REACH
RESOURCES FOR CHILD HEALTH

The Philippines National Control of Acute Respiratory Infections Program:

Initial Phase of Assessment of the Quality of ARI Training and Programming for Further REACH Technical Assistance in 1992-1993

June 16-July 3, 1992

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Initial Phase of Assessment of the Quality of ARI Training and Programming for Further REACH Technical Assistance in 1992 - 1993

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1. EXECUTIVE SUMMARY

1.1. The consultant travelled to the Philippines from June 16 to July 3, 1992. His two principal tasks were to finalize a proposal and workplan for REACH technical assistance to the CARI Program up until September 1993, and to work on a joint activity with the Quality Assurance Project aimed at assessing the effectiveness of ARI training to date.

1.2. Approximately half of the consultancy was devoted to each of these activities. A comprehensive proposal for technical assistance to the CARI Program was developed and received preliminary approval from the Department of Health and USAID/Philippines (Appendix 2).

1.3. In the course of the training effectiveness assessment, the consultant directly observed training sessions, as well as previously trained health personnel carrying out ARI standard case management in government facilities. Overall, performance was found to be remarkably good and the consultant has the impression that the training program is progressing extremely effectively. However, these initial observations are impressionistic by nature, and should be considered preliminary pending full collection and computer entry of observation data, as carried out by a contract team under the Quality Assurance Project. This is not likely to be ready for analysis and interpretation until late August or September.

1.4. The WHO Health Facilities Survey which had been scheduled for July-August has been delayed until September-October. REACH assistance in analysis is still anticipated.

1.5. The present consultancy is expected to be the last pre-implementation consultancy from REACH to the CARI Program. A full scale package of technical assistance is expected to begin in August 1992.

2. ACKNOWLEDGEMENTS

The consultant wishes to thank Dr. Maritel Costales and her able staff, particularly Ms. Nilda Silvera, for their continued warm and collegial support; Ms. Patricia Moser of USAID/Philippines for her encouragement of REACH's current and proposed activities; and the ARI Supervisory Skills trainees' meeting in Antipolo for showing that serious learning and fun are not mutually exclusive.

3. PURPOSE OF VISIT

This consultancy had two major goals:

3.1. To finalize a package of REACH technical assistance to the Philippines CARI Program intended to extend through September 1993, and to get approval for the elements of this package from officials of the Department of Health (DOH) and USAID/Philippines.

3.2. To work together with the Quality Assurance project on both defining key issues relating to essential knowledge and practices needed by health workers who deal with ARI, and on the collection of field data to assess the effectiveness of ARI training.

4. BACKGROUND

4.1. The programmatic background to this consultancy has been described in trip reports from December 1990 and November 1991. At the time of the most recent visit to the Philippines by this consultant in late 1991, it was clear that the needs and the absorptive capacity of the Philippines Control of Acute Respiratory Infections (CARI) program made this an ideal site for intensive technical assistance from the REACH Project. However, at that time budgetary constraints and a severe limitation on ARI-specific operational funding available to REACH were serious handicaps. Therefore, the feasibility of follow-through on the programmatic assistance recommendations was uncertain.

4.2. Since that time, the REACH Project underwent a mid-term evaluation which gave strong endorsement to the technical directions proposed for ARI, and recommended that significant funding from central USAID sources be allocated to ARI activities. In late spring of 1992, budgetary adjustments to the REACH Project were made which allowed consideration of substantial levels of technical assistance. Thus it was determined that a formalized package of assistance to the Philippines CARI Program should move forward as a high priority.

4.3. Among the priority items discussed with the DOH in the November 1991 consultancy was the need to determine the effectiveness of current ARI training prior to large-scale expansion of the program throughout the country. It was agreed that this was a particularly pressing issue, since the potential effectiveness of the CARI Program depended on whether trained health personnel were able to carry through program norms. This was to have been the first order of business, had substantial REACH assistance been feasible at that time. However, since this was not the case, REACH and the Quality Assurance (QA) Project discussed possible ways in which a cooperative approach, making best use of currently available resources, could meet this need.

4.4. As a consequence, the QA Project fielded several consultancies in early 1992 to develop a field study of ARI training effectiveness in the Philippines. As part of this coordinated approach, REACH agreed to field this consultant to assist with overseeing the collection of health worker performance data from the field. At a later stage, following collection and tabulation of the data, it was also agreed that REACH and QA would jointly analyze and interpret the data

collected, and make joint recommendations to the CARI program concerning modifications that might be warranted in the training program.

4.5. At the time this consultant arrived in the Philippines, almost all the scheduled observations of training sessions had been completed over the previous month. Field observation of health worker performance and activities had just begun in the National Capital Region and in Region VIII (Samar Province).

5. TRIP ACTIVITIES

5.1. The consultant departed for Manila on June 15, 1992, and arrived the next day. During the remainder of the first week of the consultancy, discussions were held with the Director of Maternal and Child Health Services, DOH, and with staff of the CARI program, concerning priorities for REACH assistance to the program. The consultant also met with QA staff and field interviewers to review and comment on the data collection forms which had already been developed for use in the study.

5.2. During the second week, the consultant spent nearly three days observing a supervisory skills course conducted by the staff of the National Capital Region. A planned field visit to Samar Province was cancelled on the advice of the DOH for security reasons because of the upcoming Presidential inauguration. He also travelled with the data collection team to several clinics in the Metro Manila area to observe ARI case management in practice by health personnel who had previously undergone training. At the end of the week, the Chief of the EPI/ARI Division returned from an extended trip, and lengthy discussions were held concerning needs for REACH technical assistance.

5.3. In the third week of the consultancy, numerous drafts of a REACH proposal for technical assistance to the CARI Program were prepared, discussed with officials of the DOH and USAID/ Philippines, and modified. Preliminary discussions were held concerning information systems, IE&C, and involvement of community health workers. The consultant had an extended informal discussion with the newly named Secretary of Health under President Ramos, who was sworn in during this week. Discussions were also held with officials of WHO/WPRO concerning plans for the WHO Health Facilities Survey and proposed REACH involvement in this activity.

5.4. Prior to his departure from Manila, the consultant debriefed with USAID/Philippines, and received informal agreement on the elements of a proposed technical assistance package, with the understanding that it still needed to be reviewed and approved by REACH/Washington and AID/Washington. The consultant departed from Manila on July 3 and returned to the U.S.

6. FINDINGS/CONCLUSIONS/RECOMMENDATIONS

6.1. The principal output of this consultancy was a formal proposal for technical assistance to the CARI Program over a fourteen month period, starting in August 1992 (Appendix 2). This proposal, forwarded to REACH/Washington for review immediately following the consultant's return, was modified and refined

based on comments, and was subsequently approved for funding by REACH/Washington and USAID/Washington, pending formal agreement by the DOH and USAID/Philippines.

6.2. This proposal (submitted separately), titled "USAID/REACH Proposal to the Philippines Department of Health, Maternal and Child Health Services Division, Control of Acute Respiratory Infections Program", will serve as the basis for a Memorandum of Understanding between REACH, the DOH, and USAID/Philippines to be negotiated during the consultant's planned August 1992 return trip to the Philippines.

6.3. At the time of the consultant's return from the Philippines, the field data collection for the training quality assessment was still ongoing, and was not expected to be completed until late July or early August. Following that, approximately one month is anticipated for data entry before preliminary analysis can be carried out. For this reason, no definitive findings from the training quality assessment can as yet be established.

6.4. However, a number of impressionistic observations warrant mention arising from training and field observations carried out by the consultant. The consultant was struck by the uniformly high quality of the training observed in the single supervisory skills training course attended. Serious and continuous attention was paid to assuring that each individual undergoing training (including a group of midwives) understood the details of standard case management, with repetition of practical drills (often based on the WHO ARI training video) aimed at assuring accurate count of respiratory rate and reliable observation of chest indrawing. The only weakness noted in the apparent transfer of knowledge and skills was a tendency to skip over danger signs and move directly to patient observation.

6.5. It was also noted that the process by which classification is carried out does not always follow the rigorous step by step approach promoted by WHO; as a consequence, severe disease was sometimes missed in favor of a clearly defined pneumonia. If the results of the data analysis bear this observation out, modifications of the training materials and procedures to emphasize this staging process would probably be warranted.

6.6. Performance observations were carried out directly by the consultant in only one health center and one hospital; therefore, conclusions are again impressionistic and must be considered tentative pending a more complete data set. However, the case management observed in the Tatalon Health Center, Quezon City, was sufficiently impressive to warrant mention. During the clinic session, a dozen cases of ARI, and five true pneumonias, were observed. In each case, standard case management was carried out precisely according to protocol. Patient flow was rapid and expeditious, indicating that standard case management does not need to slow down a clinic's operation. Respiratory rate determinations and observations for chest indrawing were uniformly accurate, cotrimoxazole was available in clinic and appropriately dispensed, mothers were appropriately counselled regarding danger signs and the need for follow-up, and the general level of satisfaction on the part of both clinic staff and patients was very high. Special commendation for the health center physician-in-charge, Dra. Beatriz Baradero, is warranted. She noted that she underwent ARI training nearly one year earlier, and that it has been a tremendous help to her in her clinical

activities. She also noted that as a consequence her antibiotic usage has actually decreased. This was truly a heartening testimonial to the value of this program.

6.7. Problems were observed, however, in the E. Rodriguez, Sr. Memorial Hospital. A case of severe pneumonia was observed, which was diagnosed and classified correctly by outpatient department staff. However, it was apparent that the treatment protocol promoted by the ARI program continued to meet with resistance on the part of senior staff. In this instance they argued that since the child in question had been previously treated with a second generation antibiotic at another facility, the program-recommended antibiotic for inpatient treatment of severe pneumonia (chloramphenicol IM) would be to no avail. Since third-generation antibiotics were not available at that facility, the mother was about to be sent out with her child with a recommendation to travel several hours across Manila to another hospital where "better" antibiotics might be available. Only with considerable difficulty and against great skepticism was the consultant able to intervene, dropping out of the role of observer, to convince the staff to admit the child and begin chloramphenicol treatment immediately. Follow-up before departure from Manila determined that the child had indeed recovered fully and uneventfully, but that skepticism concerning standard case management on the part of hospital staff persisted.

6.8. This observation is consistent with other impressions that senior clinicians, rather than lower level health personnel, remain the biggest stumbling block to full implementation of standard case management. In this regard the Philippines is no different from the U.S.

6.9. All in all, the consultant was struck with the overall high quality of ARI training and with the degree to which this training was followed in clinical situations. More complete data from the larger sample to validate or refute these impressions is eagerly awaited.

6.10. Finally, in discussions with DOH and WHO/WPRO officials, it was determined that the WHO Health Facilities Survey, originally scheduled for July-August, with which the consultant was to assist on REACH's behalf, would have to be rescheduled to September-October because of scheduling problems within the DOH, and the planned absence of both WPRO resident advisors for the entire month of August.

7. FOLLOW-UP ACTION REQUIRED

7.1. In August, a Memorandum of Understanding needs to be negotiated between REACH, the DOH, and USAID/Philippines in order to move the full package of REACH technical assistance forward.

7.2. At that time, the first set of consultancies described in the proposal should be carried out in coordination with a follow-up visit to the Philippines by the consultant, who will serve as the technical oversight of REACH inputs into the Philippines CARI Program over the next 14 months.

7.3. Also during the next consultancy, job descriptions for the proposed local hire REACH staff should be finalized in cooperation with the CARI Program staff, and recruitment initiated.

7.4. If at the time of the next consultancy, all data collection from the training effectiveness assessment has been completed, the consultant should assist the CARI Program with an initial tabulation and preliminary analysis; final analysis and interpretation of results will be carried out by the consultant together with staff from the QA Project in Washington in September. Results will be presented at a workshop in the Philippines in the later part of October.

7.5. Given the delay in implementation of the WHO Health Facilities Survey, the consultant's assistance in data analysis and interpretation for this survey will be carried out in October.

Appendix 1

Persons Contacted

USAID/Manila:

Dr. Emmanuel Voulgaropoulis, Chief, Health, Population and Nutrition
Ms. Patricia Moser, Health and Nutrition Officer
Dr. Marichi de Sales, OHPN

Department of Health:

Dr. Juan Flavier, Secretary of Health
Dr. Ellery Dayrit, Director, Maternal and Child Health Services
Dr. Maritel Costales, Chief, EPI/ARI Division
Dr. Emma Manalac, CARI Program
Mrs. Nilda Silvera, CARI Program

WHO/WPRO:

Dr. Flemming Bro, Regional ARI Technical Officer
Dr. Sergio Piesche, CDD/ARI Country Officer

Quality Assurance Project:

Dr. Stuart Blumenfeld

Appendix 2

USAID/REACH PROPOSAL

to the

Philippines Department of Health

Maternal and Child Health Services Division

Control of Acute Respiratory Infections Program

Resources for Child Health (REACH) Project
1616 North Fort Myer Dr., Suite 1100
Arlington, Virginia 22209

USAID Contract Number:DPE-5982-Z00-9034-00
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Executive Summary

The Control of Acute Respiratory Infections (CARI) program, located within the Maternal and Child Health Services (MCHS) of the Department of Health (DOH), was started in 1989. It is not a separate vertical program, but is carried out within the broad framework of the integrated MCHS. Appropriate norms and policies have been adopted, and the program is in the process of a rapid expansion directed at full national coverage within five years.

Discussions with DOH officials during the course of a December 1990 REACH consultancy determined that technical assistance could be of value to the CARI program in allowing it to move forward more rapidly and effectively.

This proposal is intended to serve as the basis for discussions regarding this programming between the DOH, USAID/Manila and REACH. Globally, REACH's approach to ARI assistance focuses on two broad themes: assuring and improving the supply of pneumonia case management services, and enhancing the appropriate demand for and compliance with these services.

REACH propose to assist the Philippines CARI program in the following areas:

-Evaluation and strengthening of the CARI training program;
-Formalization and strengthening of supervisory procedures;
-Assessment of needs for a routine health information system and development of key tools and indicators;
-General systems support and operational tools development;
-Development and testing of health education and communication training and tools for front-line health workers; and
-Assessment of the role of private pharmacies in ARI treatment

Funding for all of these elements would be provided directly by REACH from central A.I.D. funds. Direct programmatic costs would continue to be borne by the DOH through its regular internal resources as well as budgetary assistance from the Child Survival Program of USAID/Manila, UNICEF, WHO and the World Bank. Only the REACH elements are discussed in depth in this proposal.

The end of Project goals for the REACH assistance to the CARI program are:

- Improved ARI training and resultant performance for front line health workers,
- ARI health information system,
- ARI operations manual,
- ARI Educational materials for midwives.

Background

The Control of Acute Respiratory Infections (CARI) program, located within the Maternal and Child Health Services (MCHS) of the Department of Health (DOH), was started in 1989. It is not a separate vertical program, but is carried out within the broad framework of the integrated MCHS. Appropriate norms and policies have been adopted, and the program is in the process of a rapid expansion directed at full national coverage within five years.

The CARI program is expanding on a phased basis, with early focus on the daunting task of training the thousands of health care providers working throughout the government health services. A set of formalized training materials for health workers down to the level of the midwife have been developed, based on WHO manuals, and an ARI standard case management chart has been widely distributed to health facilities where staff have been trained in ARI standard case management (SCM). The plan for national coverage is ambitious, but appears to be feasible if adequate levels of financial and political support can be maintained.

In December 1990 REACH and DOH officials agreed that REACH technical assistance could help the CARI program to move forward more rapidly and effectively. USAID/Manila made clear that it was not in a position to provide funding for targeted assistance to the CARI program outside the existing framework of the Child Survival Program (CSP) and its technical assistance contractor.

The contractor's broad scope of work in support of general DOH institutional strengthening and its limited level of effort meant that technical assistance specific to CARI program development was of necessity extremely constrained, and realistically would have to be provided by REACH. Funding mechanisms other than those from USAID/Manila would be needed.

The initial REACH assessment concluded that the Philippines CARI program had potential not only to substantially decrease childhood pneumonia mortality in the Philippines, but also to serve as a model for national ARI programs throughout the world. Given the numerous operational issues which have not yet been resolved in implementing the new global recommendations for ARI control, the Philippines promised to provide important lessons with international implications. This was likely to serve a valuable function for A.I.D.-supported ARI efforts around the world.

For this reason A.I.D.'s Office of Health approved the use of central funds from REACH's core budget to provide technical assistance to the CARI program in a limited number of key technical areas. Aside from a preliminary REACH consultancy in late 1991, budget constraints made this impossible until in mid-1992, when budget revisions allowed a tentative go-ahead to be given to proceed with programming for this assistance.

This proposal is intended to serve as the basic for USAID/Manila and REACH assistance to the DOH. This assistance is to begin in August 1992. Since the current end date for the overall REACH Project is September 1993, a 14-month schedule of assistance is detailed here.

Project Strategy

Globally, REACH's approach to ARI assistance focuses on two broad themes: assuring and improving the supply of pneumonia case management services, and enhancing the appropriate demand for and compliance with these services. These two themes can be linked through a formalized process of continuous quality improvement through the use of supervision and continuing education.

The proposed assistance to the Philippines CARI program reflects these themes. Assistance will be carried out through a combination of short-term consultancies, subcontracted field studies, and full time in-country support from host-country nationals. The short-term consultancies, as detailed in the Description of Project Activities, will amount to approximately 16 person-months. This assistance will be managed by the REACH ARI Senior Technical Advisor and the REACH ARI Coordinator. A limited set of targeted field studies directed at key operational questions will be detailed by the consultants in cooperation with the CARI program. These will be carried out over the course of the next year through subcontracts with local institutions.

Full time support to these activities will be provided by two host-country nationals: a technical specialist, expected to be a physician with public health training, who will be based in the CARI office and work directly with program staff in following up and coordinating all activities described in this proposal; and an administrative coordinator, responsible for scheduling and administrative backstopping of the consultants and subcontracted tasks.

Funding for all of these elements would be provided directly by REACH from central A.I.D. funds. Direct programmatic costs would continue to be borne by the DOH through its regular internal resources and budgetary assistance from the Child Survival Program of USAID/Manila, UNICEF, WHO and the World Bank. Only the REACH elements are discussed in depth in this proposal.

Each of the tasks described in this proposal were identified by the CARI program as a priority for national program development, and several have been directly initiated by the CARI program during the course of this year. These elements are all coordinated with and complementary to inputs planned by WHO and UNICEF, and in several tasks the planned REACH technical inputs allow the implementation of activities which have already been agreed to by these other donors.

REACH proposes to assist the Philippines CARI program in the following areas:

- Evaluation and strengthening of the CARI training program;
- Formalization and strengthening of supervisory procedures;
- Assessment of needs for incorporating ARI into the routine health information system and development of key tools and indicators;
- Development of methodologies to strengthen the quality of ARI case management services and of tools to support effective supervision;
- Development and testing of health education and communication training and tools for front-line health workers; and
- Assessment of the role of private pharmacies in ARI treatment.

Project Goals and Objectives

1. Long-Term Goal

To reduce the mortality due to pneumonia in Filipino children under five years of age.

2. The end-of-project goals for the REACH assistance to the CARI program are:

- Report on key findings and recommendations of training effectiveness study;
- Report on key findings and recommendations of health facilities survey;
- Submit recommendations to the CARI program for revised training materials and/or procedures based on findings of these studies;
- Recommend a formalized set of simplified assessment tools and protocols for their use, to serve as a regular means of tracking training effectiveness and worker performance;
- Develop a modified training video specifically for Philippine health workers;
- Submit recommendations to the CARI program on the potential use of BHWs as ARI case management workers;
- Develop a supervisory manual for ARI;
- Develop a patient register for routine use in ARI treatment;
- Submit recommendations to the DOH for inclusion of ARI indicators in routine health information system;
- Submit a report and a formalized set of actionable recommendations on antibiotic procurement and management under the new local code;
- Develop a draft operational manual, with recommendations for further modification based on a pre-test;
- Conduct a training workshop on continuous quality improvement for program managers;
- Develop a set of tested health education materials for use by midwives;
- Submit formal recommendations on the use of "Talking to Mothers" as a health education tool;
- Develop a communications training video for use by health workers;
- Conduct a formal evaluation of various communications aids, and submit recommendations for which approaches are most promising;
- Submit a report on the role of private pharmacies in managing ARI cases.

Description of Project Activities

1. Training

1.1. Training effectiveness assessment

An early assessment of ARI training effectiveness is already being carried out through a joint effort by the CARI program, the Quality Assurance (QA) Project and REACH. Field work and data collection for this assessment are scheduled to be completed by mid-July, with data entry expected to take approximately another month. A preliminary tabulation and analysis could be carried out jointly with CARI staff in mid-August as part of a follow-on REACH visit. Full analysis will be carried out in Washington by the QA Project, with REACH technical input, in September.

Presentation of results and recommendations at a DOH workshop are planned for October 23-25, 1992. This workshop will be attended by both QA and REACH technical staff. REACH will provide technical assistance in following up key recommendations of this training effectiveness assessment.

Output: Report on key findings and recommendations

Time line for activities: August 1, 1992 - October 31, 1992

1.2. Health facilities survey

At the request of the DOH and WHO, REACH will provide technical assistance in analyzing and interpreting the results of the Health Facilities Survey for ARI. This will be the first full field test of this survey, which has been developed by WHO to serve as a global standard to assess national ARI programs. The survey is presently scheduled to be carried out with WHO assistance in September/October.

REACH assistance in analysis and interpretation will be provided in mid-October. Results will also be presented at the October DOH workshop.

Output: Report on key findings and recommendations

Time line for activities: October 1992

1.3. Modifications in ARI case management training

Based on findings of the training effectiveness assessment and the health facilities survey, REACH will assist the CARI program in key modifications of the current procedures and tools for training health personnel. Pending the results of these studies, modifications cannot yet be described in detail, but could involve changes to the manuals, wall chart, or training procedures.

Output: Revised training materials and/or procedures

Time line for activities: October 1, 1992 - December 31, 1992

1.4. Development of simplified assessment tools

Both the training effectiveness evaluation and the health facilities survey will serve a valuable function in allowing an early in-depth assessment of what elements of CARI training are and are not working effectively. However, they are major and costly undertakings which are unlikely to serve as practical tools for routine use by the CARI program. REACH will work with CARI to develop a set of simplified assessment tools which can be used on an ongoing basis to provide feedback to trainers and program managers for the management of the CARI program.

Output: Formalized set of assessment tools and protocol for their use

Time line for activities: October 1, 1992 - March 31, 1993

1.5. Production of training video

Currently the CARI program is making use of the WHO training video as part of its ARI training program. While many parts of this video are very effective as a training tool, there are elements which would benefit from a clearer focus on the Philippines program and its needs. REACH proposes to work with a local video production company to develop and produce a training video specifically tailored for the Philippines. The specific content and major emphasis areas of this video will depend on the findings and recommendations of the training effectiveness assessment and the health facilities survey.

Output: Modified training video for Philippine health workers

Time line for activities: November 1, 1992 - April 30, 1993

1.6. Assessment of CARI program extension to Barangay Health Workers

Barangay Health Workers (BHWs) have the potential to serve as a key element for the provision of SCM in the national ARI control strategy. Evidence from other programs has shown that community-based workers can reliably and effectively diagnose and treat childhood pneumonia, and that extension of program services into the community is a key element for maximizing impact on mortality.

In this fiscal year the CARI program has initiated a field test of the use of BHWs as case management agents in northern Samar province, with financial assistance from UNICEF. REACH will assist with the development of this field test, its analysis and interpretation, which will serve as the basis for recommendations regarding national use of BHWs in ARI case management.

Output: Completed study of BHWs as ARI case management workers, with recommendations for national programming

Time line for activities: August 1, 1992 - December 31, 1992

2. Supervision

2.1. Development of supervisory tools

Currently there is considerable uncertainty on the part of supervisory personnel at provincial, municipal and local levels as to exactly what constitutes appropriate supervision for ARI case management. Much of it is haphazard. REACH has identified ongoing supervision of front-line health personnel as a key element of effective ARI service delivery. The effectiveness of this supervision can be significantly enhanced by routine use of a set of tools by supervisors. One such tool, a supervisory checklist, is already being tested in the National Capital Region, but it appears to need further modification. In addition to standardized checklists, it is likely that a short manual directed specifically at the tasks which supervisors need to carry out, and focused on the development of supportive rather than punitive supervisory skills, would be of general use to the CARI program. REACH will work with the program in the development and field testing of such a manual.

Output: Supervisory manual for ARI

Time line: October 1, 1992 - March 31, 1993

3. ARI information systems

3.1. Development of standardized pneumonia case reporting

Currently there is no standard for record-keeping regarding pneumonia case management at DOH facilities. The establishment of such standards presents two major advantages: it can provide a direct memory aid for health workers in pneumonia case management, and it can provide information which can be reviewed and extracted for supervisory purposes. The CARI program has initiated the development of a client list, which would be kept as a separate register for all cough, cold and difficult breathing cases. REACH will assist with further development of this client list, as well as with its pretesting and modification prior to making recommendations regarding national application. The emphasis of REACH's assistance to the development of such a register will be on how it helps the health worker to manage cases, rather than how it feeds into data systems at higher levels in the health structure. It is preferable to have a more limited set of information which, because it serves the needs of the person recording it, is routinely and reliably recorded, than to try to force service delivery personnel to record data for which they have no direct use. In the latter case, even when information is recorded it is generally highly unreliable, and the health system winds up expending considerable effort in policing the process of data recording rather than in overseeing the care provided.

Output: Finalized patient register

Time line: August 1, 1992 - September 30, 1992

3.2. Development and validation of ARI indicators for eventual use in the national Health Information System

Program managers at local, provincial and national levels need a limited set of reliable information in order to adequately support service delivery, assess progress, and identify critical problem areas. REACH will work with the DOH in helping to define the key indicators and to develop simple ways to collect and process this information consistent with ongoing national HIS efforts. Important considerations in this effort will be the avoidance of a separate vertical system and a focus on developing the minimum information set needed for immediate program management. At this stage, it is REACH's view that information for longer term tracking, and for issues secondary to program management, should not be included in the initial ARI HIS.

Development of a national HIS has been supported through the USAID Child Survival Program, and is in the process of being incorporated nationally by the DOH. In the next one to two years, it is likely that a partial modification of this system based on experience with its early implementation will be undertaken by the DOH, most probably with USAID and World Bank support. At that point, introduction of the new subset of ARI indicators into the overall HIS would be feasible, and would then be routinely used throughout the health system. As an early part of this effort, a DOH workshop to finalize indicators for inclusion in this system may be useful; if so, REACH will assist with its organization.

Output: Recommendations to the DOH for inclusion in HIS

Time line: August 1, 1992 - February 28, 1993

4. Systems support

4.1. Antibiotics and the local code

Unavailability of antibiotics has been identified as a major constraint to effective program implementation. There is concern within the CARI program that this constraint may become even more significant with the adoption of the "local code" which resulted in the devolution of responsibility and authority for all procurement and logistics to the provinces and municipalities.

REACH will sponsor a study, as part of work the REACH is doing on vaccine availability, of the major structural impediments to adequate antibiotic supply provision for pneumonia case management, with recommendations for feasible actions which could be undertaken by the DOH to address this issue.

Output: Formalized set of actionable recommendations to DOH

Time line: September 1, 1992 - March 31, 1993

4.2. Operational manual

The CARI program has determined that an operational manual for ARI, similar to one developed for use in EPI, would be of use to service delivery personnel, supervisors, and program managers. Elements of such a manual are included in a number of tasks described in this workplan. In addition to these discrete elements, REACH will work with the CARI program in the development of a draft ARI operational manual, in its initial field testing, and in recommendations for modifications to this draft manual.

It does not appear feasible at this point to complete the final version of such a manual before the end of this workplan period, September 30, 1993, since many of the elements to be included in it will rely on findings from other activities to be carried out over the course of the next year. With these findings in hand, REACH anticipates that the Philippines CARI program will then be capable of completing the final version of the manual on its own, with assistance from UNICEF for printing.

Output: Draft operational manual, with recommendations based on pre-test

Time line: December 1, 1993 - August 31, 1993

4.3. Continuous quality improvement

The DOH has recognized that the quality of ARI case management services is the key both to effectiveness in mortality reduction and to satisfaction and appropriate utilization on the part of mothers and other caretakers. REACH staff have had preliminary discussions with DOH officials about the potential use of a formalized process of continuous quality improvement (CQI) to achieve this.

CQI differs fundamentally from the checklist-based approach of quality assurance, and is oriented towards daily use by program personnel and managers at the point of service delivery. It involves breaking down a process of service delivery (in this case, ARI standard case management) into discrete components, establishing priorities and essential linkages between these components (e.g. what good is adequate training if antibiotics are not generally available), and formalizing procedures for improving these components in small increments on a continuous basis. In addition, CQI follows the principle that measuring and improving mean performance results in better overall system performance than in focusing on the outliers (performance substantially below or above the accepted norm), and uses statistical techniques for defining and establishing these standards as well as programmatically acceptable variation.

There is a great opportunity for the Philippines CARI program to play a leading role in testing and implementing such a CQI approach, which REACH believes could be used throughout the health service delivery system of the Philippines and serve as a model for ARI programs in other countries. However, the full-scale establishment of a CQI process goes well beyond what is feasible under the time frame of this proposal. Therefore, REACH proposes to take the initial step in this process of conducting a short training course in CQI for a limited group of program managers, including those at national and provincial

levels. This workshop will determine whether this process holds significant potential for the Philippines; if the answer is affirmative, it will then serve as the functional foundation for further efforts to be carried out by the CARI program and the DOH, with added inputs to be defined at that stage.

Output: One week training workshop on CQI for program managers

Time line: March 1 - March 31, 1993

5. Health education (IEC)

5.1. Development of IEC materials specific to ARI

There is growing recognition that an important determinant of the impact of ARI programs is the quality of face-to-face communications between health service providers and children's caretakers (most commonly mothers). The CARI program has decided to concentrate at this stage of the program on materials for use by the midwife in communicating with mothers, since the midwife is the principle provider of primary care at the Rural Health Units (RHUs), which is the main source of health care for a majority of the Filipino population.

Currently under consideration are flipcharts, posters, and take-home leaflets that reinforce education messages. UNICEF is providing resources for limited field-testing of prototypes, when and as they are developed. CARI has indicated that REACH technical assistance would be useful in developing key messages, formulating effective approaches to conveying this information, producing prototypes, and formally assessing their effectiveness. REACH will provide direct technical assistance in formalizing a process for evaluating and modifying these materials. The critical outcome variable which will serve as the basis for this process will be the direct effect on maternal understanding of how to identify pneumonia in their children and maternal action in seeking care appropriately.

Output: Set of tested ARI health education materials for use by midwives

Time line: August 1, 1992 - November 30, 1992

5.2. Field test of "Talking to Mothers"

WHO has developed a draft module on teaching health workers how to communicate with mothers, but this has not yet been rigorously field tested. Given the level of program development, and the CARI program's own priority on communications with mothers, the Philippines appears to be a leading candidate for such a field test, and REACH is prepared to assist with such a process. Specific issues to be addressed in this assessment include objective assessment of whether use of this module actually improves health worker communications skills for various levels of health workers, time studies of the application of the recommended communications processes at the health facility, and the potential value of possible supplements (such as a video model described below, or the use of the communications aids described above) in accomplishing the

communications objectives. REACH will provide technical assistance in designing and interpreting the results of this assessment, and if appropriate may also provide funds for a local subcontract to carry out the field work for such an appraisal.

Output: Formal recommendations on use of "Talking to Mothers"

Time line: August 1, 1992 - November 30, 1993

5.3. Production of video for use in training in communications

In coordination with the training video which REACH will undertake (task 1.5), a separate video will be developed to teach health workers through demonstration how to effectively communicate with mothers. This video will make use of lessons from the field test of various communications aids, as well as the field test of "Talking to mothers." REACH will subcontract to a local production firm for this video, but will work closely with the CARI staff in directing its content and approach.

Output: Communications training video

Time line: November 1, 1992 - March 31, 1993

5.4. Assess impact of different communications aids

In addition to developing these materials, a formalized evaluation procedure is needed to provide an objective basis on which to expand program efforts. In a recent global meeting on the use of ethnographic research in ARI programming, WHO highlighted the need for objective standards for evaluating the effectiveness of communications aids and other ARI IE&C interventions. REACH is prepared to assess the benefits of the various communications aids described above, and to establish a standard method of evaluating future aids.

Output: Formal evaluation of various communications aids

Time line: January 1, 1993 - August 31, 1993

6. Study the role of private pharmacies

It is recognized that a high proportion of childhood ARI cases are taken first to private pharmacies rather than to government health facilities. This is especially prevalent in urban areas. Although it is generally assumed that the treatment given in these cases does not conform to standard case management procedures, there is little objective information concerning patterns of care-seeking, nor of treatment given in private pharmacies. Since the national ARI control strategy in the Philippines must expand to encompass sources of care beyond government health facilities, it would be useful to have objective information on which to base program decisions concerning program expansion and coverage. REACH is prepared to carry out a study of the role of private pharmacies in ARI treatment in collaboration with the CARI program.

Output: Report on the role of private pharmacies in managing ARI cases

Time line: January 1, 1993 - February 28, 1993

Monitoring and Evaluation Plan

Due to the short nature of this intervention the evaluation of REACH in the Philippines will be based on the outputs anticipated for the various activities, which are stated as end of project goals in section D. Progress toward these goals will be measured on a regular basis by the REACH ARI Coordinator and REACH Technical Director. A formal review and evaluation of REACH efforts with the Philippines CARI program will be conducted in August 1993, possible in coordination with WHO.

The REACH ARI Coordinator will travel to the Philippines at least once during the project to monitor the activities and their continued relevance to the DOH CARI program and to REACH's global mission.

REACH also anticipates dissemination of the lessons learned and the materials developed for the Philippines CARI program to other REACH ARI intervention countries.

Budget

REACH ASSISTANCE TO PHILIPPINES ARI PROGRAM

SUMMARY BUDGET	FY 1992	FY 1993	TOTAL
JSI staff(includes benefits)			
U.S.	$30,454	$72,823	$103,276
Local	$1,122	$8,976	$10,098
Consultants	$6,500	$33,280	$39,780
Travel&transport	$35,336	$102,389	$137,725
Subcontracts	$20,700	$62,000	$82,700
Other direct costs	$10,638	$14,732	$25,370
Overhead	$21,317	$50,976	$72,293
Subtotal	$126,067	$344,175	$471,243
Fee	$8,626	$23,698	$32,324
TOTAL	$134,918	$370,669	$505,586

/moms/usr1/bob/phil_pro.nls

PHILIPPINE'S ARI TIME FRAME
X=5 DAYS

TASK	PER.	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG.	SEPT
TRAINING															
1.1 ASSESSMENT	ND	X													
1.2 HEALTH FAC. SURVEY	ND			X											
1.3 ARI TRAIN. MODIFICATION	ND			X											
	RS			X											
1.4 ARI ASSESS. TOOLS	ND			XX		X									
	RS			X		X									
1.5 TRAINING VIDEO	ND					X									
	RS			X		XXX									
1.6 ASSESS. OF BARANGAY HW	ND	X		X											
	RS	XXX		X		XX			X						
				XX		X									
SUPERVISION															
2.1 DEV. OF SUPERV. TOOLS	ND														
	CON					X									
INFO SYSTEMS															
3.1 CASE REPORT	ND	X					XX		XX						
	CH	XX													
3.2 DEV. OF ARI INDICATORS	ND	X													
	CH	X					X								
SYSTEMS SUPPORT															
4.1 LOCAL CODE	BS						XX								
4.2 OPERATIONS MANUAL	ND		XX												
					XX										
4.3 CQI TRAIN.	ND														
	CON							X							
HEALTH EDUCATION															
5.1 MATERIALS DEVELOPMENT	ND	X						X				X			
5.2 FIELD TEST TALKING TO MOTH.	CON	XXX						XX							
	CON	XX		XX											
5.3 IEC TRAINING VIDEO	RS			X											
5.4 MATERIALS EVALUATION	CON		X		X										
				XX				X							
6.0 ARI AND LOCAL PARMACIES	CON							X							
REACH MONITORING															
EVAL FIELD VISIT RW							XXX								
REACH ARI COORD.						X								X	

ND=NILS DAULAIRE
RS=RENE SALGADO
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BS=BRAD SHWARTZ
RW=ROBERT WEIERBACH