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REACH

RESOURCES FOR · CHILD HEALTH

MOROCCAN PROGRAM MANAGERS COURSE FOR CONTROL OF ACUTE RESPIRATORY INFECTIONS

OCTOBER 14-29, 1991

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TRIP REPORT

MOROCCAN PROGRAM MANAGERS COURSE FOR CONTROL OF ACUTE RESPIRATORY INFECTIONS

RABAT

OCTOBER 14-29, 1991

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Acknowledgements

The author wishes to acknowledge the interest on the part of the USAID mission in Morocco and the Moroccan Ministry of Health for requesting the consultancy.

Everyone the author worked with exhibited genuine interest in starting a control of acute respiratory infections (ARI) program in Morocco. The facilitators and participants in the Program Managers Course are to be commended for the professionalism and excellence of their work.

Morocco is well on the way to establishing an ARI control program and with the dynamic interest that was exhibited it will be successful in reducing pneumonia mortality in Morocco.

Acronyms

ARI	Acute Respiratory Infections
DHS	Demographic and Health Survey
ICCARI	International Consultation on Control of ARI
REACH	Resources for Child Health
SIAAP	Service for Provincial Ambulatory Health Services
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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I. EXECUTIVE SUMMARY

Purpose of Visit:

Assist, as a course facilitator, with an ARI program managers course for four pilot Provinces in Morocco starting ARI treatment in 1992.

Background:

Morocco has decided to begin ARI programming in four provinces in 1992, on a pilot basis. UNICEF is providing funding for the purchase of drugs, materials and for supervision. The four ARI Provinces are:

Agadir
Kenitra
Marrakech
Meknes

Trip Activities:

October 16-18 was spent in preparation with the other facilitators in reviewing the modules to be used and developing the guidelines for the plans that the individual Provinces would develop as part of the program managers course.

The ARI program managers course took place from October 21-25, 1991 in Rabat for four people from each of the four pilot Provinces and two people from the national level.

Results/Conclusions:

Morocco is moving ahead rapidly on implementing an ARI program. In general the program is well motivated and has broad base support within the Division of Epidemiology and Health Programs. Dr. Safia Bouaddi has been nominated as National Program Manager for ARI.

The approach that is being taken is to decentralize all of the training and supervisory activities. The Provinces that were at the program managers course were enthusiastic about implementing an ARI program because they saw it as a priority for their child survival program.

Recommendations:

1. A trainer be provided for the training of trainers course in ARI clinical case management. The trainees will be representatives from the four pilot provinces who will provide training in their Provinces. (WHO/Geneva has agreed to provide the consultant and the MOH will need to find funding for local costs.)

2. Further REACH technical assistance should be provide to help the National Program Manager to develop a detailed work plan , with appropriate budgets, for 1992.

3. Once there is a detailed workplan for 1992 the Ministry of Health needs to identify donor, and MOH, support for the plan.

4. The technical advisory group for ARI needs to be enlarged so that there are representatives of other parts of the central MOH structure and provincial representation on the advisory group.

5. USAID/Rabat should try to send the Minister of Health and the Director of Epidemiology and Health Programs to the upcoming ICCARI meeting in Washington, DC. This conference is scheduled for December 11-13, 1991.

II. PURPOSE OF VISIT

Assist, as a course facilitator, with an ARI program managers course for four pilot Provinces in Morocco starting ARI treatment in 1992.

III. BACKGROUND

Morocco has decided to begin ARI programming in four provinces in 1992, on a pilot basis. UNICEF is providing funding for the purchase of drugs, materials and for supervision. The four ARI Provinces are:

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The Ministry of Health, through USAID Morocco, requested that REACH provide a facilitator for the first ARI program managers course in Morocco. Funding for the program managers course was provided by the world Health Organization. This course was to combine the study of WHO modules on ARI, in particular the case management of ARI module, and develop individual ARI program plans for the four pilot Provinces.

IV. TRIP ACTIVITIES

October 16-18 was spent in preparation with the other facilitators in reviewing the modules to be used and developing the guidelines for the plans that the individual Provinces would develop as part of the program managers course.

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The ARI program managers course took place from October 21-25, 1991 in Rabat for four people from each of the four pilot Provinces and two people from the national level. The following WHO ARI modules were used:

Introduction to WHO ARI Modules
Clinical Management of ARI
National Policy
National Objectives
Planning and Supervision
Evaluation

On the final day of the program managers course each province presented its plan for ARI control in 1992. These plans will be further developed by the Provincial teams and be returned to the national level to be incorporated in the national plan for 1992.

One of the four Provinces was represented by the Medical Director for the Province. The other three were represented by the Medical Director of Service des Infrastructure des Actions Ambulatoires Provincial (SIAAP). At the Province level the ARI program will be implemented by SIAAP.

The Director of Epidemiology and Health Care attended the final presentation of the plans prepared by the Provinces. He was supportive and indicated that he would be looking for further funding to support the plans of the Provinces. The Director indicated that all ARI activities would very much need to be integrated at the Provincial level.

October 29, 1991 was used for the REACH ARI Coordinator to debrief with the USAID mission and appraise them of the progress that the government of Morocco has made on ARI.

During the debriefing with USAID the REACH ARI Coordinator reviewed the questionnaire for the Demographic and Health Survey (DHS) to be done in Morocco in February 1992. USAID/Rabat funding of two participants to the upcoming International Consultation on Control of ARI (ICCARI) was also discussed.

V. METHODOLOGY AND APPROACHES

The methodology used for the ARI Program Managers Course was the standard WHO self learning approach. The materials used for the course were the ARI training modules prepared for ARI. The following modules were used:

Introduction to WHO ARI Modules
Clinical Management of ARI
National Policy
National Objectives
Planning and Supervision
Evaluation

The modules were supplemented with a planning exercise that was made Province specific by using information the teams from the different Provinces had brought with them to the training.

The teams will return to their Provinces and then refine their plans. The plans will eventually be submitted to the national level and combined with the national ARI activities to come up with the national workplan for 1992. The national workplan will include a budget and be used to obtain further donor support for ARI.

VI. RESULTS/CONCLUSIONS

Morocco is moving ahead rapidly on implementing an ARI program. In general the program is well motivated and has broad base support within the Division of Epidemiology and Health Programs. Dr. Safia Bouaddi has been nominated as National Program Manager for ARI.

The program still needs some fine tuning and the REACH/WHO team had to request that the plans for printing of a wall chart for ARI case management be stopped due to errors that were contained in the wall chart. In addition all of the UNICEF funding is being used for the purchase of drugs and materials and nothing has been reserved for training.

Discussions during the Program Managers course lead to more changes in the Moroccan ARI wall chart and hopefully the final version will be a more usable product as a result of the WHO/REACH and Provincial inputs. Annex I is a copy of the original chart as it was presented to WHO and REACH.

The approach that is being taken is to decentralize all of the training and supervisory activities. The Provinces that were at the program managers course were enthusiastic about implementing an ARI program because they saw it as a priority for their child survival program.

The activities planned, at least initially, were very ambitious and the budgets prepared by the Provinces request much more than is needed to begin the implementation of a public health approach to ARI control.

The planning process that each of the Provinces went through, as a team, brought out some very important constraints. For example when calculations were done on the number of pneumonia cases to be hospitalized it was very quickly realized that there were not enough pediatric beds in the entire province to accommodate all of the hospitalized cases.

Annex II contains the three tables that were used to calculate the number of hospitalizations and treatments for ARI in the Province of Meknes during one year. Similar calculations were done for the other three Provinces and will be part of the eventual overall national plan for 1992.

VII. RECOMMENDATIONS

1. A trainer be provided for the training of trainers course in ARI clinical case management. The trainees will be representatives from the four pilot provinces who will provide training in their Provinces. (WHO/Geneva has agreed to provide the consultant and the MOH will need to find funding for local costs.)

2. Further REACH technical assistance should be provide to help the National Program Manager to develop a detailed work plan , with appropriate budgets, for 1992.

3. Once their is a detailed workplan for 1992 the Ministry of Health needs to identify donor, and MOH, support for the plan.

4. The technical advisory group for ARI needs to be enlarged so that there are representatives of other parts of the central MOH structure and provincial representation on the advisory group.

5. USAID/Rabat should try to send the Minister of Health and the Director of Epidemiology and Health Programs to the upcoming ICCARI meeting in Washington, DC. This conference is scheduled for December 11-13, 1991.

VIII. FOLLOW-UP ACTION REQUIRED

1. REACH needs to provide follow-up technical assistance to help the Moroccan ARI program develop an overall program plan for 1992. This will be the document used by the government to obtain donor support for the ARI program.

2. USAID/Rabat needs to identify two high level Ministry of Health people to attend the December ICCARI meeting.

IX. ANNEXES

Annex I	Moroccan ARI Treatment Chart (Draft)
Annex II	Calculations of ARI Cases to be Treated for Meknes Province, per Year

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PRISE EN CHARGE D'UN ENFANT AVEC TOUX OU DIFFICULTES RESPIRATOIRES

EXAMINER

DEMANDER:

- *Quel âge a l'enfant ?
- *L'enfant tousse-t'il ?
- *Depuis combien de temps
- *Peut-il boire ?
- *A-t-il cessé de tèter
- *Depuis quand ?
- *A-t-il eu des convulsions ou des apnées ?

REGARDER , ECOUTER :

(L'enfant doit être calme)

- *Voir si l'enfant est anormalement somnolent ou difficile à réveiller
- *Rechercher une cyanose
- *Rechercher un tirage
- *Rechercher et écouter un stridor
- *A-t-il des épisodes à répétition ?
- *Mesurer la fréquence respiratoire par minute
- *Palper pour savoir si l'enfant a de la fièvre ou s'il est anormalement froid (ou prendre la température)
- *L'enfant est-il très dénutri ? (le peser)

NOURRISSON AGE DE MOINS DE 3 MOIS

CLASSIFICATION	MALADE TRES GRAVE	PNEUMOPATHIE SEVERE	PAS DE PNEUMOPATHIE
SIGNES	-Refus de l'allaitement -Convulsions -Somnolence -Agitation -Distension abdominale -Stridor -Fièvre ou corps anormalement froid	-Respiration rapide>/ 60/mn -Tirage marqué -Cyanose -Geignement ou -Apnée	-Toux -Nez bouché ou qui coule -Respiration anormale -Pas de tirage
CONDUITE A TENIR	-Hospitaliser d'URGENCE -Garder au chaud -Donner la première dose d'antibiotique	-Hospitaliser -Garder au chaud -Donner la première dose d'antibiotique	*Conseils à la mère -Eviter le refroidissement -Allaitement fréquent -Nettoyer le nez -Garder au chaud -Revoir rapidement si aggravation : -Respiration rapide -Respiration difficile -Alimentation difficile

ENFANT AGE DE 3 MOIS A 5 ANS

CLASSIFICATION	PNEUMOPATHIE TRES SEVERE	PNEUMOPATHIE SEVERE	PNEUMOPATHIE	PAS DE PNEUMOPATHIE
SIGNES	-Toux -Tirage -Cyanose -Incapacité de boire -Convulsions -Stridor -Somnolence ou agitation	-Toux -Tirage -Pas de cyanose -L'enfant peut boire	-Toux -Respiration >/ 50/mn -Pas de tirage -Pas de cyanose	-Pas de tirage -Pas de respiration rapide
CONDUITE A TENIR	-Hospitaliser d'URGENCE	-Hospitaliser (Si le transfert à l'hopital n'est pas possible, donner des antibiotiques et surveiller étroitement	-Conseiller à la mère de donner des soins à domicile -Donner un antibiotique -Traiter la fièvre -Revoir l'enfant 2 jours plus tard	-Si l'enfant tousse depuis plus de 30 jours transferer pour bilan -Rechercher et traiter un mal d'oreille ou de gorge -Conseiller à la mère des soins à domicile -Traiter la fièvre -Traiter le sifflement

REEXAMINER DEUX JOURS PLUS TARD

SIGNES	S'aggravent : *Incapacité de boire *Tirage *Autre signe de gravité	Identiques	S'améliorent: *Respire moins vite *Moins de fièvre *Mange mieux
TRAITEMENT	Transférer d'urgence à l'hopital	Changer d'antibiotique ou transférer	Terminer les 5 jours d'antibiotique

TRAITER

DONNER UN ANTIBIOTIQUE

*Donner la première dose au centre de santé

*Expliquer à la mère comment donner l'antibiotique à domicile pendant 5 jours.

AGE ou POIDS	Sultamethoxazole TRIMETHOPRIME 2 Fois/jour pendant 5 jours Comprimé, sirop simple	AMOXICILLINE 3 Fois/jour pendant 5 jours Comprimés, sirop 250 mg 125 mg
3 MOIS (5 kg)	1 2.5 ml	1/4 2.5 ml
3 - 11 mois (6 - 9 kg)	2 5 ml	1/2 5 ml
12 mois-5 ans (10 - 19 kg)	3 7.5 ml	1 10 ml

Donner un antibiotique oral à la maison uniquement si l'hospitalisation n'est pas possible pour le nourrisson de moins de 3 mois.

CONSEILLER A LA MERE DE DONNER DES SOINS A DOMICILE :

- *Alimenter l'enfant
- *Augmenter les liquides
- *Nettoyer le nez
- *Surveiller et revenir rapidement si :
  - -La respiration depuis difficile ou s'accélère.
  - -L'enfant ne peut pas boire.
  - -Si son etat s'aggrave.

TRAITER LA FIEVRE

Fièvre élevée > 38.5°C	Fièvre modérée < 38°C	Fièvre depuis plus de 5 jours
Donner un antipyrétique	-conseiller à la mère de donner davantage à * boire * bain tiède	transférer pour bilan

TRAITER LE SIFFLEMENT

- Cas sévère : polypnée intense :

  Donner un bronchodilatateur d'action rapide et transférer à l'hopital

- Cas modéré (polypnée + fièvre) :

  .Pas de signe de gravité: traiter comme pneumopathie (plus salbutamol oral pendant 5 jours)

  .Signe de gravité: transférer.

- Cas bénin :respiration normale.

  Donner un bronchodilatateur d'action rapide et revoir après 30 minutes :

  .Amélioration : donner du salbutamol oral pendant 5 jours.

  .Pas d'amélioration : considérer comme cas modéré.

SALBUTAMOL ORAL 3 FOIS PAR JOUR PENDANT 5 JOURS

AGE OU POIDS	COMPRIMES 2 mg	SIROP cuil-mesure
3-11 mois (10 kg)	1/2	1/2
1- 4 ans (10-19 kg)	1	1

Tableau I

Circonscription Sanitaire	Population Total	Enfants 0-4 ans	Nombre de Formations Sanitiare Hop	CSU	CSR	DISP	Enfants ayant acces aux Formations Sanitaires %	Nombre	Enfants ayant acces au F.S. avec P.C.S. %	Nombre
AGOURAI	36021	3095			1	4	50%	1548	100%	1548
A. JEMAA	27900	4464			1	4	50%	2232	100%	2232
A. TAOUJDATE	57876	9260	1 HR		1	4	50%	4630	100%	4630
DKHISSA	57669	9227			1	4	50%	4614	100%	4614
EL HAJEB	36359	5197	1 HR		1	5	50%	2599	100%	2599
MIDRISS	62966	9619	1 HR		1	4	50%	4810	100%	4810
POULAL	38425	5448			1	5	50%	2724	100%	2724
S. AYOUNE	32444	5131			1	4	50%	2566	100%	2566
BMO	80483	10302		1		3	100%	10302	100%	10302
BM	47383	6065		1		3	100%	6065	100%	6065
EL MERS	61683	7895		1		3	100%	7895	100%	7895
POULAIN	77644	9938		1		3	100%	9938	100%	9938
SABATA	33225	4253		1		3	100%	4253	100%	4253
S. SAID	42659	5460		1		3	100%	5460	100%	5460
V. NELLE	75931	9719	1 H	1		3	100%	9719	100%	9719
TOTAL	768668	105073	3	7	8	55	76%	79353	76%	79353

Hop=Hopital
HR=Hopital Rural
H=Hopital Regional
CSU=Centre de Sante Urban
CSR=Centre de Sante Rural
DISP=Dispensaire
F.S.=Formation Sanitaires
P.C.S.=Prise en Charge Standard

Tableau No II

Circonscription Sanitaire	Enfant 0-4 Total	Avec acces a la P.C.S.	Incidence de la Pnuemopathie Taux %	Total	Ayant Acces	Cas qui seront diagnostique et traites selon la P.C.S. %	Nombres
AGOURAI	3095	1548	30%	929	464	50%	232
A. JEMAA	4464	2232	30%	1339	670	50%	335
A. TAOUJDATE	9260	4630	30%	2778	1389	50%	695
DKHISSA	9227	4614	30%	2768	1384	50%	692
EL HAJEB	5197	2599	30%	1559	780	50%	390
MIDRISS	9619	4810	30%	2886	1443	50%	721
POULAL	5448	2724	30%	1634	817	50%	409
S. AYOUNE	5131	2566	30%	1539	770	50%	385
BMO	10302	10302	30%	3091	3091	75%	2318
BM	6065	6065	30%	1820	1820	75%	1365
EL MERS	7895	7895	30%	2369	2369	75%	1776
POULAIN	9938	9938	30%	2981	2981	75%	2236
SABATA	4253	4253	30%	1276	1276	75%	957
S. SAID	5460	5460	30%	1638	1638	75%	1229
V. NELLE	9719	9719	30%	2916	2916	75%	2187
TOTAL	105073	79353	30%	31522	23806	67%	15925

Circonscription Sanitaire	Total des cas pneumopathies avec P.C.S.	Nourissons de moins de 3 mois	Enfant de 3 mois a 4 ans	
			Pneumopathie	Pneum. Grave
AGOURAI	232	23	162	46
A. JEMAA	335	33	234	67
A. TAOUJDATE	695	69	486	139
DKHISSA	692	69	484	138
EL HAJEB	390	39	273	78
MIDRISS	721	72	505	144
POULAL	409	41	286	82
S. AYOUNE	385	38	269	77
BMO	2318	232	1623	464
BM	1365	136	955	273
EL MERS	1776	178	1243	355
POULAIN	2236	224	1565	447
SABATA	957	96	670	191
S. SAID	1229	123	860	246
V. NELLE	2187	219	1531	437
TOTAL	15925	1593	11148	3185

TOTAL A REFERES 4778