MINISTRY OF HEALTH OF THE REPUBLIC OF KAZAKHSTAN

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СОЮЗ МЕДИЦИНСКИХ КОЛЛЕДЖЕЙ КАЗАХСТАНА
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UNIVERSAL PROGRESSIVE MODEL OF HOME-VISITING SERVICES FOR PREGNANT WOMEN AND YOUNG CHILDREN AT THE PRIMARY HEALTH CARE LEVEL

Methodical Recommendations for Implementation in Primary Health Care Organizations

Astana, 2018

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The standard for the organization of pediatric care adopted by the Order No. 1027of the Ministry of Health of the Republic of Kazakhstan on January 25, 2018, governs the implementation of the universal progressive patronage nursing of pregnant women and young children at the PHC level.

These Methodical recommendations are based on the experience of national experts of the United Nations Children's Fund (UNICEF) whosupervisedthe pilot project for the implementation of the universal progressive patronage nursing of pregnant women and young children in the Kyzylorda Oblastin 2016-2018.

TheseMethodical recommendationswere written to support CEOs of healthcare organizations, doctors, social workers, patronage nurses working in PHC, teachers of medical colleges and curators of clinical nurse training bases in a deeper understanding of ideas of the new patronage model and prevention of mistakes during implementation.

TheseMethodical recommendationsare the result of cooperation of UNICEF’s national experts in the field of early childhooddevelopment, social work, and nursing with the Association ofLegal Entities "Union of Medical Colleges of Kazakhstan" and Republican Health Development Center of the Ministry of Health of the Republic of Kazakhstan.

The photo on the title page is by UNICEF / Zarina Nurmukhambetova.

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Opening statement and acknowledgements by Yuri Oksamitniy,Representative of the United Nations Children's Fund (UNICEF) in Kazakhstan

These Methodical recommendations are the result of cooperation of UNICEF's national experts in the field of early childhood development, social work, and nursing, with the Association of Legal Entities "Union of Medical Colleges of Kazakhstan" and Republican Health Development Center of the Ministry of Health of the Republic of Kazakhstan.

To assist in reforming home visiting services at the primary health care (PHC)level, UNICEF in Kazakhstan supported the development of the methodical recommendations for head doctors ofPHC organizations to implement the Patronage Service Model.

I would like to express special gratitude to the international and national experts: Tamar Gotsadze, Bettina Schwethelm, Bayan Babayeva, Natalya Kim, Dinara Yessimova, Rosa Abzalova, and Gulnar Kumarova for their effective contribution to the content development and assistance in describing the lessons learned. We hope that the practical recommendations of these experts will help not only head doctors , but also those employees who provide daily support to parents in child-rearing, healthy nutrition, safe environment, protection from violence and injuries, and importance of early childhood development.

Promoting early childhood development is one of the most effective strategies for ensuring of children's rights, reducing social and economic gaps between population groups, and promoting justice and inclusion. The Methodical recommendations, first of all, are aimed at improving the quality of care for pregnant women and families with children through anelaborated algorithm of providing services at the management level, planning based on the identified needs of population with children, mobilizing human and financial resources, enriching knowledge and professional skills among practitioners, patronage nurses, and social workers.

We thank all the employees of primary health care organizations, head doctors, patronage nurses, social workers, and psychologists who took an active part in providing information about their

experience of implementing the new universal progressive patronage nursing of families with children to write this guidance tool.

To create conditions for the sustainable development of home-visiting services for pregnant women and young children, UNICEF assisted PHC in updating professional competence, education standards for training and advanced training of nurses, general practitioners (GPs) in accordance with international standards of the World Health Organization (WHO). The proposed Methodical recommendations of UNICEF are aimed at developing professional skills of nurses, GPs, social workers, and psychologists required to supportthe updated model of home-visiting system in Kazakhstan.

In these Methodical recommendations you can find advice and recommendations on planning home-visiting services, monitoring of quality of family services based on case management approach, supportive supervision and continuous training of professionals.

Yuri Oksamitniy

Contents

List of abbreviations

WHO	World Health Organization
GP	General Practitioner
IMCI, ICAT	Integrated Management of Childhood Illnesses Computer-based IMCI training
IFDP	Individual Family Development Plan
CPDS	Continuous Professional DevelopmentSystem
CPDC	Continuous Professional Development Committee
CPD	Continuous Professional Development
NGO	Non-governmental organizations
PHC	Primary Health Care
ЮНИСЕФ	UN Children's Fund

INTRODUCTION

by: UNICEF/ Zarina Nurmukhambetova

The State Health Development Program "Densaulyk" for 2016-2020 provides for the implementation of the universal progressive model of home visiting patronage servicesin the Primary Health Care (PHC) as an effective system for improving health, development and well-being indicators of children.

The need to modernize the system of home-visiting services in PHC and migrate to the new patronage model arose due to that the current system of home visits to pregnant women and young children has ceased to adequately meet international quality requirements for PHC. Studies carried out in the countries of Central and Eastern Europe, including Kazakhstan, show that traditional, odel of home visitsfail to deliver main goals aimed at the primary prevention of diseases, injuries, accidents, abuse and violence, early detection of risks disrupting child's physical, psychosocial, and emotional development pathway. The excessive number of regulated visits (more than 20 times) is detrimental to the patronage quality. Home-visiting is reduced to a short-term contact with a mother, during which apatronage nurse mainly pays attention to the physical health of the child, invites to another vaccination or preventive routine check-up or actively visits sick children. The rest of her time the nurse spends on completing an outpatient card or following doctor's instructions when seeing children.

During the visit, the patronage nurse does not assess social risks that threaten child's health and well-being and does not focus on such important aspects as parents' affection and attachment to the child, depression of mother or father, tension in family relationships, lack of positive parenting and other factors, which ultimately determine the health, resilience, development, and well-being of the child. Even ifthe patronage nurse through her experience sees such risks, she does not know what specific steps need to be taken to eliminate or reduce them.

The universal progressive patronage of pregnant women and young children provides answers to these and many other questions. This model is recommended by WHO and UNICEF as a model of medical and social orientation that meets international quality requirements for PHC:

• Highly efficient, because it is evidence-based; The protocols and guidelines used in the model are based on the latest international research data.

• Well grounded. It leverages resource utilization, as the provision of services is differentiated. All children receive a universal basic package of patronage services, some receive an extended package, and very few receive an intensive package, which prevents unnecessary costs. Investing in early

childhood brings significant income at the level of an individual, family and community, as at this age the foundation of human health and well-being is laid.

• Improves service availability. Patronage services are provided in a timely manner, accessible in geographic, economic, cultural and other terms for any family in the interests of each child. Availability is especially improved for children from vulnerable and socially excluded families. A patronage worker can deliver necessary information and quality services to families that are for some reason hard to access health and social services (migrant families, cultural or religious beliefs, families in difficult situations, socially excluded etc.);

• Patient-oriented, since the child and his/her interests and rights are always put at the heart of services. Universal-progressive model of home-visiting services respond promptly to family needs in relation to the child, promotes child's rights to health and development. The professional qualities of the new patronage nurse in PHC, good communication skills, style of relationships with the family based on a tolerant, considerate and non-judgmental attitude allow building trusted partnerships with families. Supportive relationships of the patronage nurse help unveil family strengths enabling it to overcome life difficulties.

• Promotes equality and equity in the provision of services. Despite a general decline in infant and child mortality and improved basic health and development indicators of children (exclusive breastfeeding, early childhood development etc.), the difference of these indicators among children with different well-being levels persists. For example, children from poor families 2.5 times more likely to have low weight and 1.7 times more likely to suffer from stunting. This model makes it possible to eliminate inequality and provide each child with an equal life start, regardless of their place of residence, parents' educational background or socioeconomic status.

• Cohesiveness. Throughout the process of providing patronage services, parents and family members get a chance to receive complete and reliable information, to take decisions and participate in planning activities to address risks that threaten the health, development, safety and well-being of their child. Parents are regarded as partners, informed, trained and motivated to unlock to the greatest possible extent the child’s potential and enable him/her to achieve the highest attainablehealth and social inclusion level.

This guide explains the goals, objectives, key idea, and principles of the new patronage model and contains practical recommendations warning against hasty and wrong steps when introducing this model into practice.

These Methodical recommendations consist of four parts:

Part 1. What to know about the universal progressive patronage nursing. General recommendations for implementation (authors: Babayeva B., Sukhanberdiyev K., Tikhonova L.).

Part 2.Case management in patronage nurse’s practice. Environment mapping and individual patronage planning (authors: Yessimova D., Tikhonova L.).

Part 3. Continuous professional education and development of patronage nurses (author: Kim N.).

Part 4.Assessmentof coverage and quality of patronage services for antenatal and pediatric care at the PHC level through household satisfaction survey (LQAS) (author:Sukhanberdiyev K.).

Part 1

WHAT TO KNOW ABOUT THE UNIVERSAL PROGRESSIVE VISITING SYSTEM GENERAL RECOMMENDATIONS FOR IMPLEMENTATION

1.1. Universal progressive model of home-visiting services for pregnant women and young children at the PHC level

Definition

Universal-progressive model is an advancedsystem for conducting "home visits" by a patronage nurseto young children, including in the prenatal period. Meeting with a family in its own environment gives the professional a unique opportunity to understand issues and make the right decision.

There are 3 main patronage models, each of which has its advantages and disadvantages:

A universal model is the coverage with patronage supervision of all young children with the mandatory attendance of each child in certain age periods.

Aprogressive model is the coverage with patronage supervisionof onlythose at high risk having special needs due to health or psychosocial risks.

A universal progressive model of home-visiting patronage is a blended model that combines the advantages of the universal and targeted models through overcoming their limitations and ensuring peak efficiency.

Under the universal progressive model, universal (mandatory) home-visiting services are available for all families while progressive (reinforced + intensive) visiting services are provided to a limited number of families based on risk and needs assessment.

Those families experiencing socio-economic difficulties, psychosocial stress, and other unfavorable circumstances (for example, difficulties in child nutrition, issues with development, ensuring a safe environment etc.) receive increased support so that they can take care of themselves and their children to secure their optimal growth and development.

Intensive support is provided to families where children are highly vulnerable and in cases when cross-disciplinary support and cooperation between health, social and educational services is needed to reduce the risk.

The design of the universal progressive patronage model in PHC is given in Annex 1.1.

Implementation rationale

The implementation of the universal progressive patronage model has three stages of justification:

1) scientific findings concerning the importance of a safe, stimulating and emotionally warm environment for the development of child's brain and early life experiences, the destructive role of toxic stress on the developing child's brain and a number of other evidences show that during from conception to the third year of life there are windows of vulnerability and opportunities that have no equals throughout life. Measures to reduce vulnerabilities and seize opportunities at an early age give the ultimate result throughout human life;

2) during this period, the main social institution and mediator of the child's health and development are his/her parents and family members; andhome-visiting, when a meeting with a family takes place in their own environment, provides a unique understanding of family issues and best choice of coping strategies.

3) pregnant women, parents and children who most often fall into the "cracks" of the health care system, social protection (including protection of children) and education are the most in need of patronage visits.

Key beliefs of the new patronage model:

- parents are the first child carers;
- any family has hopes and dreams about their children, but they differ in the way they support their children's efforts to achieve these goals; the results of the child's development are more influenced by the family support to thechild rather than its social and economic status.
- all parents have the potential to support the development of their children and achievement of success in their lives, but many of them need support to unleash their potential so that they can feel and develop their strengths;
- in providing such support, any family, in whatever difficult circumstances it may be, is able to give a better start to its child;

- it is best to treat parents as equal partners;
- patronage workers can contribute to improving family resilience and improving the life quality of children and families by assessing needs and understanding the situation, identifying and supporting strengths (proactive approach). With this approach, families from serviceconsumers become active allies;
- with any parent it can be "difficult to establish contact and work", but the main responsibility for building relationships with parents and families rests with professionals;
- it is necessary to approach parents individually - no generalization and stigmatazingshould be done on the basis of their gender, ethnicity, marital status, education or material well-being.

Difference between the new and traditional patronage model:

- Focus on the quality of patronage visits not on their quantity;
- Transition from the principle "identify an issue and refer" to "timely identify and eliminate or significantly reduce the risk that may lead to anissue";
- Focus on a set of health, social, educational and other measures to create health, not only on the detection of diseases and purely medical problems;
- Focus on the physical, psycho-emotional, eraly childhood development, safety and well-being of the child not only his/her physical health;
- Child's health is considered in the context of the family (for example, depression in a mother or father, neglect or abuse) and local community but not isolated from the family and the environment;
- Equal partnerships are built with child's parents and family members, they are not treated as subordinates obliged to blindly follow health worker's advice;
- Patronage nurse does not work alone in isolation,she is a member of the team around the child along with a doctor, social worker, psychologist and other professionals. The teamwork within the establishment and mechanisms for effective interaction with other departments develop;
- Patronage nurse becomes the family's main trustee and the link between the existing services and child's needs. In the eyes of the family, the patronage nurse ceases to play a secondary role after the doctor.

Basic principles

The main goal of the universal progressive model is to protect and promote the health and well-being of children at an early age in close connection with the well-being of his/her parents and immediate environment. Realizing that the child is influenced by the situation in the family, which in turn is affected by the situation in the place of kindergartenor school and in other types of social environment, the patronage service, in accordance with Bronfenbrenner's Ecological Systems Theory, works with all

layers of social environment, from micro at family's level to macro at community's level. At the same time, the focus remains always on the child, his/her interests and rights.

To successfully implement the new patronage model in practice, it is necessary to observe the following principles:

1. Establish contact with those in most need and pay them the greatest attention, as a rule, they are the least covered by available services.
2. Shift from the mechanical model of "issue detection and referral" to "assess risk factors and act immediately until an issue has arisen," that is, switch to a risk-oriented approach. The patronage nurse assesses the basic needs of the child (Annex 1.2).
3. Overcome servicefragmentation among various establishments, health care, education and social security and individual services, develop strong intra-sectoral and cross-sectoral cooperation.
4. Develop the professional competence of patronage nurses.
5. Ensure appropriate management of patronage home-visiting services.

Expected outcomes

With the successful implementation of the universal progressive model positive outcomeson the part of children, family, parents and community can be envisaged in the short and long term.

On the part of children:

Improved neonatal indicators, such as low birth weight, premature birth, congenital malformations, improved nutrition and growth, reduced morbidity and mortality, improved immunization rates, improved cognitive and social development, reduced injuries, reduced disability and abandonment, reducedabuse and violence against children.

On the part of family and parents:

Improved prenatal care and prevention of obstetric complications, improved parental knowledge and skills in infant feeding (breastfeeding and complementary feeding), improved indicators for seeking medical help, improved parents' awareness of the prevention of infectious diseases, improved attachment and parental knowledge about child development practices, safe home environment, improved support for families having children with disabilities, reduced levels of parental stress, maternal depression and anxiety.

Onthepartofcommunity:

Reduced health protection costs, improved school readiness, academic performance and development indicators, reducedtreatment costs of vaccine-preventable diseases, reduced health care costs associated with hospitalization, reduced costs of caring for children left without parental care, children affected by abuse, costs associated with combating crime and drug addiction, reduced suicide rate.

Pilot implementation of the new patronage model in Kyzylorda Oblast showed significant results in less than two years. In the pilot areas, child mortality from controlled causes and household injuries decreased, immunization coverage increased, exclusive breastfeeding and continued breastfeeding rateincreased, respectively, feeding formula purchase costs decreased, self-esteem and job satisfaction of patronage nurses improved, knowledge and competence of patronage nurses significantly enhanced, public satisfaction with the patronage services and credibility of health and social services increased, coordination of activities of non-governmental organizations improved, the role of NGOs in the health sector increased etc.

But the pilot experience has shown that the results are achievable only through the carefully thought-out and planned work of a large number of people at different levels, from a patronage nurse to managers of different ranks, representatives of akimats and related establishments, supportive supervision,continuous training system of PHC staff etc.

The implementation of the universal progressive model cannot be a one-step action. It required step-by-step actions. At the moment, start of 2018, the pilot project wascompleted, and we are at the stage of implementing the reformed universal patronage model throughout the country. First of all, it will take a lot of responsibility of the health authorities to reach the critical (60%) level of staff trained under the new program in a short time; an effective workflow management will be required to develop a team approach, train supervisors, properly arrange continuous professional development and education system of patronage nurses and social workers, without whom the new model will not be functioning.

The provision of reinforced progressive services was mainly polished on the pilot model, its implementation will beslower, as and when experience is accumulated, and universal model workflow is improved. If the proper patronage workflow management is ensured, consisting in constant support, trust and participation, patronage nurses with each new case quickly gain professional skills, learn to make anin-depth assessment"*make the invisible visible*", prioritize, plan work, establish contact with families, properly foster a dialogue, convince, work smoothly, attentively, without missing important details and satisfied with their job. Otherwise, theyendupinemotionalburnout.

As the experience of the Kyzylorda Oblast has shown, the development of mechanisms for the provision of intensive progressive patronage services based on cross-sectional cooperation require even greater efforts and even more time. At the inception stage, building the capacity of social workers, proper organization of their work and strong focuson their participation in patronage, as well as manager's personal ability to establish referrals withakimats, NGOs, and other establishments play a decisive role.

The next chapter contains recommendations based on practical experience that will help prevent mistakes when implementingthe new patronage model of home-visiting system.

1.2. Practical recommendations for implementation of the universal progressive model

Prerequisites for implementation

1. The universal progressive patronage model can be implemented at a site where a GP works, since it is carried out at the level of the whole family. It is mandatory to have a social worker and a psychologist in a health care facilitywho are key members of the team that is engaged in work with childand family.

2. There should be three district nurses, one of whom is completely occupied with home visits (prenatal care of pregnant women, newborns and children under 5 years).

3. The work of patronage nurses should be organized so that they can devote sufficient time to effective work with families. As shown by the observation of experts and pilot experience, on average, out of every 5 families, one will be at a moderate or high risk, with which the patronage nurse works individually. The most common risks are exclusive breastfeeding, timely introduction and quality of complementary feeding, child development (especially active speech), involvement of fathers in child-rearing, safe environment and prevention of injuries, eraly childhood development(reading, playing, communicating). The primary risk assessment and family training take an average of 40-60 minutes, repeated visits as per the individual plan - 15-30 minutes, depending on the type of work performed. Thus, during the working day the patronage nurse can qualitatively serve 6-8 visits.

4. Patronage workers should be well-trained, have sufficient knowledge and skills to render required services.

5. The OblastHealth Departments should ensure the effective functioning of resource training centers (in most oblasts these are IMCI centers, wheretrainers and facilitators work, who have completed the universal patronage progressive training). The centers should be readyto ensureconsistent training of patronage nurses under the new program.

6. Primary training should be conducted by certified trainers on an out-of-the-job basis, in training centers or institutions of postgraduate education. Trainers should be well motivated, fully aware on the knowledge of new home-visiting system and follow the recommended methodology.

7. IMCI-relatedknowledge and practical skills are an indispensable condition for the work of a patronage nurse; IMCI is one of 16 modules included in the basic nursetraining. ICAT training (computer-based IMCI training) should be planned on the basis of resource centers; IMCI-related knowledge and skills should be maintained consistently.

8. Material and technical capabilities (payment, transport) should be established to develop a supportive supervision system. Facilitators and trainers of the resource center should regularly hold supportive curationvisits to trained workers to consolidate practical skills, analyze emerging issues and address them.

9. At the institution level, there should be a room where patronage nurses can conduct sessions, discuss cases, store documentation and handouts. The room must have a projector, a computer, a training board, and a lockable closet (for storing confidential documentation).

10. Patronage workers should be provided with the necessary set of materials for quality patronage (portable height meter and scales, measuring tape, 2 types of thermometerfor measuring body temperature and room temperature, tonometer, tablet or smartphone with mobile application “Patronage nurse”, hand disinfectant, minimum first aid kit), necessary source of information (Booklet of IMCI schemes and Booklet of information schemes, emergency alert scheme), handouts for families (brochures, memos etc.) on the proposed topic of counseling.

Impediments to the effective implementation of the new model

As the pilot experience shows, some factors can adversely affect the quality of outputsin home-visiting and reduce its efficiency.

• Weak input knowledge and skills of nurses on basic issues, such as integrated management of childhood illnesses, breastfeeding, proper complementary feeding, newborn health assessment, identification of dangerous signs and conditions in sick children requiring immediate hospitalization and other issues can significantlydelaythe implementation of the model. Without basic knowledge and allocated budget, further promotion of the new model is impossible.

• Weak communicative skills of patronage nurses. Building trust with the family is the basis of the new model. Without a properly structured relationship between the patronage nurse and family members, the model will not work efficiently, moreover it may pose a threat to the nurse or the child. There are risks of forming unwanted relationships on the part of the family such as dependency, welfare attitude, but not partnership and mutual responsibility.

• Emotional burnout of employees. It occurs when patronage nurses, feeling responsibility to

families who trust them, try to solve issues that go beyond their competencies or human capabilities. If, at the same time, there is no reflexive counseling, supportive supervision, and restorative supervision, the patronage nurse suffers emotional drain.

• Lack of support from the head doctor. To properly understand and manage the risks that patronage nurses identify in families and local community, managers need to be trained in modules, understand the key ideas of each module, promote teamwork, internal supervision (supportive curatorship) and cross-sectoral cooperation, create conditions for the utmost use of opportunities in the community (NGOs, support groups, volunteers etc.). Such efforts of the management guarantee sustainable results.

• Lack of continuous professional development of patronage nurses. Deeply mistaken is the idea that once trained, the patronage nurse will immediately learn to do everything, manage everything and never make mistakes.

Photo:UNICEF, Larissa Tikhonova

At the training, the patronage nurse receives initial knowledge. The strengthening of skills occurs in everyday practice, with each case of assessment, risk identification, development and implementation of an individual plan etc.

• Lack of teamwork. Thepatronage nurse alone cannot effectively identify and manage the family cases. Such an opportunity arises only with a well-organized teamwork facilitated by a general practitioner. The teamwork can only be coordinated by GP, who is informed about risk cases, knows the work of a patronage nurse, the capabilities of a social worker, a psychologist, and other professionals, as well as services that can be provided in the community. For this purpose, GP must be trained in cooperation with a patronage nurse, a social worker and a psychologist. The opportunity to openly discuss problems without fear of punishment, supportive relationshipsbetween team members contribute to the professional growth of each team member, prevents emotional burnout of patronage nurses and helps in solving complex cases.

• Lack of proper staff deployment and burden sharing. The pilot project showed that the universal progressive model can be effective only if there are three nurses on a site and provided that one of them is fully engaged in home visits.

• Lack of supportive supervision. It leads to emotional burnout, reduced motivation for work and training,failure to maintain necessary level of knowledge and skills.

Recommended sequence of actions

Step 1

Three-day orientation and information training for leaders of health departments, deputies for mother and child health issues, chief pediatricians and CEOs of PHC organizations. The program is given in Annex 1.3.

Step 2

Baseline and staffing assessment at the level of each institution:

- How many patronage nurses, senior nurses, GPs, social workers are required to work under the new model?

Step 3

Training planning.

Primary training covering 16 modules of UNICEF and containing basic program information for apatronage nurse is conducted on an out-of-the-job basis in 2 stages. Basic and Extended Training Program is given in Annex 1.4.

- How many people are required to be trained at the institution level? Make a list of those to be trained. This list should include a deputy chief medical officer, an expert, patronage nurses, a GP, a head of department, senior nurse of department, a social worker and a psychologist.
- Training should be of joint and teamwork nature (GP, patronage nurses and social workers are trained at the same time).
- The training schedule is to be agreed with the Regional IMCI Coordinator.
- Determine how long it will take to reach 60% training coverage at the institution level and at the oblast level.

Step 4

Planning of curator visits to trainees.

Training without a subsequent curator visit (supervision) is ineffective.

The curator visit is conducted by oblast trainers, who conducted primary training, or by external curators with practical work experience (such visits are conducted on the basis of contracts).

From the very beginning it is necessary to develop internal curatorship. To do this, the head of department, senior nurse or other experienced patronage nurses should go through basic training and after some time of practice - supervision training.

Step 5

Planning of implementation monitoring.

First, it is required to assess the baseline service quality. Then, in the same form, monitor indicators over time.

1.3. How to build a day-to-day work of a patronage nurse

Planning of home visits

Proper planning of patronagehome visits ensures full coverage and timely provision of home visitingservices. The source of planning is a census of population on the assigned site, a register of assigned population, and a register of pregnant women.

Two types of plan are made: universal visits (monthly plan, weekly follow-up) and progressive reinforced services (daily plan) based on the defined needs of children and their families. Every day, the plan is adjusted with assets for sick children, newborns released from the maternity hospital and those refusing vaccination. The senior nurse of department monitors the proper plan development and its implementation. She actively supervise the plan development, its adjustment as information is received.

Planning Instructions are givenin Annexes 1.5 and 1.6.

Note: with proper organization of the patronage service, there is no need forhousehold rounds (except for emergency circumstances), as the patronage nurse on a daily basis conducts in-depth systematic work on risk assessment, parent training etc. In addition, there is no need to make visits only for the purpose of inviting them to vaccination. As a rule, in most cases,this is managedover the phone.

Routine briefing

Prior to the visiting (usually on Monday morning), patronage nurses should receive routine briefing from the senior nurse. Periodically, at the same time there should be a GP (to monitor and support the senior nurse) and head of department (to monitor and support GPs).

By asking brief questions about specific visits to be made by a patronage nurse, for example, patronage of a pregnant woman at 32 weeks, initial antenatal care, patronage of a newborn, patronage at 1 month, 2 years etc., it is necessary to make sure that the patronage nurse correctly performs tasks of a specific visit. For example, she can be asked to demonstrate on a doll (simulator), in what order the newborn will be examined, to show how she will assess social risks or environment safety, to list questions of indicative interview, or what developmental milestones a 2-year-old child mayhave in active speech delay etc.

The questions should concern the upcoming real visits. Briefing is not an exam and does not serve to punish. If the answers indicate a lack of knowledge, it is necessary to de-brief and discuss in a team with other nurses. Perhaps it will be decided that a nurse who hasweak knowledge should go to visit with another, more prepared and skilled or a senior nurse.

It is necessary to plan an individual or group session on a topic that presents difficulties.

Feedback from patronage nurses

At the end of a week (usually on Friday, on the second half of the day), the patronage nurse must submit a report and completed documentation on the deliveredweek plan to the senior nurse of department (how many visits made under the universal program, what risks identified, present an individual plan and eco-card of the child for the identified riskcases, how many visits made under individual plans, what changes occurred, how many and what risks eliminated).

It is desirable to have a GP, head of department when receiving feedback on the weekly results. In any case, the list of children and pregnant women at moderate and high risk should always be on the GP’s desk, and the list with those at high risk - on the desk of the head of department. They should look into how the work on this case is progressing, what kind of assistance is required for the patronage nurse, and what resources can be used.

Team approach

The patronage nurse is a team member and works in close cooperation with a general practitioner, district nurses, a social worker, and a psychologist. The patronage nurseis aware of opportunities in the local community that can be used in her work, such as mothers' support group for breastfeeding, nongovernmental organizations and other resources available at the community level.

Continuous professional education and development

At least 2 hours per week should be devotedto training (a session is usually held on Wednesday). At the same time, the entire team (patronage nurses, GP, senior nurse, social worker) should be present. The senior nurse in advance gives the patronage nursea task. The most effective form of training is the case presentation (a difficult unresolved case or vice versa, a successfully solved case).

Usually this is a short presentation on 3-4 slides with a case description, an eco-card of a child with the clear statement of the problem and issues to be discussed. It is important that the team members take part in the discussion and everyone can openly express their opinion. This strengthens teamwork. It is also important that the participant representing the event is well prepared for the corresponding module.

Discussion should be in a narrow circle of the team, confidential; staff should not disclose information about the child and his/her family, which became known during the performance of official duties.

Supportive supervision

As practice has shown, the enabler for improving the patronage quality is supportive supervision. It should be built on and promoted from the very beginning and at all levels (at the level of the institution, at the oblast level and at the countrylevel). The key point of the new approach to supervision is overcoming the tendency oftraditional punitive supervision, such as strict verticality (the superior checks the subordinate), irregularity (usually conducted in the preparation for a meeting), emphasis on external curatorship (mainly external audit), focus on the search for the guilty and punishment, lack of knowledge and skills of the curatorhim(her)self. Supportive supervision is a continuous process of improving the quality of service delivery, which is not limited to the curator's visits and continues at the level of each employee and entire institution on an ongoing basis

The purpose of supporting supervision is to assist patronage nurses in their professional growth and achieving effective results through direct observation of their activities, discussion, practical support and training.

Tasks of supportive supervision:

1. Improvement of knowledge and consolidation of practical skills
2. Improvement of workfloworganization
3. Prevention of emotional burnout.

Levels of supportive supervision.

Supportive supervision is a three-level system: self-supervision/peer supervision, internal supervision and external supervision.

The first level and the basis of supporting supervision is self-supervision and peer supervision. Self-supervision or peer supervision means that each employee independently, and/or with the help of his/herpeers, assess the quality of implementation of professional standards, outlines specific tasks and terms for implementation, evaluates and monitors his/her own professional level and communication skills (self-supervision and professional development plan is given in the Annex).

The second level of supportive supervision is **internal supervision**. The task of an internal supervisor is to help each employee perform his/her duties in the best possible way through mentoring and performance management. A senior nurse, district GP, head of department, deputy chief medical officer, chief medical officer, i.e. everyone at his/her level is the supervisor for his/herdivisions.

Ideally, the internal supervisor of apatronage nurse is the senior nurse of department. The head of institution, in agreement with a team of patronage nurses, on the basis of electivity, can appoint an exempt supervisor by redistributing pertaining workload among the staff. The head of institution together with the human resources department assigns supervisor'sfunctions and scope of work with the redistribution of duties. To the basic functional duties of the employee appointed as the supervisor, the supervisory burden is added, namely:

1. Review and revision of the quality standards of services provided by employees of the organization;
2. Supervision and mentoring of new employees within 3 months;
3. Direct observation ofthe patronage of households (up to 3 families weekly, about 3 hours per week);
4. Individual consultation on the professional development plan with an employee through reflection and self-assessment (2 consultations a week);
5. Group sessions for employees on the basis of self-assessment and direct observation by the supervisor to improve the quality of services provided to population in accordance with the service standards (2 sessions per month);
6. Practical group training (from 4 to 7 people) to analyze clinical cases with a presentation by each employee on the basis of rotation (twice a month for 40 minutes);
7. Group sessions on emotional support for sustainable resilience (stress resistance) of employees and preventing emotional burnout with the involvement of partner organizations, psychologists (1.5 hours per week);
8. Preparation and submission of a report onsupervision activities (2 hours quarterly) to staff and management.

The standard procedures for administering internal supervision at the organization level are:

- Approval of the order of the head on internal supervision with the definition of goals, tasks, competencies of the supervisor
- Description of the supervision scope, hours and services
- A budget plan for the provision of supervision services in accordance with the contract attached to the employment contract "On supervision" with a fixed period of 1 year with a probable extension up to 6-12 months.
- Determination of a compensation to be added to the basic salary of an employee for additional supervision workload. Compensation should be proportional to the added workload, that is, the number of households serviced by the institution's employees.
- Training of a supervisor (at least 40 hours of special training in the supervision principles and methods, as well as methodology of working with families based on case management). Each appointed supervisor is required to undergo no less than 20 hours of training in "Supervision, internal supportive supervision of employees" and 18 hours in "Case management".
- Bidingof a contract with the supervisor or signing of an additional agreement to the current contract on the performance of supervision functions in accordance with the work plan for a certain period. The timing of supervision functions can vary from 6 months to 1 year, depending on the needs of the organization and capabilities of the supervisor. The head of PHC institution is to conduct a conversation with the supervisor in advance and establish the period of the additional agreement with the employee for the provision of internal supervision services from 6 months to 1 year with the potential extension for one

- Provision of a workplace/room and necessary means to ensuresupervisor's work (office equipment, computer, printer, table, chair, communication) in the organization.
- Approval of forms for the conduct of supervisor's work.

Supervisor's documentation:

- Form of supervisor's consent about confidentiality of information obtained during supervision and mentoring (self-assessment, individual consultation and group discussions) with staff;
- Questionnaire for assessing the training needs of employees;
- Form for assessing the professional competencies of staff with a 10-point scale ranking;
- Form of self-assessment by the supervisor of own professional competencies;
- Form for a focus group to obtain data from employees about main issues in the work;
- List of direct observation by the supervisor in conjunction with the employee (patronage nurse, social worker) who provides services to the family at home or on the site in the office;
- Minutes of group case discussion (in free form with the description of participants, case, recommendations for the supervision plan);

- Supervisor's work plan broken down by activities, timeframes;
- Quarterly report on the conducted supervision activities;
- Form of evaluation of supervisor's work by employees (feedback);
- Form of evaluation of strengths, weaknesses, opportunities and barriers (SWOT analysis) of employees.
- Employee's professional development plan.
- Schedule of continuous professional development of employees by name, hours spent on the following types of training and professional development: practical training, participation in a conference, round table, writing anoral presentation, speech, presentation, and holding of a training. For more details, see **Part 3. Continuous Professional System of Education and Development.**

The third level of supportive supervision is external supervision. Candidates for external supervision are approved at the level of a city, oblast, and country. External supervisors can be experienced trainers and IMCI coordinators, teachers of universities and colleges who have been trained in the universal progressive

patronage, IMCI and supportive supervision, as well as patronage nurses, GPs, social workers with practical experience in the new model (from pilot regions). External supervisors are high-level experts with practical experience in arranging the implementation of the new patronage model and solving complex cases. External supervisors support the planning oftraining and facilitation of the implementation process, organization of monitoring, development of internal supervision, and holding master classes. External supervisors work on the basis of contracts, which should reflect the visitingdate, goals, objectives and expected results, visiting conditions and payment terms for the external supervisor.

Supervision methodology.

When conducting a supportive supervision visit or performing internal supervision of patronage nurses, it is important to consider the following pre-requisites of the model:

1. Remember the main approaches in the organization of the universal progressive patronage model:
    - A risk-based approach (i.e., the shift from the mechanical principle of "identified and referred" to a flexible system "identified the risk and initiated actions to reduce it by building the capacity of the child and family and reducing vulnerabilities").
    - Presence of mechanisms of cross-sectoral links of referral and feedback (the patronage nurse knows whom, when, where and how to refer and support the family in the course of the referral, monitors to the final result of risk elimination)
    - Establishment of strong cross-sectoral cooperation and case management (development of the social sphere and close cooperation with education, social protection, NGOs etc.);
    - Development of professional competence (personal qualities, communication skills, professional attitude of patronage nurses);
    - An equity-based approach (barriers to accessibility are identified and addressed, such as cost, transportation, cultural and interpersonal barriers);
    - Appropriate servicemanagement (good management capacity at all levels).
2. Use a unified approach in assessing the performance of a patronage nurse (see the supervisors' tools - see Annex 8). Apply common assessment system:

    0 point – lack of technology or dangerous practice;

    1 point - technology is initiated, but requires significant improvement;

    2 points - technology is applied, but requires some improvement;

    3 points - technology is fully implemented as per the standard.
3. Compare information from different sources.
4. Recognize achievements of the supervised employee or institution.
5. Identify issues and analyze their root causes.
6. During the visit, as much as possible, provide practical support in emerging situations (demonstrate skills, conduct practical exercises, solve clinical situations together etc.).
7. Help the supervised employee and the team to make the right decision without imposing own opinion.
8. Document the visit (complete supervisor's forms, include in the action plan responsible persons, terms of implementation, possible risks).
9. Monitor implementation of decisions taken, ensure continuity in implementation of decisions between all interested structures.

Documentation of a patronage nurse

Documentationprovides for the use ofa home-visiting log of a district (patronage) nurse (Form 116/y), child's development record (Form 112/y); individual plan of working with the family, child's eco-card (detailed description is given in the **Section 2 of theseRecommendations**);

There is a Mobile Application for patronage nursesat the design phase in the Republican Center for e-Health, which will enable the transitionof documentation into electronic format and simplify the completing of all forms.

Implementation quality monitoring

Indicators reflecting the structure, process and results of patronage work, as well as the frequency of information collection are given in Annex 1.7. Responsible for collecting information and regularly completing forms is the senior nurse of department. Responsibility for the information reliability rests with a patronage nurse. Senior nurse and head of department regularly check the data reliability.

- Quantitative data (Section P -population) are selected from the census journals, registerof assigned population, register of pregnant women and women of childbearing age. *Absolute data should begiven.*
- Data about pregnant women (Section PW - pregnant women are selected from the register of pregnant women and women of childbearing age, the data are checked with the obstetrician-gynecologist's office for this site.) PW 12: *When calculating the indicator: denominator - women to whom a visit under the universal plan was scheduled, numerator –total women visited * 100.*
- Items PW13-16 are completed on the basis of Planning and implementation of visits to provide a universal package of services and Planning and implementation of visits to provide a progressive package of services in Annexes 5 and 6 of these Recommendations and individual plans. *It indicates% of the planned visits.*
- Section on the outcomes of labor (Section L - labor) is also completed after checking with the obstetrician-gynecologist's office for this site.
- Data on children of 0-59 months (up to 5 years) (Section C-children) are completed from several sources.
    - C1-C4 - AIS in-patient program, exchange card, obstetrician-gynecologist's office,
    - C7 – from child's out-patient card. *When calculating the indicator: denominator - children visited at 6 months; numerator - of them,exclusively breastfed children of 6 months * 100*
    - C5-C6 - individual plans. *When calculating the indicator: denominator - women visited this month, numerator - women diagnosed with depression this month * 100*
    - C8-C9 - obstetrician-gynecologist's office and personal survey
    - C10- selected from census journals, register of assigned population
    - C12 – reconciliation with Form 63
    - C13-V17 –child's out-patient card. *When calculating the indicator: denominator - children of 0-5 years old, who had anthropometry this month, numerator - children havingstunting and low weight etc. *100*
    - C18–C23 –polyclinic'sAIS program, Integrated Medical Information System, outpatient cards, statistics cards
    - C24-C36 – from МЛАД, mortality statistics, Medical Supervisory Committee's logs
- Section on child patronage (CP - patronage of children 0-59 months) and individual plans (IP - individual family plans) is completed on the basis of the weekly reporting "Planning and implementation of visits to provide a universal package of services" and "Planning and implementation of visits to provide progressive package of services"in Annexes 5 and 6 of these Recommendations.
- Section on cross-sectoral interaction (CI) is completed by a social worker on the basis of the register of intersectoral interaction cases.

Summary

The universal progressive model is an effective technology with a high level of evidence confirmed in practice. Its applicationhas a long-term impact on the health, early child development and well-being of individuals, families and community as a whole. Investments in childhood are highly recoverable and cost-effective.

The model does not give instant and rapid results, since it assumes profound changes in the relationship between the family and the patronage nurse,inside the health system and between different establishments; it is based on the professional and personal growth of home visitors, inckuding patronage nurses and social workers. However,its results are stable and long-term, positively influencing the future of children and passeddown to the next generations.

The implementation of the new model should be consistent and stepwise: from an improved universal model to the gradual expansion of progressive services.

Part 2

CASE MANAGEMENT IN HOME VISITING
ECO-CARD OF A CHILD
AND INDIVIDUAL FAMILY PLANNING

Photo: UNICEF/ZarinaNurmukhambetova

2.1. INTRODUCTION TO CASE MANAGEMENT

During home visits, the patronage nurse is given a unique opportunity to see the child in his/her natural environment. Observing the child's behavior in his/her own environment, the environment itself, the relationship of parents and other family members with each other and with the child enable the patronage nurse to see the child in the context of the family and better understand the risks that threaten the health, development and safety of the child. In addition, home visits make it possible to identify the strengths or resources available in the family and local community to support the child.

The professional purpose of the patronage nurse is the well-being of the child, protection of his/her interests and right to fulfill his/her potential. During home visits of pregnant women and families with children from birth to 5 years, the patronage nurse assesses the extent to whichchild's basic needs met,what type and level of support the family needs to ensure the child a healthy and harmonious development and safety.

Undoubtedly, children living in socially disadvantaged families,in poverty andbeggary,with undereducated parents consuming toxic products etc. are more likely to face risks to their development and well-being. These children require special attention from the PHC patronage service.

But it must be remembered that such factors as lack of reliable attachment andaffection to the child, lack of proper parenting skills, father's non-involvement in child-rearing, depression of one or both parents, neglect and abuse can occur in any family, which, according to the general economic measures of family income, can be considered safe. Therefore, universal coverage with home visits of all pregnant women and young children, a deeper approach to risk assessment and an individual approach to each family and each situation is .

To ensure an individual approach to addressing issues, the patronage nurse in each specific case must assess the child's needs and determine the scope and nature of additional assistance that the family needs. Being in any family, communicating with parents and other adult people, the patronage nurse always asks herself: "How does this situation affect the child?", "Are child's needs in proper nutrition, safety, emotional warmth, affection development, proper temperature regime and hygiene met?","Do they play with, talk and read books to him/her etc.?","What can be the consequences for the child, if not change the situation?","What opportunities does parents have?","What can they do themselves and where do they need help?"(The scale of child's needs is given in Part 1 of these Recommendations, in Annex1.2).

The patronage nurse assesses the child's needs to eliminate or mitigate existing risks, that is, to manage them.

2.2. RISK CASE MANAGEMENT OR CASE MANAGEMENT?

Case management is a process in which assessment, planning, assistance and support are combined in the delivery of services that meet the child's needs for healthy growth, early childhood development, and safety. The process is carried out by means of communication with parents and child's family through joint discussion and searchfor available resources. In the case management process, it is necessary to take into account the likelihood of working with families who are not ready for cooperation or difficult to establish contact with.

The patronage nurse, ensuring universal coverage with home visits of all families where pregnant women and young children live, assesses the social and health risks that threaten the health, cognitive and emotional development and safety of the child and plans, together with a social worker, measures to reduce risks that threaten child's health, development and safety.

Situations, in which families and young children live, may have different degrees of riskseverity: high, moderate and low. (The table revealing social welfare risks is given in Annex 2.1).

A high-risk case is managed comprehensively at the multidisciplinary level with the participation of various professionals both within the health care organization and other establishments (for example, social protection, education, internal affairs, migration officers, Akimat, NGOs and others).

Algorithm of case management at the level of primary health care

9 steps of case management

Step 1

Primary assessment of child's needs by a patronage nurse

Due to the specifics of patronage work, the patronage nurse is the first professional who conducts a primary assessment of child's needs and identifies risks that threaten his/her health and development (high, moderate or low). In low-risk situations (0), consistent work is carried out to provide the family with a universal package of services (building of parenting skills, raising their awareness of of child care and

upbringing, value of reliable attachment, counseling on breastfeeding, complementary feeding, safe environment, playing, communication, physical and psycho-emotional development etc.).

In a moderate-risk situation, when it is required to provide progressive extended services and additional visits (risks of delayed development, parent depression, lack of reliable attachment and affectionto the child, nutrition problems, risks of injury and accidents etc.), the patronage nurse generates an eco-card of the child and an individual plan of work with the family.
The child's eco-card allows the patronage nurse in anoutlined form within a short time (it takes an average of 15-20 minutes) to see the child's situation in the family, to understand the relationship between the child and his/her parents, between other family members, with other child-related people associated with this family, to understand vulnerabilities and find the strengths of the family.

If a social worker and a psychologist are required to be involved in a moderate-risk case management, also in all high-risk cases requiring a progressive intensive package of services involving other sectors, the family information is forwardedon the same day to the social worker of PHC.

The list of potential family needs, which at the primary visit can be revealed by a patronage nurse toforwards to a social worker:

Needs			
Social	Legal	Psychological and pedagogical	Health
Temporary housing; Assistance in housingrepair; Assistance in housingrent; Assistance in employment; Awarding social benefits; Awarding retirement pension; Awarding disability pension; Awarding survivor's pension; Humanitarian aid with food, soap and detergents, clothing etc.); Material assistance; Assistance in microlending; Services of crisis centers for victims of violence; Shelter services; Services of family and children support centers; Services of rehabilitation centers; Services of the disability evaluation board; Assistance in fuel supply in winter (coal, firewood); Other	Legal assistance in obtaining a passport; Support in obtaining a residence permit; Lawyer counselling on the rights of citizens to social services in the state system of social security; Attorney services; Assistance in collecting necessary documents for obtaining pensions, benefits, registration of guardianship/trusteeship , adoption, submitting materials to the court; Search and restoration of family ties; Protection of property interests of non-able citizens; Legal assistance for the protection and observance of the rights of minors; Other.	Moral and psychological support; Psychologist's services; Assistance in the restoration of child-parent relations; Counseling in Psychological MedicalPedagogical Commission; Services of the "early intervention" center; Services of daycare centers in abilitation and rehabilitation of children; Support in the integration of persons with severe or multiple health limitations into specialized institutions; Strengthening relationship between school and parents; Organization and conduct of classes in groups of mutual support, exchange clubs; Sociopedagogical counseling; Other.	Services of a local hospital; Highly qualified medical assistance; Health resort treatment; Psychotherapist's services; Material assistance to purchase medicines; Counseling at the risk of child abandonment in health care organizations; Service rendering (Mothers' House etc); Preventive talks about promoting healthy lifestyles and family planning; Other.
Opinions and comments of family members (including disagreement):			


Фото: ЮНИСЕФ/ Лариса Тихонова

Step 2

Appointment of a person responsible for the case management (Case Manager)

After that, within a day, the Chief Doctor appoints an employee responsible for the management of a family case. The responsible employee is a professional who will supervise the family and child throughout the implementation of activities listed in the plan of working with thefamily, monitor the quality of services provided, and conduct necessary consultations, and administrate the interventions to family. In the universal progressivehome-visiitng model, a family doctor (GP) is responsible for managing a high-risk case (Case Manager). The appointment of a High-Risk Case Manager is ensured by the order of the Chief Medical Officer (head doctor).

Step 3

Visitingfamily and secondary assessment

Secondary assessment is carried out in cases of moderate and high social vulnerability risk of families by a social worker when he/she visits the family on the basis of the results of a primary assessment of the patronage nurse. The information on the primary assessment is facilitated and forwardedby the GP.

After receiving information from the GP, the social worker carries out a deeper and more comprehensive assessmentwithin 3-7 days using the assessment format in accordance with the special approved forms (triangleof needs, family's eco-card, genogram (deep analysis of history and anamneses of a family) and other).

Useful forms for collecting information on the child and family in the process of the in-depth assessment using the triangle of needsto determine the needs for health, early childhood development, education, social protection, housing, including the surveying of relatives and professionals related to the child and family are provided in **Annex 2.2**.

Step 4

Family support plan development

Within 7-10 days after the social worker's visit and re-assessment,a team of PHC professionals (a patronage nurse, a GP, a social worker with the assistance of other professionals of state organizations and non-governmental sector, if necessary) develop an individualFAMILY SUPPORT PLAN on child and parental potential development (See **Annex 2.3**).

The family plan should take into account the needs of each family member and may include such areas as education (enrollingthe child in a kindergarten, early development center or pre-school center) and development of parenting skills (for example, promoting healthy lifestyles and building positive parenting skills), management of acute and chronic conditions, job search strategy, improving competence, increasing

the motivation of each family member in need of help, rehabilitation in case of an identifiedpsycho-emotional trauma resulting from violence, neglect, loss of close family members.

Family goals and actions in the Family Plan should be developed in close cooperation with the child, parents/guardians and other partners and/or organizations that could contribute to its implementation.

The activities and services of the family plan should bediscussed and agreed with the child/family reasonable and achievableby the child/family. To achieve the desired results, it is necessary to allocate enough time. Planned actions should consider the ability of the child/family to deliver them, as well as available resources to fund these actions.

The plan is further signed by child's parents/guardians, patronage nurse, social worker and GP participating in the implementation of activities, monitoring their quality and facilitating their implementation.

Interventions defined by the multidisciplinary team of professionals are aimed at improving the family stability and identifying long-term prospects. If necessary, there may be resort to psychotherapy, using different modalities, such as family conferences, counseling couples with finding solutions, group sessions. All possible assistance and care for children is provided, plan the provision of services with referral (finance, housing, legal, medical, or behavioral) to the relevant authorities is developed. Services are facilitated, especially during the transition period withsubsequent monitoring and assessment when assistance is rendered.

10 steps of effective family support planning

As the practice of piloting the universalprogressive model showed, many employees had a misunderstanding of the sequence of clear algorithm in developing the plan, they did not involve the members of child's family in formulating the purpose and necessary services, which adversely affected the quality of interventions.

Based on the lessons learned, professionals and partners formulated the following instructions for developing the plan:

1. Once you have assessed the family vulnerability and identified its needs, develop an individual family plan.

2. Formulate clear and simple family goals and actions. This should be done in close cooperation with the child, parents/guardians and other partners and/or organizations.

3. Involve the child. The child's participation depends on his/her age and development status. Limitation of mobility, lack of speech or mental disorders are not an obstacle to participation in planning.

4. Include services of a polyclinic and other organizations based on the identified family and child needs. For example, if you have identified the need for the speech development, then the plan should include working with experts in speech developing in other organizations;development needs, needs in the family environment, ability of parents to meetchild's needs.

5. Plan the implementation timing based on the child's needs.

6. Remember, the timing depends on the degree of safety threat and need for services, protection (insignificant, moderate, high). The higher the threat, the tighter should be the timing for specific actions.

7. Do not plan what the family will not be able to do. Consider the abilities and resources of the child/family to implement planned activities. Remember the support that other organizations can provide: NGOs, Crisis Center, Akimat, Employment Center, Migration Police, Children's Development Center.

8. Actively involve other professionals in the planning (including to plan their name, organization, contact information) depending on the response to the child and family needs.

9. With the involvement of other professionals along with the head of polyclinic department, initiate a cross-sectoral commission to assess the child and family needs and plan activities. Remember that the individual plan should remain flexible.

10. Follow up the plan implementation (make a monitoring plan), reassess, change goals and actions.

Step 5

Plan approval

The draft plan is submitted for discussion and adoption of a consilium (in case of moderate risk - with the participation of the senior nurse, GP, social worker, other professionals, if necessary; in case of high risk - also the head of department, deputy chief medical officer or chief medical officer, as well as professionals from other sectors and NGOs). The adoption of such a plan should be done no later than 3 days. If the family needs urgent activities, an emergency consilium meeting should be held.

Step 6

Case management and liaison with other sectors and NGOs in the service delivery

A social worker and patronage nurse must necessarily have a database of state and non-state organizations for the protection of interests and rights of the child with a list of services provided, addresses and contact details of responsible persons. It is necessary to map the resources of family support in the local community to visualize the available resources. It is also necessary to provide options for access to these structures in non-working time and emergency situations. To identify the risk of childabuse, violence, neglect, abandonment and other factors that threaten child's health and safety, urgent measures are to be taken where the social worker, together with the patronage nurse and GP, plans a series of preventive measures to hinder or eliminate negative consequences (interview with parents or guardians, informing the guardianship authorities of the district education department, interaction with the Department of Internal Affairs, crisis centers, family-type organizations, minors adaptation centers: contact details, address, position) with forwarding of family data to the relevant structures of cross-sectoral cooperation. For an example, the available resources database isgiven in **Annex 2.4.**

Step 7

Plan revision

It is necessary to periodically revise individual plans of active patronage and plans of family development.

Revision of the individual family support plan allows adjusting work, establishing new goals and objectives, timeframes, involving other interaction professionals, and officially finishing work, if the child's living conditions have become stable and safe.

Step 8

Monitoring

Regular monitoring allows the social worker responding quickly to changes in the child/family needs and, accordingly, review the service delivery.

Therefore, the social worker should ensure continuous monitoring of 1) child/family status; 2) IFDPimplementation; 3) progress in the child/family development.

Step 9

Case closing

Case closing is the process of ending the relationship between the family and social worker and, possibly, the PHC team. Before deciding to close a case, a multidisciplinary team of professionals involved in the planning and implementation of services should review the progress of the Plan implementation.

The review of progress reveals which needs were met, partially met and not met. The impact of services on the child/family and identification of services that have not been provided is considered. As a result of needs assessment,when completing the entire range of designated services in terms of family support during the completion period, the results of working with the family are summarized.

In the process of reviewing the implementation of the individual family support plan, there may be a decision to close the case based on the following criteria:

- the family is in a situation of relative stability, for example, child's health has improved, housing problems have been solved, parents have been employed;
- parents have developed abilities to care for the child and to create conditions for his/her optimal development;
- child's basic needs have beenmet;
- family's material situation has improved;
- family relationships has improved;
- the risk to the child has decreased to the acceptable level (it does not pose a risk and does not contribute to the emergence of other risks).

When completing the service delivery, the patronage nurse/social worker should do the following:

- consider the degree of risk reduction: discuss with the family special achievements byhighlighting positive changes in behavior and living conditions.
- review the goals and actions undertaken: discuss the obstacles encountered and focus on success and knowledge gained.
- consider common steps to address issues: remind the family of progress and methods that they can use if there are other issues in the future.

- discuss any remaining needs or concerns: help family members make a plan to preserve the changes achieved;discuss all the potential obstacles that may occur, as well as strategies for overcoming them.

When closing a case, the social worker should ensure that the family and other involved persons from the social environment know how to contact the social and health services in case of a change in the circumstances and situation of the family.

After the case closing, the patronage/social worker, who supervised the child and family, should ensure follow-up for 1-3 to 6-12 months, depending on the situation.

If the needs assessment at the case closing reveals unaddressed issues, namely any vulnerability risks for the child and family, it is necessary to review all previous interventions in the Plan, assess inefficient measures and risks for the family when closing the case, develop a new plan involving a multidisciplinary team of professionals or refer the family to another establishment to receive the necessary spectrum of family services and support.

An outlined overview of case management is presented in **Appendix 2.5**.

2.3. PRACTICAL RECOMMENDATIONS FOR A PATRONAGE NURSE ON INDIVIDUAL PLAN DEVELOPMENT

In identifying risks to the health of the child, the patronage nursedevelops a plan independently in consultation with the GP and senior patronage nurse.

Requirements for developing a plan

Individual work plan should be:

- Specific
- Measurable
- Realistic and achievable
- Time-bound

Example

When visiting a family, the mother of the child expressed concern that her eldest 3-year-old daughter does not speak well. During the assessment, the patronage nurse identified a problem in girl'sactive speech development.

An integrated approach to assessing the child development in 10 steps of monitoring development has shown that the mother is mainly engaged in caring for her 6-month baby and does not pay attention to her elder daughter.

The father is not involved in the process of care and upbringing, as he believes this is a female prerogative: "We were not brought up in our childhood, we grew up ourselves". Visually: the girl is smaller than her peers for the given age, slim and short.

In this case, it is necessary to determine what risks with the 3-year-old child we can observe. To which risk group, high, moderate or low, will we refer this child? What activities need to be placed in the activepatronage nursing plan?

#	*Goal:* *actions, events*	*Responsible persons/*	*Deadlines*	*Expected outcome*	*Completion status*
1	*Assessment of physical development and counseling in 10 steps of monitoring*	*Patronage nurse/GP*	*12 February 2018*	*Assessment of physical development, exclusion of delays and risks in 4 areas of development.*	☐Completed ☐ Uncompleted
2	*CounselinginModule 3. Nutrition*	*Patronage nurse*	*15 February*	*Organization of child nutrition by age, norms, volume, amount, nutritional value*	☐Completed ☐ Uncompleted
3	*Home counseling on development care, Module 5. Involvement of fathers.* *Note: consultation of both parents together, before arrival, the patronage nurse agrees with the father the visit time and the duration for counseling.*	*Patronage nurse*	*18 February*	*Involving the father in the care and upbringing of the child*	☐Completed ☐ Uncompleted
4	*Homecounselingondevelopment care, Module 6. Talk, read. Whyisitimportanttoreadandtalktoachild?.*	*Patronage nurse*	*22 February*	*The child hears at least 2000 words a day. Involvement of parents in communication with the child. There appeared*	☐Completed ☐ Uncompleted

				books corresponding to the child's age. Indicator: father reads at night 15 minutes a day.	
5	*Home counseling on development care, Module 6. Love, play. Why is it critical to love and play with a child?.*	*Patronage nurse*	*26 February*	*Organization of game activity with the child according to her age. Parents acquired age-appropriate toys, in case didn't..*	☐Completed ☐ Uncompleted
6	*Home counseling inModule 7. Mental well-being of parents. Using the Edinburgh scale*	*Patronage nurse*	*3 марта*	*Results of theassessment of mother's psychoemotional state. If at risk, the involvement of a psychologist in the plan.*	☐Completed ☐ Uncompleted
7	*Home counseling on parenting styles. Module 8. Unicef*	*Patronage nurse*	*7 марта*	*Changing parental strategies in relation to the daughter.*	☐Completed ☐ Uncompleted
Parent's/Guardian'sname			*Signature*		*Date*
1					
Child (children)'sname			*Signature*		*Date*
1					
Patronage nurse's name			*Signature*		*Date*
GP's name			*Signature*		
Social worker's name			*Signature*		*Date*

The practice of piloting the universalprogressive patronage has shown that at a home visit there should not by consultation on several topics. The most effective in practice is the 'onevisit-one consultation' strategy.

On average, the consultation takes at least 40 minutes subject to all stages of counseling (interview, active listening, praise, recommendations, and feedback). In case of combining two topics, home consultation will take at least 1.5 hours, which is undesirable

Summary

The implementation of the universal progressive patronage for pregnant women and young children makes it possible not only to identify but manage risks that threaten the life, health, development and safety of the child.

The methods of work recommended by this section, applied by a qualified patronage nurse, such as case management, environment mapping, individual plan ofworking with the family, identification of needs and risks, can successfully address many issues related to the well-being of children.

Photo by: UNICEF/ Larissa Tikhonova

Part3

CONTINUOUS PROFESSIONAL DEVELOPMENT OF PATRONAGE NURSES

Photo by: UNICEF/ Zarina Nurmukhambetova

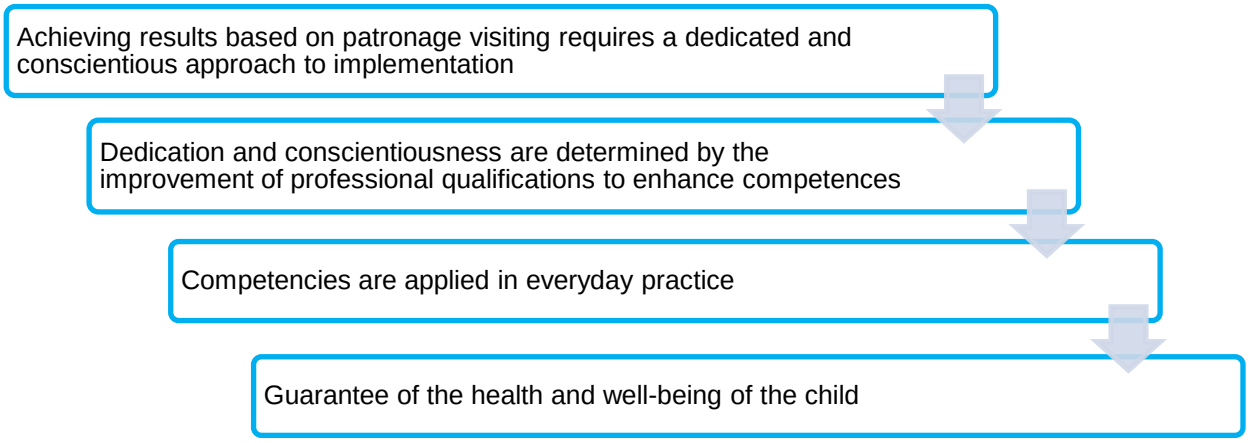
3.1. INTRODUCTION TO CONTINUOUS PROFESSIONAL DEVELOPMENT

Continuous professional development (CPD) is an activity in which any person develops new skills or knowledge related to his professional duties. The CPD is a continuous cycle process in which individuals practice and evaluate their knowledge and skills, determine their learning objectives, make decisions about measures necessary to achieve these objectives, implement a training plan and assess its effectiveness.

CPD needs to be implemented to strengthen the professional development of patronage nurses as part of patronage visiting programs.

Achieving results based on patronage visiting requires a dedicated and conscientious implementation. Dedication and conscientiousness are driven by the increase of professional qualifications for the upbringing and improvement of competencies of patronage nurses. Developed and improved competencies are applied in everyday practice and contribute to the health and well-being of children and their families.

Key moments



Why should patronage nurses participate in CPD?

Benefits of participating in CPD activities:

For families:	*For patronage nurse:*	*For PHC organization*	*For profession*
Families receive services considering identified issues and risks with a focus on the child.	Increases confidence in the provision of professional services; Promotes and supports competence in practice; Increases job satisfaction; Provides the structure and support of patronage nurses, contributes to the achievement of their goals; Opens career opportunities.	The organization receives professional and competent staff; Improves the work of a multidisciplinary team of PHC professionals; Increases staff motivation and discipline; Enabled to achieve organizational goals; Promotes the quality of services provided.	Raises the profession status; Promotes evidence-based clinical practice with increased professional recognition; Confirms professional commitment and high-quality service by employees of the organization.

3.2. TYPES OF CONTINUOUS PROFESSIONAL DEVELOPMENT

CPD refers to any activity in which a person is continuously trained. It is based on everyday experience, performance analysis, peer discussion, on-the-job training, critical analysis and personal reflection.

CPD includes clinical observation, lecturing, training at the patient's bed, report writing, analysis and discussion of a specific clinical case.

Any activity that does not have a clearly defined training goal related to the activity of patronage nurses and their specialization is not considered as CPD.

Examples of CPD activities for patronage nurses:

#	*CPD activity*	*Formal*	*Informal*	*Participation*	*Presentations*	*Contribution to knowledge*
1	Attending professional courses, conferences and production trainings (with clearly defined training goals and results, where proofs can be provided upon request)	✪				
2	Formal training and development in a health care institution, for example, attending atechnical on-the-job training	✪				
3	Formal training/education for others (interactive and related tutoring and/or training of others, which includes the identification of clear goals and learning outcomes)	✪				
4	Self-study (for example, tutoring, including current technical, management and commercial journals)		✪			
5	Participation in conferences		✪			
6	Workshops, technical presentations, unscheduled technical visits to enterprises and workshops (formal events may include workshops and courses lasting more than four hours);		✪			
7	Development of personal and practical skills through activities such as observation and tutoring (active and passive)		✪			
8	Informal training/training for others			✪		
9	Mentoring (giving instructions, guidance and support to trainees or students)			✪		
10	Development of new workplace policies or procedures			✪		
11	Peer discussion of a clinical case			✪		
12	Expert evaluation (clinical audit, observation etc.)			✪		
13	Participation in the peer discussion of a clinical case					
14	Presentations during a production event or a workshop and/or a conference, seminar				✪	
15	Presentation of a report on a "difficult case" relating to technical topics, where to increase the level of one's own understanding/ knowledge, research and preparation were required				✪	
16	Writing articles for a newsletter or journal					✪

17	A master's thesis on a one-time basis after successful defense and approval					✪
18	Review of articles for publication					✪
19	Peer-review of articles for publication					✪

Patronage nurses are recommended to undergo a CPD course with an average duration of 80 hours per year (240 hours for three years in total). For example, if for the first year of the total training time was 70 hours, and the next year - 90 hours, in the third year such a time should be at least 80 hours. Hours are counted on the basis of continuous professional development sessions (CPDS).

Photo by: UNICEF/ Zarina Nurmukhambetova

3.3. CATEGORIES OF CONTINUOUS PROFESSIONAL DEVELOPMENT

1. Formal (max. 50 CPDS per year)

Formal activities are often designed for academic credit and may include an evaluation process. If such an evaluation is not available, a credit can be claimed in this category for activities lasting at least four hours, such as a professional development workshop, course or practical workshop.

For the activities claimed in this category, proof of attendance (certificate etc.) is required. Training can take place in a traditional classroom or by means of distance learning tools such as correspondence, online conferencing, video conferencing, CD-ROMs or interactive electronic exchange of information.

Formal activities include:

- Training offered by universities, technical institutes, colleges, employers;
- Formal training and development in a health care institution, for example, attendance of on-the-job training on technical topics.
- Formal training/training of others (interactive and related tutoring and/or training of others, which includes the identification of clear training goals and outcomes).

One hour of attendance is equal to one CPDS.

2. Informal (max. 50 CPDS per year)

Informal activities are usually shorter in duration, do not provide for any evaluation, but increase the level of knowledge, abilities and skills.

Informal activities include:

– Self-study (for example, tutoring, including current technical, management and commercial journals).
- Participation in conferences.
- Workshops, technical presentations, unscheduled technical visits to enterprises and workshops (formal events may include workshops and courses lasting more than four hours);
- Development of personal and practical skills through activities such as observation and tutoring (active and passive)

One hour of attending an informal activity is equal to one CPDS.

3. Participation (max. 40 CPDS per year)

Focused on interaction with peers and providing access to new ideas and technologies, such events contribute to the development of professional competence and serve the public interest.

These activities include:

- Mentoring/tutoring as a designated mentor for a student or applicant.
- Informal training/training for others
- Development of new workplace policies or procedures
- Peer discussion of a clinical case
- Expert evaluation (clinical audit, observation etc.).

One hour of a participation activity is equal to one CPDS.

4. Professional presentations (max. 20 CPDS per year)

Presentations are made:

- at conferences, meetings, courses, councils or seminars;
- presentation of a report on a "difficult case" and/or on technical topics where research and training were

required to improve one's own understanding/knowledge.

Several reports within one presentation are considered as one presentation. One hour of training and report is equal to one CPDS.

5. Contribution to knowledge (max.30 CPDS per year)

This category includes activities that expand or develop a technical knowledge base. These activities include:

- Writing articles for a newsletter or journal (each published document is equal to 10 CPDS with maximum 10 CPDS per year).
- A master's thesis on a one-time basis after successful defense and approval (each thesis is equal to 30 CPDS)
- Analysis of articles for publication (one hour of analysis is equal to one CPDS with maximum 10 CPDS per year).

Peer-review of articles for publication (one hour of peer review is equal to one CPD.

Brief description of CPD activities:

Category	*Hours (sessions)*	*Maximum per year*
Formal	1 hour = 1 CPDS (Continuous Professional Development Session)	50 CPD
Informal	1 hour =1 CPDS	50 CPD
Participation	1 hour =1 CPDS	40 CPD
Presentation	1 hour =1 CPDS	20 CPD
Contribution to knowledge		30 CPD
• Writing articles for a journal	1 article =10 CPDS	
• Master's thesis	1 thesis = 30 CPDS	
• Review of articles for publication	1 hour=1 CPDS (max. 10 CPDS)	
• Peer-review of article for publication	1 hour = 1 CPDS	

3.4. ROLE OF ADMINISTRATION IN CPD PLANNING

In Kazakhstan, with the aim of improving the patronage system, it is planned to create an informal CPD system based on pilot healthcare institutions. The implementation of such a CPD system in other institutions, as well as the development and implementation of a formal CPD system, depend to a large extent on the results of its work.

In order for the experimental individual CPD system to work effectively, the administration of ahealthcare institution has an obligation to plan, organize and monitor CPD activities and results within the patronage nursing system.

The head of health care institution createsa CPD Committee (CPDC) in the person of deputy head of health care institution, senior nurse, senior patronage nurse and deputy head of audit department. The administration of the healthcare institution can fulfill its training obligations in various ways to ensure the competence of its employees (patronage nurses).

Assisting employees in the training process - employees should be supported in personal training - this is an important part of the employer's responsibilities. Staff can be offered financial support in training, allocated time off work for training or attending courses, or time for on-the-job training.

Providing a training and advanced training system – the best practice in policy-making in the context of staff training and development. For this purpose, on-the-job training or distance learning can be provided. The CPDC should take into account different ways of providing and organizing all categories of CPD activities. Do not just be limited to technical skills and abilities, include also computer skills, writing reports or IT

Implementingthe system for keeping records of training activities for employees – the record-keeping system of a health care institution is a valuable tool for staff (patronage nurses) in the context of keeping records oftraining activities, success and professional growth, and also allows the administration of the health care institution keeping records of the implemented and/or organized CPD activities.

Identifying and addressing gaps in training– the administration of the healthcare institution must develop and implement a procedure to identify any gaps in training at the personal level, at the object or department level. Managers should identify the areas of training for participants that should be directly related to the evaluation process of the health care institution in the context of training and development of participants. It is noteworthy that the method and system for assessing the effectiveness of the performance of a patronage nurse, which is planned to be implemented in pilot health institutions, is currently under development.

The administration of the health care institution can allow participants keeping a record of personal and corporate training. The record-keeping system should allow participants planningtraining objectives, activities, evaluate training outcomes, and take into account other skills and abilities that need to be improved. In the absence of an electronic record-keeping system at the level of a healthcare institution, a paper-basedrecord-keeping system is used (described above)

Planning CPD activities. Sample CPD Plan:

#	*CPD activity*	*CPDS*	*Dates*	*Responsible person*
1	Preparation "……."	20	02.02.18-05.02.18	Head of department GP
2	Presentation of difficult cases	20	Weekly	Senior patronage nurse
3	Participation in weekly patronage discussions	2	Weekly	Senior patronage nurse
4	Expert evaluation - direct observation	4	Once a month	Senior patronage nurse
5	Clinical audit of PNrecord-keeping	5	Once a month	
6	Preparation "……."	10	05.06.18-06.06.18	Head of department GP
7	Conference on the assessment of patronage nursing service once every 6 months		10.06.18	Head of health care institution
	Participants	3		
	Speakers	5		

Maintenance of individual CPD participants' log

The CPDC is responsible for maintaining individual CPD logsabout staff (patronage nurses). It may appoint a responsible person for maintaining separate logs for each patronage nurse.

Ideally, this is the senior patronage nurse. After completing all CPD activities, the individual CPD log is to be completed, as shown on the template form below. The individual CPD log is retained in the employee's personal record.

INDIVIDUALCPD LOG

PN name: _____

Year: _____

№	*CPD event*	*CPD activity type*	*Date*	*CPDS*

SIgnature: _____ Date: _____

The senior nurse and senior patronage nurse undertake a quarterly analysis of all CPD logs on the whole staff, arrange separate meetings with those patronage nurse (if necessary) who are lagging behind in reaching the established CPDS rate.

In this regard, on the basis of individual CPD logs, the senior nurse and senior patronage nurse complete the annual CPD log (below is a template form) for all staff.

ANNUALCPD LOG

Year: _____

#	PN name	EarnedCPDS					Total earned CPDS during the year	TotalCPDSfrompreviousyears	EstablishedCPDSrate per year	Carry-forward into subsequent period
		Formal	Informal	Presentation	Participation	Contribution to knowledge				
1										
2										
3										
4										

Siganture: _____ Date: _____

3.5. CPD PLANNING PROCESS

The CPD planning process consists of four stages:

1. Setting objectives and tasks
2. Analysis of personal needs
3. Identifyingpersonal needs
4. Identifying gaps in existing skills

Stage 1: Setting objectives and tasks:

Define the objectives you want to achieve. These can be short, medium and long-term objectives.

Professional objectives/tasks of CPD

Date of definition	*Objective/task*	*Short, medium and long-term perspective*	*Forecasted*	*Date of definition*	*Objective /task*
	Organization of own personal development portfolio	Short-term			
	Improving the consultations skills of mothers with postpartum depression	Mid-term			
	Improving the skills of using electronic form of recording patronage visits	Short-term			
	Improving presentation skills	Short-term			
	Improving task delegating skills	Mid-term			
	Improving the skills of risk management analysis	Short-term			

Stage 2: Analysis of personal needs

This process involves determining your current knowledge, skills and abilities, as well as strengths and weaknesses.
Begin with listing the identifiable qualifications and competencies, and then go on to personal qualities, start with describing skills. The second step is to describe the existing skills before identifying the gaps that need to be closed.

Required skills	*Current skills*	*Gaps*
Consultation skills of mothers with postpartum depression.	Keeping focus on patient problems	Mastery in conducting a survey, checking for dependency, aggression and danger to the self and/or others, using effective verbal or non-verbal communication
Ability to use the Internet for electronic correspondence.	No	Theory and practice of the required skill.

Stage 3: Identifying personal needs

- Assess the training opportunities and resources required.

- Ask your manager to assign scheduled training for the reporting period.
- Is it possible to conduct a distance learning?
- Do you read professional journals?
- Will the organization cover training costs or will you pay for the tuition yourself?
- Are you able toallocate some free time, or do you have to do it by any effort at short intervals between meetings?

- **Stage 4: 4. Identifying gaps and developing an individual CPD plan**
- By implementing process consistently, you will become clear in terms of what is available and what is required. The final step is to create a list of your development needs to close the gaps
- The list of development needs is the true measure of your CPD goals.
- Proposals should clearly indicate what needs to be achieved, it is important to take them into account in terms of professional growth. This is done in the table above. It is not necessary to do it exactly that way, it is important to have the means to create a list of your development needs.
- This four-stage process provides for either individual execution or a discussion with the immediate manager.
- Assess your progress.
- Periodically assess your success in achieving your planned targets:
- Determine whether you have learned or developed new skills, achieved the training objectives and met the CPD requirements.
- Regularly review your training requirements and take necessary measures.

Professional development plan

The professional development plan is a resource for supporting lifelong learning, which is designed as a personal document for each employee's career development. Developing the plan gives the patronage worker an opportunity to focus on his/her career aspirations and can become a tool for recording and considering decisions and actions.

Name: …….. Supervisor's name:……

Place of work: …….. Date:……..

Purpose and need for development is an area of interest	Relevant area of my work and career	Required number of hours and date of achieving objectives	What will I do to achieve my objective? (resources and support needed)	How will I apply the lessons learned in my work?	How will I know that I am successfully developing (what has changed)	How will I share my knowledge with my colleagues?

Part 4

ASSESSMENT OF COVERAGE AND QUALITY OF PATRONAGE SERVICES FOR ANTENATAL AND PEDIATRIC CARE AT THE PHC LEVEL THROUGH HOUSEHOLD SATISFACTION SURVEY

Lot quality assurance sampling (LQAS)

Photo by: UNICEF/ Zarina Nurmukhambetova

DEFINITION

Lot quality assurance sampling (LQAS) method is based on a stratified random sampling to collect data and to test a unilateral hypothesis in data analysis.

LQAS (*Lot Quality Assurance Sampling*) is an effective tool for assessing the quality of services at the primary health care (PHC) level through a household survey to examine the population's satisfaction. It is a sampling methodology that uses small samples from each locality to determine whether the main public health indicators/targets have been achieved. Although this method was originally developed to monitor the quality of industrial products, it has been used successfully and widely around the world to monitor and evaluate a variety of public health programs (Robertson S.A., 2006; Valadez J.J., 2003; Valadez J.J., 1991). At the level of a specific territory, LQAS uses a binomial probability to determine whether the set targets have been achieved. However, when its results are compiled at the national level and weighed according to the population size of each territory, it is also possible to calculate the numerical coverage rates at the national level (based on mothers' reports at the time of the study).

The advantage of LQAS assessment is the identification of main factors affecting the quality of services and formulation of response to implementing the universal progressive home-visiting model.

The assessment results help PHC managers build a step-by-step action plan for improving the system of care for mothers and children at an early age.

To assess the quality of the patronage service, antenatal or pediatric care at the PHC level via LQAS, it is necessary to trainthe team of interviewers and data collection experts for conducting a studyat the community level. To avoid subjectivity in the assessment process, it is necessary to involve partners at the oblast level, representatives of Akimat, NGOs, and CEOs of PHC organizations. Due to the involvement of different parties in the assessment planning process, matters regarding the sampling frame, interviewer teams, their training, and implementation schedule are addressed together considering all possible risks and estimation of response interventions for their leveling.

Regular LQAS provides an opportunity to track progress in the improvement of PHC health services. To obtain more objective data in the LQAS framework, it is important to replace punitive measures, often used in the health care system, with modern effective methods of quality control. Finally, for the successful LQAS implementation in the country, it is extremely important to stimulate its utilization at the local level along with continuous supportive follow-up.

In this regard, the importance of expanding coverage of quality PHC services in addressing these and other problematic issues should not be underestimated. It is recommended to train the interviewer team and conduct the study with trained experts from the Republican Center for e-Health (RCEH) and the United Nations Children's Fund (UNICEF).

LQAS SOBJECTIVES AND TASKS

The objective of LQAS is to qualitatively assess the coverage and quality of PHC services in sites within one oblast by random lot selection.

LQAS tasks are:

- Assessment of the patronage coverage and quality in the antenatal period (patronage of pregnant women)

Assessment of the patronagecoverage and quality in pediatric care with emphasis on such priority issues as exclusive breastfeeding, complementary feeding and caring for a sick child.

- Identification of sites "short of" target indicators and in need of support as well as sites "long on"

target indicators and able to serve as examples in peer-to-peer training.

Capacity building at the national and oblast levels for periodic study using the LQAS methodology.

METHODOLOGY

Firststagedefines an actual list of settlements with population in each of them. This list is a sampling tool. The larger the settlement, the greater is the likelihood of its selection for participation in the study and selection of more respondents in it.

Secondstageprovides an optional sampling of a reference household for assessment using the segmentation method. When mapping a large settlement, the segmentation method helps save time. The main idea of this method is to not map the entire settlement, but divide it into relatively equal segments using landmarks, after which each segment is assigned a number, and optionally select any of these segments. If the selected segment is of a foreseeable size, it is mapped, each household is numbered, and then selected in random order. If the selected segment is too large, it must be divided into sub-segments, (if required into sub-sub-segments) to achieve the required number of households.

An optionally sampled household is considered a reference. It is not studied. The first respondent is selected from the next nearest household, which is the starting surveying point

Thirdstageis the choice of a respondent in the household. Respondents can be representatives of several target groups in one house or several potential respondents from one target group. An interviewer must outline the household structure, and if there are several capable persons, then one of them is selected for the survey (by random sampling). Then sucha respondent is to be surveyed.

After completing the survey of the required number of respondents, the data processed by manual tabulation while computer analysis of data is possible.

Processed data are discussed within the team after which a list of priority tasks for improving the quality of services is developed based on the identified indicators.

LQAS assessment should be done only after the training together with representatives of the Republican Center for e-Health.

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ANNEXES

Annex1.1

Design of the universal progressive patronage of children under 5 years (home visits by a patronagenurse)

Type of services provided	Service recipients	Timing	Home-visited by
Universal service package	All pregnant women	Up to 12 weeks of gestation or at the first appearance 32 weeks of gestation	Patronage nurse
	All newborns and children under 3	The first 3 days after discharge from the maternity hospital 7 days of life 1-2 months 3 months 6 months 12 months 18 months 24 months 36 months	Patronage nurse
Progressive servicepackage	Pregnant women at risk	In accordance with an individual plan	Patronagenurse, social worker, psychologist, if necessary
	All newborns and children under 5 at risk	In accordance with an individual plan	Patronagenurse, social worker, general practitioner/pediatrician, psychologist, if necessary - determined by child's individual needs

Annex 1.2

Earlychildhoodneedsassessmentscale

	Early childhood needs criteria	Age of the child when it is necessary to assess this need									
		In utero (prenatal patronage)	3 days	7 days	1 month	3 months	6 months	12 months	18 months	24	36 months
1	Safe environment in terms of sudden infant death syndrome		+	+	+	+	+	+			
2	Safe environment in terms of injuries, poisoning and accidents	+	+	+	+	+	+	+	+	+	+
3	Housing conditions meet temperature and light requirements;no dampness		+	+	+	+	+	+	+	+	+
4	There is a place to sleep, bed linen is clean with warm blanket		+	+	+	+	+	+	+	+	+
5	There are clothes corresponding to age, size and season. The same - shoes for older children		+	+	+	+	+	+	+	+	+
6	Both parents take care of the child, even if they do not live together	+	+	+	+	+	+	+	+	+	+
7	The child does not feel neglect, abuse, any kind of violence from anyone	+	+	+	+	+	+	+	+	+	+
8	In the child'senvironment there is no abuse between people, scandals, fights, foul language	+	+	+	+	+	+	+	+	+	+
9	Child'senvironment is not cruel to animals	+	+	+	+	+	+	+	+	+	+
10	Child and his/her family do not experience any kind of discrimination or stigmatization	+	+	+	+	+	+	+	+	+	+
11	Child with disabilities receives a social allowance		+	+	+	+	+	+	+	+	+
12	Child is registered and has a birth certificate		+	+	+	+	+	+	+	+	+
13	Child's parents have all necessary documents, the lack of which somehow affects child's well-being	+	+	+	+	+	+	+	+	+	+
14	Child's parents are informed of all types of health and social services provided by the state in their situation and know how to receive these services	+	+	+	+	+	+	+	+	+	+
15	Child's parents are informed of their rights and obligationfor childcare and upbringing	+	+	+	+	+	+	+	+	+	+
16	Child's parents observe their childcare obligations	+	+	+	+	+	+	+	+	+	+
17	Parents know and respect child's rights	+	+	+	+	+	+	+	+	+	+
18	Child feels the care of adults and is under their constant supervision		+	+	+	+	+	+	+	+	+
19	Child has conditions and opportunities for playing - a safe place, safe toys, a place for physically active games, children's books and pictures		+	+	+	+	+	+	+	+	+
20	Child has the opportunity for early development: physical, motor, speech, social-emotional, cognitive and communicative		+	+	+	+	+	+	+	+	+
21	Child can attend pre-school facilities										+
22	Child lives in a psychologically favorable and emotionally warm environment and has a reliable attachment to the parent		+	+	+	+	+	+	+	+	+
23	Child is not in a state of toxic stress		+	+	+	+	+	+	+	+	+
24	Parents choose the right parenting style (do not apply physical punishment, psychological pressure)		+	+	+	+	+	+	+	+	+
25	Parents interact with the child in a quality way: they devote time to playing, communicating, reading and teaching of skills		+	+	+	+	+	+	+	+	+
26	Parents have no depression	+	+	+	+	+	+	+	+	+	+
27	Child is exclusively breastfed		+	+	+	+					
28	Child continues to be breastfed						+	+	+	+	

29	Child receives ultimate complementary feeding (corresponding to 6 requirements)						+	+	+	+	+
30	Child consumes clean potable water						+	+	+	+	+
31	Parents ensure child's personal hygiene and home hygiene (hygiene supplies and hygiene skills are in place)		+	+	+	+	+	+	+	+	+
32	A pregnant woman and a breastfeeding mother can eat wholesome foodand get regular meals	+	+	+	+	+	+	+	+	+	
33	Child receives all preventive vaccinations in accordance with the approved calendar		+	+	+	+	+	+	+	+	+
34	A pregnant woman in a timely manner becomes registered for all necessary examinations and regularly visits a doctor (at least 4 times with favorable gestation course)	+									
35	Child passes all necessary screenings and preventive examinations according tohis/her age.		+	+	+	+	+	+	+	+	+
36	Child receives the adequate treatment of common diseases (diarrhea etc.) in accordance with IMCI, eliminating unnecessary medication and hospitalization		+	+	+	+	+	+	+	+	+
37	Child receives proper care during illness at home		+	+	+	+	+	+	+	+	+
38	A pregnant woman and family members are aware of alarming signs of pregnancy and individual action plan in emergency situations	+									
39	Child’s parents are aware of dangerous signs of a child's illness and immediately seek medical help		+	+	+	+	+	+	+	+	+
40	Child has access to essential medicines and timely quality emergency care		+	+	+	+	+	+	+	+	+
41	Child with severe chronic illness has access to all moderndiagnostic assessment and treatment available in the country		+	+	+	+	+	+	+	+	+
42	Child with disabilities receives rehabilitation services		+	+	+	+	+	+	+	+	+

Annex 1.3

Program of informationpractical training "Universal Progressive Patronage of Young Children"for chief medical officersand deputy chief medical officers

Time	*Topic*	*Delivery form*
Day 1		
09.00-09.20(20 min)	Registration. Greetings. Pre-test.	
09.20-10.00(40 min)	Rationale for the modernization of the patronage of pregnant women and young children at the primary health care level	Interactive presentation
10.00-11.00(1 hour)	Module 1.Early childhood is a time of limitless opportunities	Interactive presentation
11.00-12.00(1 hour)	Module 2.The new role of the patronage nurse	Interactive presentation
12.00-13.00(1 hour)	Module 3.Breastfeeding	Interactive presentation
13.00-14.00	Lunch	
14.00-15.00(1 hour)	Breastfeeding practice	Practice in a maternity hospital
15.00-16.00(1 hour)	Module 3.Complementary feeding	Interactive presentation
16.00-17.00(1 hour)	Complementary feeding. Technology of preparation	Practical exercise
Day 2		
09.00-10.00(1 hour)	Complementary feeding	Practice in a polyclinic
10.00-11.00(1 hour)	Module 4.Developing attachment between parent and child	Interactive presentation
11.00-11.30(30 min)	Module 5.Involving fathers	Interactive presentation
11.30-12.00(30 min)	Module 6.The art of education: love, play, talk, read	Interactive presentation
12.00-13.00(1 hour)	Practice on playing, communicating, reading, building attachments and involving fathers	Practice in a polyclinic
13.00-14.00	Lunch	
14.00-14.30(30 min)	Module 7.Well-being of parents	Interactive presentation
14.30-15.30	Nutrition pyramid of a pregnant and breastfeeding mother	Practice in a polyclinic
15.30-16.00(30 min)	Module 8.Common anxietiesof parents	Interactive presentation
16.00-17.00(1 hour)	Module 9.Home environment and safety	Interactive presentation
Day 3		
09.00-09.30(30 min)	Module 10.Communication skills	Interactive presentation
09.30-10.30(30 min)	Module 11.Overcoming stigma, discrimination. Promoting justice, inclusion and respect for diversity	Interactive presentation
10.30-11.00(30 min)	Module 12.Children developing differently	Interactive presentation
11.00-12.00(1 hour)	Module 13.Monitoring and screening of development	Interactive presentation
12.00-13.00(1 hour)	Module 14.Trying to protect children from abuse, lack of attention and abandonment	Interactive presentation
13.00-14.00	Lunch	
14.00-15.00(1 hour)	Module 15.Cross-sectoralinteraction	Interactive presentation
15.00-16.00(1 hour)	Module 16.Supervision	Interactive presentation
16.00-17.00(1 hour)	How can I organize my work to improve partnership with families for improving the well-being of young children? Feedback	Group work and group presentation
17.00	Post-test. Completion of training.	

Annex 1.4

Training program "Universal Progressive Patronage of Young Children"for PHC doctors, nurses, social workers

Part 1. Basic training "Development of young children"
(taking into account the new recommendations of UNICEF. Modules 1, 3, 4, 5, 6, 7, 8, 9, 13)

Duration - 5 days, 40 hours
Theory- 28 hours, practice -12 hours

Day 1		
09.00-09.30	Registration. Introduction. Pre-test. Training goals and objectives.	Presentation
09.30-11.00	Module 1. Early childhood is a time of limitless opportunities	Interactive presentation
11.00-11.15	Break	
11.15-13.00	Module 3. Breastfeeding	Interactive presentation. ICAT video
13:00-14:00	Lunch	
14.00-15:30 (including trip)	Clinical practice of breastfeeding	In a maternity hospital
15.30-15.45	Break	
15.45 -17.30	Module 3. Complementary feeding	Interactive presentation.
17.30	Homework. ReadModules 1, 3 (sectionsBreastfeedingandComplementary feeding)	
Day 2		
09.00-11.00 (including trip)	Clinical practice of complementaryfeeding	In a polyclinic
11.00-11.15	Break	
11.15 -13.00	Technology of preparation complementary feeding. Technical workshop on complementary feeding.	Practical exercisein a Resource Center. Presentation. IMCI movie "Nutrition of Young Children"
13:00-14:00	Lunch	
14:00-15:30	Module 5.Involving fathers	Interactive presentation.
15.30-15.45	Break	
15.45-17.30	Module 6.The art of education: love, play, talk, read	Interactive presentation. Demonstration of the correct use of toys (by age, safety, household items, homemade toys). Requirements for books.
17.30	Homework.ReadModules 5 and 6	
Day 3		
09:00-11.00 (includingtrip)	Clinical practice of the art of child-rearing and involving fathers in child-rearing	In a polyclinic
11.00-11.15	Break	
11.15-13.00	Module 4.Attachment	Interactive presentation.
13:00-14:00	Lunch	
14.00-15.30	Evaluation of physical development. Interpretation of graphs, monitoring of physical development.	Using ICAT section "Consult". Part "Physical development". Video materials, graphics, tasks.
15.30-15.45	Break	
15.45-17.30	Module 13.Monitoring and screening of development	Interactive presentation Using the 10-Step Guide to Monitoring.

17.30	Homework. ReadModules 4 and 13	
Day 4		
09:00-11.00 (including trip)	Clinical practice of child development monitoring	In a polyclinic
11.00-11.15	Break	
11.15-13.00	Module 8.Common problems of raising children	Interactive presentation.
13:00-14:00	Lunch	
14:00-15:30	Module 7.Well-being of parents	Interactive presentation.
15.30-15.45	Break	
15.45-17.30	Tasks of prenatal patronage. Nutrition pyramid of pregnant women. Consulting a pregnant and breastfeeding mother.	Method of 24-hour playback (practical exercise in a classroom). UsingForm 112.
17.30	Homework. Read Modules7,8	
Day 5		
09.00-13.00 (including trip)	Large clinical practice of Modules 3,4,5,6,7,8,13 (nutrition pyramid of pregnant and breastfeeding women, identification of depression in pregnant women, counseling children on the game, communication, reading, revealing affection, involving fathers in child-rearing).	In a polyclinic
13:00-14:00	Lunch	
14.00-15.30	Module 9.Home environment and safety	Interactive presentation.
15.30-15.45	Break	
15.40-16.10	Self-study "How will I start applying this knowledge in practice?Developing a personal plan.	Presentation and discussion of plans
16.10-16.30	Post-test. Final questionnaire; delivery of certificates.	

Annex1.5

Part 2. Advanced training "The New Role of the Patronage Nurse"
(taking into account the new recommendations of UNICEF. Modules 2,10,11,12,14,15,16)

Duration - 5 days, 40 hours.
Theory- 20 hours, practice - 20 hours

Day 1		
09.00-09.30	Registration. Introduction. Training goals and objectives. Link to the first part of the training.	Presentation
09.30-10.00	Care and education of young children in Kazakhstan according to UNICEF Role and importance of the PHC service. Patronage research data in Kazakhstan. Modern requirements to the organization of the patronage service for pregnant women and young children.	Introductorypresentation
10.00-11.00	Module 2.The new role of the patronage nurse	Interactive presentation
11.00-11.15	Break	
11.15-13.00	Practical exerciseof child's environment mapping and developing an individual plan	Work in small groups. Group presentation.
13:00-14:00	Lunch	
14.00-15.30	Module 10.Communication skills	Interactive presentation
15.30-15.45	Break	
15.45 -17.30	Practical parton Module 10	Practical exercise
17.30	Homework. Read Modules2, 10	
Day 2		
09.00-11.00	Module 11.Overcoming stigma, discrimination. Promoting justice, inclusion and respect for diversity	Interactive presentation. Practical part – 1 hour (case presentation)
11.00-11.15	Break	
11.15 -13.00	Module 12.Children developing differently	Interactive presentation
13:00-14:00	Lunch	
14:00-15:30	Practical parton Module 12	Practical part. Work in groups
15.30-15.45	Break	
15.45-17.30	Module 14.Protecting children from abuse	Interactive presentation
17.30	Homework. Read Modules 11, 12,14	
Day 3		
09:00-11.00	Module 15.Working with other sectors. Group work on case management.	Interactive presentation. Work in groups. Case presentation.
11.00-11.15	Break	
11.15-13.00	Module16.Supervision	Interactive presentation
13:00-14:00	Lunch	
14.00-15.30	Supervision on SOP "Patronage of a pregnant woman". Training in indicative interviewing. Identification of depression. Standard questions onabuse. Training inalarming signs of pregnancy. Developing an emergency plan.	Practical exercise. Role-play using supervision check-lists
15.30-15.45	Break	
15.45-17.30	Continuation of supervision on SOP "Patronage of a pregnant woman." Motivation for breastfeeding. Training in breastfeeding technology. Evaluation of the family's readiness for a newborn.	Continuation of practical exercise
17.30	Homework. Read Modules 15, 16, SOP "Patronage of a pregnant woman".	
Day 4		
09:00-12.00	Supervision in a polyclinic on SOP: • Patronage of a newborn • Monitoring the development of a child of	Practice in a polyclinicon supervision of SOP execution

	different ages in 10 steps (including physical development) • Consultation on breastfeeding • Consultation on complementary feeding • Consultation on the game, communication, reading • Consultation on the involvement of fathers in child-rearing	
12.00-13.00	Discussion of real examples from practice. Feedback on supervision skills.	Interactive discussion
13:00-14:00	Lunch	
14:00-15:30	Environmental safety assessment. Use of the environmental safety assessment scale. Solution of situational tasks.	Practical exercise
15.30-15.45	Break	
15.45-17.30	Training a family in first aid.	Practical exerciseof first aid
17.30	Homework. Repeat allSOPs.	
Day 5		
09.00-10.00	Final test and clinical tasks for all modules.	
10.00-11.00	Planning visits of the patronage nurse. Preparation of patronage nurse to visiting.	Practical exercise
11.00-11.15	Break	
11.00-13.00	Work scope performed at each visit. Documentation. Training in working with mobile applications 1 and 2.	Practical exercise
13:00-14:00	Lunch	
14.00-16.00	Presentation of test results and solution of clinical problems. Group work "Presentation of the work plan of a patronage nurse and its organization at the polyclinic level"	Group presentation
16.00	Completion of the training. Delivery of certificates.	

Annex 1.6

Planning and implementation of visits for the provision of theuniversal services

Completion guidelines

Scheduling planned visits on the assigned site is carried out by a patronage nurse. Planning is performed in Excel. An electronic copy of the plan is given to the senior nurse of department. The senior nursemonitors itsreliability and implementation.

By the beginning of a month, the patronage nurse must have a targeted plan, which is subject to planned patronage visiting during this month. The plan of visits is distributed for each week of the month. All columns with the mark "Week 1" etc. are to be filled with real dates. For example, «12.02.-16.02.2018». Scheduled visits are to be marked with 1 opposite the patient's name. During the week, the patronage nurse adjusts the visiting schedule independently, so that by the end of the week the plan is completed.

After the visit and risk assessment, the column is colored red (high risk), yellow (moderate risk) or green (no risk).

If the visit is not completed, the digit is changed to 0.

The sum formulas are set horizontally in the columns "Visits per month", "Visits per quarter", "Visits per year", vertically - in each column opposite "Total visits made".

	Scheduled visits to pregnant women (at 12 weeks and 32 weeks)								
		Addre ss	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Visits per month	Visits per quarter	Visits per year
	Last and first name of a pregnant woman								
1	…								
2	…								
	…								
	Total visits made to pregnant women								
	Assessment results:								
	at high risk								
	at moderate risk								
	no risk								
	Scheduled visits to newborns discharged from the maternity hospital (1st visit)								
		Addre ss	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
	Last and first name of anewborn								
1	…								
2	…								
	…								
	Total visits made to newborns								
	Assessment results:								
	at high risk								

	at moderate risk								
	no risk								
	Scheduled visits to children who are 7 days old this week(2nd visit)								
	Last and first name of a child	Addre ss	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
1	…								
2	…								
	…								
	Total visits made tochildren 7 days old								
	Assessment results								
	at high risk								
	at moderate risk								
	no risk								
	Scheduled visits to children who are 1 month old this week (3rd visit)								
	Last and first name of a child	Addre ss	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
1	…								
2	…								
	…								
	Total visits made to children 1 month old								
	Assessment results								
	at high risk								
	at moderate risk								
	no risk								
	Scheduled visits to children who are 3months old this week (4th visit)								
	Last and first name of a child	Addres s	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
1	…								
2	…								
	…								
	Total visits made to children 3 months old								
	Assessment results								
	at high risk								
	at moderate risk								
	no risk								
	Scheduled visits to children who are 6 months old (5th visit)								
	Last and first name of a child	Addres s	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
1	…								
2	…								
	…								

	Total visits made to children 6 months old								
	Assessment results								
	at high risk								
	at moderate risk								
	no risk								
	Scheduled visits to children who are 12 months old (6th visit)								
	Last and first name of a child	Address	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
1	…								
2	…								
	…								
	Total visits made to children 12 months old								
	Assessment results								
	at high risk								
	at moderate risk								
	no risk								
	Scheduled visits to children who are 18 months old (7th visit)								
	Last and first name of a child	Address	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
1	…								
2	…								
	…								
	Total visits made to children 18 months old								
	Assessment results								
	at high risk								
	at moderate risk								
	no risk								
	Scheduled visits to children who are 24 months old (8th visit)								
	Last and first name of a child	Address	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
1	…								
2	…								
	…								
	Total visits made to children 24 months old								
	Assessment results								
	at high risk								
	at moderate risk								
	no risk								
	Scheduled visits to children who are 36 months old (9th visit)								

	Last and first name of a child	Address	Date of birth	Week 1 (dates)	Week 2 (dates)	…	Per month	Per quarter	Per year
1	…								
2	…								
	…								
	Total visits made to children 36 months old								
	Assessment results								
	at high risk								
	at moderate risk								
	no risk								
	Total number of visits to provide the universal patronage services								

Annex 1.7

Planning and implementation of visits to provide the progressive services (according to an individual plan)

Completion guidelines

To beperformed in Excel.

After the assessment and identification of risks, the patronage nurse includes those at risk (high and moderate) in the plan of progressive services. She lists reason for and date of individual registration. All the columns marked "Day 1" etc. are to be filled with real dates. She immediately puts 1 opposite to the day of the nearest visit, which she agreed with the family. After developing an individual plan, the dates of further visits are also recorded in the chart under the digit 1. All visits performed are marked in red, yellow or green, depending on the remaining risk degree. If the risk is eliminated, the date of elimination is recorded in the appropriate box. If the planned visit is not completed, the digit 1 is replaced by 0.

The sum formulas are set horizontally opposite each name in the columns "Visits per week" and Visits per month", vertically in each column opposite "Total visits made on an individual plan" (number of daily, weekly, monthly visits).

#	Last and first name	Address	Date of birth	Age	Reason for individual registration	Date of individual registration	Date of individual de-registration	Week 1				Week 2	Visitsper month
								Day 1	…	5th day	Visits for the Week 1	…	
1	…												
2	…												
	Total visits made on an individual plan												

Annex 1.8

Indicators of monitoring the main patronage performance parameters

		Reporting period
P	**Population**	
P1	Total number of households in the pilot areas (for 6 months)	twice a year
P2	Total number of households with children from 0 to 5 years in the pilot areas (for 6 months)	twice a year
P3	Total number of households living in urban areas in the pilot areas (for 6 months)	twice a year
P4	Total number of households living in rural areas in the pilot areas (for 6 months)	twice a year
P5	Total number of households arrivedin the current month (once a month)	monthly
P6	Total number of households departed in the current month (once a month)	monthly
P7	Total population in the pilot areas (for 6 months)	twice a year
P8	Total population arrived at the site in the current month*	monthly
P9	Total population departed of the site in the current month*	monthly
P10	Total number of women of reproductive age in the pilot areas (for 6 months)	twice a year
P11	Total number of women of reproductive age in the pilot areas arrived in the current month*	monthly
P12	Total number of women of reproductive age in the pilot areasdeparted in the current month*	monthly
P13	Number of children aged 0 to 13 months (1 year) in the pilot areas in 6 months	twice a year
P14	Number of children aged 0 to13 months arrivedin the current month*	monthly
P15	Number of children aged 0 to13 months departed in the current month*	monthly
P16	Number of children aged 1-5 years in the pilot areas	twice a year
P17	Number of children aged 1-5 years arrived in the current month*	monthly
P18	Number of children aged 1-5 years departed in the current month*	monthly
PW	**Pregnant women**	
PW1	Number of pregnant women in the estimated period (18 and older) for 6 months	twice a year
PW2	Number and percentage of pregnant women in the sites registered with the antenatal clinic at the time of pregnancy up to 12 weeks for 6 months	twice a year
PW3	Number of pregnant women arrivedin the current month*	monthly
PW4	Number of pregnant women departed in the current month*	monthly
PW5	Number of pregnant adolescents in the pilot areas(12 to 18 years) for 6 months	twice a year
PW6	Number of pregnant adolescents arrivedin the current month*	monthly
PW7	Number of pregnant adolescents departed in the current month*	monthly
PW8	Number and percentage of pregnant women in the pilot areas, who visited the clinic at least 4 times during pregnancy (during the year)	twice a year
PW9	Number and percentage of pregnant women in sites with a complicated pregnancy in the current month	monthly
PW10	Number and percentage of pregnant women on sites with extragenital diseases in the current month	monthly
PW11	Number and percentage of women on sites with prenatal depression in the current month	monthly
	Work of a patronage nurse with pregnant women:	
PW12	Number of pregnant women visited at home atup to 12 weeks and 32 weeks (% of the universal plan implementation)	monthly
PW13	Of them - identified risk groups (%)	monthly
PW14	Of them, individual emergency plans were developed jointly with a midwife (%)	monthly
PW15	Number of visits to pregnant women on individual plans (% of the progressive plan implementation)	monthly
PW16	Of them–de-registered due to the elimination or reduction of risk (%)	monthly
L	**Outcomes of labor**	
L1	Number of maternal deaths on the site	once a year
L2	Number of maternal deaths per month	monthly
L3	Total number of births per year on the site	once a year
L4	Number of laborson the site in the current month	monthly
L5	Number of women who gave birth on the site in the current month	monthly
L6	Number and percentage of births in the perinatal center of Level 1 per month	monthly
L7	Number and percentage of births on the site in the perinatal center of Level 2 per month	monthly
L8	Number and percentage of births on the site in the perinatal center of Level 3 per month	monthly

L9	Number of premature births on the site in the current month	monthly
L10	Percentage of premature births on the site from the total number of births in the current month	monthly
L11	Number of cesarean sections on the site in the current month	monthly
L12	Percentage of cesarean sections on the site from the total number of births in the current month	monthly
L13	Number and percentage of newborns on the site born before 34 weeks of pregnancy in the current month	monthly
L14	Number and percentage of children born on the site with a low birth weight in the current month	monthly
L15	Number of stillbirths on the site in the current month	monthly
L16	Number of neonatal mortality cases on the site (up to 28 days) in the current month	monthly
C	**Children aged 0-59 months**	monthly
C1	Of them, the number of households with newborns on the site visited at home during the first 7 days after giving birth in the current month	monthly
C2	Percentage of households with newborns on the site visited at home during the first 7 days after giving birth in the current month	monthly
C3	Number of women who gave birth on the site withpostpartum complications during 7 days from the time of delivery and visited at home by patronage nurses or midwives in the current month	monthly
C4	Percentage of women who gave birth on the site with postpartum complications during 7 days from the time of delivery and visited at home by patronage nurses or midwives in the current month	monthly
C5	Number and percentage of women on the site with postpartum depression in the current month	monthly
C6	Number and percentage of women on the site with postpartum depression referred to professionals in the current month	monthly
C7	Number and percentage of mothers on the site, whose children are exclusively breastfed for up to 6 months in the current month	monthly
C8	Number and percentage of women on the site consulted on modern contraceptive methods	monthly
C9	Number and percentage of women on the site using modern contraceptive methods in the current month	monthly
C10	Number of children on the site at the age of 12 months in the current month	monthly
C12	Of them, number and percentage of children immunized in full	monthly
C13	Number and percentage of young mothers on the site, whose children are exclusively breastfed for up to 6 months	monthly
C14	Number and percentage of young mothers on the site, whose children timely began to receive complementary feeding at 6 months	monthly
C15	Number and percentage of children aged 0-5 years on the site with low weight or undernourishment (Z-2-Z-3)	monthly
C16	Number and percentage of children aged 0-5 years on the site with overweight or obesity (Z-2-Z-3)	monthly
C17	Number and percentage of children aged 0-5 years on the site withstunting (Z-2 - Z-3)	monthly
C18	Number and percentage of children under 5 years on the site diagnosed with diarrhea and receiving treatment at home	monthly
C19	Number and percentage of children under 5 years on the site diagnosed with ARI/pneumonia and receiving home treatment	monthly
C20	Number and percentage of children aged 0-13 months on the site died of a trauma or an accident at home in the current month	monthly
C21	Number and percentage of children under 5 years on the site hospitalized as a result of an injury	monthly
C22	Number and percentage of children under 5 yearson the site hospitalized with diarrhea	monthly
C23	Number and percentage of children under 5 yearson the site hospitalized with pneumonia	monthly
C24	Number of children died at the age of 29 days to 13 months	monthly
C25	Number of children died at the age of 29 days to 13 months at home	monthly
C26	Number of children died at the age of 0 to 12 months	monthly
C27	Number of children died at the age of 0 to 12 months in a maternity hospital	monthly
C28	Number of children died at the age of 0 to 12 months in an in-patient hospital	monthly
C29	Number of children died at the age 0 to 12 months in an in-patient hospitalup to	monthly

	24 hours	
C30	Number of children died at the age of 0 to 12 months at home	monthly
C31	Number of children died at the age of13 to 59 months	monthly
C32	Number of children died at the age of 13 to 59 months at home	monthly
C33	Number of children died at the age of12 months to 5 years old	monthly
C34	Number of children died at the age of 12 months to 5 years oldin an in-patient hospital	monthly
C35	Number of children died at the age of 12 months to 5 years in an in-patient hospital up to 24 hours	monthly
C36	Number of children died at the age of 12 months to 5 years at home	monthly
CP	**Patronage of children aged 0 to 59 months**	
CP1	Number of planned mandatory home visits to children aged 0-3 years (universal plan)	monthly
CP2	Number of completed home visits to children aged 0-3 years (% of the universal plan implementation)	monthly
CP3	Number of children aged 0-3 years for the first time recognized at risk of health and social problems (% of children visited)	monthly
CP4	Number of planned additional home visits to children aged 0-5 years according to individual plans (progressive plan)	monthly
CP5	Number of completed additional home visits to children aged 0-5 years (% of the progressive plan implementation)	monthly
CP6	Number of children aged 0-5 years excluded from health or social risk group (% of children at risk)	monthly
CP7	Including social risks	monthly
CP8	health risks	monthly
CP9	development risks	monthly
CP10	risks of injuries at home	
CP11	risks of neglect and abuse	
IP	**Individual family support plan on the site**	monthly
IP1	Number of individual family support plans on the site led by the patronage nurse	monthly
IP2	Number of individual family support plans on the site led by the social worker	monthly
IP3	Number of initiated individual family support plans (cases) in the current month	monthly
TS1	Number and percentage of households with children under 5 years with social problems registered in the current month as per main problem groups:	monthly
A	Poor housing conditions (dampness, cold, lack of a water supply system, overcrowding etc.)	monthly
B	Low material level of all household members (lack of work or low-paid work of one or both parents/ household members)	monthly
V	Poor sanitation and hygiene conditions	monthly
G	Lack of safe home environment for the child, risks of injuries, poisoning and accidents	monthly
D	Poor psychological microclimate in the family (constant disputes, fights, physical punishment, neglect of child's needs)	monthly
E	Use of alcohol, drugs, toxic products by family members	twice a year
ZH	Smoking mother, father or other family members. Smoking in the presence of the child	monthly
Z	Child neglect, abuse, violence	monthly
I	Child and mother receive unbalanced, poor nutrition	monthly
K	Child does not possess certain development skills for his/her age	monthly
L	Other	monthly
TS2	Number and percentage of households with children under 5 years visited by social workers during the estimated period	monthly
TS3	Number and percentage of households with children under 5 years having social problems that were de-registered in theestimated period	monthly
TS4	Number and percentage of households with children under 5 years having social problems that were de-registered in theestimated period as per main problem groups	monthly
TS5	Number of closed individual family support plans (cases) in the current month	monthly
A	Poor housing conditions (dampness, cold, lack of a water supply system, overcrowding etc.)	monthly
B	Low material level of all household members (lack of work or low-paid work of one or both parents/ household members)	monthly
V	Poor sanitation and hygiene conditions	monthly
G	Lack of safe home environment for the child, risks of injuries, poisoning and	monthly

	accidents	
D	Poor psychological microclimate in the family (constant disputes, fights, physical punishment, neglect of child's needs)	monthly
E	Use of alcohol, drugs, toxic products by family members	monthly
ZH	Smoking mother, father or other family members. Smoking in the presence of the child	monthly
Z	Child and mother receive unbalanced, poor nutrition	monthly
I	Child does not possess certain development skills for his/her age	monthly
K	Child neglect, abuse, violence	monthly
L	Other	monthly
CI	**Cross-sectoral interaction**	
CI1	Number of cases referred to the cross-sectoral commission for 6 months	twice a year
CI2	Of them, number of cases examined in 6 months	twice a year
CI3	Of them, number of cases closed	twice a year
CI4	Number of cross-sectoral group meetings for 6 months	twice a year

Annex 1.9

Patronagequalityassessmenttool

Organization_____ Chief Medical Officer_____

Curator_____ Curatorship date_____

#	Assessment criteria	Source of information				Curator's comments
		Direct observation	Questionnairefor parents	Questionnaire for health/social worker	Documentation	
RISK ASSESSMENT AND IDENTIFICATION						
1	Identifies family's social well-being risks					
2	Identifies the risks of abuse, violence, neglect in the family					
3	Identifies risks in the environment safety, injuries and accidents					
4	Identifies perinatal depression					
5	Monitors child's development jointly with parents. Helps them in the individual child development mapping.					
6	Identifies the degree and orientation of risks during prenatal care					
7	Identifies the extent and orientation of risks when visiting a child at home					
RISK MANAGEMENT						
8	Properlydevelops an individual risk reduction plan based on an environmental principle and uses a proactive approach					
9	Uses cross-sectoralinteraction mechanisms in addressing issues (give examples)					
10	Uses non-cross-sectoral interactionmechanisms in addressing issues(give examples)					
RECOMMENDATIONS, INFORMING AND CONSULTING THE FAMILY						
11	Has the skills of proper communication, duly interacts with parents and colleagues					
12	Comes prepared for patronage (knows a specific goal, tasks, looks up current information)					
13	Provides up-to-date information to the family					
14	Has knowledge and skills on:					

a)	Assessments of the state of newborn and young children (knowledge of dangerous signs and signs of "pink ")					
b)	Breastfeeding and exclusive breastfeeding					
c)	Introducing complementary feeding in 6 months					
d)	Development care: Strengthening linkage and attachment					
e)	Main education elements: games and toys, reading, communication and manifestation of love for the child					
f)	Involving the father in child-rearing					
g)	Postpartum depression					
h)	Safe environment and prevention of injuries and accidents					
i)	Emergency care in case of acute foreign body in the respiratory tract, burns, drowning, falling from a height, poisoning					
j)	10 steps of child development monitoring					
k)	Identification of signs of neglect, abuse and violence and tactics in identifying them					

Key strengths

Key weaknesses

What is done by the Curator:

Additional information

Annex 1.10

Report on the Supervision Meeting

Supervisor: _____

Employees:

_____

_____

_____

_____

Meeting type
(individual, group, field visit for observation purposes):

_____

Meeting date _____

Meeting place _____

Agenda:

Discussed topics and questions	Recommended activities and required resources	Responsible person	Deadline

Supervisor's signature: _____

Signature of patronage workers,
social workers _____
participated in the meeting: _____

Date of the next meeting/field visit for supervisory purposes

_____

Annex 1.11

Annual Supervisory Report

Date of meeting	Supervision type	Discussed topics	Place	Attended by

Analysis of the issues discussed at the meeting, difficulties in delivering tasks, the most frequent ways to address issues, suggestions for increasing the effectiveness of social workers etc. (to be presented in a descriptive form).

Signature of Manager/Head of Health Care Institution

Date of report submission _____

Annex 2.1

Table of evaluating risk degree and orientation in prenatal nursing and identifying risks in family's social and living conditions

	Risk orientation	☐ =1 point, ☐= 0 point in the following items:	High risk (total points)	Moderate risk (total points)	No risk (total points)
I.	**Family's social and living conditions**				
1	Family composition				
2	Psychological microclimate in the family. Family's social health level				
3	Housing conditions (dampness, cold, overcrowding)				
4	Family's financial standing in terms of income				
5	Lack of work or low paid work for one or both spouses				
6	Low level of education of one or both spouses				
7	Family'ssanitary and housing conditions				
8	Ability to manage the household (issues with cooking, washing, cleaning, waste management etc.)				
9	Safety of home environment in terms of injuries, poisoning and accidents				
10	Heavy physical work (lifting heavy weights, carrying water etc.)				
11	Alcohol abuse or drug use among family members				
12	Smoking family members				
13	Issues with law enforcement bodies among family members				
14	Issues with partner/husband (constant disputes, aggressiveness, sexual problems, violence, lack of attachment)				
15	Issues with other adults in the family (constant disputes, neglect of each other, prolonged separation etc.)				
16	Problems with adolescents in the family				
17	Sexual harassment, abuse and domestic violence (last 6 months). Long-term stress, life in fear.				
18	Chronic patients, individuals with disabilities, mental patients requiring constant care				
19	Chronic infectious patients in the family (HIV, tuberculosis, STI)				
20	Impact of stigma or marginalization				
	Total points for the family's social and living conditions		***0-12***	***13-18***	***19-20***
II.	**Health of a pregnant woman**				
1	Under 18 or over 35				
2	Had 4 or more previous pregnancies				
3	Interval between births is less than 2 years				
4	In the anamnesis - premature birth or birth of a child with a weight less than 2 kg				
5	In the anamnesis - stillbirth				
6	In the anamnesis - cesarean section				
7	In the anamnesis - children born with conformational abnormalities				
8	In the anamnesis - children born with hereditary diseases				

9	In the anamnesis - children died of diseases				
	Total points forthe health of a pregnant woman		***0-5***	***6-8***	***9***
III.	**Current pregnancy course**				
1	Current pregnancy is wanted/planned				
2	Timely registration				
3	Pregnancy occurs against a normal body mass index(at the time of pregnancy BMI - 19-24)				
4	Extragenital diseases (as perthe therapist opinion)				
5	Pregnancy complications (as per the obstetrician-gynecologist's opinion)				
6	Ultrasound revealed pathology				
7	Unstable ABP				
8	Physical activity				
9	Good nutrition				
	Toxic effect on the fetus. On the mother's part:				
10	• Smoking				
11	• Alcohol				
12	• Drugs				
13	• Other toxic substances				
14	Stress, anxiety, depression				
	Total points forthecurrent pregnancy course		***0-8***	***9-13***	***14***
IV.	**Needfor emergency medical assistance**				
1	Genital tractbleeding				
2	Convulsions				
3	Strong headache				
4	Abdominal pain				
5	Abundant and incessant vomiting				
6	Rare or lack of fetal movement				
7	Fever				
8	Severe swelling on the limbs and other parts of the body				
9	Discharge of amniotic fluid				
	Total points for theneed for emergency medical assistance		***0-8***	***-***	***9***
	SUMMARY: GENERAL DEGREE AND ORIENTATION OF RISKS FOR PREGNANT WOMEN				

Note: the presence of a "yes" answer in points related to violence, abuse, toxic effects on the fetus or any threatening sign requiring emergency care, regardless of the total points, is considered a high risk.

Annex 2.2

In-depth assessment of child and family needs

Organization:	Site	Name of child and parents:
Address:	Name of social worker working with the family	
Start and end dates of the in-depth assessment (day/month/year)	Date of joining the support program (day/month/year)	

Family'saddress (including postal code, if applicable):	Phone:

PERSONAL DATA OF THE CHILD (CHILDREN) TO BE ASSESSED:
(Complete this table, if this information was not received during the Initial assessment)

Child's first name	Child's last name	Date of birth (or expecteddate of birth)	Gender (✓)	
			F☐	M ☐
			F☐	M ☐
			F☐	M ☐

PERSONAL DATA OF PARENTS/GUARDIAN

Parent/Guardian	Full name	Date of birth	Gender	Citizenship

Family members over 18 broken down by sex and age:			
Age	18-24	25-59	60+
Male			
Female			

Data of other persons living together with the family:

Full name	Date of birth	Relationship to the child (children)/young person

Family type

☐led byparents
☐led bysingle parent
☐led bychild (under 18)
☐led bysibling (18+)
☐led bygrandfather or grandmother
☐led byuncle or aunt
☐led byother relative
☐led byfoster parents
☐led bynon-relatives
☐led byadopters

☐pregnant woman intending to leave the child

Target group (multiple choice)	
☐with HIV/AIDS	☐pregnant woman intending to leave the child
☐victims of domestic violence	☐ child preparing to be reunited or already reunited with his/her family
☐ representatives of ethnic, religious or other minorities	☐child or parent with a severe illness
☐refugee/displaced person	☐low-level parenting skills
☐single parent	☐suffering from alcohol or drug addiction
☐multi-child family	☐families with a very low income source
☐minor parent	☐child or parent with a disability
☐other:	

IMPORTANT INFORMATION ABOUT THE CHILD FOR IN-DEPTH ASSESSMENT

CHILD, CHILDREN, FAMILY MEMBERS AND ORGANIZATIONS (including school/preschool attended by the child (children) and OTHER PERSONS PARTICIPATED IN THE IN-DEPTH ASSESSMENT

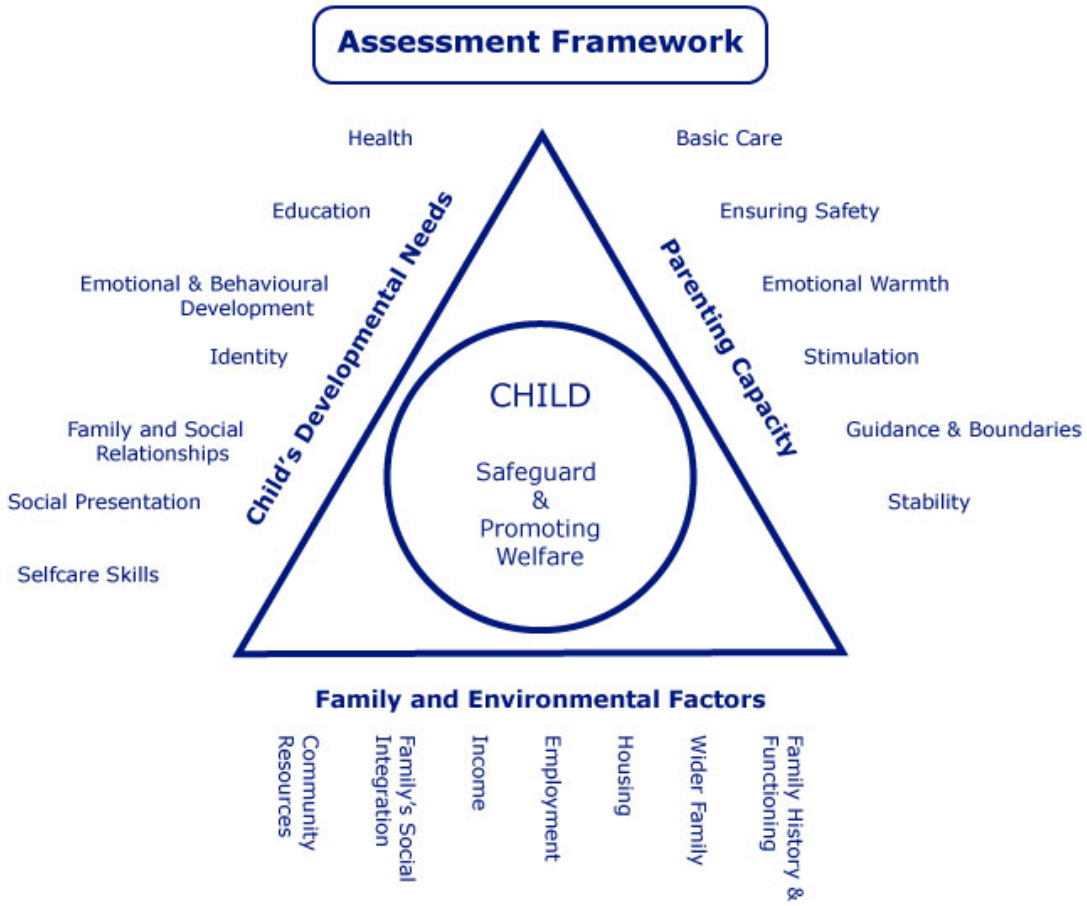
Date of interview:	Full name of the person (child, young person, family members, other persons) with whom the meeting/ interview was held:	Organization (if applicable)/ position	Relationship to the child (children)/young person	Contact address/ phone

LIST OF DOCUMENTS FOR IN-DEPTH ASSESSMENT OF THE FAMILY AND THE CHILD

Document name	Yes	Not applicable
Opinion of a patronagefemale/male nurse or GP	☐	☐
Findings of psychological assessment	☐	☐
Findings of legal assessment	☐	☐
Opinion of another specialist (e.g., professional in employment, teacher, speech therapist etc.)	☐	☐
Family's environment map	☐	☐
Family history	☐	☐
Other	☐	☐

**Note: Legal and other documents should be considered (for example: passport, health/disability certificate, student's report card etc.); if necessary, the in-depth assessment form of the family is attached its copies, as well as opinions of the psychologist and other professionals.*

CHILD'S NEEDS TRIANGLE



ASSESSMENT: STRENGTHS AND NEEDS

1. INFANT OR CHILD DEVELOPMENT (INCLUDING PRENATAL PERIOD)

A social worker should make a professional decision about whether all sections of the assessment need to be filled or focus on the most important ones. It is not necessary to comment on each element. Where possible, comments should be based on evidence, not opinions, and it is necessary to indicate exact evidence. At the same time, in cases of strong differences of opinion, such discrepancy must also be registered.

1.1. CHILD'S FULL NAME:	

1.2. HEALTH: CHILD'S DEVELOPMENT NEEDS *Includes the provision of the universal package of PHC home-visiting services of patronage nurses and progressive package in case of moderate and high social vulnerability, appropriate medical care in case of illness, adequate nutrition, physical exercises, necessary immunizations and development check, including dental and sight check, and for older children - providing relevant information and advice on issues affecting health, including sexual education and drug use. It implies growth and development, as well as physical and mental well-being. It is also possible that genetic factors must be taken into account.*
Nutrition and growth:
Immunization:
Limited capacity/Disability (physical, mental, sensory, multiple) and severe illness (HIV/AIDS, tuberculosis etc.):
Physical development (sight and hearing, fine motor skills, large motor skills):

Clothing and personal hygiene:

Access to and use of professional health services (information from a patronage nurse, family doctor, pediatrician, speech therapist, defectologist, dedicated professionals, development monitoring, in-patient treatment, injuries, medical advice etc.):

Child abuse:

Child received necessary vaccinations in accordance with national standards	☐yes	☐no	☐ no information	Note (for example, type of vaccine):

1.3. HEALTH						
Limited capacity/ disability	☐ mental disorder	☐ physical disorder	☐ multiple disorders	☐ sensory disorder	☐no	☐ no information
Description of limited capacity/ disability:_____						
Child with disabilities receives support:	☐yes	☐no	☐ no information	Type of support for children with disabilities:		
Severe illness:	☐yes	☐no	Ifyes, type of severe ilness:			

HEALTH: PARENTS 'CAPABILITIES

To what extent does the parent/guardian understand and respond to the development needs of the child in the field of health? The child is provided with food, drink, warmth, shelter, clean and suitable clothing, and adequate personal hygiene. The parent/guardian takes measures to meet the child's physical needs and provide appropriate medical and dental care. The child is adequately protected from dangers or harm. He/she is protected from contact with dangerous adults/other children and from causing harm to him(her)self. Risks and dangers are understood both in the house and outside it.

Summary of a social worker. Please write down information on strengths, unmet needs and evidence that indicates that the child is or may be harmed in relation to his or her health.

Strengths

Weaknesses

Conclusions and comments

1.4. EDUCATION: CHILD'S DEVELOPMENT NEEDS

It covers all areas of the child's cognitive development from the moment of birth.

It includes the ability to play and interact with other children, access to books, acquisition of various skills and interests, experience of success and awareness of own achievements.

It includes the participation of an adult who is interested in the educational activity of the child, his/her progress and achievements, takes into account the starting point of development and specific educational needs of the child.

Participation in education and training (formal, informal and non-formalized):

Education progress and achievements:

Child labor and other aspects:

EDUCATION		
Child attends an educational institution	☐yes	☐no
If yes, name of the educational institution:		
Care in early childhood:	☐yes	☐no
Education at the moment		

☐completed school education
☐not applicable (child - infant)
☐ school for children with special needs
☐dropped out of school
☐ other types/extracurricular education
☐professional education
☐higher/secondary education
☐preschool education
☐never attended
☐primary school

If the child is enrolled in a kindergarten/child development center/preschool/school:	Year of start:_____

Child labor:	☐yes	☐no	

EDUCATION: PARENTS 'CAPABILITIES

To what extent does the parent/guardian understand and respond to the developmental needs of the child in the field of education? Education and intellectual development of the child is provided through encouragement, cognitive stimulation and access to social opportunities.

Summary of a social worker. Please write down information on strengths, unmet needs and evidence that indicates that the child is or may be harmed in relation to his or her education.

Strengths

Weaknesses

Conclusions and comments

1.5. PSYCHOSOCIAL DEVELOPMENT

It includes Emotional and behavioral development, Identity, Family and social relations, Social presentation and Self-care skills.

Emotional and behavioral development

It affects the adequacy of child's reactions manifested in his/her feelings and actions, initially with regard to parents and guardians, and then, as he/she grows up, towards people outside the family. It includes the nature and quality of early attachments, temperament characteristics, adaptation to changes, reaction to stress and adequate self-control.

Emotional development

Behavioral development

Family and social relations *Ability to empathize and build stable and gentle relationships with other people, including family members, peers and other people in the community.*

Child currently lives with his/her family	☐yes	☐no	
Orphan status:	☐mother's death ☐father's death ☐death of both parents ☐none of the above		
Born out of wedlock:	☐yes	☐no	☐no information

PSYCHOSOCIAL AND BEHAVIORAL DEVELOPMENT: PARENTS 'CAPABILITIES *To what extent does the parent/guardian understand and respond to the child's psychosocial development needs? A stable family environment is provided by the parent/guardian. Emotional needs of the child are met, and the child feels that the parent/guardian appreciates him/her. The child's need for reliable, stable and loving relationships with a significant adult is met, adequate sensitivity and responsiveness to the child's needs are ensured. The child is allowed to regulate his/her emotions and behavior. This includes avoiding hyperprotection and preventing the child from cognitive activity and learning. The parent/guardian establishes appropriate behavior rules and boundaries in such areas as: solving social problems, managing anger, respecting and paying attention to others, effective discipline and shaping behavior.*
Summary of a social worker. Please write down information on strengths, unmet needs and evidence that indicates that the child is or may be harmed in relation to his or heremotional and behavioral development
Strengths
Weaknesses
Conclusions and comments

**Add sheets to assess the development needs of another child (children) in the family and assess according to the structure*

2. FAMILY AND ENVIRONMENT FACTOR

2.1. LIVING CONDITIONS Does the family own a house or rent an apartment/house? Are there any necessary conditions and amenities in the child's place of residence that correspond to his/her age and development and other family members living there. It includes the internal and external features of housing and its immediate surroundings. Basic amenities include water, heating, sanitation, cooking facilities, bed, and cleanliness, hygiene, safety and their impact on the child-rearing.

STABILITY OF THE PLACE OF RESIDENCE			
1. Place of residence is reliable.	2. Place of residence is stable at the current time, but there is a risk of its loss in the future.	3. Place of residence is unstable with immediate risk of loss of housing and permanent change of residence.	4. Family is currently homeless or lives in a shelter.

2.2. EMPLOYMENT Who does work in the family, what is the nature of such work and have there been any changes in connection with employment? What impact does this have on the child? How is the presence or absence of work perceived by family members? How does this affect their relationship with the child? *It includes* the child's work experience and its impact on the family.
2.3. INCOME

Availability of income for an extended period of time. Is the income sufficient to meet the family needs? How are the resources available to the family used? Are there any financial difficulties that affect the child?

WELFARE AND INCOME SUSTAINABILITY			
1. Stable and sufficient	2. Stable but limited	3. Unstable, limited or inadequately managed	4. Unstable, extremely limite or poorly managed
Income amount	_____		

Income source	☐casual earnings (task work)	☐pension
	☐seasonal earnings	☐family savings
	☐permanent earnings	☐no
	☐self-employment earnings	☐other
	☐social assistance/social benefits	

Summary of a social worker on how the living conditions, employment and income affect the child and parents/ guardians'capabilitiesto adequately respond to the child's needs.

Strengths

Weaknesses

Conclusions and comments

2.4. FAMILY HISTORY AND ITS FUNCTIONING

Heredity of the child includes both genetic and psychosocial factors. The family functioning is influenced by those who live in the family and how they are related to the child; significant changes in the family composition; childhood history of parents; life events important for the family and their significance for family members; family functioningnature, including communication with siblings and its impact on the child; strengths and difficulties of parents, including missing parents; relationships between parents who live separately.

Annex2.3

Individual family support plan

Organization:	*Site No.* _____ *Full name of patronage nurse who sends information and data about the child and family* _____	*Full name of social worker working with family* _____

Start date of plan implementation:	*End date of plan implementation:*	*Family's residence address:*

CHILD (CHILDREN)'s PERSONAL DATA:

Child's first name	*Child's last name*	*Date of birth (or expected date of birth)*	*Gender (✓)*	
			F☐	*M* ☐
			F☐	*M* ☐
			F☐	*M* ☐
			F☐	*M* ☐

Family members, including children involved in the process of family development planning (parents / guardians, relatives, other family members etc.):

Full name	*Relation to the child*	*Contact details:*
1		
2		
3		

Representatives of state bodies, NGOs, local social services etc. involved in the process of family development planning:

Full name	*Organization*	*Contact details:*
1		
2		
3		

№	*Goal:* *actions, events*	*Responsible persons/Organization*	*Timing*	*Completion status*
1			_____/_____ *day/month/year*	☐Done ☐Undone
2			_____/_____/ *day/month/year*	☐Done ☐Undone
3			_____/_____ *day/month/year*	☐Done ☐Undone

AGREEDPROGRESSREVIEWDATES:

Signatures:

Parent/Guardian Name	*Signature*	*Date*
1		
Child (children) name	*Signature*	*Date*
1		
Patronage nurse name	*Signature*	*Date*
GP name	*Signature*	
Social worker name	*Signature*	*Date*

The plan is signed in ... copies and provided to:

Familty _____Patronage nurse_____

Annex 2.4

Resource mapping (example)

Listoforganizationsandindividualsin (district/city/oblast) _____, providing services to pregnant women and families with children aged 0 to 5 years					
№	Child needs	Services	Partners, organizations	Position, name	Contact details, address
	PRIMARY CHILD NEEDS				
1	living and growing in a family, family environment	prevention of abandonment, temporary residence, relatives of the child, legal services			
2	nutrition	exclusive breastfeeding from 0-6 months, complementary feeding, consultation on the introduction of a balanced complementary feeding, parents consulting on healthy nutrition and prevention of obesity			
3	health	services of a patronage nurse of a polyclinic, immunization, assessment of the needs of the child and his/her parents/guardians			
4	affection of parents	positive parenting formation services			
5	living in a safe housing (access to sewage, water, electricity, heat)	registering on a waiting list, housing repair, maintenance of access to potable water, sanitation			
	EARLY CHILDHOOD DEVELOPMENT				
6	speech, playing, reading	speech development services, training parents to play with children, access of families and children to children's books, library-based reading rooms for children and parents			
7	father's involvement	community of fathers, support groups			
8	preparation for school				
9	recreation	children's playgrounds, summer camp			
10	additional education (sports, music, drawing, dancing, chess)				
11	self-service skills				
	SAFE ENVIRONMENT AND PREVENTION OF HOME ACCIDENTS				
12	protection from neglect	services of a family psychologist, consultations on parenting skills			
13	protection from injuries and accidents	parent counseling services			
14	protection from poisoning and burns	services for informing parents and guardians about the importance of child's safe environment			
15	non-violent methods of upbringing	schools of positive parenting, counseling for parents and guardians			
	CHILD NEEDS WITH DEVELOPMENTAL CHALLENGES				
16	access to special services	services of a psychotherapist,			

	of professionals	speech therapist, defectologist, teacher			
17	child's access to playgrounds				
18	access to an inclusive kindergarten, a development center				
19	need for treatment	getting a quota, family supervision while receiving services in another city, region, outside the country.			
20	emotional discharge of parents	psychological counseling, organization of self-support groups for parents of children with special needs, family support on a peer-to-peer basis			
21	playing sports				
22	creativity				
23	preparation for school				
	SOCIAL PROTECTION				
24	employment/job placementof one or both parents				
25	retraining, training, advanced training for one or both parents				
26	child benefits, disability benefits, survivor benefits, childcare, targeted social assistance, day-care centers etc.				
27	receiving medicines and other supportive means				
	LEGAL PROTECTION				
28	consulting on family and housing law				
29	protection of the rights and interests of the child in cases of violence and neglect				
30	protection of the rights and interests of children in the families of migrants				

Annex2.5

Design of the assessment process, information sending and reporting at the PHC level