MONITORING COMPLIANCE TO PROTOCOL IN THE EPICS TRIAL

Data Monitoring Committee (DMC) scheduled for 24th of May 2010

Compiled by Ila Fazzio

This document summarizes the compliance to protocol focusing on the core components of intervention and data monitoring as described in the trial protocol.

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SUMMARY TABLE

ACTIVITY OR PERSONNEL	DATES & DETAILS	INFORMATION
Registration - Intervention	Sept to mid-December of 2007	A total of 5686 eligible women were interviewed at baseline survey. 5059 of them registered for the Health Clubs and Clinical Services. A total of 10,378 women registered for the Health Clubs and Clinical Services (data from Mar 2010) (see Primary Carer card - Appendix 1)
Health Clubs (HC)	Started in Jan 2008 Integrated Strategy from Jan 2009 In 2008 - there were weekly health clubs in around 135 locations	**HC sessions conducted** (total 40) 22 in 135 locations 18 in 111 locations **Topics covered** (see HC member card - Appendix 2) • Danger Signs and Evacuation • Diarrhoea • Dehydration • Managing Dehydration: ORS • Malaria: Signs and Treatment • Malaria: Causes and Prevention • Respiratory Infections: Signs and Treatment • The Antenatal Consultation A & B • The First Hours of Life • Routine Care of the Newborn A & B • Breast Feeding A & B • Infections of the Newborn 1 • Infections of the Newborn 2 • Immunisation • Revision Sessions: • Diarrhoea • Malaria • Pneumonia • Preventing tetanus • The umbilical cord • Breastfeeding **Participation** (average of all registered) First Phase: 36.29% Integrated Strategy: 38.44%
Health Promoters	In 2008: 24 HPs + 3 supervisors Since Jan 2009: 10 HPs and 1 Supervisor	**Trainings** First (5 weeks – Jul- Aug 2007) covered: 'What are HCs' Key messages on child health How to conduct a HC Motorbike training Second (2 weeks – Jan 2009) covered: Key messages on maternal health Integrated strategy Third (2 days – Oct 2009) covered: Key messages on nutrition. In addition, there have been intermittent top-up review trainings. Every month, HPs go through the information to be covered the following month. **Supervision/Monitoring** Each supervisor is responsible for 7 or 8 HP. Supervision forms (Appendix 3 a and b) HP Reporting form (Appendix 4) Regular checkings by the Programme Manager.

ACTIVITY OR PERSONNEL	DATES & DETAILS	INFORMATION
Health Volunteers	Since Jan 2009 About 367 HC volunteers	**Training & Supervision** Trained and supervised by the HP each month in 1+ key messages **Topics**: • Measles • Pneumonia • Diarrhoea • Malaria • Tetanus • The Umbilical Cord • Breastfeeding • Nutrition
Nurse Trainers (NT)	9 NTs are currently active and each one is responsible for a sector. Until Feb 2010 one nurse was based in Catio Hospital to improve delivery services.	Services provided by NTs are shown in Appendix 5, 6, and 7 **Training** (see Figure 1) 3 main events and one refresher (June 07, October 07, May 08, January 09) 10 NTs were trained (one passed away). In addition the NTs were all trained on how to conduct VHW/TBA trainings and supervisions before each event. **Supervision/Monitoring** Once a month, field supervisor and Programme Manager conduct a meeting to: give feedback on field problems present and discuss data collected by NTs conduct revisions sessions as required
Village Health Worker (VHW)	165 VHWs have been trained in total, including 114 active and 51 non-active trainees. This gives an average of 1.4 VHWs per village.	**Training** • Module 1 – Diarrhoea & Dehydration Attendance – 148 VHWs (93.1 of total registered) • Module 2 – Fever & Cough with Difficult Breathing Attendance – 149VHWs (93.7 of total registered) • Module 3 – Child Health and Nutrition Attendance – 163 VHWs (98.8 of total registered) • Catch up Trainings Attendance – 164 VHWs (99.4 of total registered) **Supervision/Monitoring** Once a month VHW are monitored by their assigned NT (Supervision Form in Appendix 9): - compliance to procedures checked in the Child Treatment form (Appendix 8) - spot checks of some cases - knowledge on all topics they have covered in training and given regular individual revision on the basis of what is required. **Incentive** All VHWs receive an incentive that is calculated according to their amount of work (monthly records) and the feedback from their NT.
Traditional Birth Attendant (TBA)	There are currently 114 TBAs active and 67 non-active trainees.	**Training** 3 training events - 180 TBAs trained. • Camp 1 - Care of the newborn - Attendance: 165 (91.2% of registered) • Camp 2 - Safe childbirth - Attendance: 170 (93.9% of registered) • Camp 3 - Catch up training or additional TBAs - Attendance: 20 (M3) and 17 (M4) After catch up Trainings – final attendance: 180 (99.4% of registered) **Monitoring** TBAs are monitored once per month by their assigned nurse trainer (see TBA - Matrona Supervision form in Appendix 10).

ACTIVITY OR PERSONNEL	DATES & DETAILS	INFORMATION
Conditions Treated & Treatments Given	Table 2 shows a list of conditions treated and respective treatments according to place where it is provided. Table 3 shows a list of medicines/delivery kits according to place/system where it is provided.	**Children** (Section 1.3.6) Treatments given to children by month and condition treated in Figures 4 to 6. Malnourishment - Identification, Counseling and Follow-Up of Malnourished Children (page 22) Figure 7. **Women** (Section 1.3.7) Figure 8 - Prenatal and postnatal consultations (clustered by visit order). Figure 9 - Treatments given to women (clustered by condition and sector)
Mobile Clinics Service Delivery	From June 2008. Before that NTs were treating cases which the VHWs could not treat in village visits (2 times per month).	Basic health services are provided in the community once a month by highly trained NT: vaccinations, antenatal and postnatal consultations and monitoring of high risk women and children. **Services provided in the community:** **Children** % of overall vaccine Vitamin A and Mebendazole coverage by the Programme (children 10-20 months, as estimated November 2009) see Table 4 **Women** Antenatal and postnatal consultations (>90% of women are receiving up to the 4th prenatal consultation by Dec 09) see Figure 8 Treatments given to women see Figure 9 Number of deliveries and % of institutional deliveries see Figure 10
Mapping & Baseline survey	From Mar to Jun 2007	241 rural villages in trial regions were mapped and identified to be included in the trial (about 76% of all rural villages). The identification process is detailed in the protocol (Mann et al. 2009). Each cluster defines a population of approximately 350 people Data were collected in each cluster during three days by 5 fieldwork teams (one supervisor and 5 fieldworkers).
Quarterly Monitoring (QM) Survey	Since Dec 2007 Interviewers and supervisors visit registered women and children every 3 months	**Monitoring Forms (who carries out - see in)** • Quarterly Monitoring Form (interviewers - Appendix 11a & 11b) • Pregnancy Outcome (interviewers - Appendix 12) • Verbal Autopsy List (field Supervisors - Appendix 13) • Maternal Verbal Autopsy (field Supervisors) • Child and Neonatal Verbal Autopsy (field Supervisors) **The Reports:** • Baseline Validation Error Report (Appendix 15) • Quarterly Monitoring Validation Errors (Appendix 16) • Pregnancy Outcome Form Errors (Appendix 17) • List of VAs to be carried out Every eligible woman included in the trial is interviewed using the quarterly monitoring form (Appendix 11a - QM form and 11b - QM instructions). **Training** Quarterly Monitoring forms and procedures: 1st Training – 6th to 12th Dec 2007 Fieldworkers and supervisors were trained by the research manager - QM main forms and procedures. 2nd training – 7th to 9th Jan 2008 Fieldworkers and supervisors were trained by the research data manager - QM Error forms and procedures. Verbal Autopsy: Child and Neonatal Verbal Autopsy - June and Aug 2009 - 10 days - 2 trainings: Supervisors were trained by the research manager and BANDIM doctors. Maternal Verbal Autopsy 5 days – Aug 2009 Supervisors were trained by the research manager and BANDIM doctors. Health Knowledge Assessment Evaluation survey carried out in a randomly selected sub-sample of women from the intervention clusters – Sept 2008.
Stillbirths' Verification Survey	Between March and April 2010	The last 150 stillbirths recorded were verified (see form in Appendix 17).

1. INTERVENTION

The health services were introduced to the intervention villages from November 2007 and were divided into a health promotion and a clinical services component.

The health promotion component of the programme started in earnest in January of 2008. It followed a baseline health knowledge survey of men and women (King et al., in press).

As of January 2009, Health Clubs (HC) became monthly, and so the intervention programme was streamlined and integrated so that Health Clubs and Mobile Clinics (MC) take place in the same village on the same day every month. The monthly work plans of Nurse Trainers (NT) and Health Promoters (HP) have been synchronized and mothers have access to both services on the same day with the intention of increasing the intervention's efficiency and cost-effectiveness, as well as participation in the HCs.

The clinical programme started with the IMCI training for the NTs (from June 07). This was followed by the sensitisation and the community election of Village Health Workers (VHW) and their training conducted by the. In addition, NTs started conducting village' visits to attend any severe cases as well as cases the VHWs were not yet trained to treat. In these visits they supervised the VHW in their sector twice a month, worked in their sector headquarters' health centre and managed evacuated cases. In the second phase, NTs conducted two training camps for Traditional Birth Attendants (TBA) in care of the newborn and safe childbirth. These village visits were replaced by structured monthly Mobile Clinics offering paediatric and antenatal and post-natal consultations conducted on a fixed day and the supervision and mentoring of TBAs' work in a second monthly visit.

Moreover, NTs, VHWs and TBAs also promote the health messages conveyed in the HCs.

1.1. Registration Process

The first step in implementing the programme was to sensitise the intervention communities and begin the registration process. Registration took place over a window of six months that gave the majority of the eligible intervention population the chance to sign-up and be issued with Primary Carer Cards and Health Club Member Cards.

Out of the 5686 eligible women that were interviewed and registered for the trial at baseline survey, 5059 of them registered for the Health Clubs and Clinical Services. A total of 10,407 women and 7,951 children (under 6 years old) are registered for the Health Clubs and Clinical Services (data from Mar 2010).

From mid-September to mid-December of 2007 the health promotion and research teams conducted a campaign to enumerate households and individuals, and register those eligible to become Health Club members and Primary Carer Card holders, and who would therefore be

eligible to use the programme's clinical services. The registration of eligible individuals is the only way that enables them to access the EPICS trial's intervention services and is an effective 'control' to prevent those from the control villages participating. Proof of being registered to the Health Clubs is shown by the Health Club Member Card and for the clinical programme services eligibility is proven by the Primary Carer Card that lists all children aged 5 years and under eligible for care. Without these cards people cannot access the Health Clubs or Mobile Clinics and children cannot receive treatment from their local VHW or TBA.

1.2. Health Promotion and Health Clubs (HC)

During the first year of the health promotion campaign (January – December 2008), 23 HPs and 3 supervisors worked under one programme manager to implement two programme activities: weekly health clubs in around 135 locations and household-level health knowledge checks in around 5000 households. During the second year of the health promotion campaign (January – December 2009), 10 HPs and one supervisor worked under one programme manager to implement two programme activities: monthly health clubs in around 120 locations and training of around 300 volunteers to deliver health education in around 5000 households.

Health Clubs are a forum for the dissemination of key messages related to maternal and child health that aims to develop appropriate health knowledge, treatment seeking behaviour and the correct preventative behaviour within an entire community. Key messages are conveyed using participatory activities such as visual aids, games, stories, songs, role plays, discussion and dialogue led by the HP. Each HC session focuses on transmitting certain key messages about maternal and child health. These meetings are conducted by Health Promoters (HP) and anyone normally resident in the intervention villages is eligible to attend.

The "Health Club" methodology[1] was shown to be a successful and cost-effective model of community health promotion that has been implemented in Zimbabwe, Uganda and South Africa and Sierra Leone.

1.2.1. Health Promoters (HP)

In the first year of programme there were 24 HPs + 3 supervisors. Since the start of 2009, there are 10 HPs and 1 supervisor.

Health Promoters' Training & Monitoring

The first training (5 weeks – Jul- Aug 2007) covered:

- ✓ 'What are HCs'
- ✓ Key messages on child health

[1] www.africahed.org

- ✓ How to conduct a HC
- ✓ Motorbike training

The second training (2 weeks – Jan 2009) covered:

- ✓ Key messages on maternal health
- ✓ Integrated strategy

The third training (2 days – Oct 2009) covered:

- ✓ Key messages on nutrition.

In addition, there have been intermittent top-up review trainings. Every month, HPs go through the information to be covered the following month.

There were 3 supervisors selected from the health promotion team, chosen for their experience and aptitude shown during the training. Each one supervised 7 or 8 Health Promoters as the first point of supervision; the Programme Manager was the next point of supervision and monitoring. The Health Club supervisors had comprehensive supervision forms (Appendix 3 & 4) and had to check that each member of their Health Promotion Team was following the work plan. This required impromptu visits to observe Health Promoters facilitating their Health Clubs and ensuring that they were doing their house visits for the Health-Knowledge checks.

The supervisors revealed that while Health Promoters had no problems with going to the villages, or with conducting the Health Clubs on the given day, some however were less active than others in promoting participation door-to-door around the villages and conducting the Health-Knowledge checks.

1.2.2. Sessions Conducted

In total there were 40 HC sessions conducted:

- 22 in 135 locations
- 18 in 111 locations

Topics covered in these sessions (see HC card in Appendix 2):

- Danger Signs and Evacuation
- Diarrhoea
- Dehydration
- Managing Dehydration: ORS
- Malaria: Signs and Treatment
- Malaria: Causes and Prevention
- Respiratory Infections: Signs and Treatment
- The Antenatal Consultation A & B
- The First Hours of Life
- Routine Care of the Newborn A & B

- Breast Feeding A & B
- Infections of the Newborn 1
- Infections of the Newborn 2
- Immunisation
- Revision Sessions:
- Diarrhoea
- Malaria
- Pneumonia
- Preventing tetanus
- The umbilical cord
- Breastfeeding

1.2.3. Health Knowledge Integrated strategy (Jan 2009)

A system of HC volunteers was developed from the HC to increase the coverage of the HC messages. Each volunteer been assigned to 16 households (close to their own house) to be responsible for.

Each month, HC volunteers are trained on 1+ key message by the HP and asked to disseminate the messages to people living in the 16 households. The process is participatory and HC volunteers are taught to use flipcharts and some games.

HC Volunteers cover the following topics:

- Measles
- Pneumonia
- Diarrhoea
- Malaria
- Tetanus
- The Umbilical Cord
- Breastfeeding
- Nutrition

1.2.4. HC attendance

The participation of registered women in the HCs during the first phase (Child Health) was on average 36.29%. This has gone up to 38.44% since the start of the integrated strategy (Jan 2009).

1.2.5. Health Knowledge Monitoring Survey

The health knowledge monitoring survey is an internal assessment of the impact of the health promotion activities on health knowledge within the intervention areas. This assessment is used to understand which key messages require further emphasis and in which regions. It consisted of 26 questions which review key messages that have been discussed within the programme to date. It was conducted twice: in Sept – Oct 2008 and again in Oct – Nov 2009.

1.3. Clinical Services

EI collaborated with the MINSAP (Ministry of Health) body responsible for developing community IMCI, the Centre for Family Health. Being the first NGO to attempt this in Guinea-Bissau it was important to develop training according to the country's evolving IMCI guidelines.

Centre for Family Health trained all nurses and midwives in clinical IMCI, and one trainer was invited to deliver training on the community IMCI model that had been developed internally by EI.

1.3.1. Nurse Trainers (NT)

NTs are responsible for visiting the villages (mobile clinics - MC) and providing treatment and vaccination to children and women and antenatal and post-natal consultation. The forms used by NTs to provide services are shown in Appendix 5, 6, and 7.

Nurse-trainers visit each village health worker once per month to monitor the quality of the VHW and TBAs' work, provide advice, and reinforce the training, and test their knowledge.

NT Training & Supervision

There were 3 main training events and one refresher (June 07, October 07, May 08, January 09) where a total of 10 NTs were trained.

In addition the NTs were all trained on how to conduct VHW/TBA trainings and supervisions which took place prior to the respective training camps. All training events conducted in 2007/8 are described in Table 1.

Once a month NTs have a supervision meeting. They submit data and have it checked, and to meet for a qualitative feedback meeting. Field supervisor and programme manager discuss with NTs problems they have encountered in the field. The group are asked to present a case, and discuss potential solutions and target problematic areas in the programme: a form of 'situation autopsy' which is a tool for qualitative improvement. NTs present their work for the month and any addition revisions sessions are conducted by the field supervisor and programme development manager as required.

Table 1 - Clinical Component Training Events Conducted in Year 1 of the Programme.

Training event:	Trainees:	Sources:	Topics covered:
Nurse trainer IMCI training June 07 (10 days)	10 nurse trainers + 1 Programme manager	IMCI training manuals (WHO)	Integrated Management of Childhood Illnesses as conducted by WHO employed trainers
Nurse trainer phase 1 training October 07 (3 weeks)	10 nurse trainers + 1 Programme manager	Nurse Trainer Handbook Part 1: the selection, supervision and training of village health workers	Community sensitisation Election of village health workers Supervision of VHWs procedures Registration of births and deaths Nurse trainer treatments procedures Quadbike handling Health and safety
Mobile Clinics Training Camp May / June 08 (3 weeks)	10 nurse trainers 8 local partners 1 programme manager and 1 clinical field supervisor	Nurse Trainer Handbook Part 3: Conducting Mobile Clinic Services	Logistics, work plans, equipment Antenatal consultation Obstetric risk assessments IPT and anaemia prevention Identification of STIs Post-partum risk assessment and consultations Newborn assessment Treatment of newborn infections and sepsis Child growth monitoring Vaccination (using Penta and yellow fever) Breastfeeding management and consultations Tagging and other record keeping strategies
Refresher training (2 weeks) Jan 09	10 nurse trainers 9 local partners 1 clinical field supervisor	Supervision revision; Newborn resuscitation (WHO manual)	Coartem use for malaria treatment Resuscitation of the newborn and use of ambubag Refresher Training for mobile clinics procedures Revised methods for supervision of the VHWs Integrated Strategy– new timetables
VHW facilitator trainings 5 events – 3-4 days each before camps	10 nurse trainers	Working with TBAs Diarrhoea and dehydration Fever and cough Care of the Newborn Safe Childbirth Child health and nutrition	Teaching and supervision of Diarrhoea and dehydration, fever and cough (1 week) October 07 Care of the Newborn (4 days) April 08 Safe Childbirth (3 days) July 08 Child health and nutrition (3 days) November 08

1.3.2. Village Health Worker (VHW)

The village health worker/s (VHW) is the key advocate of health service uptake in each of the intervention villages where they work. They fill in a Child treatment form (Appendix 8) for every case they treat. Their roles are as follows:

- To diagnose and treat registered eligible children with IMCI target conditions of diarrhoea, fever and cough with difficult breathing (administering medicines when required, including ORS, paracetamol, bactrim, and chloroquine);
- To provide home-based care and support for the sick child for five days post-episode;
- To recommend and facilitate evacuations as and when required according to IMCI protocol;
- To monitor all registered children monthly / bi-monthly for malnutrition;
- To report and register births and deaths of registered women and children;
- To co-ordinate mobile clinic events and mobilise the target population for vaccination, supplementation and deworming;
- To monitor intensely all low weight and vulnerable infants as required, and facilitate a home-based enhanced feeding scheme.

VHW Training & Monitoring

The EPICS Trial's clinical intervention has always adopted the IMCI strategy. As IMCI follows a simple and logical algorithm for identifying conditions and classifying risk, it is an ideal format for training inexperienced VHW. The system simply lends itself to visual representation, which could rapidly be interpreted by the VHW: green (normal), yellow (community-treated) and red (danger/ evacuation) signs could be reproduced and easily remembered by illiterate trainees.

A total of 165 VHWs have been trained in total, including 114 active and 51 non-active trainees. This was the total required to cover all villages and gives an average of 1.4 VHWs per village due to the high number of very small villages or those that share VHWs.

- ✓ Module 1 – Diarrhoea & Dehydration
  Attendance – 148 VHWs (93.1 of total registered)
- ✓ Module 2 – Fever & Cough with Difficult Breathing
  Attendance – 149VHWs (93.7 of total registered)
- ✓ Module 3 – Child Health and Nutrition
  Attendance – 163 VHWs (98.8 of total registered)
- ✓ Catch up Trainings
  Attendance – 164 VHWs (99.4 of total registered)

VHWs are monitored once per month by their assigned nurse trainer (see Monitoring form in Appendix 9). The nurse trainer checks records and medicines distributed against stock (see – Child treatment - VHW records). They also select about ten treated cases at random and conduct home visits to check the health of the child and to interview the mother about the treatment. They are additionally assessed for knowledge on all topics they have covered in training and given regular individual revision on the basis of what is required.

All VHWs receive an incentive that is calculated according to their amount of work (monthly records) and the feedback from their nurse trainer.

1.3.3. Traditional Birth Attendant (TBA)

TBAs provide home-based services for the mother and infant (see Appendix 2 – NTs and TBAs child and women treatment form). Their role is as follows:

- Promoting the Program by community mobilisation to mobile clinics and health clubs.
- Identifying pregnancies, maintaining a register and reporting all new pregnancies and deliveries to the nurse trainer.
- Assisting Mobile Clinics: organises the event; all consultations; provides case briefings for midwife based on her home visits; translation and support for midwife as needed.
- Conducting home visits of pregnant, and nursing mothers to provide the following home-based services:
  - ✓ Carrying out health checks on mother and newborn.
  - ✓ Family counselling & supportive care.
  - ✓ Promoting institutional delivery and assisting women preparation in cases of home delivery.
  - ✓ Giving support during and after home deliveries using safe methods, and conducting the correct immediate post partum assessment and procedures.
  - ✓ Carrying out post-partum follow-up with home visits (minimum for ten days after delivery)
  - ✓ Disseminating and revising health care messages (healthy pregnancy, danger signs, care of the newborn etc), through the communities on an individual and health club basis.
  - ✓ Facilitating and accompanying evacuation of women in labour.

TBA Training & Monitoring

There were three training events where a total of 180 TBAs were trained.

Training module / camp events for TBAs were as follows:

- ✓ Camp 1 - Care of the newborn - Attendance: 165 (91.2% of registered)

- ✓ Camp 2 - Safe childbirth - Attendance: 170 (93.9% of registered)
- ✓ Camp 3 - Catch up training or additional TBAs - Attendance: 20 (M3) and 17 (M4)
- ✓ After catch up Trainings – final attendance: 180 (99.4% of registered)

There are currently 113 TBAs active and 64 non-active trainees (2 died and 1 dropped out).

TBAs are monitored once per month by their assigned nurse trainer (see TBA - *Matrona* Supervision form in Appendix 10).

1.3.4. Conditions Treated & Treatments Given

EPICS clinical services has been given free first and second line treatments of target conditions for children under five, institutional deliveries for high risk mothers and delivery kits to all pregnant mothers. The package of medicines that is provided free of charge to children and women registered in the intervention villages is based on IMCI guidelines and the final list was elaborated together with local experts and visiting doctors and approved by the Ministry of Health. The list of conditions detected, and the treatment given in the villages and health centres is presented in Table 2.

Treatment and prevention of HIV/AIDS and other STIs at this stage are not included, but women are encouraged to access services where they are available. At tertiary level all institutional care is covered up to a maximum value of care (50,000 CFA) and use of official ambulances is also covered.

Table 2 - list of conditions treated and respective treatments according to place where it is provided

Condition detected	Village level intervention	Health centre
Malaria in pregnancy	Chloroquine / quinine (as per government protocol)	Intravenous fluids, quinine
Anaemia	Iron tablets	Iron tablets; blood transfusion as required
Haemorrhage during or before delivery	Evacuation	Iron tablets Blood transfusion
Childbirth - simple	Home delivery kit Assistance by trained matrona Home visiting and support by TBA (10 days) Home visit by NT	Institutional delivery kit Diazepam Injectable antibiotics See Table 3 – as required by health centre
Complications of delivery	Evacuation Home visiting and support by TBA (10 days) Home visit by NT	As required by hospital to value of 50,00CFA
Post-partum fever	Home visiting and support by TBA (weekly)	Oral antibiotics or as required by health centre
Hypertension in pregnancy	Home visiting and support by TBA (weekly) Monthly visits by NT	Aldomet (methyldopa)
STIs in pregnancy including HIV	Evacuation	Referred to health centre

The list was devised and few changes were made since early 2007, except where it was felt local context required it, e.g. the addition of the anti-hypertensive drug alpha-methyldopa (Aldomet) given in cases of moderate to severe pre-eclampsia, which is allegedly common amongst the Guinean population.

In view of that, the list of medicines/delivery kits provided at the community level (VHWs and TBAs), in the mobile clinics (by the NTs) and at the health centres and hospitals is presented in Table 3.

Table 3– list of medicines/delivery kits according to place/system where it is provided

Community (VHW / TBA)	Mobile Clinic – community (NT)	Health centres / Hospitals
Paracetamol tablets	Oral rehydration salts	As listed for mobile clinics, plus
Chloroquine tablets / syrups	Paracetamol	
Bactrim tablets	Co-trimoxazole tablets and syrup	Benzyl penecillin IM
Alcohol	Chloroquine tablets	Gentamycin IM
Clean delivery kits	Coartem	Quinine dihydrochloride injectable
Antibacterial soap	Tetracycline ointment	Dextrose 5%
Tetracycline ointment	Antiseptic solution - germobacter	Sodium chloride solution 0.9%
Multivitamins	Alcohol	Distilled water
	Gentian Violet	Lactase ringers solution
	Amoxycillin tablets and syrup	Ampicillin ampoules (500mg)
	Quinine tablets	Adrenalin 1mg / ml
	Mebendazole	Hydrocortisone injection
	Vitamin A	Ergometrine maleate (0.2mg/2ml
	Folic acid and iron	Intravenous giving sets
	Diazepam	IV catheter needles
	Aldomet (methylodopa)	Nasogastric tubes
	Bacitracin + neomycin ointment	
	Paraceck – malaria testing kit	Institutional delivery kits
	Urine testing kit	Caesarean kits provided by the hospital
	Sterile lancet	
	Haemoglobin colour testing kit	
	Disposable syringes	Reimbursable system implemented for hospitals.
	Sulphadoxine & pyromethane (fansidar)	
	Medicine sacks	
	Latex examination gloves	Equipment provided
	Sterilizing fluid	Midwifery kit
	Cotton wool, NON-Sterile	Ambubag and attachment kit
	Antiseptic soap	Caesarin delivery surgical equipment (1 set at Catio).
	Child vaccination cards	
	Pregnancy cards	
	IEC materials	Provided by the health centres
		All vaccines
	Equipment	Tetanus vaccine card
	First aid kit	Vaccine cool box
	Stethoscope binaural and pinard	
	Surgical apron	
	Thermometer	
	Sphymanomometer	
	Ice packs for cool box	

1.3.5. Mobile Clinics Service Delivery

Mobile Clinics is an outreach strategy to provide basic health services in the community, vaccinations, antenatal and postnatal consultations and monitoring of high risk women and children. Monthly regular visits of Mobile Clinics (providing all services) started from June 2008. Before that NTs were treating cases which the VHWs could not treat in village visits (2 times per month).

Vaccines, Vitamin A and Mebendazole

The 'catch up' of vaccination coverage is completed, and now has been implemented as a routine service, despite occasional irregularities in service delivery due to supply chain (see Challenges).

Table 4 shows vaccine, vitamin A and mebendazole coverage in children targeted by EPICS mobile clinics – note, Penta replaced DTP as vaccine standard in November 2008[2]. Figures 1, 2 and 3 show the numbers of children vaccinated at each mobile clinic event per vaccine given.

Table 4 - % of overall vaccine Vitamin A and Mebendazole coverage by the Programme, as estimated November 2009

	BCG	OPV0	OPV1	OPV2	OPV3	Measles	Yellow fever
EPICS group 10-20 months	88.2	35.4	94.4	87.5	81.9	86.1	72.9

	DTP1	DTP2	DTP3	PEN1	PEN2	PEN3	DTP/ PEN1	DTP/ PEN2	DTP/ PEN3
EPICS group 10-20 months	15.3	12.5	12.5	81.9	79.2	72.9	93.8	91.7	84.0

		Vitamin A	Mebendazole
Age 10-20 months	within 6 months	76.4	66.1
	within 1 year (eligible only)	86.8	71.9
Age 36+ months	within 6 months	48.9	43.2
	within 1 year (eligible only)	59.0	51.8

2 Data in table 4 were taken from the monitoring survey – sampled by random selection from the two age groups and corrected for eligibility (under one year excluded for Mz coverage). Data may be underestimated as they work in collaboration with the ministry of health to do VitA / Mz campaigns.

Figure 1– Number of children that received Penta vaccines by EPICS programme in Mobile Clinics (MCS).

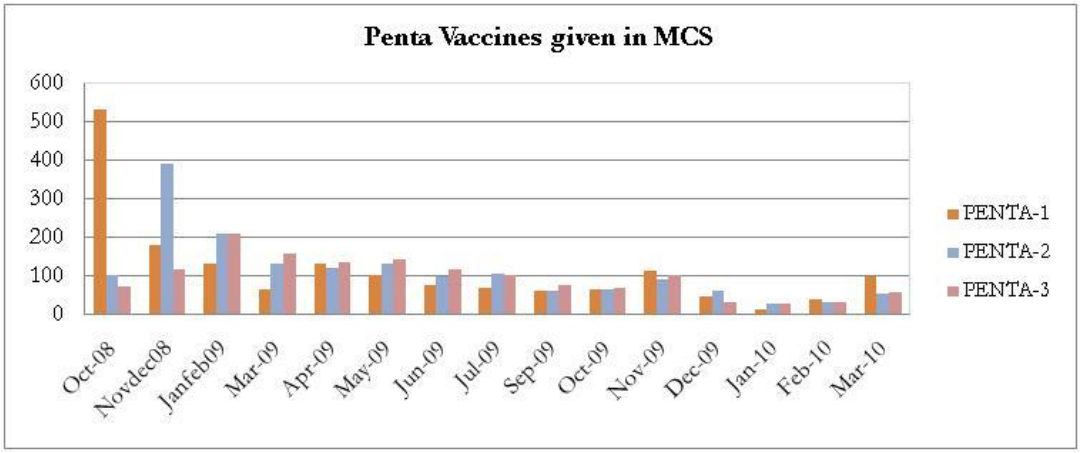


Figure 2- Number of children that received BCG and OPV vaccines by EPICS programme in Mobile Clinics (MCS).

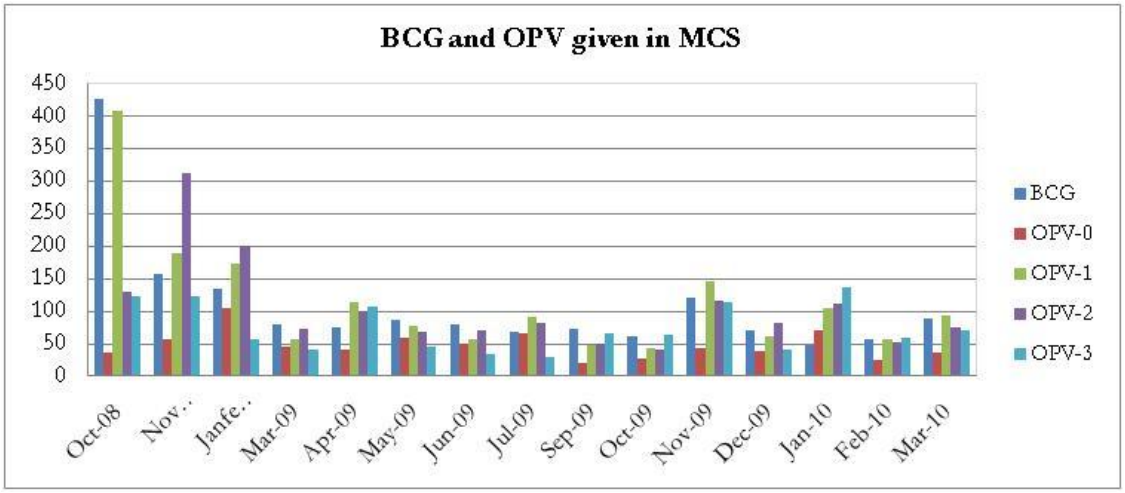
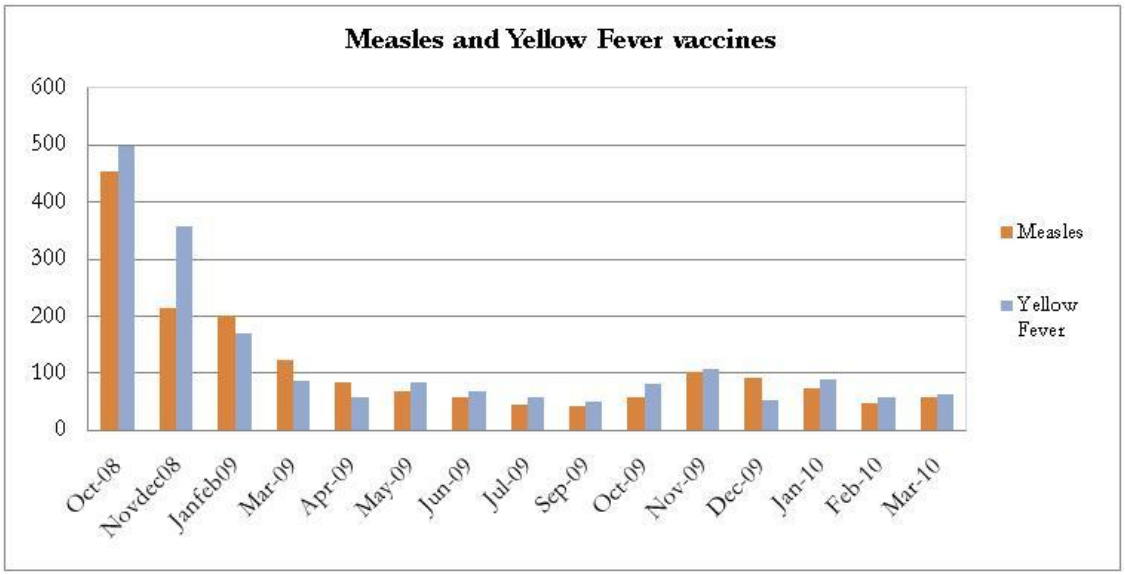


Figure 3 - Number of children that received Measles and Yellow Fever vaccines by EPICS programme in Mobile



1.3.6. Treatments given to Children

Figures 4, 5 and 6 show number of treatments given to children by month and condition treated.

During the first year VHWs were trained to give treatments, but not yet fully confident. Thus a very high numbers of cases were treated at the mobile clinic by NTs. June marks the launch of the mobile clinics campaign and saw another surge in attendance and illness claims. Figure 6 shows how VHWs gradually took over control of responsibility for simple cases, under the promotion of the NT at mobile clinic days and heavy supervisions.

Figure 4 – Total number of consultations given to children by NTs per month by condition treated.

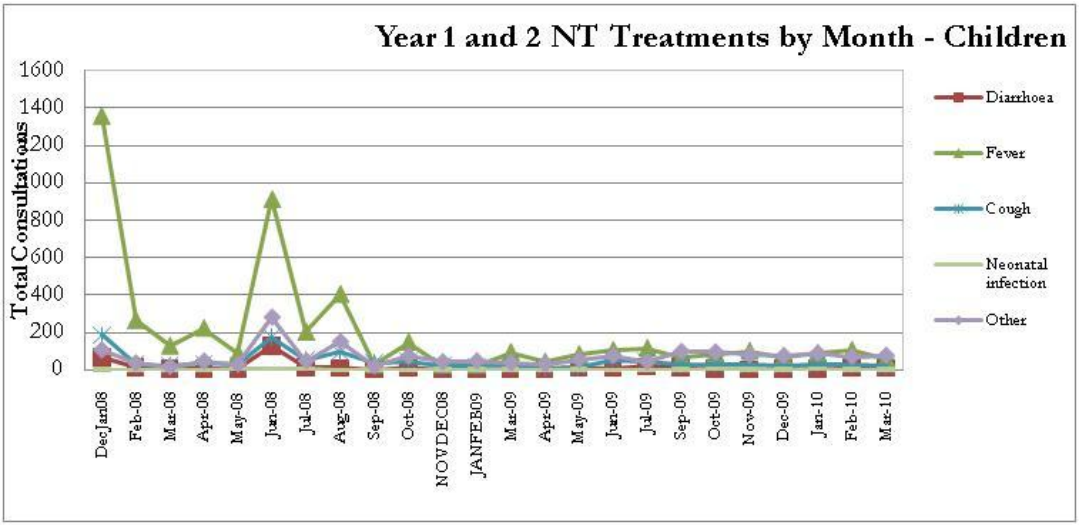


Figure 5 – Treatment given by the VHWs per condition treated.

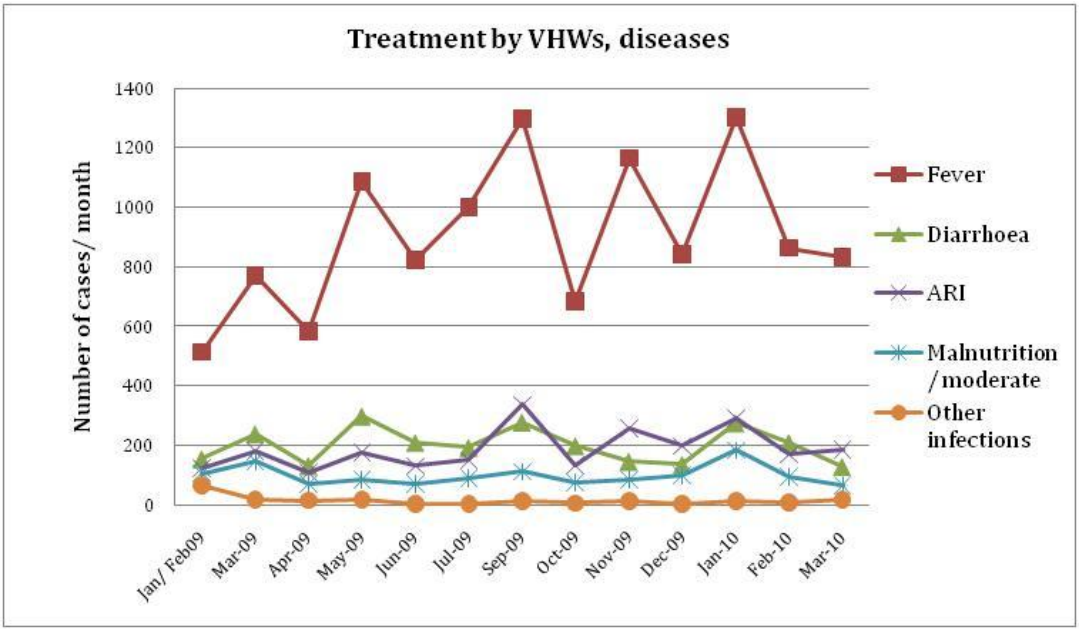
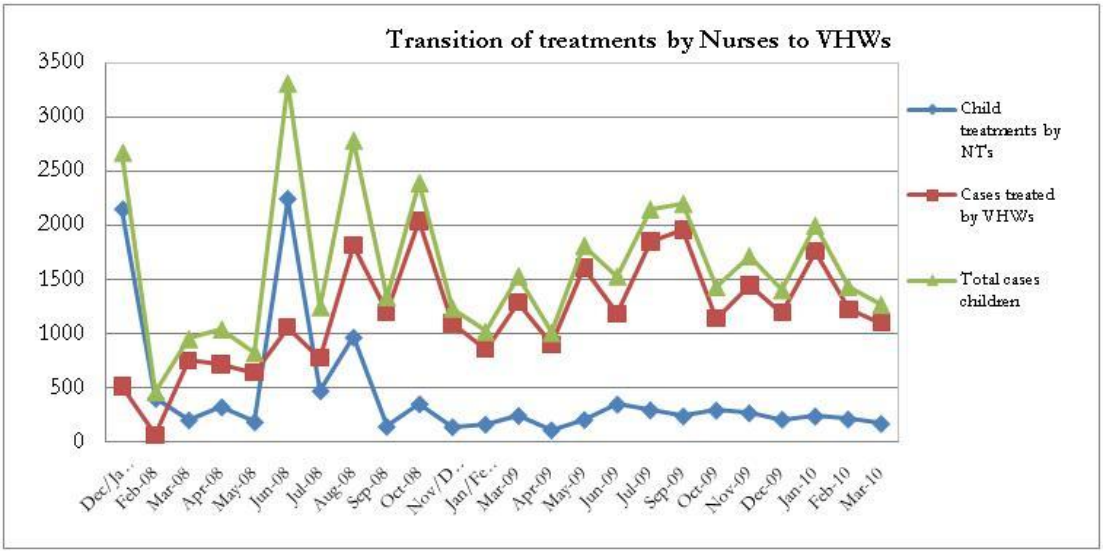


Figure 6 - Transition in the treatment given by NTs to VHWs.



Identification, Counseling and Follow-Up of Malnourished Children

EPICS does not include a formal feeding programme, as it was felt that this was beyond the scope of the programme, and also that knowledge of appropriate nutrition of children was a key limiting factor. The intervention targets in the detection of cases (Figure 7)[3], and supporting families through education and home visiting to improve nutrition of the child, and complicated cases are referred to the health centre or hospital as required.

Identifying moderate and severely malnourished children (M and MS cases):

- ✓ VHWs conduct screening of all children >6 months with MUAC arm band once per month or two-monthly (for larger villages).
- ✓ All children presenting at the mobile clinic are weighed and checked for M / SM

Handling of M and MS cases:

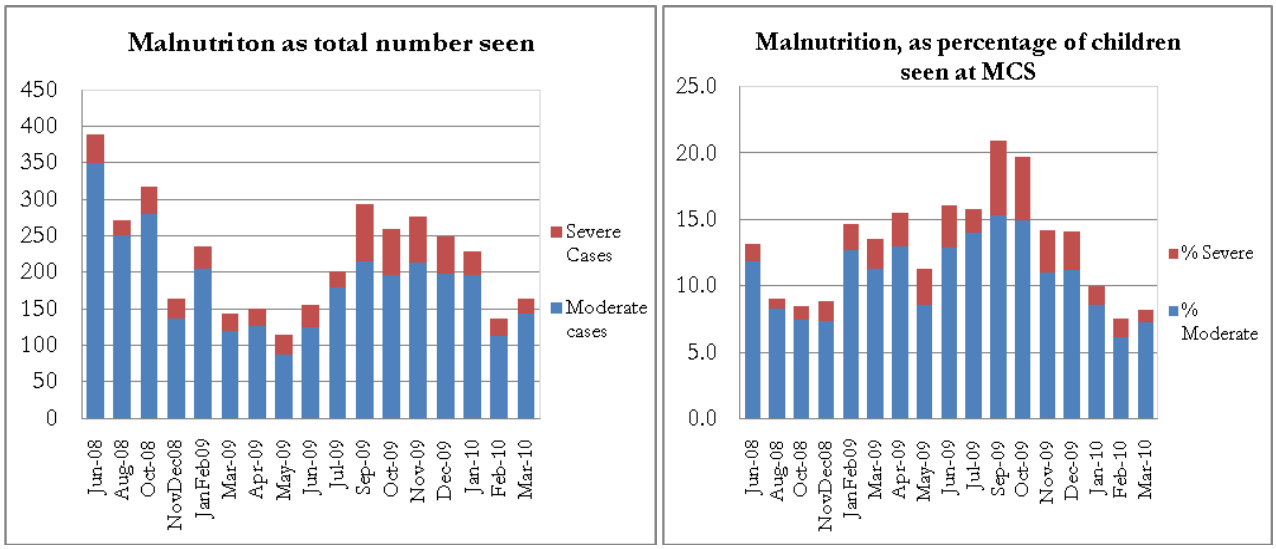
- ✓ The Primary Carer Card is 'tagged' with a red mark to remind the mother to attend the mobile clinic every month until the child recovers and the red mark is removed.
- ✓ The VHW holds a list of all cases; home visits are conducted weekly (M) and 3 x weekly (SM); VHWs assist the mothers to ensure increased breastfeeding, meal frequency and

3 As malnutrition is seasonal it is better to compare the same month in different years: from Jun 08 to Jun 09 we saw a dramatic fall in the number of cases. Rice harvests were very poor in 2008 and 2009 however and 'hunger season' was certainly apparent in the numbers. As percentage of children seen we felt confident that we had coverage of re-attendance at the MCS and good recovery rates.

improved food quality. He completes a 'food diary' to monitor intake of protein and energy rich foods.

- ✓ Multivitamins, mebendazole and iron tablets are provided as required by the NT.
- ✓ VHWs are taught how to prepare a range of high energy / protein dishes, including a simple food supplement based on ground peanuts.

Figure 7a – Total number and (b) percentage of moderate and severe cases of malnutrition



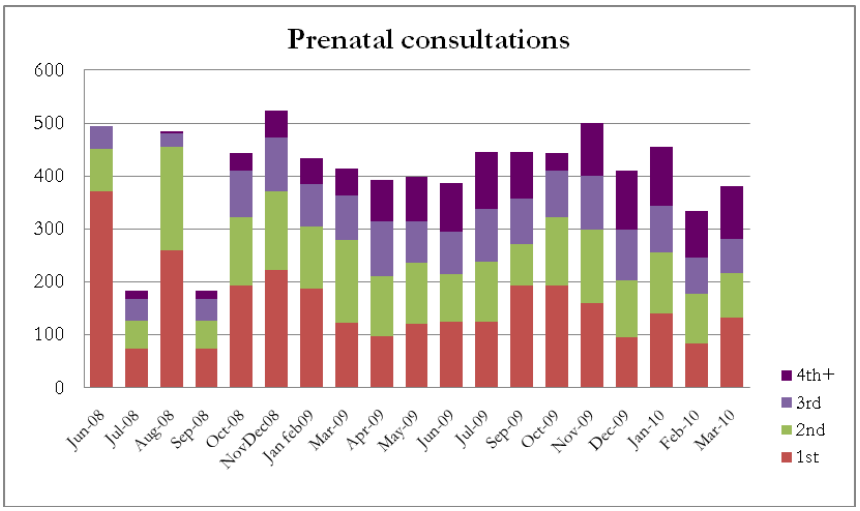
1.3.7. Treatments given to Women

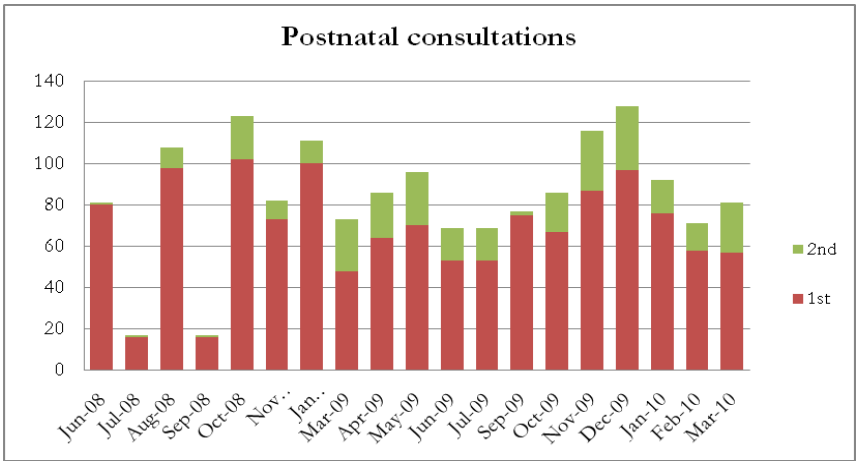
Antenatal and Postnatal Consultations

The number of women seen in a prenatal and postnatal consultation is show in Figure 8. It has been estimated >90% of women are receiving up to the 4th prenatal consultation by Dec 2009[4].

4 Although we recommend that women have a second postnatal consultation up to 60 days, few women choose to attend. Yet, they are also all visited at home during this period.

Figure 8 - Number of women who received prenatal (a) and postnatal (b) consultation clustered by the visit order (whether it was the 1st, 2nd, 3rd or 4th+ visit).



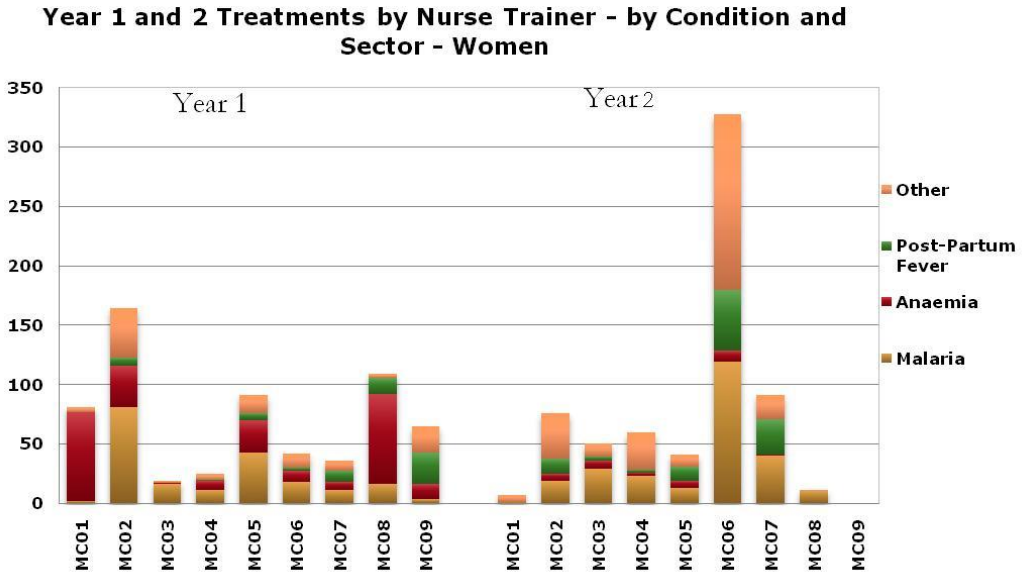


Conditions treated

Figure shows the number of eligible women treated by EPICS program in Year 1 and 2 according to the condition treated.

Sector 6 is a highly populated area – during year 1, only after the first 8 months he sector was split into 2 sectors (6 and 9) as full coverage of prenatal care was not possible using a single vehicle. There is a very high rate of bacterial vaginal infections amongst certain populations which the NTs have undertaken to treat under MINSAP guidelines.

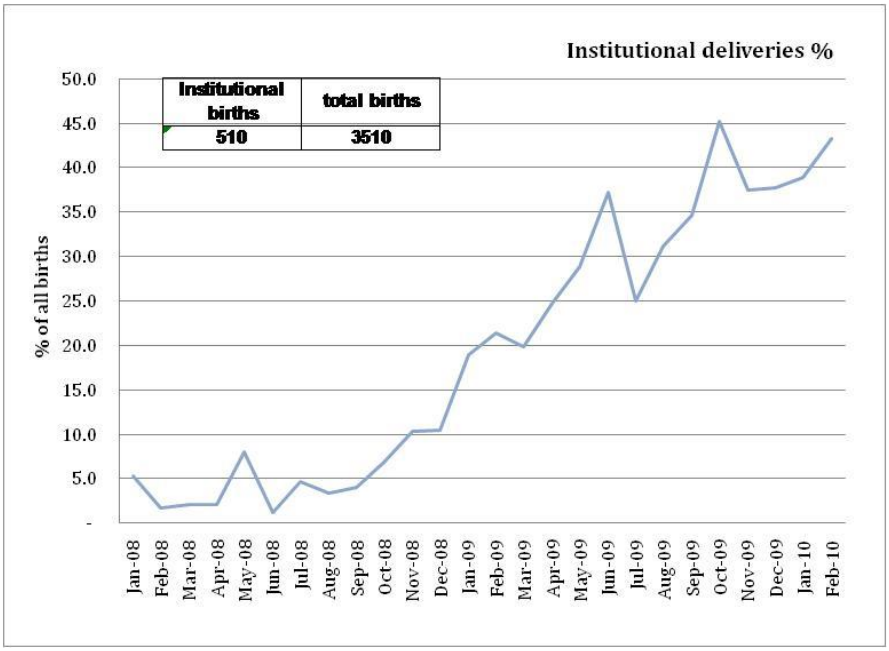
Figure 9 - Number of women treated by the nurse trainers clustered by condition and by sector.



1.3.8. Births in Villages and Institutions

The programme promotes institutional delivery through the TBA counselling the family alongside the nurse trainer. From October 2009 EPICS initially decided to reimburse women for travelling to the health centre to deliver with a small amount of money (3000 CFA) towards transport costs. Figure 10 shows the overall number of deliveries recorded at the village level in each month according to the database.

Figure 10 – % of all births and institutional deliveries (in Hospital/Health Centres) and total numbers recorded at the village level in each month.



2. RESEARCH & DATA MONITORING

The research component had two distinct stages. The first stage involved the mapping, household registration and the baseline survey, in which they collected data on ethnicity, demography, location, fertility, and maternal and child mortality, prior to randomisation. The Research Manager had met with the London School of Hygiene and Tropical Medicine (LSHTM) statisticians to design the content of the baseline survey. The baseline survey was conducted to enumerate eligible women/children, to collect information about the villages and about women's full birth history, and to provide an initial estimate of mortality.

In the second stage, the team has been carrying out Quarterly Monitoring Surveys (QM surveys) with all the eligible women/ children that were registered and accept to participate.

2.1. Identifying clusters and conducting a Baseline survey

The main villages in the study regions of Quinara and Tombali were identified using existing maps. Short fieldwork trips were conducted prior to the survey to map all villages (with local informants' help and a GPS) in the area. One hundred and forty six clusters comprising 241 rural villages, about 76% of all rural villages in these regions, were identified to be included in the trial. The identification process is detailed in the protocol (Mann *et al.* 2009). Villages were eligible to be included in the trial if they: (1) had an estimated population of 300 to 2000; (2) were not closer than 4 km to another cluster village; and (3) gave the consent to participate in the trial. If a village had less than 40 houses, up to 4 nearby villages (within 3 km) were grouped to reach the target 40 houses. Each cluster defines a population of approximately 350 people.

In large villages, only a sub-sample of 52 eligible houses was selected walking away from the centre of the village in all directions Data were collected in each cluster during three days by 5 fieldwork teams (one supervisor and 5 fieldworkers).

A household was eligible if it had at least one eligible woman present to be interviewed. A woman was eligible for the trial if she: (1) was normally resident in the eligible village and house ; (2) reported to be between 12 to 49 years old at the time of the visit or the primary care taker of a child (younger than 5 years of age); (3) gave consent to participate in the trial. All eligible women present in the selected households were interviewed.

Child mortality data were obtained from detailed questionnaires and interviews based on DHS model for collecting information on births histories. Births and deaths were dated using events, seasonal calendars, inter birth intervals, and cross-referencing to births of other known-aged children.

To attribute ethnicity, each woman was asked to which ethnic group's set of rituals and beliefs she felt the closest affinity. The predominant ethnic groups are: Beafadas, Balantas and Fulas. Other groups include: Nalus, Mandingas, Susso, Bijagós, Pepels, Tandas, Bitcheforés, and

Mansuancas. Women were also asked how many co-wives they had and the number of co-wives living with them (referred as polygyny, i.e. marriage system whereby a man can accumulate more than one wife).

The estimated 'walking distance' from each village to the nearest health centre was calculated in hours considering short-cuts and the time to cross the river by canoe).

2.2. Quarterly Monitoring (QM) survey

Data on pregnancies, births, deaths and migration have been collected in all clusters (both intervention and control arms of the trial) using exactly the same forms and procedures by 4 fieldwork research teams (composed by 1 supervisor and 4 interviewers) on a quarterly basis.

Verbal autopsies are also carried out for all deaths of women and children that are monitored during the trial. Other research related to health knowledge, use of health services, and nutrition are planned to be conducted.

The data collected in the field is then double entered in a database and the information is used to produce forms for the following monitoring period. Data are collected and entered on an ongoing basis.

2.2.1. Trainings

Quarterly Monitoring forms and procedures:

- ✓ 1st Training – 6th to 12th Dec 2007
  Fieldworkers and supervisors were trained by the research manager - QM main forms and procedures.
- ✓ 2nd training – 7th to 9th Jan 2008
  Fieldworkers and supervisors were trained by the research data manager - QM Error forms and procedures.

Verbal Autopsy:

- ✓ Child and Neonatal Verbal Autopsy - June and Aug 2009 - 10 days - 2 trainings:
  Supervisors were trained by the research manager and BANDIM5 doctors.
- ✓ Maternal Verbal Autopsy 5 days – Aug 2009
  Supervisors were trained by the research manager and BANDIM doctors.
- ✓ Health Knowledge Assessment
  Evaluation survey carried out in a randomly selected sub-sample of women from the intervention clusters – Sept 2008.

5 http://www.bandim.org/index.php?PHPSESSID=5c8a6e0b62057e3f479fd7bd841eb04d

In addition research fieldwork teams receive periodic revision trainings by the research manager and the research data manager.

2.2.2. Quarterly Monitoring (QM) data collection

Each fieldwork team visits one cluster per day. During this day interviewers and supervisors make multiple attempts to meet the registered women and children. Every eligible woman included in the trial is interviewed using the quarterly monitoring form (Appendix 11a - QM form and Appendix 11b - QM instructions). If the woman is not coming back to the village in the visit-day another person, preferably from the same house is interviewed and the relationship of this person and the registered woman is recorded in the form.

In the QM form it is recorded whether a woman is pregnant and if so how many months she is pregnant. The previous information about a woman's pregnancy status is printed in the QM form. So, every time a woman whose previous pregnancy status was positive and in the present monitoring she is reported as 'not pregnant' interviewers have to fill in a Pregnancy Outcome form (Appendix 12 - POF final version). This form records the outcome of each pregnancy, information about the delivery and whether it was a live birth, and whether the baby is still alive. Questions about the neonatal care were included in the POF from September 2009. These questions were not included initially because it was concluded that it was a better strategy to keep POF simple in order to assure high quality in the QM data collection. Once fieldworkers were familiar with QM forms and procedures these questions were incorporated to the QM data collection.

The QM form also reports if the registered women and children are still alive. Whenever a registered woman or child is reported to have died, an interviewer records the death in the QM form and a supervisor visits the house in the same day to confirm the death and record the date s/he died in the Verbal Autopsy list form (Appendix 13 - VA list form).

QM, POF and VA list forms are used to measure the primary endpoints of the trial on an ongoing basis. Furthermore there are reports to rectify inconsistencies and complete missing or 'unknown' information from the previous period.

Thus, the main forms used during the monitoring are (see in brackets the responsible for carrying out the interview):

- Quarterly Monitoring Form (interviewers)
- Pregnancy Outcome (interviewers)
- Verbal Autopsy List (field Supervisors)
- Maternal Verbal Autopsy (field Supervisors)
- Child and Neonatal Verbal Autopsy (field Supervisors)

The Reports:

- Baseline Validation Error Report (Appendix 14)
- Quarterly Monitoring Validation Errors (Appendix 15)
- Pregnancy Outcome Form Errors (Appendix 16)
- List of VAs to be carried out

All information collected during the Quarterly Monitoring is carefully verified by the field supervisor and the research officer. The research officer reports to the research data manager who periodically goes with fieldwork teams to check data collection. Research manager designs all material implemented in the field and does periodical visits to support and check data collection.

Verbal Autopsy

Verbal autopsies are conducted for all registered women and children who died during the trial period.

For EPICS trial, Neonatal, Child and Maternal verbal autopsies were designed to obtain a reasonable estimation of the causes of mortality in the communities monitored. Forms, trainings and procedures are largely based on WHO and INDEPTH materials, and they were adapted to the local context with the help of Dr. Cabral and Dr. Carlitos (BANDIM project) and the Fieldwork Manager (who is finishing her degree as a medical doctor). This includes a section on vaccination that was designed with the help of Dr. Peter Aaby.

Most VA interviews are conducted between 60 and 120 days after the death. According to the physicians' field experience (BANDIM project), the mourning period in this area is 60 days. In some cases the recall period is longer due to operational constraints.

Supervisors are responsible for conducting VA interviews. They received a rigorous training by: Dr. Cabral and Dr. Carlitos, the Fieldwork manager and the Research Manager, and are constantly checked by the Research Data Manager. Although not medically trained, they all have completed secondary level and are experienced interviewers (previous and during EPICS: baseline and monitoring – since March 2007).

Mortality surveillance, VA interviews and coding were integrated into the routine functions of fieldwork teams and data processors since September 2008

An inventory with diagnoses to neonatal, child and maternal deaths was compiled and coded from WHO document: 'Verbal Autopsy Standards: Ascertaining and attributing causes of death' by the Research Manager (http://www.who.int/whosis/mort/verbalautopsystandards/en/index.html). This inventory lists 89 possible diagnoses, their respective correlation with ICD 10 (International statistical classification of diseases and related health problems, 10th revision:

http://www.who.int/classifications/icd/en/), a description of the diseases, related health problems grouped in each VA code, and some comments.

The process of analysing the VA interviews entails that:

- ✓ Each VA is analysed by at least two doctors.
- ✓ Each doctor is 'blind' to the other doctors' diagnosis.
- ✓ If there is a disagreement, a third doctor should be involved in the process and if necessary a meeting to discuss the case should be arranged with these three doctors.

As a conclusion of this process, the research data manager should be able to record the code for one cause of death (or 'unknown', or 'no data').

2.2.3. Stillbirths' Verification Survey

Between March and April 2010 a verification survey was carried out to check whether the last 150 stillbirths recorded have been correctly recorded (see form in Appendix 17).

The reasons for carrying out this survey are:

- ✓ There is a high number of stillbirths recorded during the quarterly monitoring
- ✓ It is not always possible to interview the mother for a pregnancy outcome form (POF)[6]
- ✓ The death of a child is a sensitive topic.

Data collection is completed and the information is currently been double entered. The results will be available for the meeting.

3. Challenges

Guinea Bissau is one of the poorest countries in the world, with more than two-thirds of its population living below the poverty line. Its recent history is marked by socio-economic constraints, lack of resource investment and appropriate management, armed conflicts and coups. The economy is very weak depending mainly on agriculture; and cashew nuts, peanuts and fishing are its major exports. To worsen the political and economical instability Guinea Bissau has lately become a focus point for cocaine trafficking. All these aspects contribute to making it perhaps one of the most difficult places in the world to implement a highly controlled and well monitored programme.

6 According to the database, in the last 150 stillbirths recorded, only in 61.7 % of the cases the mother was the person interviewed.

One of the biggest challenges was to select and 'groom' the programme staff to a high level of professionalism, training and experience. These were possible to achieve by a joint effort of the teams and by constantly addressing and working to overcome the difficulties.

3.1. Challenges in Implementing the Trial

Capacity and Experience of Staff

Most of the staff was not familiar with the tools and techniques that were needed to perform their role:

- ✓ Only two of the Fieldworkers and Supervisors had previously carried out interviews.
- ✓ Most of the Health Promoters were coming from a teaching background but with no experience in conducting community meetings.
- ✓ There were no nurses who had IMCI / IMPAC training, and experience in outreach programmes and data collection/management. Similarly VHWs and TBAs were largely new and had no experience or training, some of them following traditional practices

Logistical limitations

- ✓ All teams are constantly facing the challenge of keeping the schedule on track due to difficult access during rains (as some villages are inaccessible) and the vehicle maintenance.

Limitations of collaboration

- ✓ Vaccine availability – frequent fluctuations in availability and functionality of the cold chain has affected the distribution of vaccines. NTs run 'catch-up' days as and when vaccines become available but delays are frequent in certain locations. The programme depends on health centres to provide vaccines.
- ✓ The majority of health centres have no access to emergency transport/ambulance services. Those few that do have it are often out of order or not available at the required time of evacuation.

Technical limitations

- ✓ We have had to follow the regulation of the Ministry of health even when methods are outdated – e.g. the use of chloroquine instead of coartem; the late introduction of yellow fever and Pentavalent vaccines.
- ✓ Caesareans at Catio hospital have been heavily limited by absences of the qualified surgeon, regularly present in the hospital.
- ✓ Onwards evacuations – for complex cases that require high level care Catio and Bissau are the only hospitals in the area. Travelling time from the intervention area varies

between 3- 6 hours from Bissau and hence onwards evacuation is not possible in very urgent cases.

Community limitations

- ✓ The Death of a child is a difficult and sensitive topic to discuss with mothers, in particular amongst the animists.
- ✓ Some mothers continue to rely upon traditional remedies and spiritual healers in spite of availability of modern medicines.
- ✓ Mothers frequently in the past have delayed care seeking to conduct ceremonies.
- ✓ Financial limitations to evacuation: families often refuse to evacuate mother or child due to financial limitations, although the programme provides medicines food and travel expenses affect decision-making for health. Mothers leave health centres/ hospitals before the child is well due to financial restrictions.
- ✓ Travel: the population is highly mobile, especially women. Deaths reported often have occurred when the woman and child travel outside of the village / area and hence have no access to health care except the government system.

Appendix 1– Primary Carer Card

Primary Carer Card

Effective Intervention

□□□
CLUSTER

Identification Number	□□□ - □□□ - □□ TABANCA NO. HOUSEHOLD NO. WOMAN NO.	
Health Club Promoter		
Date of Registration		
Woman's Name		**Identification mark**
Age		
Name of Spouse		
Name of Mother		
Pregnant – date first registered		

Registered children – all under five years

No.	Name	Sex M / F	Date of birth
01			_ _ / 200_
02			_ _ / 200_
03			_ _ / 200_
04			_ _ / 200_
05			_ _ / 200_
06			_ _ / 200_

TAG

TT1	
TT2	
TT3	
TT4	
TT5	

visit

Antenatal Care Record

Maternal Tetanus
Date, and sign if given during

Pregnancy 1

Mobile Clinic		**RC** 3 – high 2 – moderate 1 – low	**Factor** (list all observed)			**ITN**	**Delivery kit**	**Date and signature**		
Date of last period										
Expected delivery date										
Antenatal visit	**1st**									
	2nd									
	3rd									
	4th									
Delivery location *(tick as applicable)*	**Hospital**		**Outcome** *(tick)*	**Alive**		**Delivery Type** *(tick)*		**Normal**		
	Clinic			**Miscarriage**				**Complex**		
	Matrona			**Still birth**				**Caesarean**		
	None of above			**Perinatal death**				**unknown**		

Pregnancy 2

Mobile Clinic		**RC** 3 – high 2 – moderate 1 – low	**Factor** (list all observed)			**ITN**	**Delivery kit**	**Date and signature**		
Date of last period										
Expected delivery date										
Antenatal visit	**1st**									
	2nd									
	3rd									
	4th									
Delivery location *(tick as applicable)*	**Hospital**		**Outcome** *(tick)*	**Alive**		**Delivery Type** *(tick)*		**Normal**		
	Clinic			**Miscarriage**				**Complex**		
	Matrona			**Still birth**				**Caesarean**		
	None of above			**Perinatal death**				**unknown**		

Vaccine record *(date if known)*							
Measles							
OPV3							
OPV2							
OPV1							
DTP3							
DTP2							
DTP1							
BCG							
Mobile clinic check ups V – vaccine M - malnutrition R - referral							
10							
9							
8							
7							
6							
5							
4							
3							
2							
1							
Vaccine card completed							

Child no.	Date	Location (X)			Diagnosis	Treatment	Name and signature of healthcare provider
		Tabanca	Clinic	Hospital			

Appendix 2 – Health Club Member Card

Effective Intervention

Health Club Member Card

Identification Number	□□□ - □□□ - □□□ - □□□ CLUSTER NO. TABANCA NO. HOUSEHOLD NO. HC member no. *or* woman no.
Health Club Promoter	
Date of Registration	

	Topic	Date	Signature HP	Signature HCS
1	Topic 1: Danger Signs			
2	Topic 2: Diarrhoea and Dehydration			
3	Topic 3: Managing Dehydration: ORS			
4	VHW Review 1: Diarrhoea			
5	Topic 4: Malaria: Signs and Symptoms			
6	Topic 5: Malaria: Causes and Prevention			
7	Topic 6: Respiratory Infections: Signs and Symptoms			
8	VHW Review 2: Fever and Cough			
9	*Revision*			
10	Topic 7: Institutional Delivery			
11	Topic 8: Home Delivery			
12	Matrona Review 1: Training			
13	Topic 9: Breastfeeding and Weaning			
14	Topic 10: Recognition and Treatment of Neonatal Infections			
15	*Revision*			
16	**Xxx**			
17	Topic 11: Safe Drinking Water			
18	Topic 12: Faecal-Oral Route 1: Hand Washing			
19	Topic 13: Faecal-Oral Route 2: Sanitation			
20	**Xxx**			
21	Topic 14: Good Nutrition			
22	Topic 15: Child Growth and Malnutrition			
23	Topic 16: Immunisation, Vitamin A and De-worming			
24	VHW Review 3: Nutrition			
25	*Revision*			
26	Topic 17: HIV/AIDS			

Appendix 3 –Health Promoter Reporting form

CLUBES DE SAÚDE: INTEGRATED STRATEGY

HEALTH PROMOTER REPORTING FORM

Nome do(a) Promotor(a) de Saúde:			
Indicadores de seguimento	**Resultados**		
Did you conduct the Mothers' Health Club in each *tabanca* this month?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Did 40% or more registered women attend the Mothers' Health Club in each *tabanca* this month?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Have you maintained the *tabanca* Attendance Register and completed the Attendance Rate Total Forms?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Did you conduct the Health Club Volunteer training in each *tabanca* this month and were all the Health Club Volunteers present?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Did you conduct the Health Club Volunteer supervision in each *tabanca* this month?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Did you conduct the Health Knowledge Check in each *tabanca* this month?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Did 50% or more registered women in every *tabanca* answer the question(s) correctly this month?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Have you recorded the results of the Health Knowledge Checks on your Health Club Volunteer Supervision Form?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Have you completed the relevant section of the ASB and *matrona* incentive sheets, if applicable this month?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Mantiveste o teu Diario diariamente?	Nao	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Mantiveste o Teu Caderno de Bordo diariamente e devolvidos ao seu Supervisor?	No	Parcial.	Sim
Se for nao, ou parcialmente, explique porque:			
Outros problemas identificados.			
Data:			
Assinatura:			

Appendix 4a – Supervisor Monitoring form 1

HEALTH PROMOTION			
FICHA DE SEGUIMENTO DAS ACTIVIDADES DOS HEALTH PROMOTERS 1: MOTHERS' HEALTH CLUBS / HC VOLUNTEERS TRAINING			
Nome do Promotor de Saude			
Nome da Tabanca:			
Data:			
Preparation			
Observa o Promotor de Saúde: O Promotor de Saúde arrived the previous evening e is the Health Promoter totalmente preparado para a sessions? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observa o Promotor de Saúde: O Promotor de Saúde visit each Health Club Volunteer to ensure that they remind Health Club members in their designated households to attend the Health Club? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Health Club			
Observa o Clube de Saúde: O Promotor de Saúde comunicar com sucesso as Mensagens Chaves da sessão? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observa o Clube de Saúde: O Promotor de Saúde conduct the activities in accordance with the manual and the training? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observa o Clube de Saúde: O Promotor de Saúde comunica bem com os membros do Clube de Saúde? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observa o Clube de Saúde: Os membros do Clube de Saúde estão a participar na discussao and activities durante a sessão? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Attendance no Clube de Saúde Check that the Health Promoter signs the Health Club Member Cards and marks the Attendance Register correctly.			
Attendance no Clube de Saúde Check that the Health Promoter completes the Attendance Records Total Form correctly.			
Attendance no Clube de Saúde Verifica o numero de participantes no Clube de Saude and verify the number of participants attending the Mobile Clinic. Se os numeros nao estao a corresponder, discuta o problema com o Promotor de Saudee concorda numa accao para encontrar uma solucao. Regista as suas observacoes e discussoes aqui:			
Regista aqui as fraquezas que observaste no Clube de Saude.			
Regista aqui as forcas que observaste no Clube de Saude.			
Health Club Volunteer Training			
Observe the Health Club Volunteer Training O Promotor de Saúde provide suitable feedback from the supervision findings? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observe the Health Club Volunteer Training O Promotor de Saúde comunicar com sucesso as Mensagens Chaves da sessão? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim

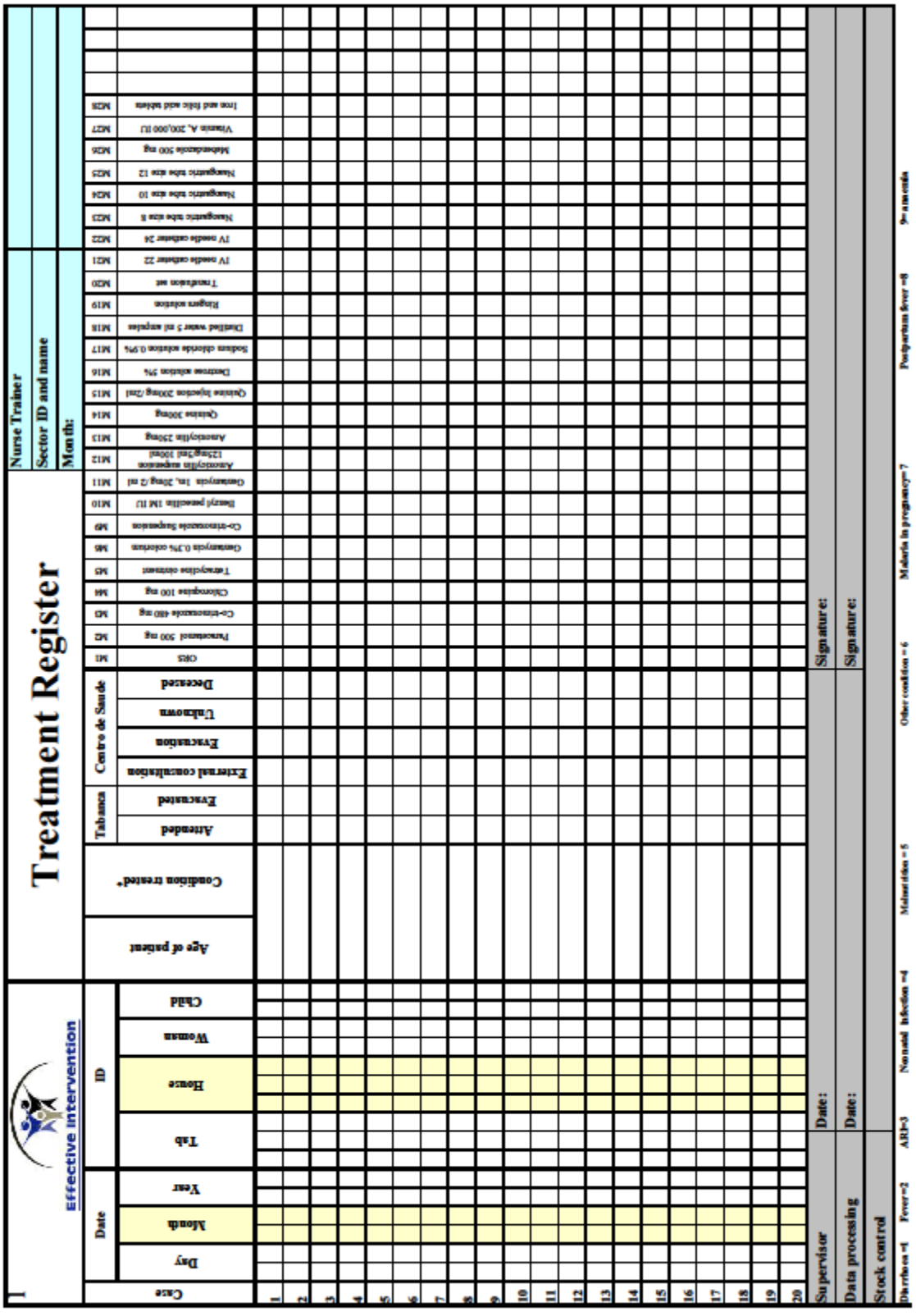
Observe the Health Club Volunteer Training **O Promotor de Saúde provide the explanations and conduct the demonstrations in accordance with the manual?** **Se for não ou parcialmente, explica porquê e onde havia problemas:**	**Não**	**Parcial.**	**Sim**
Observe the Health Club Volunteer Training **O Promotor de Saúde rigorously train the Health Club Volunteers to provide the explanations and conduct the demonstrations in accordance with the manual?** **Se for não ou parcialmente, explica porquê e onde havia problemas:**	**Não**	**Parcial.**	**Sim**
Observe the Health Club Volunteer Training **O Promotor de Saúde go to one designated household with each Health Club Volunteer in accordance with the manual?** **Se for não ou parcialmente, explica porquê e onde havia problemas:**	**Não**	**Parcial.**	**Sim**
Records			
Validar o Diário: **A informação registada no Diário combina com o Plano de Trabalho e o Registo do Caderno de Bordo (isto é todos os registos colocam o PS na mesma localidade no mesmo dia)? Se for no ou parcialmente, explica porquê e onde havia problemas:**	**Não**	**Parcial.**	**Sim**
Validar o Diário: **O Promotor de Saude registou todas as informacoes necessarias no diario: Data; Localidade; Topico; Numero de Participantes; Forcas do Clube de Saude; Problemas do Clube de Saude e Solucoes Sugeridas** **Se for não ou parcialmente, explica porquê e onde havia problemas:**	**Não**	**Parcial.**	**Sim**
Validar o Caderno de Bordo **A informação registada no Caderno de Bordo combina com a Quilometragem na Moto?** **Se for não ou parcialmente, explica porquê e onde havia problemas:**	**Não**	**Parcial.**	**Sim**

Accao para o Promotor de Saude tomar	**Accao Tomada**
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
Data:	
Assinatura:	

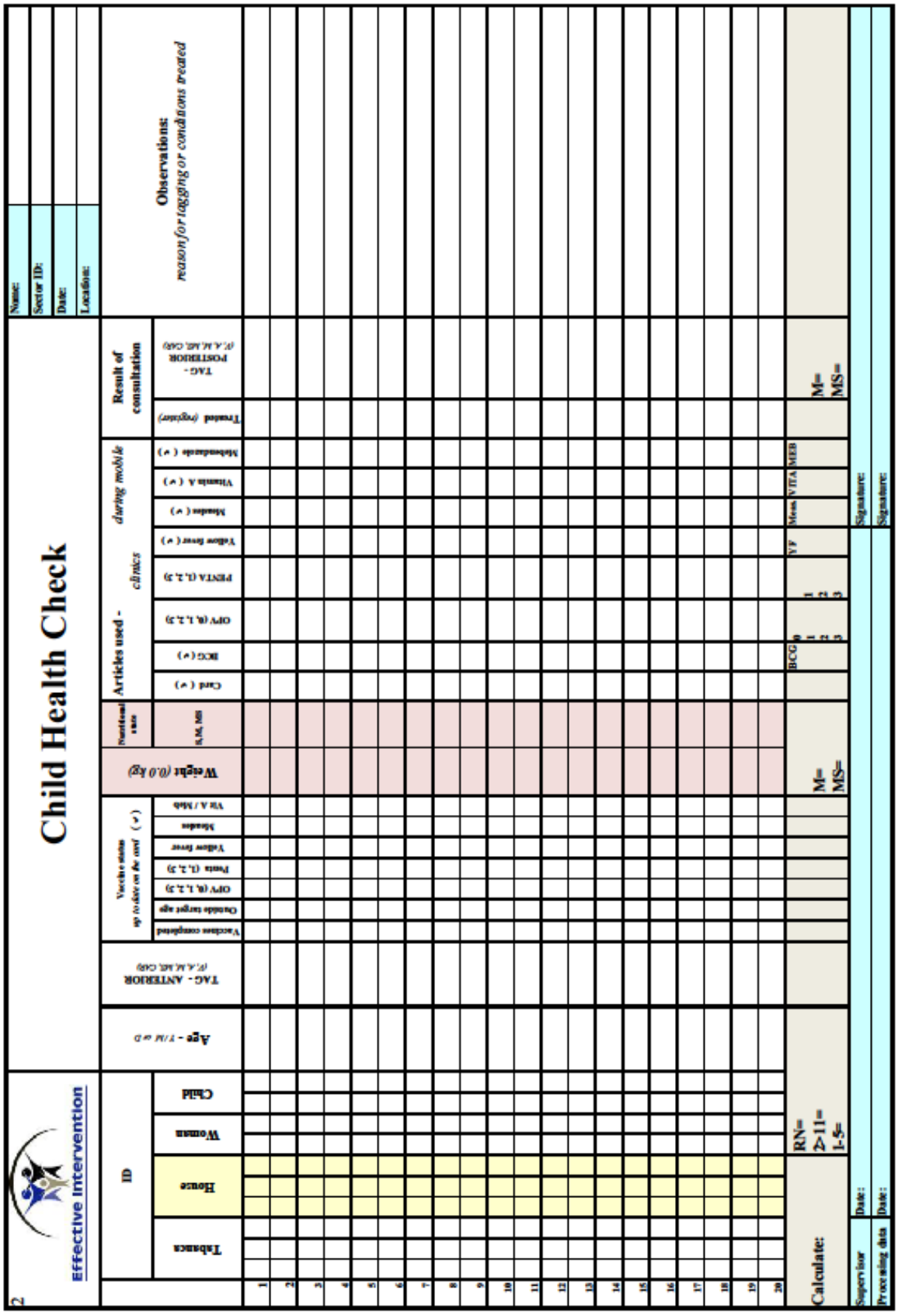
Appendix 4 b– Supervisor Monitoring form 2

HEALTH PROMOTION			
FICHA DE SEGUIMENTO DAS ACTIVIDADES DOS HEALTH PROMOTERS 2: HC VOLUNTEERS SUPERVISION			
Nome do Promotor de Saude			
Nome da Tabanca:			
Data:			
Preparation			
Observa o Promotor de Saúde: O Promotor de Saúde arrived the previous evening or a soon as possible in the afternoon e is the Health Promoter totalmente preparado para a supervision? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observa o Promotor de Saúde: O Promotor de Saúde correctly select Health Club Volunteers to supervise i.e. if there are more than two Volunteers in the *tabanca* , is the Health Promoter ensuring that he or she alternates the supervisions? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observa o Promotor de Saúde: O Promotor de Saúde correctly use the Health Club Volunteer - Household list to select one household in which to supervise the Volunteer and four households in which to conduct the health knowledge check? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Health Club Volunteer Supervision			
Observa o Supervision: Did the Health Promoter encourage and motivate the Health Club Volunteer? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observa o Supervision: O Promotor de Saúde ensure that the Health Club Volunteer transmitted the key messages accurately? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim
Observa o Supervision: O Promotor de Saúde ensure that the Health Club Volunteer conducted the activities correctly? Se for não ou parcialmente, explica porquê e onde havia problemas:	Não	Parcial.	Sim

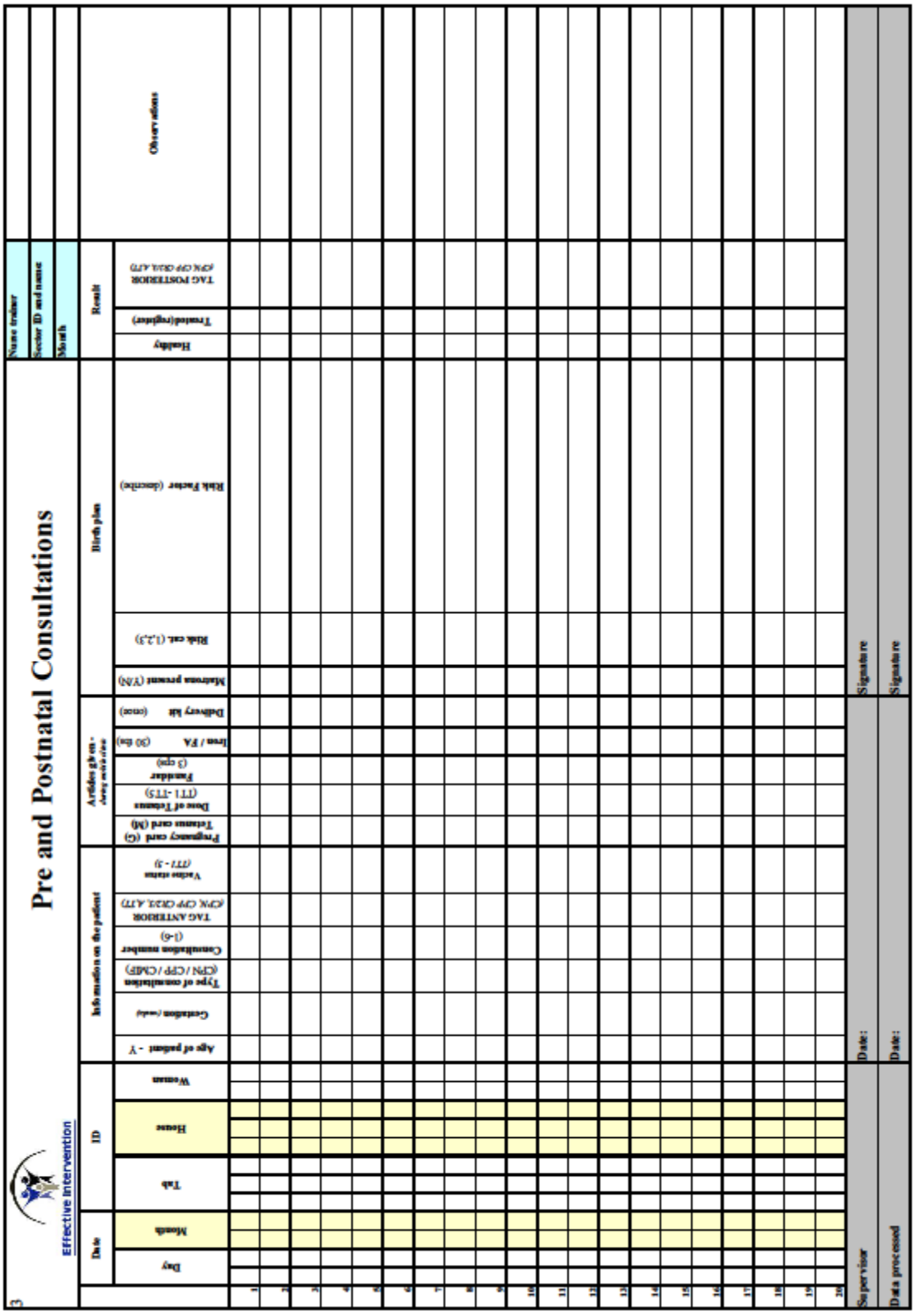
Appendix 5 – NTs and TBAs child and women treatment form.



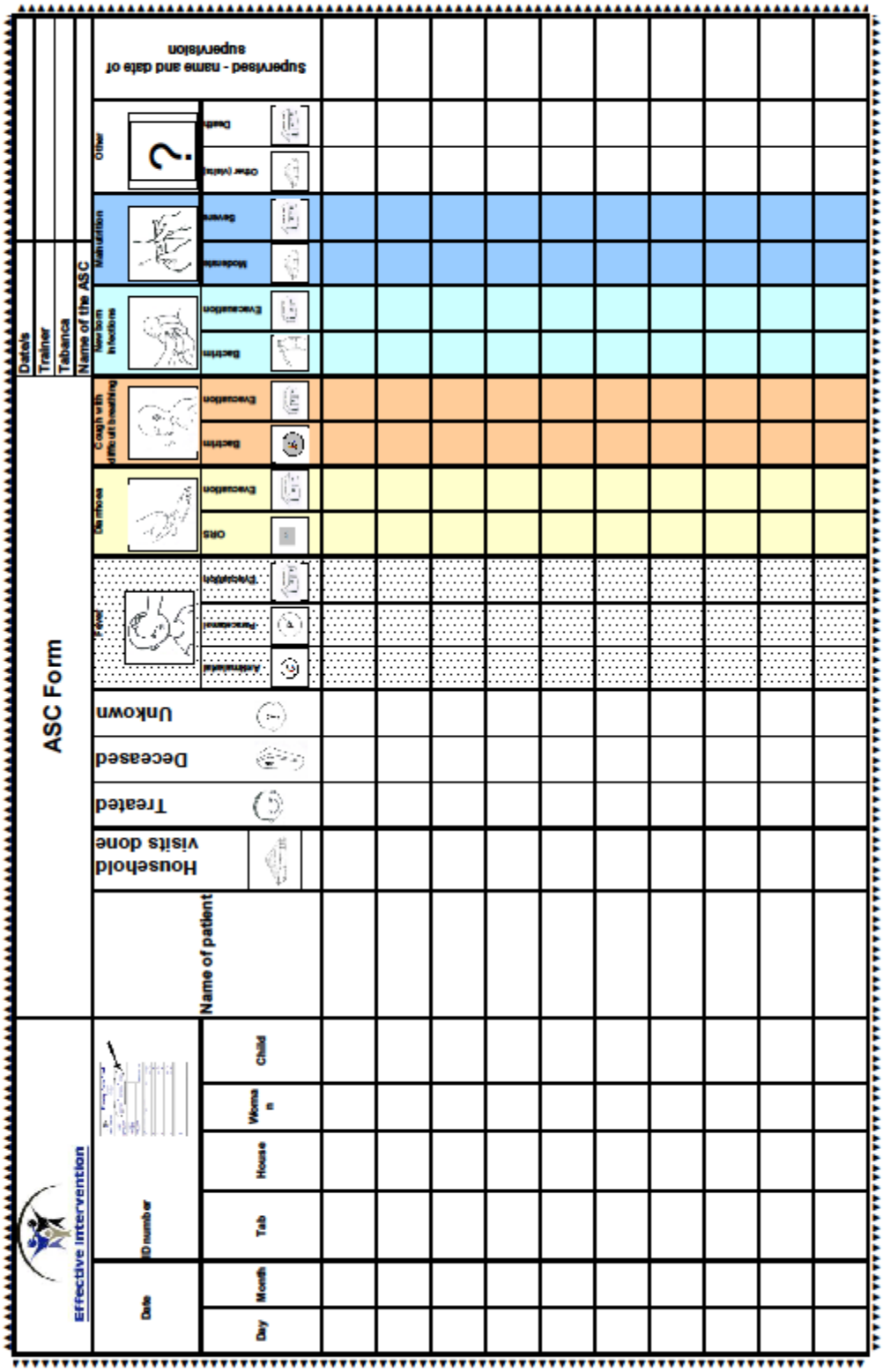
Appendix 6 – Child health checks' form used by NTs during MCs



Appendix 7 – Pre and Post natal consultation Form used by NTs during MCs.



Appendix 8 – VHWs' child treatment form



Appendix 9 – VHW Monitoring Form

Effective Intervention

VHW signature_____ **VHW Supervision Form**

Part a: Basic information

A1	**Name of Nurse Trainer:**				
A2	**Sector:**				
A3	**Tabanca code:**				
A4	**VHW under supervision***(code/name)* *Active/not – active?*				
A5	**Date of supervision**				
Stock Check					
	Item	**Stock (previous month)**	**Left (on the form)**	**Current Stock**	**Stock correct?**
A6	Chloroquine				
	Bactrim				
	Paracetamol				
	ORS sachets				
	Tetracycline ointment				
A7	Total number of cases treated/visited – whole month				
A8	Number of evacuations				
A9	Deaths number				
A10	**Activities** The VHW actively assisted the Mobile Clinic?				**Passed this section?**
	The VHW register is up to date?				

Part b: Selection of Cases

	Case	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
B1	**Date that the event was first noticed**										
B2	**Mother ID number**										
B3	**Child ID number**										
B4	**Name of the child**										
B4	**Condition diagnosed** Diarrhoea = 1 Fever= 2 Cough/breathing difficult = 3 Fever with cough = 4 Neonatal Infection = 5 Malnutrition = 6 Not clear= 7										
B5	**Response** Treated in the community = 1 Evacuated = 2										
B5	**Treatment and at**(all ORS sachets										
	Chloroquine										

	data)	Paracetamol										
		Bactrim										
		Other (Tetracycline /Multivitamin /iron)										
B6	**Follow-up visits reported/ registered**											

Part C: interview family

	Case	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
C1	**Family visited by NT** Interviewed = 1 Missing = 2 You have not agreed to be interviewed = 3										
C2	**The child was assessed during the visit of NT** Not = 1 Yes = 2										
C3	**The diagnosis of VHW was appropriate** Not = 1 Not clear= 2 Yes = 3										
C4	**The treatment of VHW was appropriate** Not = 1 Not clear= 2 Yes = 3										
C5	**The family received the treatment/ registered visits** Not = 1 Not clear= 2 Yes = 3										
C6	**Appropriate and sufficient counselling given to parents** No or, the advice given was incorrect = 1 Not clear= 2 Yes, advice clear and correct = 3										
C7	**Appropriate follow-up visits** No, VHW haven't visited = 1 VHW visited a few days, not all = 2 Yes, all days visited = 3										
C8	**Result registered correctly** Not = 1 Not clear= 2 Yes = 3										
C9	**Treatment carried out** The child did not start the treatment = 1 The child did not complete = 2 The child completed the treatment = 3										
C10	***Evacuation recommended* and** The child has been examined in HC= 1 The child has not been examined in HC = 2 The child was evacuated to another place = 3										
C11	**Member of the family interviewed** Primary carer = 1 Another household member = 2 Non-household member = 3										
	Performance total treatment /follow-up of VHW Count C3 to C8	**/18**	**/18**	**/18**	**/18**	**/18**	**/18**	**/18**	**/18**	**/18**	**/18**
	C5 must be 3-x/ ✔										
	Approved or not x/ ✔										
	Average performance	**0> 12 FAILED**			**NORMAL 12 > 17**				**17-18 EXCELLENT**		

D. Knowledge Check

D1	**General danger signs in children (4)**		Inability to drink/ breastfeed Unconscious/ lethargic		Vomiting everything ingested Convulsions
D2	**Signs of evacuation of diarrhoea/dehydration (5)**		Blood in stool Suspicion of cholera Slow skin pinch		Fontanel sunken Eyes sunken
D3	**Prepare SRO (4)**		Boil the water Cool the water		Use a packet to 1 litre Filter the water
D4	**Care of a child with diarrhea (4)**		Give more than usual to drink Give (correct) quantity of ORS after each diarrhoea		Increases breastfeeding Return immediately if danger signs are noticed
D5	**Evacuation signs for cough/difficulty breathing (2)**		Chest indrawing		Noisy breathing / grunting/ stridor
D7	**Signs of cough/difficulty breathing to treat in tabanca at different ages (2)**		Rapid Breathing > 50 children 2-12 months		Rapid Breathing, > > 40 children 12 months
D8	**Treatment of pneumonia – what is the treatment and how? (4)**		Use bactrim Treatment is given twice per day		Treatment is taken 5 days Different age groups have different quantities
D9	**Advice on the care of a child with cough/difficulty breathing (6)**		Wrap the child warmly Clean the nose frequently Give more food to eat		Give more drinking fluids Increases the suckling Allow much sleep
D10	**Danger signals for fever (3)**		Skin rash Swollen fontanel		Neck stiffness
D11	**Treatment of a child with fever – what is used and how? (4)**		Chloroquine/coartem Taken 1 time per day (2 coartem)		Taken during three days Various age groups take different amounts
D12	**Advice on the care of a child with fever (6)**		Do not wrap up the child Keep cool Give more to eat		Give more to drink Increases breastfeeding Return immediately if the child worsens
D13	**Use of Paracetamol – what it does and how is it used? (4)**		Lower temperature of a child Don't give more than once in every 6 hours		Taking the maximum of 4 times per day. Various age groups take different amounts
D14	**That signals on the growth curve indicate that a child may have malnutrition? (2)**		Reading in yellow, red or area below the red zone		A flat or descending line
D15	**What are the five golden rules of good breast feeding? (5)**		Start the 1st hour of life Exclusive Breastfeeding to 6 months Breastfeeding free demand/8-12 times per day minimum		Keep breast feeding with complementary food up to 2 years Avoid artificial milk
D16	**Which colours in the MUAC indicating the severe and moderate malnutrition? (2)**		Yellow = moderate		Red = severe
D17	**What are the complications of malnutrition (2)**		Marasmus = baggy trousers		Kwashiorkor= Oedema, both feet
D18	**How to prepare a SAT? (5)**		1 cup of milk/beans cooked/1 egg ¾ crushed peanuts 1 multivitamins per day (per cup)		1 cup of sugar ½ cup of oil
D19	**How to give SAT (4)**		Max.1 cup per day Under the supervision of the NT		After each meal (3-5) or between meals Much water for drinking
D20	**Detection and treatment of anaemia (4)**		Lack of blood/iron. Pallor of the eyes and hands		Ferrous sulphate ½ pill per day until better
D21	**What are the vaccine and when given (5)**		BCG 0-15 days OPV: 0, 6, 10, 14 weeks PENTA: 6, 10, 14 weeks		Measles 9 months Yellow Fever 9 months
D22	**Home Visits: When do visits (6)**		Diarrhoea – every day the ETA improves		Fever / ARI - 5 days
			All diseases – visit control in 8th day		Severe malnutrition = 3 x weekly
			Moderate malnutrition = 1 x weekly		Anaemia/high risk child = 1 time weekly
D23	**Danger signs of infants up to 2 months – general**		Unable or reduced to breast-feeding		Swelling of the navel

	danger signs (12)		Lethargic unconscious/reduced activity		Pus/bad smell of navel
					Redness of the navel
					Quick Respiration (> 60rpm)
			Convulsions		Fontanel swollen
			Vomiting everything ingested		Fever
			HEG		Cold Body
	Max. points possible for questions asked	**Points achieved in questions asked**			**%**

SUPERVISION incentives

Period of supervision	From _____ to_____			**_____ Total**
Presence at the health club	Over 40% of women registered participated in health club Name of the session ____ _____ _____ _____ _____ _____ _____ _____ 1000CFA			***_____ 1000CFA***
Key message health club volunteers	More than 50% of homes replied correctly Name of the session ____ __ __ _____ _____ _____ _____ _____ _____ 1000CFA			***_____ 1000CFA***
Treatment and disease management	Abuse---------- 0-12 performance 0 CFA. Loss of cases……	12-16 performance CFA + number 0 Cases……..	17–18 performance Bonus 1000 CFA + number of cases….	***_____ 3500 CFA***
	Number of cases = 0 cases 0CFA……..	Number of cases 1-5 cases 2000CFA……	Number of cases 5 + cases 2500CFA……	
Section a. activities of the VHW	The VHW monitored properly and helped actively mobile clinics 500CFA The VHW has updated and correct records 500CFA			***_____ 1000CFA***

Approval of the supervisor Program _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Appendix 10 – TBA Supervision Form

Effective Intervention

Matrona Supervision Form

Part a: Basic information

A1		**Nurse Trainer:**			
A2		**Location:**			
A3		**Name and code of tabanca:**			
A4		**Matrona under supervision:** name and code; Active/not active?			
A5		**Dates of supervision beginning / end (supervision monthly)**			
A6	**Inventory check**	Kit of Matrona is complete and cleaned			
		Antiseptic			
		Tetracycline ointment			
		Delivery kits			
A7		Number of pregnant in the register of tabanca			
A8	PLA	Childbirth *in tabanca* since last supervision	**CR1**	**CR2**	**CR3**
A9		Births *in health centres* since last supervision	**CR1**	**CR2**	**CR3**
A10		Births *in hospital* since last supervision	**CR1**	**CR2**	**CR3**
A11		Number of evacuations assisted women pregnant or during childbirth accompanied by matrona	**CR1**	**CR2**	**CR3**
A12		Number of cases follow-up post childbirth			
A13		Number of infection of newborns registered			
A14		Number of newborn evacuations assisted			
A18	**Activities**	The matrona actively assisted Mobile Clinics? The registration of tabanca this updated?			**Passed section?**

Part b: Check cards and Interviewing the Family: follow-up of Pregnant:

Copy B1-B7 registration of tabanca. Select cases randomly, before conducting visits houses: try to cover a selection of cases of different risk categories, stages of pregnancy and location in tabanca up to 5 cases, if a question is not appropriate in these cases write NA.

	Cases	**1**	**2**	**3**	**4**	**5**
B1	**Gestation time (trimester)**					
B2	**ID of the pregnant woman**					
B3	**Name of pregnant woman**					
B4	**No. home visits recorded since one month**					
B5	**Observations recorded** (list all) None = 0 Anaemia = 1 Oedema = 2 Abnormal foetal position = 3 Heartbeat not detected = 4 The mother not attended prenatal consultation = 5					
B6	**Evacuation /danger signs** (list all) None = 0 Fever = 1 Bleeding = 2 Abdominal pain = 3 STI = 4 Generalized oedema = 5 Anemia serious/3rd trimester = 6 Another reason = 7					
B7	**Risk category** *CR1, CR2, CR3*					
Interviewing family						
B8	**Pregnant interviewed during the visit of EF** Interviewed = 1 Not this = 2 Present but not agreed to be interviewed = 3					
B9	**Condition of pregnant during the visit** Healthy = 1 Needing references = 2 Needing treatment = 3 Decreased = 4					
B10	**Pregnant confirmed that all visits were made** Not = 0 Not clear = 1 Yes = 2					
, B11	**Number of visits was appropriate by stage of pregnancy and risk factors** no/inappropriate = 0 Not clear or not all visits = 1 Yes = 2					
B12	**Woman confirmed that all checks were made** No / incorrectly = 0 Not clear or not all = 1 Yes = 2					
B13	**Woman confirmed the matrona gave advice appropriate nutrition and personal care** No = 0 Not clear or not all = 1 Yes = 2					
B14	**Advice on birth plan were made properly and with the family** No/incorrectly = 0 No clear = 1 Yes = 2					
B15	**Danger signals encountered** Yes/no					
B16	**Response of danger signs** No appropriate = 0 Evacuation advised, but not done = 1 Appropriate/no pre-generated = 2					
	Result __ _____ _____ _____ _____ _____	**/12**	**/12**	**/12**	**/12**	**/12**

Part c: verifies the chips and Interviewing the family – Follow-up Post Calving:

Copy information from the registration of tabanca for the C1-C7. Select randomly: try cases cover all cases or select randomly including various categories of risk, stages of pregnancy and location in tabanca, up to 5 cases. If a question is not appropriate in these cases write NA.

		Number of event	1	2	3	4	5
Result of childbirth	C1	**Date of confinement**					
	C2	**Mother's ID number**					
		Name of Mother					
	C3	**Women's risk category**					
	C4	**Birth location** Tabanca = 1 Health Centre = 2 Hospital = 3					
	C5	**Result of delivery** Mother and baby healthy = 1 Mother deceased = 2 Baby/s deceased = 3 Mother and baby/s deceased = 4					
	C6	**Matrona assisted childbirth** No = 1 Yes = 2					
	C7	**No. of home visits marked**					
	C8	**Follow-up form were completed** Incorrectly = 0 With some difficulty = 1 Correctly = 2					
Interviewing family – without fine matrona							
Result of childbirth	C9	**Family interviewed during the visit of EF** Interviewed = 1 Not this = 2 This but not agreed interview = 3					
	C10	**Condition of child/s during visit** Healthy = 1 Child/s need referral = 2 Child/s needing treatment = 3 Child/s deceased = 4					

C11	**Mother confirmed the location of delivery of confinement** Not = 0 Yes = 2					
C12	**Mother confirmed that the delivery kit was used** no, or inappropriately = 0 Is not clear = 1 Yes, properly = 2					
C13	**Danger signals during childbirth observed** Yes/no					
C14	**Danger signs during childbirth** Not appropriate = 0 Evacuation advised, but not done = 1 Appropriate = 2					
C15	**Procedure of immediate care (eye care, comfort, navel, suckling)** Incorrect = 0 It is not clear = 1 Clear and correct = 2					
C16	**Birth weight measured and recorded** not done/incorrectly = 0 It is not clear = 1 Correctly done = 2					
C17	**Mother confirmed that all visits were made** Not = 0 Not clear = 1 Yes = 2					
C18	**The visit scheme was suitable for the case.** Not sufficiently visited = 0 Visited some but not all days = 1 Visited properly = 2					
C19	**The mother confirmed that activities (verifications of mother and child, breastfeeding, cord stump check) were done** Incorrectly = 0 It is not clear or partially = 1 Correctly = 2					
C20	**The mother has confirmed that the matrona gave advice on postnatal care** Not given or incorrectly = 0 It is not clear/partially correct = 1 Correct and clear = 2					
C21	**Postpartum danger signs of child/s** None identified = 0 General danger Signals = 1 Breathing Problems = 2 Infection umbilical = 3 Tetanus = 4 Another = 5					
C22	**Postpartum danger signs of mother** None identified = 0 Fever = 1 Pain = 2 Bleeding = 3 Another = 4					
C23	**Response to postpartum danger signs** Not appropriate = 0 Evacuation advised, but not done = 1 Appropriate/not required = 2					
C24	**Common postpartum problems (mother or child), if identified, were managed** Incorrect = 0 Not clear/partial = 1 Correct or no problem encountered = 2					
	Total count, gray areas above **Result**	**/ 24**	**/ 24**	**/ 24**	**/ 24**	**/ 24**

Parte D. Knowledge test During supervision –**ask at least 8 questions** of these listed – not everything in one visit. Circle questions.

D1	**Danger signals during pregnancy (7)**		Fever Abdominal pain Edema Abnormal foetal position		Anemia Bleeding Premature water bursts
D2	**Home Visits: what are the checks that the matrona must perform? (5)**		Anemia Prenatal Consultation Foetal heartbeat		Fetal Position Edema
D3	**What are the advices for a healthy pregnancy (7)**		Good nutrition Good hygiene Rest, without grunt work Take iron		Participate in program Light exercise Avoid alcohol, smoking, salt caffeine
D4	**Plan and prepare (3)**		Describe correctly birth plan for CR2/3 Describe correctly emergency plan Describe correctly site preparation of confinement		
D5	**Danger signals during childbirth (4)**		Prolonged Childbirth Bleeding		Convulsions/loss conscience Abnormal fetal position
D6	**Use of delivery Kit** (4) *describe correctly usage of each article of the kit*		Gloves		Towel
			SOAP and Towel		Clamp and blade
D7	**Danger signals in woman post childbirth (4)**		Fever Abdominal pain		Bleeding Severe Anaemia
D8	**What are the postnatal care advice (6)**		Good nutrition Light exercise Rest		Iron adherence Good hygiene Consultation attendance
D9	**Danger signs of infants up to 2 months – general danger signals (4)** *Ask matrona what are the 4 General danger signals a child, and specifically in the new babies (includes activity reduced or reduced capacity to breastfeed)*		Lethargic unconscious/reduced activity Unable to breastfeed or breast-feeding reduced Convulsions Vomiting everything		
D10	**Signs of danger – breathing difficulties (3)** *What are the signs of a baby < 2 months that has an infection indicated by breathing difficulties*		Rapid breathing Chest indrawing Noisy respiration / grunting /stridor		
D11	**Umbilical Infection (3)** *What signs indicate infection of umbilical cord?*		Swelling Pus/bad odour/wet Redness extending to skin		
D12	**Other signs (4)** *What are the signs of the temperature of the body?* *What are the signs and tetanus infection of the brain?*		Fever Cold Body		Fontanel swollen HEG
D13	**Newborn care in the first hour of life (6)** *Describe that care would immediately after birth the child. How to keep heat? What should you do?*		Describe the procedure correct cutting and care of cord stump Correct procedure to maintain comfort Monitoring of respiration Breastfeeding Eye Care Weigh the baby		
D14	**Newborn care – foetal suffering and response (5)** *Ask matrona how it can tell if your baby suffered asphyxia? And what should you do? What does if the baby stops breathing?*		Slow Breathing, shallow or irregular Not breathing Cyanosis Describe the procedure correctly of mouth to mouth Describe evacuation for all cases of choking		
D15	**Guidelines for breastfeeding (4)** *Ask matrona what are important components of the guidelines of breast-feeding?*		Immediate breastfeeding Exclusive for six months The free demand/at least every three hours Describe good position and attachment		
D16	**Common problems in newborns (4)** *Ask matrona what are the common problems in babies? How can they manage these cases?*		Describe correctly care of ocular infection Describe correctly care of infection of the skin Describe correctly care of diarrhoea Describe correctly care of breast problems		
D17	**Care of vulnerable children and mothers (5)** *Ask matrona which are highly vulnerable babies/mothers that extra care must be given? How often should they visit these babies/ mothers?*		Identifies > types of 3 vulnerable children Identifies an example of vulnerable mother Describes how to weigh the baby at birth Extra warmth, hygiene monitoring and power Visit frequency correct		
	Max points from questions asked		**Points, achieved in questions asked**		**%**

Effective Intervention

Form2 - Quarterly Monitoring

Monitoring Period 01

Cluster Number: 1 **Ethnic Group:** FULA **Tabanca Number:** 001 **Tabanca Name:** NHALA (BUBA)

Monitoring Date Day | Month | Year

Interviewer's Name

Previous Monitoring					Current Monitoring								
ID No.	House No.	Women's Name	Possibly Pregnant	Was Living in House	Who Is Giving Info	Is Woman Alive?	Is she Pregnant?	Months Pregnant	Is she still living in this house?	Child No.	Child's Name	Is Child Alive?	Is child living in this house?
0011001	10	FATUMATA CAMARA	0-00	1						**Children of FATUMATA CAMARA**			
										001100103	SADJO KULUBALI		
										001100101	NHIMA SILLA		
0011002	10	FATUMATA SILLA	0-00	1						**Children of FATUMATA SILLA**			
										001100206	MUMINE SILLA		
0011101	11	META CULBALI	1-09	1						**Children of META CULBALI**			
										001110109	LAMARANA TURE		
0011102	11	CADIDJATO BALDE	0-00	1						**Children of CADIDJATO BALDE**			
										001110203	MAMADUALIO TURE		
0011103	11	MARIAMA BENTE CAMARA	Died	[redacted]						**Children of MARIAMA BENTE CAMARA**			
										001110303	ADULAI SISSE		
										001110302	IERO DJUMA SISSE		
0011201	12	BABITIDA NATAMBA	1-01	1									
0011202	12	DOMINGAS IALA	8888	1						**Carry out an interview with Form B**			
0011301	13	MARIAMA SISSE	0-00	1									
0011302	13	MALADO SANHA	0-00	1									
0011401	14	ADAMA QUEITA	1-05	1						**Children of ADAMA QUEITA**			
										001140104	SUMAILA QUEITA		
										001140103	UMARU DJALO		
0011501	15	MARIAMA CAMARA	0-00	1						**Children of MARIAMA CAMARA**			
										001150106	SADJO CULBALI		
0011502	15	SALIMATU TURE	0-00	1						**Children of SALIMATU TURE**			
										001150205	LASANA CULBALI		
										001150204	DENBA CULBALI		
0011601	16	URI TURE	0-00	1						**Children of URI TURE**			
										001160109	BRAIMA CULUBALI		
										001160108	FATUMATA CULUBALI		
0011602	16	CADIDJATO CULBALI	1-06	1									
0011603	16	BINTA CULUBALI	0-00	1									

Appendix 11b –Instructions to fill in the QM form

Appendix 12 –Pregnancy Outcome Form: final version

PREGNANCY OUTCOME FORM

Effective intervention

Date of the interview	Interviewer's name	Tabanca name	Tabanca ID
Day Month Year			

House Number	Woman's ID Number	Woman's Name

Who is giving the interview?
(1= woman who gave birth, 2=husband ,3=maternal kin, 4=paternal kin, 8=non-kin informant)

Were you present at the delivery?
0=No, 1=Yes

Single or multiple births?
(1 = single, 2 = twin, 3 = triplet, 4 = quadruplet, 8=don't know)

Where did she deliver?
(1=woman's house, 2=family's house, 3=USB , 4=Health Centre, 5=Catió Hospital, 6=Bissau Hospital, 7=other, 8= don't know)

When was the delivery?
(Day/month/ year) 88/88/8888=Don't know)

Day Month Year

Who helped during delivery? (write the letters that correspond to all those who helped)
A=midwife/ doctor, B=TBA, C= woman's relative, D=co-wife/ friend, E=husband, F=nobody, G=other, H = husband relative, X= don't know

Baby ID	Was he/she born alive? Or was it a stillbirth, a miscarriage or woman was not pregnant?	Sex?	What was used to cut the umbilical cord?	Was anything applied to the cord stump? If yes, what?	How long after giving birth did mother start breastfeeding?	When was the baby 1st wrapped?	When was the baby 1st in contact skin-to-skin with mother?	When did the baby have the 1st bath with water?	Is the child still alive?	Child's name
1										
2										
3										
4										
Baby ID	1=born alive 2= stillbirth 3=miscarriage 4=she was not pregnant 8 = DK	0=boy 1=girl 8 = DK	0=non sterilized instrument 1=sterilized instrument 8=DK	A=nothing B=alcohol/ antiseptic cream C=palm oil X=other W=DK	0= more than 1 hour after delivery 1=less than 1 hour 7=Not applicable 8=DK	0=more than 1 hour after delivery 1=less than 1 hour 7=Not applicable 8=DK	0=more than 1 hour after delivery 1=less than 1 hour 7=Not applicable 8=DK	0=in the day of the delivery 1=after 7=Not applicable 8=DK	0=No 1=Yes 8= DK	Write the name given to the child and if they still have to be given a name write - Bebe

Field supervisor's signature

Effective Intervention

VERBAL AUTOPSY LIST - 1ST QUARTERLY MONITORING

CLUSTER 43 – CA BEAFADA 210

MONITORING DATE –

FIELD SUPERVISOR'S NAME –

Tabanca No.	House No.	Woman's No.	Woman's name	Child No.	Child's name	Why not carried out last time?	Which VA to be carried out?	Date of death	Why not carried out this time?
210	01	01	AISSATU BANORA	08	AMADU GOMES	1	Child VA	25/08/2007	
210	05	03	SIREM CAMARA	-	-	0	Maternal VA	12/08/2007	
210	23	01	ALIMATU SAMBU	05	MUSSA DJASSI	1	Neonatal VA	11/07/2007	
210	46	01	LIDIA NANQUI			0	Maternal VA	26/07/2007	
								……/……./…….	
								……/……./…….	
								……/……./…….	
								……/……./…….	
								……/……./…….	
Tabanca number	**House number**	**Woman's number**	**Complete with her name (see Quarterly Monitoring form)**	**If a child does not have a no. leave it blank**	**Complete with child's name (see Quarterly Monitoring form). If child does not have a name write BEBE**	**0=no one eligible was present. 1=no one eligible wanted to give an interview**	**1=Maternal VA 2=Child VA 3=Neonatal VA**	**Day/month/year**	**0=no one eligible was present. 1=no one eligible wanted to give an interview 2= VA ok**

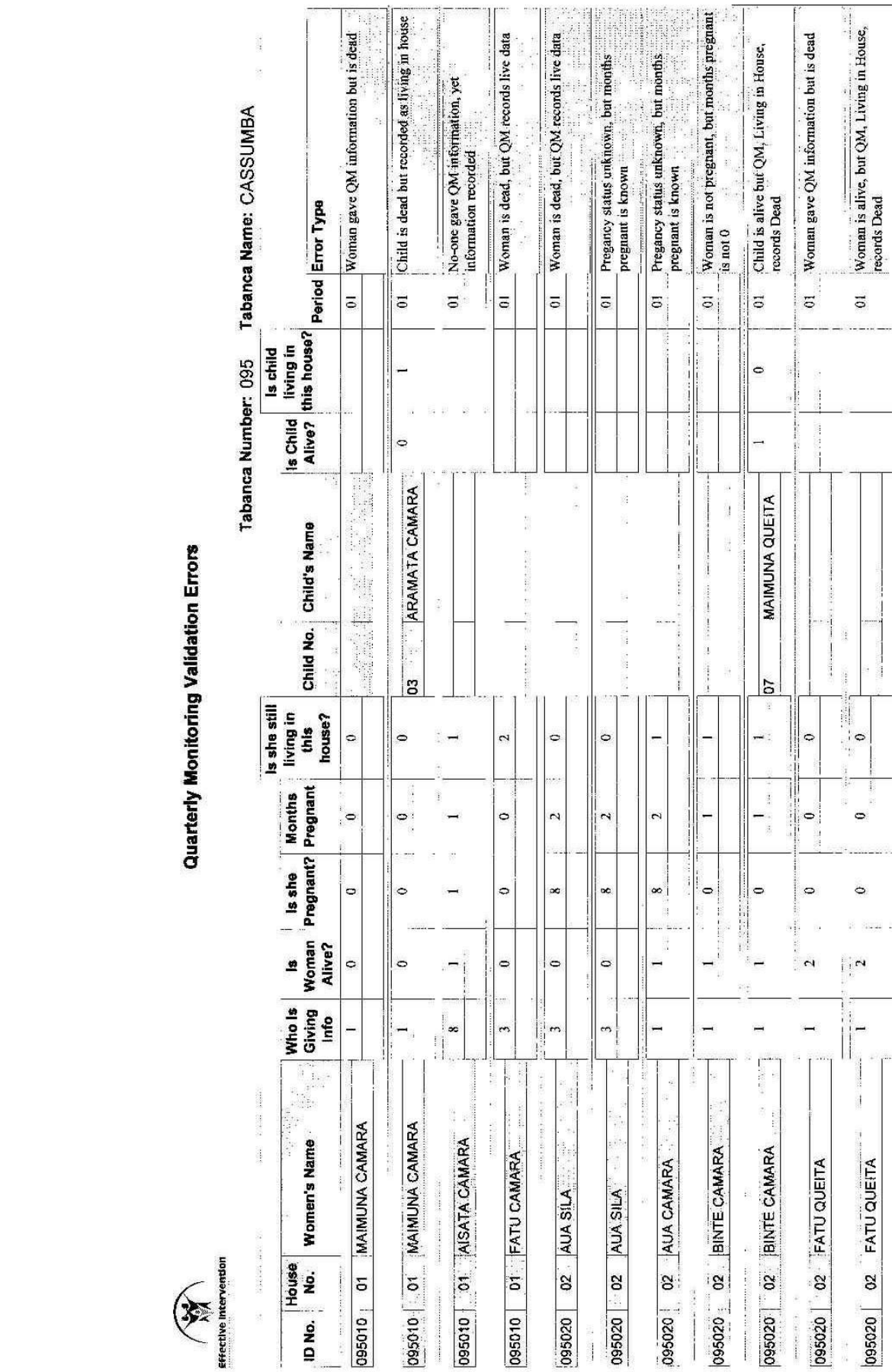
Appendix 14 – Baseline Validation Error Report

Validation Error Report

Tabanca: NHALA (BUBA) **Tabanca ID: 001** **House ID: 01**

Women ID:	Woman's Name:	Child ID:	Child's Name:	Error:	Action to take
01	Adama kulubali			Said live birth, but no children in system	Interview for Children
01	Adama kulubali			Missing Has Co-wives	Do you have a co-wife? 0 NO 1 YES
01	Adama kulubali			Missing Lives with co-wives	Do you live in the same house with other co-wives? 0 NO 1 YES
01	Adama kulubali	01	Mariama cante	No name for child	Child Name
01	Adama kulubali	02	Satenen Cante	All 3 (days, months, years) when died are null	How Old Was The Child When He/She Died Days/Months/Years ☐☐ ☐☐ ☐☐
01	Adama kulubali	03	Samba Cante	Missing Biological/Foster	1 BIOLOGICAL 2 FOSTER
01	Adama kulubali	03	Samba Cante	Missing Gender for child	0 BOY 1 GIRL
01	Adama kulubali	04	Sadjo Cante	Missing Child Alive Or Not	Is The Child Alive 0 NO 1 YES
01	Adama kulubali	05	Bebe Kulubali	Missing If Living with Mum	Is The Child Is Living with Mum 0 NO 1 YES
02	Ussainatu Djaquite			Co-wife ranking error Number of Co-wives=2 but Position of Ranking=4	Are you first, second, or…among your co- wives? ☐
02	Ussainatu Djaquite			Missing Belief	Among these groups which one you most identify in 1 BALANTA 2 BIAFADA 3 FULA 4 NALU 5 MANDINGA 6 SUSSO 7 BIJAGÓS 8 OTHER
03	Fatumata Ba			Missing Months Pregnant	How many months are you pregnant? ☐
03	Fatumata Ba			Missing Marriage Status	1 MARRIED OR LIVING TOGETHER 2 SINGLE 3 WIDOW
05	Taibo Cante			Inconsistant Date of Birth Age=20 and Month of Birth=5 and Year of Birth=1976	Enter Month and Year of Birth ☐☐ ☐☐☐☐ Enter Age ☐☐

Appendix 15 – Quarterly Monitoring Validation Report



Effective Intervention

Quarterly Monitoring Validation Errors

Tabanca Number: 095 **Tabanca Name:** CASSUMBA

ID No.	House No.	Women's Name	Who Is Giving Info	Is Woman Alive?	Is she Pregnant?	Months Pregnant	Is she still living in this house?	Child No.	Child's Name	Is Child Alive?	Is child living in this house?	Period	Error Type
095010	01	MAIMUNA CAMARA	1	0	0	0	0					01	Woman gave QM information but is dead
095010	01	MAIMUNA CAMARA	1	0	0	0	0	03	ARAMATA CAMARA	0	1	01	Child is dead but recorded as living in house
095010	01	AISATA CAMARA	8	1	1	1	1					01	No-one gave QM information, yet information recorded
095010	01	FATU CAMARA	3	0	0	0	2					01	Woman is dead, but QM records live data
095020	02	AUA SILA	3	0	8	2	0					01	Woman is dead, but QM records live data
095020	02	AUA SILA	3	0	8	2	0					01	Pregancy status unknown, but months pregnant is known
095020	02	AUA CAMARA	1	1	8	2	1					01	Pregancy status unknown, but months pregnant is known
095020	02	BINTE CAMARA	1	1	0	1	1					01	Woman is not pregnant, but months pregnant is not 0
095020	02	BINTE CAMARA	1	1	0	1	1	07	MAIMUNA QUEITA	1	0	01	Child is alive but QM, Living in House, records Dead
095020	02	FATU QUEITA	1	2	0	0	0					01	Woman gave QM information but is dead
095020	02	FATU QUEITA	1	2	0	0	0					01	Woman is alive, but QM, Living in House, records Dead

Pregancy Outcome Form Errors

Tabanca NHALA (BUBA) **Tabanca ID 001** **House ID 01**

Woman ID	Woman's Name	Date of Interview	ErrorType	Action to be taken	Action to be taken
0010101	Adama kulubali	01/02/2008	Baby born in future	**Child ID** 07 **Single/Multiple** SINGLE **Born** miscarriage **Gender** BOY **Delivery Date** 01/03/2009 **ChildsName** Peter	Enter correct date of delivery Days/Months/Years ☐☐ ☐☐ ☐☐
0010101	Adama kulubali	01/02/2008	Missing Single/Multiple Birth	**Child ID** 06 **Single/Multiple** No Data Entered **Born** born alive **Gender** No Data Entered **Delivery Date** 99/99/0099 **ChildsName** bebe	1 SINGLE 2 TWIN 3 TRIPLET 4 Quads 8 Don't know 9 No Data Entered If not single, complete another POF
0010101	Adama kulubali	01/02/2008	Missing Gender	**Child ID** 06 **Single/Multiple** No Data Entered **Born** born alive **Gender** No Data Entered **Delivery Date** 99/99/0099 **ChildsName** bebe	0 BOY 1 GIRL 9 No Data Entered

Appendix 17 – Stillbirths' Verification form

Effective Intervention
EPICS PROJECT

STILLBIRTHS VERIFICATION

Date Printed: 10/03/2010
Tabanca name NHALA (BUBA)
Tabanca ID 001

CONSENT: You HAVE TO interview someone that was present during the delivery in each case you investigate. Read the consent, mark for each case and start the interview if s/he agrees to be interviewed.

Interviewer's signature:..... ID ☐☐

STILLBIRTH INFORMATION	QUESTIONS
Sadjo Cante **0010104** **Stillbirth Information** **Date of the interview** 30/10/2009 **Who is Giving Interview** Maternal Kin **Single / Multiple Birth** SINGLE **Gender** BOY **Where did she deliver?** family's house **Delivery Date** 15/8/2009 **Who helped deliver?** Don't know	**Who was interviewed?** A= Mother B= Birth Attendant C= Midwife and/or doctor D= someone else who assisted delivery W=Not possible to find eligible person - finish interview **Did they give consent?** 1=Yes 0=No - finish interview **Did you see baby immediatly after s/he came out?** 0=No 1=Yes **Did child show signs of life (breathing, heart beat, pulsation of the umbilical cord, movement)?** 0=No 1=Yes 2=birth attendant says Yes, but mother says No (or DK) 3=birth attendant says Yes, but other person says No (or DK) 4=mother says Yes, but birth attendant says No (or DK) 5=mother says Yes, but other person says No (or DK) 6=one person says Yes, but other person says No (or DK) 8=don't know (DK) **Was resuscitation attempted?** 0=No 1=Yes 2=Baby died before onset of labour 8=Don't know
FATUMATA SILLA **0012502** **Stillbirth Information** **Date of the interview** 05/07/2009 **Who is Giving Interview** Maternal Kin **Single / Multiple Birth** SINGLE **Gender** BOY **Where did she deliver?** other **Delivery Date** 9/4/2009 **Who helped deliver?** midwife/ doctor	**Who was interviewed?** A= Mother B= Birth Attendant C= Midwife and/or doctor D= someone else who assisted delivery W=Not possible to find eligible person - finish interview **Did they give consent?** 1=Yes 0=No - finish interview **Did you see baby immediatly after s/he came out?** 0=No 1=Yes **Did child show signs of life (breathing, heart beat, pulsation of the umbilical cord, movement)?** 0=No 1=Yes 2=birth attendant says Yes, but mother says No (or DK) 3=birth attendant says Yes, but other person says No (or DK) 4=mother says Yes, but birth attendant says No (or DK) 5=mother says Yes, but other person says No (or DK) 6=one person says Yes, but other person says No (or DK) 8=don't know (DK) **Was resuscitation attempted?** 0=No 1=Yes 2=Baby died before onset of labour 8=Don't know

ABREVIATIONS

CFA – West African CFA franc (the local currency in Guinea Bissau – 1,000 CFA = 1,32 GBP, 7/05/2010)

EPICS – Enabling Parents to Improve Child Survival

GPS - Global Positioning System

HC – Health Club

HP – Health Promoter

IMCI – Integrated Management of Childhood Illnesses

IMPAC – Integrated Management of Pregnancy and Childbirth

LSHTM – London School of Hygiene and Tropical Medicine

MC – Mobile Clinic

M – Moderate Malnourishment

MS – Severe Malnourishment

NT – Nurse Trainer

POF – Pregnancy Outcome Form

QM – Quarterly Monitoring

STI – Sexually Transmitted Infections

TBA – Traditional Birth Attendant

VA – Verbal Autopsy

VHW – Village Health Worker

WHO – World Health Organization