MANUAL FOR RUNNING A MOBILE CLINIC

Adapted for the North-West & South-West regions of Cameroon

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Abbreviations

AAP	Accountability for affected populations
ANC	Antenatal care
BV	Bacterial vaginosis
CMR	Clinical Management of Rape
IYCF	Infant and young child feeding
MAM	Moderate acute malnutrition
MHPSS	Mental Health and Psychosocial Support
MUAC	Mid-upper arm circumference
NWSW	Northwest Southwest regions of Cameroon
OTP	Outpatient therapeutic programme
PEP	Post-exposure prophylaxis
PHC	Primary health care
PNC	Postnatal care
RUTF	Ready to use therapeutic food
SAM	Severe acute malnutrition
STI	Sexually transmitted infection
TV	Trichomonas vaginalis

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Summary

In emergency or humanitarian settings, mobile clinics are used to bring essential lifesaving health care to communities affected by crises. Though there are standard emergency benefit packages for health services during emergencies, there are however no agreed or standard way of running mobile clinics in such settings. Drawing on the experiences of running mobile clinics in the NWSW and relevant literature, this manual provides a practical example of how to set up and run a mobile clinic in an African humanitarian setting in hard to reach communities with limited resources.

Key elements from planning, human resources, training, logistics, structure, community mobilisation, gender consideration, and training modules are presented in this manual. Other aspects not considered in this manual could be added based on context and location. Updates to this manual will occur as the situation changes.

Background

Conflict within Northwest and Southwest regions of Cameroon (NWSW) over the last 3 years has reduced access to primary health care (PHC) services and sexual and reproductive health (SRH) services Reductions in immunization uptake, antenatal care attendance and reduction in skilled birth attendants at deliveries leave women and children vulnerable (OCHA, 2019). Closure of health facilities has interrupted care of patients with non-communicable diseases, people living with HIV and people living with disability.

The Health Cluster recommended the mobile clinic strategy in 2020 as part of the Humanitarian Response Plan for the NWSW. This strategy was endorsed due to over 30% of health facilities were closed, most operational health facilities had limited staff due to displacement and there was limited movement of essential medications around the 2 regions due to attacks on healthcare (International Organisation of Migration, 2019; WHO, 2020; OCHA, 2019). As security constraints make it challenging for some communities to access health care, mobile health clinics have been implemented by multiple agencies in hard-to-reach areas, offering PHC, SRH and malnutrition services.

This manual aims to provide humanitarian professionals and organisations with a guide to use in similar settings to run mobile clinics. This manual primarily draws from the experience of Reach Out in running mobile clinics in the NWSW regions of Cameroon.

Objective

To provide humanitarian stakeholders with a framework to implement mobile health clinics efficiently, effectively, and safely as well as support uniformity of procedure and reporting across the 2 regions.

Scope

This manual is designed for use by any implementing partner in the NWSW of Cameroon, or in other conflict-affected areas of Africa. It has been adapted from Guidelines for the Operationalization of Mobile Medical Services, developed by the Iraq Health Cluster (Health & Nutrition Cluster, Iraq, 2014) for use in a conflict setting in Africa, and has been trialled in NWSW for 9 months and further adapted based on experience. The manual advices on preparation for mobile clinics, every day running of mobile clinics, stock management, monitoring and evaluation and accountability for affected persons. This manual has been created in parallel with reporting tools compatible with WHO and OCHA reporting templates.

Module 1: Mobile Clinic Preparation

1.1 Human Resources

Each mobile clinic team is made up of 6 staff members; 1 doctor, 3 nurses, 1 driver, 1 safety officer. They are covering approximately 20 communities. The team should work for 5 days a week, Tuesday to Saturday and report on a Monday. This schedule is based on the recurring “Ghost Towns” instituted by the non-state armed groups which are operational in NWSW, where movement is restricted on Mondays. The days of work during the week could vary depending on the context. Every member of the team should wear their jacket with organisational branding and wear a badge with their full name and organisation at all times.

1.2 Training

Every member of the team should attend the training. This includes drivers and safety officers. Potential topics for training can be seen in Table 1.

Table 1. Potential training topics

Training topics
Security
Humanitarian Principles
Layout of mobile clinics
Nutrition (if incorporated)
Practical sessions using RDTs & equipment
Practical sessions for reporting tools / stock management
Antenatal care / Postnatal care
Management of communicable and non-communicable diseases
Outbreak prone disease management
Child protection in emergency settings
Gender based violence (GBV)
Local referral pathway (district and other humanitarian organisations)
Prevention of Sexual Exploitation and Abuse
Prevention of corruption
Accountability
Mental health care & psychosocial support (MPHSS)

1.3 Office space

The teams work out of a local office, made up of 2 rooms; one for storage and one functioning as an office. This office should be located in a neutral location. These offices are based in the safest town in the division, and the team commutes daily. In areas where the security situation is too dangerous for the teams to live in the local town, they should commute from the nearest safe location. This office will be used for drug storage, stock counts and data entry from paper reporting tools used in the field.

1.4 Vehicles

Each team should have access to a 4x4 vehicle, with high levels of visibility (flag, stickers). The same vehicle should be used every day to ensure local communities are aware of the car. Using cars which are associated with certain groups (e.g. military or non-state armed groups) should be avoided. Rented local cars are less recommended, as they may have been used by local stakeholders before and may pose a security risk to the team. Motorbikes can be used in areas where cars are unable to pass, however, this has a higher level of risk and should be discussed on a case-by-case basis with safety advisors.

1.5 Equipment

A list of equipment that should be considered to taking to the field daily is seen in table 2 below.

Table 2. Equipment to be considered

Equipment
2 x table
5 x chairs
1 x lightweight canopy
1 x tarpaulin
1 x handwashing station
1 x Jerry can for carrying water & 10L of treatable water
Water purification tablets
1 x cup
1 x baby scale
1 x adult scale
1 x Megaphone
5 x MUAC tape
Medical equipment
Drugs
Documentation (authorisation letters)

1.6Targeting

Due to the access constraints within the NWSW, this will likely play the greatest role in determining which areas will be targeted by the mobile clinics. Steps should be taken to work predominantly in areas where there are no functional health facility, or in areas where the health facilities are overwhelmed due to the high number of internally displaced persons. This is to avoid competition with the functional facilities. Targeting communities where health facilities are functional poses a threat to health system strengthening efforts from all partners and the Ministry of Health. Other strategies are used in areas where there are functional health facilities.

Project managers should review the Multi-Sector Needs Assessment carried out by the International Office of Migration and discuss with local health authorities to assist in targeting. It is suggested that easier to access communities are targeted at the start of the project, and then as community acceptance increases, the teams can venture further and towards more hard-to-reach populations.

A list of the most commonly encountered diseases in these 2 regions by mobile clinics by Reach Out's mobile clinics can be found in Appendix 1.14.

1.7 Community Mobilisation

Community mobilisation is a key factor when running mobile clinics and must be taken seriously. Motivation for community mobilisers should be taken into consideration at the time of budget planning. The alternative methods for mobilisation include utilising existing community health workers in the villages, visiting villages ahead of time and engaging with community leaders to assist with mobilisation. From then on, mobilisation can be predominantly carried out by telephone in areas where there is signal. Another possibility is setting fixed dates with the community, however the high level of insecurity in the NWSW makes this more challenging.

1.8 Gender considerations

Mobile clinics should be accessible to all those who need health care. Some mobile clinics will be specifically geared towards SRH and will therefore need to adapt to target these beneficiaries. Mobile clinics should be set up in areas which are safe for all to access, close to community structures and away from any armed groups. It may be appropriate to have separate days for different genders, especially when running SRH campaigns to encourage women and girls to attend and discuss family planning, GBV or antenatal care (ANC).

Module 2: Drugs

Management of drugs is a key element of effective mobile clinics, and a potential risk of harm for beneficiaries if not carried out well. This section covers procurement, storage, rotation and disposal of medications, such as tablets, liquids and creams. It does not cover management of the cold chain or vaccines. It has been adapted from the WHO Good trade and distribution practice of pharmaceutical starting materials (WHO, 2002).

2.1 Procurement

Medications should be procured through donors, or if not possible should be procured through a reputable drug distributer. In the NWSW, the Regional Drugs Funds should be used in the first instance in order to support these institutions and ensure high quality medications. Other organisations used should be a certified drug supplier in order to ensure the highest quality of safety controls. These drugs should be managed using the standard operating procedures for drug management.

A full list of suggested medications and tests for mobile clinics for use within the NWSW can be found in Appendix 1.12. This has been adapted from a list of essential medication received from the South West Drug Fund.

2.2 Personnel

All personnel involved in management of medications should receive training in relation to good storage practice, regulations, procedures and safety. All members of staff should be trained in, and observe high levels of, personal hygiene and sanitation.

2.3 Premises and facilities

Precautions must be taken to prevent unauthorized persons from entering storage areas. All storage areas should have a lock, and key should be held by the project coordinator storing the medications, or the team leader in the field. Storage areas should be of sufficient capacity to allow the orderly storage of medications in use as well as rejected, returned or recalled products.

Storage areas should be designed or adapted to ensure good storage conditions. In particular, they should be clean and dry and maintained within acceptable temperature limits. Where special storage conditions are required on the label (e.g. temperature, relative humidity), these should be provided, checked, monitored and recorded. Materials and pharmaceutical products should be stored off the floor and suitably spaced to permit cleaning and inspection. Pallets should be kept in a good state of cleanliness and repair.

Storage areas should be clean, and free from accumulated waste and vermin. A written sanitation programme should be available indicating the frequency of cleaning and the methods to be used to clean the premises and storage areas and the programme for pest control. The pest-control agents

used should be safe, and there should be no risk of contamination of products. Adequate lighting should be available.

Use of the “first expired/first out” principle is recommended. Materials and pharmaceutical products should be handled and stored in such a manner as to prevent contamination, mix-ups and cross-contamination. Broken or damaged items should be withdrawn from usable stock and separated.

Narcotic drugs should be stored in compliance with international conventions, and national laws and regulations on narcotics.

2.4 Monitoring of Storage Conditions

Temperature monitoring should be conducted, and the data should be available for review. The equipment used for monitoring should be checked at suitable predetermined intervals and the results of such checks should be recorded and retained. All monitoring records should be kept for at least the shelf-life of the stored material or product plus 1 year, or as required by national legislation.

2.5 Storage Requirements

Records should be kept for each delivery including the description of the goods, quality, quantity, supplier, supplier’s batch number, the date of receipt, assigned batch number and the expiry date.

2.6 Labelling and containers

Products should be stored in containers which do not adversely affect the quality of the materials or products concerned, and which offer adequate protection from external influences. All containers should be clearly labelled with at least the name of the material, the batch number, the expiry date or retest date, the specified storage conditions and reference to the pharmacopoeia, where applicable. Unauthorized abbreviations, names or codes should not be used.

2.7 Receipt of incoming materials and pharmaceutical products

On receipt, each incoming delivery should be checked against the relevant purchase order and each container physically verified, e.g. by the label description, batch number, type of material or pharmaceutical product and quantity.

2.8 Stock rotation and control

Periodic stock reconciliation should be performed by comparing the actual and recorded stocks. It is recommended a basic stock check is done monthly, and a complete stock check every 3 months. All significant stock discrepancies should be investigated as a check against inadvertent mix-ups and/or incorrect issue.

2.9 Dispatch and transport

Materials and pharmaceutical products should be transported in such a way that their integrity is not impaired and that storage conditions are maintained. It is imperative to travel with your authorization documents for conducting mobile clinics, as well as an inventory and these should be included with drug deliveries to the field.

Module 3: Daily mobile clinic

3.1 Structure

If possible, try to identify a building with several areas / rooms that the community are happy for the team to use. If not, identify a shaded area and set up separate areas; waiting area, triage, consultation room, laboratory, pharmacy (figure 3). Each area should be labelled so patients know where to move to. On arrival, request from community leaders drinking water, chairs and tables. The team should have access to backup water and water purification tablets if the communities supply is not available.

At the start of the clinic, whilst the team is setting up sensitization on any health/nutrition topic should occur (see module 5 for Covid-19 specific guidelines). This could occur in the waiting area. This can be repeated later in the day if there has been sufficient turnaround of beneficiaries.

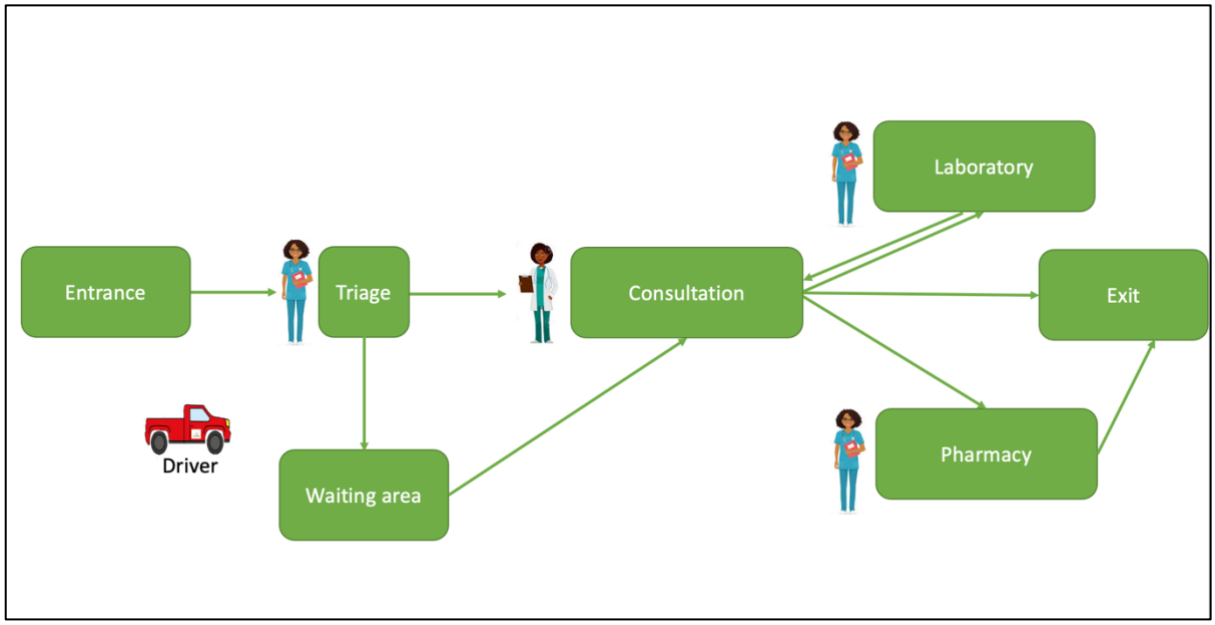

Figure 1 Layout of a mobile clinic

3.2 Entrance

This is the point of first contact between the beneficiary population and the mobile clinic. It is very important because the reception of the people makes the first impression. It is at the entrance that crowd control is most important. COVID-19 preventative measures should be incorporated into the clinic. Beneficiaries should wash their hands at the entrance of the clinic, and if possible, should wear a mask. The crowd controller, who in most cases is the driver alone or alongside a community volunteer, directs people to the triage and give them specific numbers which will be used to determine the order

of consultation based on arrival. This helps reduce arguments and sets the pace for order. After taking their numbers at the entrance patients go to the waiting area until their number is called up to triage.

3.3 Waiting area

The waiting area should be a shelter or hall with sufficient socially distanced chairs and or benches for the beneficiaries. The nurse in charge of vital signs calls patients one at a time according to the numbers given at the entrance by the crowd controller. After taking the vital signs patients go back to the waiting area. The doctor will call the beneficiary in number order from the waiting area. The waiting area is also used by patients who are awaiting the laboratory or returned from the laboratory.

3.4 Triage

Triage is managed by one of the nurses and should have two chairs and a table. It is where the patient cards are filled with patient information and where all vital statistics and anthropometric measurements like blood pressure, pulse, respiratory rate, temperature, weight and MUAC for children less than 5 years are taken. The immunization status of children is inquired and documented on the patient cards. Patients are prioritized based on their need, and if a medical emergency is identified the patient will be sent to the doctor immediately. Otherwise, patients will be seen in number order.

3.5 Consultation

The consultation area should be private and be a significant distance from any other areas to promote confidentiality and privacy of the patients, and is staffed by the doctor. It should have at least 2 chairs and a table. After consultations, a patient can either be sent to the laboratory, sent to the pharmacy, or to the exit directly based on doctors' diagnoses. Patients sent to the lab come back to the consultation unit to have the doctor interpret the results and prescribe their medications. It should also be noted that the consultation area in this model also serves as the emergency area. The outpatient register is also filled in this area by the doctor. The doctor should have access to a hard copy of the "Medicins Sans Frontieres" Medical Guidelines at all times.

3.6 Laboratory

The laboratory is run by one of the nurses or a lab technician and should at least have a working surface which could be a table or a flat raised surface or flap and 2 chairs. Basic tests run by the mobile clinic are conducted by a competent nurse. Results are recorded on the patient health cards and the patient then returns to the doctor for interpretation of the results and management.

3.7 Pharmacy

The pharmacy dispenses all prescribed medications, administers Vitamin A and deworming medication, issues vaccinations and manages dressings and wound care. It is run by one of the nurses and should

be located away from direct sunlight. It should have at least a chair and a table and access to clean drinking water.

3.8 Equipment in each area

Table 3. Minimal equipment set for a mobile clinic

Waiting area & Triage
Large space with bench or chairs. The chairs should be adapted to maintain social distancing.
Shade / shelter
Table + chair for triage nurse + patient
Hand washing station with soap
Scale (adult and child)
Thermometer
BP machine (stethoscope if manual)
MUAC
Disinfectant for cleaning thermometer
Health cards (Appendix 1.3), tally sheet for MUAC x 2 (Appendix 1.1 & pen)
Consultation areas
Tables + chair for doctor/nurse
Stethoscope
Outpatient register
Pen
Otoscope
Pinard
Medical protocols + Nutrition Protocols/Job Aids
Referral forms
Emergency box (Appendix 1.12)
Laboratory
Table and chair for nurse and patient
Malaria RDT
HIV test (Determine and oraquick)
Glucometer and strips
Haemoglobin monitor and strips
Pregnancy test
Cotton
Lancets
Safety sharps box
Blood typing
Syphilis strips
Chlamydia strips
Alcohol wipes
Pharmacy
Table and chair for nurse and patient
Drinking water
Cup
Medications
Field stock sheet (Appendix 1.6)
Pen

Dressings
Minor surgical equipment
Tablet counter
Drugs bags
Safety sharps box

Module 4: Sexual and Reproductive Health

4.1 Antenatal care

The safest place for ANC to be carried out is at the facility that the women plans to deliver, and this should be encouraged. If this is not possible then ANC should be offered by the mobile clinic whilst assisting them to identify a safe place for delivery.

WHO previously recommended 4 antenatal care appointments, which has since been widened in 2016 to a minimum of 8 visits (WHO, 2018). However, in most communities in the NWSW many women make less than four ANC contacts during pregnancy and this can be accounted by the long distances, no access to transportation, high user fee, and conflicts. Mobile health clinic offers a great opportunity to women who haven't started ANC or have missed an appointment. For booking visits, the required information is obtained from the woman like in any other visit and some vital parameters measured. Basic routine examinations are carried out like haemoglobin, urinalysis, VDRL, HIV, blood typing and malaria testing after which a physical examination is carried out on the woman. Mobile clinics also calculate the gestational age, measuring the fundal height this guides the personnel attending to monitor the progress of pregnancy. A brief health talk is given to the woman based on the need after which routine ANC drugs are administered to the woman depending on her test results and the progress of pregnancy. It is worth mentioning that during mobile clinics individualized care is essential despite the inconvenient environment in carrying out the activity.

Mobile clinics work in collaboration with the DHS and other stakeholders. For the case of ANC routine vaccination and intermittent preventative therapy is made available by the DHS, and this should be offered if women are not able to attend the facilities. The mobile clinic also carries out referral of ANC cases that cannot be handled at their level. These women are referred on time to a health facility to prevent further complication. Postnatal care should also be available from the mobile clinic. There is a proforma for postnatal and antenatal care to be found in Appendix 1.10.

4.2 Sexually Transmitted Infections

Aetiological diagnosis of STI is problematic in many settings, especially mobile clinics in low resource settings, as it can be time consuming, costly, and often tests have very variable reliability. To counter this, a syndrome-based approach to the management of STIs was developed and is in use in many countries in the developing world. Syndromic management relies on groups of symptoms and easily recognized signs (syndromes), and then delivers treatment which covers the majority or most serious organisms which could cause the syndrome. The information provided below has been taken from the Guidelines for the Management of Sexually transmitted Infections from the WHO (WHO, 2001).

4.2.1 Urethral Discharge

Recommended syndromic treatment

- therapy for uncomplicated gonorrhoea
  PLUS
- therapy for chlamydia

Patients should be advised to return if symptoms persist 7 days after start of therapy.

Table 4. Treatment for urethral discharge

Treatment options for Gonorrhoea	Treatment options for Chlamydia
Ciprofloxacin	Doxycycline
Azithromycin	Azithromycin
Ceftriaxone	
Cefixime	
Alternatives	
Trimethoprim/Sulfamethoxazole	

NB Tetracyclines are contraindicated in pregnancy

4.2.2 Genital Ulcer

Recommended syndromic treatment

- therapy for syphilis

PLUS EITHER

- therapy for chancroid where it is prevalent
  OR
- therapy for granuloma inguinale where it is prevalent
  OR
- therapy for LGV where it is prevalent

Table 5. Treatment for genital ulcer

Treatment options for syphilis	Treatment options for chancroid	Treatment options for granuloma inguinale	Treatment options for LGV
Benzathine	Ciprofloxacin	Azithromycin	Doxycycline
Benzylpenicillin	Erythromycin	Doxycycline	Erythromycin
	Azithromycin		
Alternatives			
Procaine	Ceftriaxone	Erythromycin	
Benzylpenicillin		Tetracycline	
		Trimethoprim/Sulfamethoxazole	
Penicillin allergy and non-pregnant			
Doxycycline			
Tetracycline			

NB Patients taking metronidazole should be cautioned to avoid alcohol. Tetracyclines are contraindicated in pregnancy

4.2.3 Scrotal swelling

Recommended syndromic treatment

- therapy for uncomplicated gonorrhoea
  PLUS
- therapy for chlamydia

4.2.4 Cervical infection

Recommended syndromic treatment

- therapy for uncomplicated gonorrhoea

PLUS

- therapy for chlamydia

4.2.5 Vaginal infection

- therapy for bacterial vaginosis (BV)

PLUS

- therapy for Trichomonas vaginalis (TV)

AND, WHERE INDICATED

- therapy for Candida albicans

Table 6. Treatment for vaginal infections

Treatment for BV	Drug options for TV	Drug options for candida
Metronidazole	Metronidazole	Miconazole
		Clotrimazole
		Fluconazole
Alternatives		
Clindamycin		Nystatin
Metronidazole gel		
Clindamycin vaginal cream		

NB Patients taking metronidazole should be cautioned to avoid alcohol

4.2.6 Lower abdominal pain (in females)

Care should be taken with the diagnosis of pelvic inflammatory disease, and that other serious pathologies have been excluded before diagnosis. Recommended syndromic treatment

- single-dose therapy for uncomplicated gonorrhoea

PLUS

- doxycycline, 100mg orally twice daily, or tetracycline, 500mg orally, 4 times daily for 14 days

PLUS

- metronidazole, 400-500mg orally, twice daily for 14 days.

NB Patients taking metronidazole should be cautioned to avoid alcohol. Tetracyclines are contraindicated in pregnancy

Alternative syndromic treatment where single dose therapy for gonorrhoea is not available

- trimethoprim (80mg)/sulfamethoxazole (400mg), 10 tablets orally once daily for 3 days, and then 2 tablets orally, twice daily for 10 days

PLUS

- doxycycline, 100mg orally, twice daily, or tetracycline, 500mg orally, 4 times daily for 14 days

PLUS

- metronidazole, 400-500mg orally, twice daily for 14 days.

NB Patients taking metronidazole should be cautioned to avoid alcohol. Tetracyclines are contraindicated in pregnancy

4.2.7 Family planning

Family planning services should be offered as part of the mobile clinics. This should include free dispensation of condoms and femidoms, as well as access to longer acted contraception such as the contraceptive injection. If a member of the team is trained in the insertion of the implant, then this should also be offered.

4.3 Clinical management of rape

Most likely, mobile clinics will only be able to offer a limited clinical management of rape (CMR) service, but all mobile clinics should be aware of the GBV referral pathway to ensure any survivor is referred for a comprehensive review. However, mobile clinic should be able to offer the medical aspect of CMR, and as such should have access to medications such as emergency contraception, antibiotics for treating STIs, and post-exposure prophylaxis (PEP). If the clinic is not able to procure PEP, they should know where the nearest supply of PEP is. A full set of guidelines for treatment CMR can be found through the link below. The following guidelines have been adapted from Clinical Management of Rape Survivors Developing protocols for use with refugees and internally displaced persons by WHO (World Health Organisation, 2004).

4.3.1 Medical

Whether the survivor presents within 72 hours or not will determine the treatment that will be offered. Male survivors require the same medical treatment for STIs and vaccinations as female survivors.

Table 7. Presents in under 72 hours

Risk	**Treatment**
STIs	Antibiotics according to local protocols
HIV	PEP
Pregnancy	Emergency contraception
Tetanus	TT

For antibiotics, those recommended by local protocols to avoid resistance should be used. The shortest, most convenient route should be used. For example, 1g azithromycin orally and cefexime 400mg orally would presumptively treat chlamydia, gonorrhoea and syphilis.

An assessment should be carried out to determine if the survivor should start PEP. This should include considerations for number of attackers, penetration, injuries sustained. If the HIV status of the If the HIV status of the assailants is not known, assume they are HIV-positive, particularly in countries with high prevalence. If PEP is not available at the mobile clinic, the survivor should be referred urgently to a facility which has access.

Tetanus vaccination should be considered for those who have sustained wounds. Suture wounds which can be adequately cleaned within 24 hours, if not allow for secondary healing.

Table 8. Presents after 72 hours

Risk	Treatment
STI	Treat if symptomatic or if test positive
HIV	Refer survivor for HIV testing at 3-6 months after the incident
Pregnancy	Pregnancy test Up to 5 days, progesterone only pills can reduce the chance of pregnancy
Tetanus	If not fully vaccinated, vaccinate again Refer if any signs of tetanus

4.3.2 Psychosocial Support

Social and psychological support, which includes counselling are essential components of the clinical management of the rape survivor. In time, most survivors will regain their psychological health through the emotional support and understanding of people they trust, community counsellors, and support groups. At the time of clinical assessment, do not push the survivor to share personal experiences, but allow them to share what they want to. The survivor may benefit from counselling at a later time, and should be offered a referral for psychosocial counselling through the GBV referral pathway. The most up to date GBV referral pathway can be requested from the GBV sub-cluster or the Health Cluster.

Module 5: Immunisation

Mobile clinics can either offer vaccination monitoring or vaccination implementation.

In some areas, data on vaccination rates are hard to find. For this reason, and to help with future advocacy for vaccination, it is recommended that the clinics are used to collect data on vaccination. At the triage stage, using the vaccination schedule, the triage nurse should identify if the child is up to date with their vaccination. If they are, no data needs to be entered. If they are not, a note should be taken in the missed vaccination form (Appendix 1.8) as to what vaccine has been missed. If vaccines are available, the child should be immediately vaccinated. Immunisation rates in NWSW Cameroon have dropped below 50% in the last 3 years. Immunisation has successfully been delivered using a mobile clinic structure. Close collaboration with the EPI unit is essential for this to occur. It is imperative that there is accurate and timely reporting.

Table 9. Vaccination schedule for children in Cameroon (free vaccine)

Age	**Vaccine**
Birth	BCG
	OPV 0
	Hepatitis B
6 weeks	Penta 1
	Pneumo 1
	OPV1
	Rota 1
10 weeks	Penta 2
	Pneumo 2
	OPV2
	Rota 2
14 weeks	Penta 3
	Pneumo 3
	OPV 3 / IPV
6 months	Vitamin A
9 months	MR
	Yellow fever
15 months	MR
	Meningitis A

Table 10. Vaccination schedule for pregnant women in Cameroon (free vaccine)

Stage of Pregnancy	Vaccine
At first contact	TT1
1 months after TT1	TT2
6 months after TT2	TT3
1 year after TT3	TT4
1 year after TT4	TT5

It is possible that the mobile clinics will identify children who have had an interrupted immunisation schedule due to displacement or violence. Recommendations on how to manage delayed or interrupted routine immunisation can be found in Figure below.

(Updated September 2020)

Table 3: Recommendations* for Interrupted or Delayed Routine Immunization - Summary of WHO Position Papers

Antigen		Age of 1st Dose	Doses in Primary Series (min interval between doses)**	Interrupted primary series***	Doses for those who start vaccination late		Booster
					If ≤ 12 months of age	If > 12 months of age	
Recommendations for all immunization programmes							
BCG [1]		As soon as possible after birth	1 dose	NA	1 dose	1 dose	Not recommended
Hepatitis B [2]		As soon as possible after birth (<24h)	Birth dose <24 hrs plus 2-3 doses with DTPCV (4 weeks)	Resume without repeating previous dose	3 doses	3 doses	Not recommended
Polio [3]	**bOPV + IPV**	6 weeks (see footnote for birth dose)	4 doses (IPV dose to be given with bOPV dose from 14 weeks of age) (4 weeks)	Resume without repeating previous dose	4 doses (IPV to be given with 1st dose of bOPV)	4 doses (IPV to be given with 1st dose of bOPV)	Not recommended
	IPV / bOPV Sequential	8 weeks (IPV 1st)	1-2 doses IPV and 2 doses bOPV (4 weeks)	Resume without repeating previous dose	1-2 doses IPV and 2 doses bOPV	1-2 doses IPV and 2 doses bOPV	Not recommended
	IPV	8 weeks	3 doses (4 weeks)	Resume without repeating previous dose	3 doses	3 doses	If the primary series begins < 2 months of age, booster to be given at least 6 months after the last dose
DTP-containing vaccine (DTPCV) [4]		6 weeks (min)	3 doses (4 weeks)	Resume without repeating previous dose	3 doses	3 doses with interval of at least 4 weeks between 1st & 2nd dose, and at least 6 mos between 2nd & 3rd dose (if > 7 yrs use only aP containing vaccine; if > 4 yrs Td containing vaccine is preferred and should only be used for >7 yrs)	3 boosters: 12-23 months (DTP-containing vaccine); 4-7 years (Td/DT containing vaccine), see footnotes; and 9-15 yrs (Td containing) (if > 7 yrs use only aP containing vaccine) If tetanus vaccination started during adolescence or adulthood only 5 doses required for lifelong protection
***Haemophilus influenzae* type b** [5]	Option 1	6 weeks (min)	3 doses (4 weeks)	Resume without repeating previous dose	3 doses	1 dose >5 yrs not recommended if healthy	None
	Option 2		2-3 doses (8 weeks if 2 doses; 4 weeks if 3 doses)		2-3 doses		At least 6 months (min) after last dose
Pneumococcal (Conjugate) [6]		6 weeks (min)	3 doses (3p+0) with DTPCV (4 weeks) or 2 doses (2p+1) (8 weeks)	Resume without repeating previous dose	2-3 doses	1-5 yrs at high-risk: 2 doses	Booster at 9-18 months if following 2 dose schedule Another booster if HIV+ or preterm neonate
Rotavirus [7]		6 weeks (min)	2 or 3 depending on product given with DTPCV	Resume without repeating previous dose	2 or 3 depending on product	>24 months limited benefit	Not recommended
Measles [8]		9 or 12 months (6 months min, see footnote)	2 doses (4 weeks)	Resume without repeating previous dose	2 doses	2 doses	Not recommended
Rubella [9]		9 or 12 months	1 dose with measles containing vaccine	NA	1 dose	1 dose	Not recommended
HPV [10]		As soon as possible from 9 years of age (females)	2 doses (5 months)	If 1st dose given before 15 years of age resume without repeating previous dose	NA	Girls: 9-14 years 2 doses (see footnote)	Not recommended

* For some antigens the WHO position paper does not provide a recommendation on interrupted or delayed schedules at this present time. When the position paper is next revised this will be included. In the meantime, some of the recommendations are based on expert opinion.
** See Table 2: Summary of WHO Position Papers - Recommended Routine Immunizations for Children for full details (www.who.int/immunization/documents/positionpapers/).
*** Same interval as primary series unless otherwise specified.

P.1 /10

Figure 1: Recommendation for interrupted or delayed routine immunization (World Health Organisation, 2020)

Module 6: Nutrition

Nutritional services will be integrated in the mobile clinic and should be considered when the mobile clinic is being set up. The 4 components that can be added to a mobile clinic include MUAC screening of every child aged 6 to 59 months who attends the clinic, sensitization on appropriate infant and young feeding (IYCF), vitamin A supplementation, deworming and outpatient treatment of severe acute malnutrition (SAM) for uncomplicated cases.

Prior to integrating any nutritional activities into the mobile clinic, mapping of current services should be carried out and the Nutrition Cluster should be contacted for information and assistance. The additional resources that would be needed if a nutritional component is being added to the clinics is seen table below.

Table 11. Resources required for adding nutritional services to mobile clinics

Resource required
RUTF
Manual Scales
MUAC tapes
Nutrition register
Vitamin A
Mebendazole / Albendazole
Amoxicillin
Measles vaccination
Image boxes / education materials for IYCF

6.1 MUAC screening

Every child aged 6 to 59 months who attends the clinic will be screened for malnutrition. This can be recorded in a MUAC tally and should be sex disaggregated.

6.2 Infant and young child feeding

Sensitization of IYCF-E will also be incorporated targeting the caregivers of children aged between 0 - 23 months. Image boxes and counselling cards will be used to deliver key messages to the caregivers. Individual counselling will also be conducted by the nurses to caregivers who need more attention.

6.3 Vitamin A Supplementation and Deworming

Vitamin A supplementation and deworming can be incorporated into the mobile health clinics and this will be in line with the national protocol. Guidelines for this can be seen in Figure 8. Dispensation can occur at the pharmacy and can be considered for any child who has missed routine immunisation aged 6 months to 5 years. Deworming should be given biannually or annually using single dose albendazole

(400mg) or mebendazole (500mg) to young children aged 12 months to 12 years. A half dose of albendazole should be given to children aged 12 – 24 months (WHO, 2021).

Table 12. Vitamin A supplementation. Taken from Vitamin A supplementation in infants and children 6–59 months of age (WHO, 2020)

Suggested vitamin A supplementation scheme for infants children 6–59 months of age		
Target group	Infants 6–11 months of age (including HIV+)	Children 12–59 months of age (including HIV+)
Dose	100 000 IU (30 mg RE) vitamin A	200 000 IU (60 mg RE) vitamin A
Frequency	Once	Every 4-6 months
Route of administration	Oral liquid, oil-based preparation of retinyl palmitate or retinyl acetate[a]	

6.4 Management of acute malnutrition

Parents and/or caretakers of children identified as having moderate acute malnutrition (MAM) should receive nutritional counselling. Children identified as having severe acute malnutrition (SAM) with medical complication will be referred to the nearest health facility with capacity to manage these cases. Those without medical complication and with appetite will be managed as part of an outpatient therapeutic programme (OTP). Whatever the case maybe, parents and or caretakers of children diagnosed with SAM or MAM should always be counselled on IYCF-E.

6.5 Management of SAM (uncomplicated)

The outpatient management of SAM should only be added to a programme if the staff are trained in management of malnutrition and there are supplies available, typically requested from the UNICEF or the Regional Delegation of Public Health. A child with SAM can be managed in the community only if they do not have complications. Complications include severe oedema, danger signs or failure to pass an appetite test amongst others. Any child with SAM who fails the appetite test should be referred to the nearest health facility. A helpful pictogram of the management of SAM as an outpatient can be seen in appendix 1.13.

6.6 Appetite test

An appetite test is carried out when a child has been diagnosed with SAM using a MUAC tape, with a measurement of less than 115mm and or nutritional oedema.

1. Ask the caregiver to wash their hands with soap and clean water and take the child to a quiet, private area.
2. Give the caregiver a packet of RUTF and show them how to open it and eat it from the packet or on a spoon.
3. Do not force the child to eat the RUTF. Children may need gentle encouragement to eat, especially if they are sick.
4. Offer plenty of boiled or treated drinking water to the client while eating the RUTF.

5. Watch to see how much the child eats. The test should take a short time, but may take up to 30 minutes.

Any child with SAM who fails the appetite test should be referred to the nearest health facility.

Table 13. Table of RUTF needed to be eaten to pass an appetite test

Minimum amount of RUTF the child should eat to pass the appetite test	
Client weight (kg)	Packets of RUTF
< 4.0	⅛–¼
4.0–6.9	¼–⅓
7.0–9.9	⅓–½
10.0–14.9	½–¾
15.0–29.9	¾–1
≥ 30.0	1

The OTP provides home-based treatment and rehabilitation for children with uncomplicated severe acute malnutrition. These children can be admitted directly into an OTP, treated with routine drugs and given RUTF to eat at home. The children attend the OTP, which is this case is a mobile clinic, every 1–2 weeks for a medical check-up, receive additional medical treatments if required and are given a 2-4 week supply of RUTF. The quantity of RUTF required to be dispensed to a child is seen in Table 13.

Table 14. Table of RUTF needed to be eaten to pass an appetite test

	RUTF	
Weight (kg)	sachet per day	Sachets per week
3.0–3.4	1¼	8¾
3.5–4.9	1½	10½
5.0–6.9	2	14
7.0–9.9	3	21
10.0–14.9	4	28
15.0–19.9	5	35

Module 7: Stock Management

5.1 Stock sheets

Drugs should be stored in the office, using WHO Guidelines on storage medications. Stock management should be carried out manually and electronically. Each drug should have a stock sheet. The quantity of drugs put in and taken out of the store should be documented on these sheets. Drugs which are close to expiration should be documented by the nurse in charge of the pharmacy unit and handed to the doctor. This may avoid wastage. An example stock sheet can be seen in Appendix 1.5.

5.2 Field Stock Control sheets

The drugs taken to the field should be managed on a field stock control sheet. An example can be seen in Appendix 1.6. Each medication taken to the field should be listed on this control sheet, and held at pharmacy. Whenever a medication is dispensed, this should be tallied on the sheet, and at the end of the day, the total number of medications dispensed should be calculated. All medications should be measured by tablet, except for antimalarials, which are dispensed as a pack. For example, a pack of 28 tablets of amoxicillin 500mg will be recorded as 28. 1 pack of 6 tablets of antimalarials will be recorded as 1.

5.3 Stock management

Stock management should be carried out by a designated team member supervised by the team leader. Frequent (at least monthly) independent stock counts should be conducted by a designated controller outside of the team (could be an accountant, tally clerk, or supervisor during mission). Out of date medication should be disposed of at a health facility, and used sharps should be taken to a facility and either incinerated or placed in a sharps pit.

Module 8: COVID-19

It is imperative that routine PHC continues during the pandemic (WHO, 2020), and for this reason adaptations are needed to be made for mobile clinics. Each mobile clinic should carry a wash station, a jerrycan of water and soap to all mobile clinic sites, and a wash station should be placed at the entrance of the clinic. The driver can be mobilised to encourage social distancing of beneficiaries, and to encourage those that have them, to wear face masks. Every member of the team should have adequate personal protective equipment, in the form of a surgical face mask and gloves. The local cases of COVID-19 should be tracked by close collaboration with the DHS, and protocols adapted to spikes in cases. The mobile clinic should refer any patient suspected of having COVID-19 to the local testing facility.

Sensitization activities needs to be adapted to ensure they do not lead to the spread of COVID-19. This can be done by either, in areas where there is lots of space, carrying out sensitization for short periods of time with adequate social distancing, or to run multiple sensitization activities throughout the day with smaller groups, socially distanced.

Module 9: Monitoring & Evaluation

Monitoring and Evaluation is key to the success of the mobile clinics. Early consideration should be made as to whether it is safe to take electronical equipment to the field to do direct data entry or not. If electronical equipment is not being taken to the field, as a security measure, then paper data collection tools should be used and then data entry conducted in the field office. A Kobo tool for data entry has been developed by OCHA. This has the benefit of being easy to use, working online and offline, and collecting data is a format which is sharable with partners and with the clusters through the 5Ws system. This should be filled in weekly. This link for this can be found below.

https://ee.humanitarianresponse.info/x/rIYCGaEU

9.1 Data from consultations

Each consultation will be entered into the consultation register by the doctor/ nurse consulting. Within the consultation register the data, location, patient name, age, sex, disability status, diagnosis and management should be entered (appendix 1.2). The diagnoses entered into the consultation book should match those listed in the tally (appendix 1.4) as these will match the data entry in the Kobo tool. It is recommended that a separate book of HIV tests conducted, with results, defaulted or new case and linkage is kept. At the end of each week, the diagnoses should be tallied and entered into the Kobo tool.

9.2 Data from malnutrition

A MUAC tally is used at triage to collect data regarding normal nutritional state, MAM and SAM (appendix 1.1). This will be reported weekly into the Kobo tool. Each child identified with SAM needs to be entered into the malnutrition database (appendix 1.7) to ensure follow up.

9.3 Referral forms

Referral forms should be available for patient who present with conditions that cannot be managed by the mobile team, including clinical history, observations, examination, differential and medications given. Counter referrals should be collected, especially for HIV linking cases (Appendix 1.11).

9.4 Health Card

Health cards should be printed (4 per A4 page). This health card will be given to the patient and will remain with the patient throughout the clinic. They should never be separated from their health card (Appendix 1.3). This contains their data from triage, any test requests as well as the diagnosis and management plan.

9.5 Evaluation meetings

It is recommended that evaluation meetings are held every 3 months, to identify any challenges of the clinics, and ensure the clinics are on track to reach their indicators. This should follow an Action After Review format.

Module 10: Access

Access is a particular challenge within the NWSW, with large areas of the 2 regions difficult to enter due to presence of non-state armed groups and state forces. Ensuring safe access is the key to effective and safe mobile clinics.

10.1 Preparation

It is advisable to begin access mapping and mediation at least 2 months before the beginning of the project, and to identify a small selection of communities to begin working in, while access mediation continues. Avoid putting the team in a situation where the only place where they can meaningfully operate is not a safe place. A comprehensive stakeholder mapping should be conducted. If there are other humanitarian organisations on the ground their strategies should be analysed and if possible, consultations carried out for insight. Access requires transport and credit and is extremely time consuming and taxing for your safety officers. Put mechanisms in place to ensure efficient spending and accountability, and ensure they have the tools they need.

Safety training should be conducted at the start of the project for all team members. It should be an honest conversation, draw on past review of incidents, and include role playing.

10.2 Strategies

There are two major access strategies used in the NWSW. One is about attempting to identify the most relevant leaders for each locality and talking with them to ensure acceptance before any intervention, and the other is about relying on the humanitarian image and community sympathies to hope for safe access. We advise strongly against the second strategy. Do not go to a community without an express go ahead and ideally one given face to face. Mediation or negotiations should not be happening with the clinic deployed.

All staff contribute to access with their attitude of service, empathy and calmness. But only one (generally a safety/access person, otherwise a management staff or an appointed team member) should play the role of mediator. Most staff might want to go beyond by engaging in parallel access conversations. These can lead to confusion and tension and should be controlled. It is recommended a safety staff leads negotiations first and then accompanies the teams in all missions.

10.3 Day to day

It is important to note mobile clinics are not ambulances and they save lives by staying in operation. You should never feel forced to go to a particular location right now. Operations should be cancelled, delayed, or relocated if the operating area is not safe. The majority of safety incidents start with avoidable human mistakes. More than half involve going late to the field. Many happen in places where

you have operated 100 times before, but most happen between the first and third time you go to a location.

Access is not granted by bribes, and usually these will make the situation worse for all humanitarians and your team in the short, mid, and long term. Feel free to disconnect from any area that you feel has no solution other than payment.

Module 11: Accountability for Affected Populations

Accountability for affected populations (AAP) should be considered from the outset of the programme. This can be conducted in one of several ways. The simplest method of AAP would be to collect numbers of beneficiaries and conduct a randomised survey to determine the quality of the mobile clinic. This could be carried out at regular intervals throughout the project and be done by those who are not directly implementing. Community meetings could help in key villages targeted by the clinics at regular intervals throughout the project. These meetings should include members of the community from a wide range of demographics, including youths, the elderly, men and women and people living with disability. A more comprehensive method of AAP would be to set up a hotline for complaints and feedback. This would allow for a more thorough AAP, with the opportunity for feedback in essential topics such as prevention of sexual exploitation and abuse. This hotline should be on the project banner, and given to all quarter heads, chiefs and community leaders in villages accessed.

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Appendix 1:

1.1 MUAC Tally

MUAC TALLY

VILLAGE (S)_____

Date Range : _____/_____/_____

Boys

GREEN																			YELLOW					RED				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	1	2	3	4	5	1	2	3	4	5
20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	6	7	8	9	10	6	7	8	9	10
39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	11	12	13	14	15	11	12	13	14	15
58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	16	17	18	19	20	16	17	18	19	20
77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	21	22	23	24	25	21	22	23	24	25
96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	26	27	28	29	30	26	27	28	29	30

Girls

GREEN																			YELLOW/ORANGE					RED				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	1	2	3	4	5	1	2	3	4	5
20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	6	7	8	9	10	6	7	8	9	10
39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	11	12	13	14	15	11	12	13	14	15
58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	16	17	18	19	20	16	17	18	19	20
77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	21	22	23	24	25	21	22	23	24	25
96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	26	27	28	29	30	26	27	28	29	30

Number of persons screened

BOYS	**A : Total GREEN**		**B : Total YELLOW**			**C : Total RED**		**Total = A + B + C**
GIRLS	**A : Total GREEN**		**B : Total YELLOW**			**C : Total RED**		**Total = A + B + C**

RECORD FOR SAM

NAME	AGE	SEX	MUAC (MM)	ADDRESS

1.2 Sample Outpatient Register & HIV testing

Outpatient register

Name	Age	Sex	Telephone	Disability (Y/N)	Diagnosis	Medication

HIV register

Date/Location								
Name	Age	Sex	Telephone	Disability (Y/N)	0/1	New/Defaulter	ARVs	Linked

1.3 Sample Health Care

Name: Age: Sex: Muac:

EPI status: Weight (kg): Disability (Y/N):

Consultation:

Pulse	
RR	
BP	
Temp	

Tests:

Diagnosis:

Follow up:

Treatment:

1.4 Diagnosis tally

Acute conditions										
	0-11 months		12-59 months		5-17 years		18-59 years		>59 years	
	M	F	M	F	M	F	M	F	M	F
Upper Respiratory Tract Infection										
Lower Respiratory Tract Infection										
Watery Diarrhea										
Bloody diarrhea										
Malaria										
Severe Malaria										
Skin infections										
Scabies										
Eye infection										
Ear infection										
Dental condition										
Intestinal worms										
Acute jaundice syndrome										
Measles										
Meningitis										
Acute Flaccid Paralysis										
Tuberculosis (suspected)										
Fever of Unknown origin										
Sexually transmitted infection										
HIV										

Urinary Tract Infection										
Chicken pox										
Acute malnutrition										
Gynecological condition										
Musculoskeletal										
Physical trauma (it is recommended a code word is used)										
Other										
Chronic conditions										
Diabetes										
Hypertension										
Asthma										
Ischemic Heart Disease										
Cardiovascular diseases										
Chronic Obstructive Pulmonary Disease										
Liver disease										
Thyroid problems										
Cancer										
Gastritis / Ulcer disease										
Other										
Mental conditions										
Epilepsy										
Alcohol & Substance abuse										
Psychotic disorder										
Severe emotional disorder										
Other somatic symptoms										

Accidents										
Burns										
Bites										
Injury										
Mother and Child										
ANC 1										
ANC 2+										
PNC										
Immunisations										

1.5 Stock management form

ITEM:				CODE NUMBER:			
UNIT + SIZE:			PRICE:	REORDER LEVEL:			
DATE	RECEIVED FROM	QUANTITY RECEIVED	ISSUED TO	QUANTITY ISSUED	BALANCE IN STOCK	REMARKS	SIGNATURE

Stock management form, taken from the handbook of supply management at first level health care facilities (WHO, 2006).

1.6 Field stock management

FIELD DRUG CONTROL SHEET

Project_____ Partner _____

Location _____ Period under Control_____

Item Description	Unit of measurement	Stock at beginning of period	Incoming	Outgoing (tally)	Balance

Store Keeper _____ Signature _____ Date _____

1.7 Nutrition database

					Entry to the Programme							
Date (MM/DD/YY)	Reg. #	SAM #	Patient Name	Address & Phone No	Type of admission (New Admission/Relapse etc)	Sex	Age (Mo)	Weight (Kg)	Height/Length (cm)	WHZ	Oedema (+, ++, +++)	MUAC (mm)
11-Feb-19	XXX		Marcel tembu	Jakiri	New	M	25	12	85		No	112

Exit from the Programme					Type of Exit		Date of Minimum Weight	Minimum Weight	Length of Stay (LOS)	Average Weight Gain(AWG)	Comments
Date (MM/DD/YY)	Weight (Kg)	Height/Length	Oedema (+, ++, +++)	MUAC (mm)	Type (Cured, Death,Default)	Transfer Out					
23-Apr-19	16	86	No	126	Cured				71		

1.8 Missed vaccination form

Missed doses Week starting _____ Location_____

1 = missed dose
Record the age and sex of the child and mark what immunisation they have missed
The example shows a two-year-old male who has missed his 14-week immunisation.
There is no need to complete this form for children who are up to date of their immunisation.
New sheet for each community

Number	Age	Sex	Birth	6 weeks	10 weeks	14 weeks	6 months	9 months
e. g	2	M				1		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
Total								

1.9 Vaccination form

Immunisation record

		0-11m		12-59m		>59		ANC/PNC
		M	F	M	F	M	F	F
Birth	BCG							
	Hep B							
	OPV 0							
6 weeks	Penta 1							
	Pneumo 1							
	OPV 1							
	Rota 1							
10 weeks	Penta 2							
	Pneumo 2							
	OPV 2							
	Rota 2							
14 weeks	Penta 3							
	Pneumo 4							
	OPV 3							
9 months	MR1							
	YF							
15 months	MR2							
	Men A							
ANC/PNC	TT1							
	TT2							
	TT3							
	TT$							

1.10 ANC card

Taken from MSF Antenatal and Postnatal guidelines (Medicine Sans Frontiere, n.d.; Medicine Sans Frontiere, n.d.)

Observations or examinations:

Antenatal care card n°:

Name: Age:

Address:

Obstetric history

Last menstrual period: **Gravidity:** **Parity:**

Previous pregnancies:

Live birth	Yes	Number:	No
Still birth (born dead)	Yes	Number:	No
Neonatal death (< 1 month)	Yes	Number:	No
Infant death (1 month - 1 year)	Yes	Number:	No
Abortion (spontaneous or induced)	Yes	Number:	No

Problems during previous pregnancies

Anaemia	Yes	No
Hypertension/pre-/eclampsia	Yes	No
Ante-partum haemorrhage	Yes	No
Other		

Problems during previous deliveries

Prolonged labour	Yes	No
Malpresentation (breech, other)	Yes	No
Caesarean section	Yes	No
Instrumental extraction	Yes	No
Placenta (manual delivery)	Yes	No
Episiotomy	Yes	No
Post-partum haemorrhage	Yes	No
Puerperal infection	Yes	No
Fistula	Yes	No
Other		

Medical history

Hypertension	Yes	No
Diabetes	Yes	No
Tuberculosis	Yes	No
Sexually transmitted infection	Yes	No
HIV infection	Yes	No
Abdominal surgery	Yes	No
Other		

Tetanus vaccination (TV)

	Date	Next appointment
TV1		
TV2		
TV3		
TV4		
TV5		

	1st visit	2nd visit	3rd visit	4th visit	5th visit
Date					
Examination					
Gestational age					
Weight (+ height if appropriate)					
Blood pressure					
Mid-upper arm circumference (if appropriate)					
Uterine fundus height (cm)					
Foetal heart rate (beats/minute)					
Foetal movements (present/absent)					
Position (longitudinal, transverse, oblique)					
Presentation (cephalic, breech, transverse)					
Conjunctiva (pale, yellow)					
Oedema					
Complaints (use back page if needed)					
Laboratory tests					
Syphilis test					
Haemoglobin					
HIV test					
Urine analysis					
Rapid malaria test					
Pregnancy test (if appropriate)					
Other tests (e.g., blood type)					
Treatments					
Ferrous salts + folic acid or multiple micronutrients					
Albendazole (contra-indicated in 1st trimester)					
Intermittent preventive treatment of malaria (if appropriate)					
Malaria curative treatment (if appropriate)					
Urinary tract infection treatment (if appropriate)					
Syphilis treatment (if appropriate)					
Sexually transmitted infection treatment (if appropriate)					
Other treatment(s)					
Other distributions (if appropriate)					
Mosquito nets (2 nets at the first visit)					
Supplementary food					
Clean delivery kit (3rd trimester)					
Next appointment					

Examined by:

Date of next visit:

Date of discharge from PNC:

For follow--up vaccines and growth monitoring:
(name of the service/facility where the child is referred)

Observations or examinations:

Postnatal care card n°:

Name: Age:

Address:

Gravidity: Parity:

Came to ANC: Yes ☐ No ☐

Date of delivery: Full term ☐ Pre-term ☐

Child's name: Birth weight:

If more space is needed in case of multiple births, use a separate PNC card to record child observations.

Previous pregnancies *(to be filled only if no antenatal card available)*

Live birth	Yes ☐	Number:	No ☐	
Still birth (born dead)	Yes ☐	Number:	No ☐	
Neonatal death (< 1 month)	Yes ☐	Number:	No ☐	
Infant death (1 month - 1 year)	Yes ☐	Number:	No ☐	
Abortion (spontaneous or induced)	Yes ☐	Number:	No ☐	

Problems during this pregnancy and delivery	
Anaemia (indicate Hb if known)	
Hypertension/pre-/eclampsia	
Ante-partum haemorrhage	
Premature rupture of membranes	
Prolonged/obstructed labour	
Malpresentation (breech, other)	
Caesarean section	
Instrumental extraction	
Placenta (normal/manual delivery)	
Episiotomy	
Perineal laceration (tear)	
Fistula (present/management)	
Post-partum haemorrhage	
Puerperal infection	

Medical history *(to be filled only if no ANC available)*

Hypertension	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	HIV infection	Yes ☐ No ☐
Abdominal surgery	Yes ☐ No ☐	Other	
Sexually transmitted infection	Yes ☐ No ☐		

	1st visit (2-7 days post-delivery)	**2nd visit** (4-6 weeks post-delivery)
Mother		
Blood pressure		
Temperature		
Anaemia (conjunctiva, haemoglobin)		
Breasts (infection, engorgement)		
Uterine involution		
Lochia (colour and quantity)		
Healing (if laceration or episiotomy or C-section)		
Passing urine and stool normally		
Mother-child interaction		
Treatments		
Tetanus vaccine		
Ferrous salts + folic acid or multiple micronutrients		
Retinol (vitamin A)		
Others		
Laboratory test results (if any)		
Child (in case of multiple births, use a separate PNC card to record other child's observations)		
Temperature		
Heart rate		
Respiratory rate		
Weight		
Appearance: colour, breathing, activity, etc.		
Head-to-toe exam		
Cord condition		
Feeding (observe)/weight gain		
Passing urine and stool normally		
Treatments (if not done at birth)		
Tetracycline eye ointment		
Vitamin K		
Vitamin D		
Vaccines (hepatitis B, BCG, polio)		
Others		
Health education		
Self and child care		
Danger signs for mother and child		
Breastfeeding (exclusive breastfeeding, support, etc.)		
Contraception		
Resumption of menses and sexual activity		
Child growth monitoring and vaccinations		

1.11 Referral form

Referral Form for Mobile Clinics

Date of referral		Time	
Patient's name		Age	Sex
Caretaker		Contact	
Address			
This patient is referred to:			
Presenting symptoms	**Reasons for referral**	**Treatment given before referral**	
Additional notes			

Name and signature of referrer

Counter Referral Form for Mobile Clinics

Date received		Time	
Patient's name		Age	Sex
Caretaker		Contact	
Address			
Summary of Management at health facility	**Treatment to be given at home/ follow up instructions**		
Additional notes			
Name and signature of health personnel	**Health Facility Stamp**		

1.12 List of essential medications

SOUTH WEST REGIONAL FUND FOR HEALTH PROMOTION
ESSENTIAL MEDICINES - FAST MOVING ITEMS
ITEMS
Betamethasone 0.1% Ointment
Aluminium Hydroxide 500 mg Tablets
Albendazole 400mg Tablets
Aluminium Hydroxide 500 mg Tablets
Alcohol 70% 125ml
Cotton Absorbent Non Sterile, 500 g
Cotton Absorbent Non Sterile, 50g
Amoxicillin 250mg/5ml oral Suspension 100 ml
Amoxicillin 500 mg Capsules
Ampicillin 1g Vial for Injection
Artemether 80 mg/ml injection
Artemether/Lumenfantrine 20/120mg 6x1 Tablets
Artemether/Lumenfantrine 20/120mg 6x2 Tablets
Artermether Lumenfantrine 480mg tablet (6x1)
Artesunate + Amodiaquine 25/67.5 mg Baby 3 Tablets
Artesunate +Amodiaquine 100/270mg 6 Tablets
Artesunate +Amodiaquine 50/135mg Child 3 Tablets
Artesunate 60 mg Injection -5years
Artesunate 60mg injection
Artesunate+Amodiaquine 100/270 mg 3 Tablets
Benzyl Benzoate 25% Lotion 125 ml
Benzathin Benzyl penicillin 2.4 MUI
Carbocisteine 5% Syrup (Adult)
Condom – male and female
Crêpe Bandage 10cm x 4m
Ceftriazone 1g Vial for injection
Chlorphenamine 4 mg Tablets
Ciprofloxacin 500mg Tablets
Cloxacillin 250mg Capsules
Cloxacillin 500mg Caps
Co-Trimoxazole 200mg+40mg/5ml Oral Suspension
Co-trimoxazole 400mg + 80mg tablets
Dexamethasone 4mg/ml Ampoules for Injection
Dextrose 5% Solution for Infusion 250ml
Dexamethasone 5mg Tablets
Dextrose 10% Solution for Infusion 500ml
Dextrose 5% Solution for Infusion 500ml
Diazepam 10 mg/2 ml Ampoule for Injection
Diazepam 5 mg Tablets
Diclofenac 50mg Tablets
Diclofenac 75 mg/3ml, 25mg/ml, Ampoule
Disposable Syringes 10ml
Disposable Syringes 5ml
Disposable Syringes 2ml
Depo-Provera 150 mg/ml Ampoule for Injection (+Syringe)
Determine HIV 1/2 TEST KIT DE 100
Doxycycline 100 mg Tablets
Erythromycin Stearate 500mg Tablets
Ferrous Sulfate+Folic Acid (66 mg++0.25mg)
Fluconazole 200mg Tablets
Furosemide 40mg Tablets
Furosemide 20mg/2ml Ampoule for Injection
Gentamicin Sulfate 80mg/2ml Ampoule for Injection

Griseofulvin 500 mg Tablets
Gentamicin 0.3% Eye/Ear Drops 10 ml
Gloves Sterile Size 7.5 (Pair)
Hydrochlorothiazide 50mg Tablets
Hartmanns(Ringer's Lactate)Solution 500ml
Ibuprofen 400mg Tablets
Infusion Set
Iron/Folic/Vit B12 Syrup 200 ml
Jadelle 2 x 75 mg Implant
Lisinopril 20mg
Lidocaine 2% 20mg/ml
Mebendazole 100 mg Tablets
Metformin 500mg Tablets
Metronidazole 125 mg /5 ml Oral Syrup
Metronidazole 250mg Tablets
Metronidazole 500 mg Tablets
Metronidazole 5mg/ml (500mg/100ml) Infusion
Metoclopramide Chlorhydrate 5mg/ml, 10 mg/2ml Ampoule
Miconazole 2% Cream
Multivitamin Tablets
Nifedipine 10mg Tablets
Normal Saline (Nacl)0.9% Solution for Infusion 500ml
Nystatin 100 000UI/5ml Oral Suspension 30 ml
Omeprazole 20mg Capsules
Oral Rehydration Salts + ZINC 2 Sachets
Oxytocin 10UI/ml Ampoule
Paracetamol 100mg Tablets
Paracetamol 120mg/5ml Oral Syrup
Paracetamol 500 mg Tablets
Phenobarbital 100mg Tablets
Phytomenadione (Vitamin K1) 1mg/mi Injection
Prednisolone 5 mg Tablets
Ranitidine 150mg Tablets
Ready to Use Food
Sayana Press (Medroxyprogesterone Acetate 150mg/ml injection)
Sulfadoxine + Pyrimethamine 525 mg Tablets
Surgical Blade Sterile n°4 n°23
Suture Nylon 2
Tetracycline Ophtalmic 1% Ointment 5g
Vitamin B Complex (B1 +B6 +B12) Tablets
Vitamin B Complex injection 10ml
Water for Injections 10ml

1.13 Management of SAM

MANAGEMENT OF SEVERE ACUTE MALNUTRITION—OTP—AMBULATORY NUTRITION CENTER FOR SAM CASES

Admission Criteria

Children 6 to 59 months	W/H < -3 z-scores And/or MUAC < 115mm And/or Bilateral edema + and ++
Adolescent (> 120 cm to 18 years)	W/H < 70% Bilateral edema

Systematic Treatment

Drugs	When	Age/weight	Dose
Vitamin A	Single dose 4th visit	6-8 Kg (or 6-11months)	One blue capsule bleue (100.000 UI)
		>8 Kg (or 1year and plus)	One red capsule (200.000 UI)
Amoxicilline	for 7 days from admission	All the children	50-100 mg/Kg/day for 7 days
Mebendazole 500mg	Single dose 4th visite	< 12 months	DO NOT GIVE
		> 12 months	1 tb = 500 mg
Measles Vaccination	4th visite	Children ≥ 9 month without vaccination-cards	Standard

National Protocol
INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION

Key information on RUTF at home

RUTF is a food and a drug

It should not be shared with other members of the family

Wash the hands and face of the child with soap

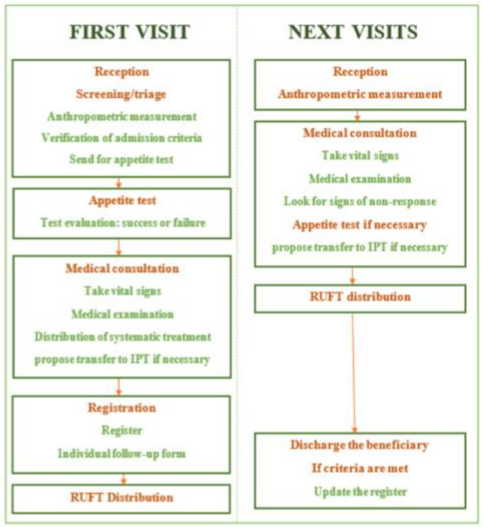
RUTF is the only food the child needs

Do not give any other food

The child should never be forced to eat

Give enough water alongside the RUFT

Beneficiary's Course at OTP



What to monitor in OTP

Look for edema	Every visit, All patient
Take the MUAC	Every visit , All patient
Take the weight	Every visit, All patient
Determine the W/H ratio	Every visit, patient admitted on W/H
Take the height	On admission and when there is a suspicion the child was substituted with another
Mesure the temperature	Every visit, All patient
Appetit test	Every week except the child has gained enough weight

Criteria for referral from OTP to IPF

Failure of appetit test

Increase/development of nutritional edema

Appearance of refeeding diarrheoa leading to weight loss

Presence of one of the criteria « treatment failure »

Weight loss during 2 consecutive weighing

Weight loss more than 5% at any visit

Stagnant weight 3 consecutive weighing

Discharged Criteria

Cured	
children 6 to 59 months	W/H ≥ -1,5 z-scores after two consecutive visits or MUAC ≥ 125mm after two consecutive visits AND No bilateral edema for the past 2 weeks.
Adolescent (>120 cm to 18 years)	W/H ≥ 85% after two consecutive weighing AND No bilateral edema for the past 2 weeks

1.14 Most common diseases

Top consultations	
1	Muscular skeletal conditions
2	Malaria
3	Skin infections
4	Gastritis / Peptic ulcer disease
5	Other acute conditions
6	Hypertension
7	Intestinal worms
8	Upper respiratory tract infection
9	Urinary tract infection
10	Antenatal care
11	Other chronic conditions
12	Watery diarrhoea
13	Gynecological conditions
14	STI
15	Diabetes
16	Pyrexia of Unknown Origin
17	Lower respiratory tract infection
18	Physical trauma
19	Eye infection
20	HIV