the required information of the action plan with/without a format.	Action plan format?

Process	Title	Purpose	Contents/Activities	Material
			Explain what the "non-theoretical tools" for facilitation are.	Sample tools such as illustration or flip chart, etc.
		Encourage the participant to produce output.	Deadline, format, methodology/process of evaluation for assignment will be explained.	
16	Course evaluation; Self-assessment	Evaluation of the reaction & learning.	Written questionnaire on course evaluation and self-assessment. Self-Assessment can be done in the same format by the same person to assess improvement and needs for further improvement.	

*Table1

Outline of CG

Index	Summary of description
Role	
Members	
Process of Development	
Activities	
Relationship with stakeholders	
Extension(= Development of CmSGs, CGs)	
Any other issue	

*Table 2

Outline of CmSG

Index	Summary of description
Role	
Members	
Process of Development	
Activities	
Relationship with stakeholders	
Extension(= Development of other CmSGs, federation of CmSGs)	
Any other issues	

[Fishbowl: a practice of facilitation skill]

1 Divide the group into 2 small groups (10 - 15 persons); Team A& B.
2 Team A sit in a circle, and Team B sit in a circle outside the Team A circle to observe them.
[Team A is the "fish" in the fishbowl to be observed by Team B.]
3 Team A appoint a main facilitator and a sub-facilitator among the members.
The sub-facilitator can make a record of discussion on a flip chart, etc., as a part of helping the main facilitator.
4 Team A starts a discussion about an agenda for 15 minutes.
One member in Team B becomes a time-keeper.
5 The facilitator with the help of sub-facilitator "facilitates" the meeting.
6 Team B observes how the facilitators of Team A facilitate the meeting.
7 After 15 minutes, Team A stops discussion.
8 Team B gives feedback about how Team A facilitators facilitated, and how the members participated for next 15 minutes.
9 Next, Team B can sit inner circle and do the same process with the same/different agenda.
10 Team A gives feed back, as Team B did for the first run.

*For the Fishbowl (3) & (4), two volunteers from the participants can play the Course Facilitators' role to manage the "Fishbowl session".
Therefore, they can get some feedback for their facilitation of the Fishbowl session.

Fishbowl (3): Team A = fish, Team B= observers.
Fishbowl (4): Team B = fish, Team A= observers.

[Sample]

Self-Assessment for the participants: Pre-training assessment and post-training assessment with the same questionnaire.

CG Field Trainer Competency Self-Assessment Sheet: Check the appropriate level of competency that most fits to yours.

Name: Date:		1	2	3	4	5
	Level of Competency:	Excellent	Very good	satisfactory	needs improvement	no competence
Knowledge						
1	Knowledge of social mobilization activities					
2	Knowledge of socio-economic impact on reproductive health					
3	Knowledge of all the process of developing CmSG/CG					
4	Knowledge of CG operational guideline					
Skills						
1	Time management					
2	skills to use interactive/entertaining techniques					
3	Ability to ensure equal participation					
4	Use of non-theoretical (easy, or visual) approach					
5	Encourage the marginalized					
Attitude						
1	Good listener					
2	Honor people's concern					
3	Friendly					
4	Equal attitude to all participants					
5	Attentive to the marginalized					