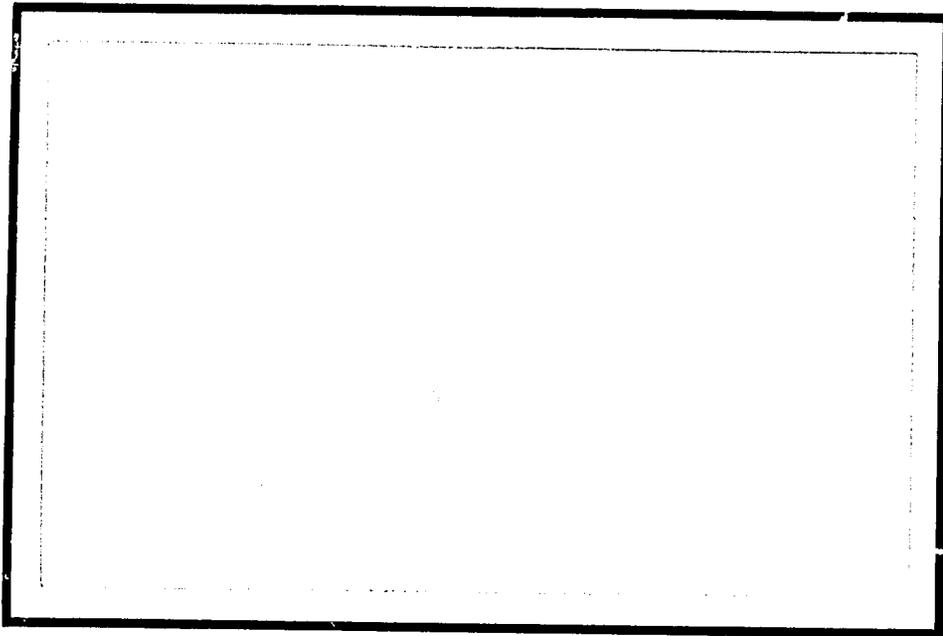


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EVALUATION REPORT ON THE PHILIPPINES
DIARRHEA CLINICAL TRAINING PROGRAM
PART A

A Report Prepared By: Consultants:
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During The Period:
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INTRODUCTION

In accordance with the PRITECH scope of work No. HSS 115-PH dated August 16, 1991, Dr. Larry Casazza proceeded from Kenya to Manila, the Republic of the Philippines to participate in the joint effort by PRITECH, the Quality Assurance project and WHO to provide technical assistance to the Department of Health (DOH) in order to evaluate its national CDD training program. In Manila he was joined by Jeanne Newman PhD from PRICOR/Quality Assurance project and Tarja Rautanen MD, a consultant from WHO, together with staff from DOH, we completed Part A of the two-part evaluation.

Also Ms. Danielle Grant, administrative officer from PRITECH/Washington assisted in the arrangements for this part as well as preparing for Part B of the Study which will take place in January 1992. Ms. Maricor de los Santos, PRICOR representative in the Philippines, managed data entry and analysis.

BACKGROUND

Early in 1990, Dr. Elvira Dayrit, Chief, MCH/DOH, requested PRITECH to assist the DOH to evaluate the quality of the national CDD training activities. Training had been ongoing since 1985 with the establishment of the first Diarrhea Training Unit at San Lazaro Hospital in Manila (currently known as the National Rehydration, Treatment and Training Center or NRTTC). Since then, two other DTU's have been set up in Cebu and Zamboanga.

In addition to the evaluation of its DTU-based training, Dr. Dayrit also wanted a detailed study of the subsequent performance of the healthworkers after returning to their facilities. The original date for the study was set for 1990, but the diarrheal season had passed by the time arrangements could be finalized and the study was postponed for a year.

As the new date approached, it became clear that more detailed planning was needed in order to finalize the methodology to be used in the study. As a result, a meeting was held in Geneva in May, 1991 that combined the efforts of WHO/CDD, PRITECH and the PRICOR/Quality Assurance projects to develop this design. Close liaison with the National CDD Program (NCDDP) was maintained through Dr. Sergio Pieche, WHO medical officer, CDD-ARI/Philippines.

But the eruption of Mount Pinatubo caused another postponement of the study. Finally in late July, 1991, Dr. Mariam Claeson WHO/Geneva and I visited Manila to finalize the protocol with DOH staff, draft the budget and make the necessary logistical plans. At that time it was agreed that the study would be carried out in two parts; the first, scheduled for September, 1991 would assess two on-going DTU courses and the second, to take place in January, 1992 would follow up healthworkers' performance in the field.

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In summary, the goals of the study are:

Part A - 1) to assess the quality of DTU training

2) to assess the ability of the trainees to apply new knowledge and skills at the end of the course

Part B - 1) to assess their strengths and weaknesses after the training; to identify other key determinants influencing healthworker performance in the field besides training.

SUMMARY OF PART-A RESULTS

Two simultaneously run courses in diarrheal case management (CMT) were conducted at the NRTTC in Manila and the Southern Islands Medical Center (SIMC), Cebu from September 2-6, 1991. Dr. Rautanen with staff from the DOH monitored the course in Manila while Drs. Casazza and Newman observed the SIMC training. Attachment A contains the specifics on the methodology and the preliminary results of Part-A; these findings were shared with officials from the DOH and WHO in a wrap-up meeting on September 13, 1991. The letter from Dr. Dayrit shown in Attachment B acknowledges this effort and encourages the completion of the second part of the study in January, 1992.

In summary, the two courses observed appear to have had interesting characteristics which distinguished them from one another; both had their strengths and weaknesses. Their major difference was the number of diarrheal cases seen during the practicum (54 in NRTTC compared with eight in SIMC). The simulation testing would indicate that the participants at the NRTTC course had better skills in assessment and management at the end of the course due to more extensive practical training. It appears that it is difficult to replace the experience and confidence gained in actually managing cases with any other training method.

The evaluation of both the post- course knowledge and skills of the participants and the content and teaching methods of the training courses themselves has provided information that should be of considerable value to the DTU faculty in both institutions and to the CDD program in planning for future DTU training. At the same time, this part of the study provided a base against which it should be possible to measure subsequent participant performance in the field.

The teams' experience with the use of case simulations as a means to evaluate the skills learned by the participants deserves mention. This was the first attempt at measuring competency using standardized "patients" and it proved to be of value in uncovering deficiencies in participant knowledge and skills that would have

otherwise gone undetected. This was particularly true in Cebu where the facilitators had less opportunity to observe participants with cases on the wards. They were surprised to see some of the problems the participants were having during the simulations in all three major skill areas: assessment, treatment, and counseling.

FOLLOW ON ACTIVITIES PLANNED FOR PART-B

During the visit, arrangements to administer the funding for Part B of the study were made by Ms. Grant. She drafted a scope of work and budget for the SGV accounting firm in Manila shown in Attachment C; Ms. Evie Reyes, formerly of PRICOR, will assist in the logistical arrangements. The timetable and the composition for the teams to undertake the fieldwork is shown in Attachment D. These preparations were reviewed with Dr. Sergio Pieche, WHO medical officer, Philippines and DR. Juanita Basilio, MCH/DOH. Also they will be shared with WHO/ Geneva; the WHO office in Geneva will serve as the contact point for correspondence regarding any changes in the study protocol or logistical arrangements.

Finally, Dr. Dayrit suggested that after Part B has been completed that a consultative meeting be organized in order to prioritize the study's recommendations and to plan necessary follow-up activities. This meeting is tentatively scheduled for February 11, 1992.

Philippines National CDD Training Evaluation Study

**PRELIMINARY RESULTS OF PART-A
PHILIPPINES DTU TRAINING EVALUATION**

August 30 - September 13, 1991

Submitted to: NCDDP/Philippines DOH

**by: Dr. Larry Casazza, PRITECH
Dr. Jeanne Newman, PRICOR/Quality Assurance
Dr. Tarja Rautanen, Consultant**

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PHILIPPINES DTU TRAINING STUDY REPORT-PART A-1991

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PRELIMINARY RESULTS OF PART A PHILIPPINES DTU TRAINING EVALUATION

1. INTRODUCTION

1.1. Case management training on diarrhoeal diseases in the Philippines

The national CDD programme of the Philippines (NCDDP) was formally initiated by the Department of Health in 1980. A joint Comprehensive Review of the Philippine CDD Programme conducted in 1985 uncovered considerable resistance on the part of medical professionals to promote oral rehydration therapy. To address this problem, the NCDDP decided to initiate hands-on training of medical professionals in diarrheal case management following the training guidelines and materials prepared by WHO.

The first Diarrhoea Training Unit (DTU) was established in San Lazaro Hospital, Manila, in 1985 (currently known as the National Rehydration, Treatment and Training Center or NRTTC). Two additional subnational units were established in 1986 in Cebu and in 1988 in Zamboanga. In 1990, the first regional DTU opened in Tacloban and during 1991, six additional regional DTUs will conduct their first training courses. All these units are expected to conduct training courses giving updated technical information on diarrhoeal diseases and more importantly, to expose participants to hands-on experience of treating cases of diarrhoea with oral rehydration therapy.

During the joint CDD comprehensive desk review conducted in 1990, it was estimated that only 10% of the target audience of physicians and nurses had been trained in these units. In order to be able to train more people, NCDDP has taken the initiative to establish the additional six regional DTUs mentioned above.

Since training began in 1985, the NCDDP has carried out regular monitoring visits and has conducted several provincial programme reviews. These evaluation activities have identified some constraints to the implementation of skills by trainees after training. This has led to questions regarding the quality and effectiveness of training as well as weaknesses in supervision and follow-up to trainees. To find answers to these questions, the Department of Health of the Philippines decided to conduct an evaluation of case management training and early in 1990 requested PRITECH technical assistance with this exercise.

1.2 History of the development of the Study

In order to undertake a comprehensive evaluation of its CDD training efforts, the NCDDP in consultation with technical staff from WHO/CDD in Geneva and PRITECH/Washington requested that a detailed study of its DTU-based training as well as the subsequent performance of the trainees be conducted. The original date for this task was set for 1990, but the diarrheal season had passed by the time arrangements could be finalized. July, 1991 was the next scheduled date for the study.

As this date approached, it became clear that more detailed planning was needed in order to finalize the methodology to be used in the study. As a result, a meeting was held in Geneva in May, 1991 that combined the efforts of WHO/CDD, PRITECH and PRICOR/Quality Assurance projects to develop this design. The participants were Drs. Mariam Claeson and Susan Zimicki, WHO/CDD; Drs. Scott Endsley and Larry Casazza, PRITECH; and Dr. Jeanne Newman, PRICOR/Quality Assurance Project. Close liaison with the NCDDP was maintained through Dr. Sergio Pieche, WHO Medical Officer, CDD-ARI/Philippines.

But the eruption of Mount Pinatubo caused another postponement of the study. Finally in late July, 1991, Drs. Mariam Claeson, WHO/Geneva and Dr. Larry Casazza, PRITECH, visited Manila to finalize the draft protocol with the MOH and the study's budget and logistics requirements. At that time it was agreed that the study would be carried out in two parts; the first, scheduled for September, 1991 would assess two on-going DTU courses and the second, to take place in January, 1992 would follow-up health workers' performance in the field.

1.3 Goals and objectives of the overall study

The study is a collaborative effort undertaken by the DOH, WHO, PRITECH and PRICOR/Quality Assurance projects. The goals for the evaluation of CDD case management training are:

1. To assess the quality of DTU courses;
2. To assess the ability of DTU trainees to apply knowledge and skills at the end of the courses;
3. To assess the strengths and weaknesses in the performance of DTU trainees after the training; to identify other key programme related determinants of quality of performance beyond training.

It is envisioned that the data from the evaluation will be used by the NCDDP of MCH/DOH to:

- strengthen the training activities; and
- implement other activities to maximize the benefits of training on case management of diarrhoea at health facilities.

Furthermore, it is expected that this evaluation will provide lessons learned in CDD which may be applied to CDD training in other countries and to the training in other MCH/PHC programmes, for example, ARI.

The evaluation will consist of two parts with the following objectives:

Part-A - Evaluation of DTU training

1. To observe and systematically assess the quality of case management training at DTUs.
2. To assess the ability of trainees to apply new knowledge and skills at the end of the course.

Part-B - Evaluation of trained health workers performance

1. To assess the performance of DTU trainees using a simplification of the Health Facility Survey, identifying factors other than the quality of training that influence their performance.

2. STUDY - PART-A

2.1 General description of the study design - Part-A

In the July, 1991 meeting with Dra. Dayrit, Director of MCH services, it was decided that two teams of three persons each would directly observe DTU training courses at two DTUs: the NRTTC at San Lazaro, Manila and the Southern Islands Medical Center (SIMC) in Cebu from September 2-6, 1991. In addition to evaluating the quality of the training, the teams would also assess the ability of the trainees to apply their skills and knowledge at the end of the training.

Two days prior to the initiation of the respective courses, a day-long briefing was held for the DTU directors and facilitators in order to introduce them to the teams' activities and to train persons (facilitators) who would be involved in conducting the post- training skills testing on the last day of the course. Data analysis would directly follow the DTU training and feedback of preliminary Part-A results would be given to MCH/CDD staff within a week of the course observations.

2.2 Description of the study methodology

The ultimate test of the effectiveness of a training course is the performance of the trainees when they have returned to their home facilities; Part-B of the study is designed to make such an assessment. However, because many other factors influence health worker

performance in the field, in order to interpret the findings from Part-B it is important to assess the level of participant knowledge and skills at the completion of the training course, relating this both to the level of knowledge they brought with them to the course, and key characteristics of the course itself. This is the objective of Part-A of the study. Accordingly, each of the participants and facilitators was asked to take part in a series of activities designed to capture selected aspects of the participants' knowledge, both before and after the training program, and their skills in applying that knowledge after the course.

These activities included a written pre- and post test of knowledge, post-course evaluation by the facilitators of the skills of each individual participant, and a post-course series of timed, structured case simulations, each designed to assess a different and important task the health worker should be able to perform rapidly and correctly at the end of the course.

At the same time, systematic observations of the course itself were made, both of content and teaching methodology; structured observations were made of each of the lectures, classroom exercises, practical sessions, case presentations, and sessions to develop and present participant plans to improve case management at their own facilities.

Finally, each participant was asked to evaluate the course, overall and for specific components. Copies of all forms appear in Annex 1.

Scoring for evaluation of the individual participants was designed to permit separate analysis of participant knowledge and performance in the three major skill areas of case management: assessment, treatment, and counseling. Scoring for the quality of the individual course components addressed both content and methodology, where feasible. Although some of the items scored required a considerable degree of subjectivity, objective indicators were employed in so far as possible. Criteria of acceptable performance were established by the two teams in consultation. These appear on the forms in Annex 1. Analyses at this time have been limited to frequency distributions, grouped by major skill areas. Additional analyses are anticipated prior to undertaking Part-B of the study.

2.3 SIMC DTU course

2.3.1 Introduction

The SIMC located in Cebu is the focal point for much clinical basic training as well as continuing education programs for physicians, nurses and public health officers in the Visayas. Its support of CDD case management training (CMT) is obvious in the enthusiastic efforts of the DTU director, Dra. Pat Angos and her staff.

After a gap in 1990, the SIMC-DTU started to conduct CMT courses again in 1991. Dra. Angos agreed to schedule this course to coincide with the evaluation even though the peak diarrheal season had passed. It was hoped that sufficient cases might still present themselves due to the somewhat prolonged rainy season observed this year. As it was, this

was not the case and only eight cases were available for hands-on experience during the week-long course.

2.3.2 General course description

In Cebu, the DTU-CMT course is characteristically a five-day exercise which starts at 8:00 AM each morning and runs until 10:00 PM on the second, third and fourth days; no evening session is scheduled for days one and five. It accommodates up to fifteen participants who relate directly to the Director and the three DTU facilitators for all lecture presentations and monitoring of their performance. This faculty function as full-time DTU staff only during an actual course and is fully integrated into the Department of Pediatrics. The DTU faculty members are not involved in candidate selection nor do they have any follow-up contact with the participants after the course.

The actual physical arrangements for running the course at SIMC are less than ideal. The diagram shown in Annex 2 depicts the complex dynamics of patient flow for diarrheal cases coming to the hospital. This makes it difficult to monitor all sites that might contribute diarrheal cases to the course. The training conference room itself was crowded but air-conditioned. It is equipped with all the necessary A-V equipment including video but lacks any training films or tapes.

There has been a long-standing but unsuccessful effort to get the hospital to provide food to diarrheal patients during their stay (up to twelve hours for Plan-B cases). Only cases fully admitted to the hospital get food. Mothers do not routinely receive health education materials and any needed IV solutions, set-ups or medications must be purchased on the outside and brought into the hospital for the patient's care.

In theory, the DTU course outline as shown in Annex 3(a) is designed to have approximately 55% of the participants' time spent in actual case management practice. But because of the few cases seen (eight cases in total: four with no dehydration, four with some dehydration, one with dysentery and none with severe dehydration), only about 23% of the time was spent in working up patients and during those time periods not all of the six teams had cases to manage.

This course enrolled thirteen participants listed in Annex 3(b), including one observer. But one physician dropped out on Day Two due to a personal emergency. As seen in the agenda, the first day is almost exclusively devoted to lectures (eight in all with an additional six more scattered throughout the week). All the topics listed in the WHO guidelines are adequately covered and in addition, lectures on breastfeeding, growth monitoring, and communication skills are included.

The faculty attempted to compensate for the lack of clinical cases with detailed presentations of the few cases seen, as well as with exercise activities in order to drill on subject matter not seen on the wards directly.

2.3.2 Course evaluation results

Using the questionnaires shown in Annex 1, the three observers assigned to SIMC evaluated the lectures, exercises, case presentations and practices, and the planning session for their "quality". For the most part, the lectures were well presented and deemed to be "acceptable" for content. All were evaluated for method and six of the 13 lectures were found to be "unacceptable" because they did not allow for any discussion and were not conducive to stimulating questions or participation on the part of the participants. The volume of material covered on Day One especially was probably overwhelming to most of the participants. Furthermore, the tight schedule including the heavy evening agenda left them with insufficient time to digest all the information.

All of the practical sessions (only six of a total eight were observed) were evaluated as acceptable as were all ten of the exercises used during the course. The faculty often resorted to using exercises in lieu of practical sessions when no cases were available. They are to be commended for their resourcefulness in exploiting the actual case presentations to their fullest, as well as their ability to adroitly improvise with the exercises in the WHO materials.

The procedure used in making the formal case presentations could be modified from the current practice of keeping the entire class waiting while the presenter writes the pertinent data on the blackboard. The presentations themselves were all graded as acceptable.

Finally, the instructions for the planning session were clearly given to the group the day before the exercise. Seven groups reported with one member of each group serving as the spokesperson. While the attention of the facilitators and the class was obviously keener for the first few presentations, the participants did find the exchange useful.

2.3.3 Evaluation of trainees' knowledge and skills

Comparison of the pre- and post-test scores from the participants demonstrated improvement in their knowledge of the etiology and epidemiology of diarrheal disease and the principles of case management and diarrhea prevention. But the faculty at SIMC still uses the test supplied in the original WHO guidelines which contains some wording that confused many participants. The revised test eliminates this problem considerably.

Generally speaking, those participants with the poorer scores in the pre-test showed the greatest improvement in the post-test. But all participants, even the high scorers, showed improvement in their knowledge of diarrhea prevention and the principles of clinical management.

The case simulations revealed that indeed the participants' case assessment and treatment skills were surprisingly weak. Even the most straightforward Plan-B and Plan-C cases were missed by some of the trainees. Likewise, the performance of the counseling skills was

weak with 17% and 42% scoring in the acceptable range on the two simulations which tested that skill. None of the participating "mothers" and facilitators seemed to have trouble presenting the simulations in the local dialect; only one person felt that the time was too short to handle the exercise.

2.3.4 The participants' evaluation of the course

As the participants were about to depart, they were asked to complete the course evaluation. Their responses indicated that some of them did not completely understand the questions being asked and to some degree this limited the value of the exercise. Nonetheless, they pointed out that the course lacked sufficient practical experience and that the tight schedule did not provide enough time to read the course materials. In general, the lectures scored very highly except for the one on etiology and epidemiology of diarrhea. However, 50% felt that the course was too short in relation to the amount of material it attempted to cover.

2.4 San Lazaro DTU course

2.4.1 General description of the DTU

The San Lazaro DTU was established in 1985 and has conducted 28 courses until now, including three intercountry courses. The physical set-up of the unit is optimal, having separate triage-area, ORT-area and diarrhoea ward, all closely connected. The DTU has a full-time director and sufficient staff. Supplies and equipment for treatment and training are adequate (refer to checklist F in Annex 1), however, the facilities in the trainees' dormitory are not optimal (no running water). During training courses, meals for the participants are provided by an outside caterer. The patients receive three meals in the DTU (breakfast, lunch and dinner) regardless of if they are admitted or just staying at the ORT-unit.

2.4.2 General description of the course

The course was a five-day, live-in course. The course schedule was adapted from the WHO DTU Teaching materials and is attached as Annex 4. The schedule was followed during the course, with minor flexible adaptation due to patient flow. 40% of the time was assigned for clinical practice and additional time for case presentations. The participants had practical work usually from 10:00 am to 3:00 or 4:00 pm and again from 5:00 pm to 10:00 pm. This allowed the participants to see enough cases: 54 cases, out of which 31 had signs of dehydration (28 with some dehydration and three with severe dehydration).

The course had 15 participants and three facilitators, list attached as Annex 5. Participants were divided into eight teams, two participants in each team (one "team" had only one

participant). Each new case was assigned for one team, which assessed, treated and followed-up the case throughout the management. Participants used a case record form adapted from WHO DTU Teaching materials (see Annex 6).

The course had nine lectures, six of them as outlined in the WHO DTU Teaching materials and three additional ones: "Sharing of experience", "Setting-up of ORT units" and a "Health teaching session". Four out of the nine lectures were given by the DTU staff and 5 by outside resource persons. These resource persons had not attended facilitators' training.

Besides lectures and practical work, the third important component of the course was the preparation of action plans for improving current case management practices in trainees' own hospitals and drawing of floor plans for possible ORT units in these hospitals. Each hospital presented its plans to other members of the course.

During the course, the WHO revised case management chart was used as reference material. Also, other materials were distributed as shown in Annex 7. At the end of the course, participants received some key supplies for starting an ORT unit (see Annex 8).

2.4.3. Course evaluation results

I. Observers' evaluation of quality of training

a) Lectures

The quality of lectures seemed to be the weaker component of the course at San Lazaro. Only five out of the nine lectures (three out of the six lectures outlined in WHO DTU teaching materials) could be scored as acceptable when evaluating the contents of the lectures. The main reasons for a lecture to be scored as unacceptable were that the objectives for the session were not covered, the lecture did not satisfactorily cover the items included in the WHO DTU teaching materials or that these gaps were not brought up during the discussion by other faculty members. The outside resource persons who were responsible for five lectures, were not well aware of the objectives of the course. These resource persons were not clinicians and so not very familiar with the practical problems faced by the participants. In the future, it might be safer to use DTU staff in giving lectures or only resource persons who have attended facilitators' training.

When looking at the methodology used in presenting lectures, six out of the nine lectures scored acceptable. Reasons for failing were either unclear speaking, poor quality slides, overheads or other teaching aids, or failure to keep up audience's interest. When starting the lecture, the lecturers did not usually present the objectives for the session (only one lecturer did so).

b) Practical work

The practical work was the strongest component of the San Lazaro course and was well conducted. The number of cases was adequate (54) and facilitator-participant ratio was adequate. Although the case load was heavy, distribution of patients to participants was handled smoothly and facilitators monitored their cases and trainees closely. The attitude of the whole DTU staff was positive towards training.

Treatment practices were good. No antidiarrhoeal, unnecessary antibiotic nor unnecessary IV-use was noticed during the evaluation. Three severely dehydrated cases were seen during the course and they were switched to ORT within three - six hours and IV-lines were removed within six hours.

Patients receive food free of charge three times a day in the unit, both in the ward and in the outpatient unit.

Ten out of the 13 practical sessions observed were scored as acceptable (one session meaning one two-hour observation with one facilitator), for details in scoring, see evaluation forms in Annex 1. One session could not be scored as there were no patients during that two-hour period. The reason for failing was facilitator's inability to give feedback after participants had counseled the mothers.

In general, the counseling was the weakest component of the practical work. The trainees were well guided on assessment and treatment but they were not requested to demonstrate ORS preparation to the mothers, nor to use the health education flip chart available in the ORT-unit when talking to mothers. This is reflected in the case simulations as poor performance when asked to counsel the mothers. Especially, more emphasis should be put on the nutritional management of diarrhoea at home, use of home fluids and importance of breastfeeding.

c) Case presentations

In general, the case presentation sessions were conducted well. Participants presented their own cases with the help of transparencies and overhead projector. They presented information concerning history, assessment of degree of dehydration, selection of treatment, follow-up and outcome. Respective facilitators and the audience commented. Discussion was always lively during these sessions.

The observers felt that this was a good way to handle the sessions. Not too much time was spent on explaining and on writing facts on the whiteboard as they were already written down on the transparencies.

Two out of the three sessions observed were scored acceptable. The third session failed as one facilitator gave inaccurate feedback. The feedback given concerning breastfeeding during diarrhoea was not in line with the revised WHO treatment chart.

d) Planning exercise

This exercise was conducted in three parts. On the third day, one facilitator gave a presentation on how to set up ORT units, after which participants were asked to form teams according to the hospitals they were representing, and to prepare a floor plan for a possible ORT unit in their hospital. After 20 minutes each hospital was requested to present their plan by drawing it on the whiteboard. After each presentation, the facilitator and audience gave comments. Discussion was lively.

On the fourth day, participants were given a format to prepare a 90-day action plan on how to improve the current case management practices in their hospitals (format attached as Annex 9). On the fifth day, each hospital was again asked to present their plan with comments from the facilitator and from the audience. Presentations were given with the help of transparencies and overhead projector. Although these steps were quite time-consuming, the observers felt that the exercise was helpful and practical.

Copies of the plans of action were taken by the DTU faculty. One will be sent to the participant's hospital director together with Department Circular No. 88, that urges doctors and hospitals to promote ORT. One copy was also given to the NCDDP, to be used during future monitoring visits.

The procedure of sending one copy of the action plan to trainee's hospital director can be essential to support participant's future efforts in establishing ORT units and improving case management practices. The effects of this procedure should be thoroughly evaluated during the second phase of the evaluation.

e) Other training activities

Five videotapes and two films were shown during the training course, usually during the morning practical session while participants were for waiting new cases to come (list of films attached as Annex 10). The films were of acceptable quality and contents satisfactory. However, the method of showing the films was unacceptable. The facilitator did not stay in the room during the show and was usually not available when the film ended, not allowing trainees to ask questions or give comments concerning the films.

II. Evaluation of trainees' knowledge and skills acquired

When comparing results from the pre- and post-tests, all the participants improved their knowledge, the best improvements being made in questions concerning assessment of dehydration, treatment of diarrhea, and prevention of diarrhea. These results may reflect

the positive effect of sufficient experience gained during the course. The mean number of wrong answers decreased from 16.7 in the pre-test to 8.2 in the post-test (51% reduction).

According to the case simulations, NRTTC participants acquired good skills in assessment and treatment: 100% of the participants assessed dehydration correctly (three different cases), 100% treated Plan-B and -C cases correctly (two different cases), and 40% to 93% treated complicated cases correctly (three cases). Refer to Table 1 for the results. However, none demonstrated acceptable performance in counseling. This reflects the less active health education component in the NRTTC course.

III. Participants' evaluation of the course

The participants were asked to fill up a self-evaluation form on their clinical skills and on the entire course. Concerning clinical skills each participant was able to assess and select treatment for five - nine patients: administer ORS to three - seven patients and teach mother how to treat diarrhoea at home in four - eight cases. 100% of the participants felt confident in managing plan A cases and 87% felt confident in managing Plan-B and C cases. Participants were fairly satisfied to the contents of the course and to the time spent on different activities. The actual results from these evaluation forms and special recommendations made by the participants can be seen in Annex 11.

3. DISCUSSION OF PART-A STUDY RESULTS

3.1 Comparative strengths and weaknesses of the respective courses

The two courses observed appear to have had interesting characteristics which rendered them distinct from one another; both had their strengths and weaknesses. Their major difference was the number of diarrheal cases seen during the practicum (54 in NRTTC compared to eight in SIMC). The simulation testing would indicate that the participants in NRTTC had better skills in assessment and management of diarrhea at the end of the course due to practical experience. It appears that it is difficult to replace the experience and confidence gained in actually managing cases with any other training method.

However, the faculty in Cebu was very resourceful in trying to find methods to replace the lack of patients. Case drills from the supervisory skills course, exercises in growth monitoring, and the role plays in counseling were used to increase case management skills.

The lectures in SIMC were comprehensive and of high quality. Besides the six lectures in WHO DTU teaching materials, there were eight other lectures given. This led to a very tight schedule including the need for evening sessions and resulted in fatigue for the participants and might have reduced the effectiveness of otherwise good lectures.

The NRTTC training course did not put special emphasis on health education practices. Counseling was not practiced through role plays during the course and when given during the practice, was hardly ever using demonstration or return demonstration. During the second phases of the evaluation (Part-B of the study), efforts will be made to determine the importance of these differences in the two training courses and their effect on later performance of the trainees.

3.2 Team assessment of the methodology used for this evaluation

The evaluation of both the post-course knowledge and skills of the participants, and the content and teaching methods of the training course itself, have provided information that should be of considerable value to the DTU faculty in both institutions and to the CDD program in planning for future DTU courses. At the same time, it has provided a base against which it should be possible to measure subsequent participant performance in the field.

Disaggregation of the results from the pre- and post-tests of knowledge has helped identify specific areas of strength and weakness, and highlighted topics that may need to be given further attention during the course. Such disaggregation is recommended, and an appropriate tally form should be developed to aid in this task. Use of the newer version of the test form would clear up some of the problems that Cebu participants were experiencing, and is recommended.

Because there had been no opportunity to pre-test and adapt the case simulations prior to this exercise, a number of changes have been suggested in the details of specific cases. Differences in the experience of Cebu and Manila with some of the cases, however, highlight the need for careful selection of those who will play the part of the 'mother' in the simulations, and of careful preparation and rehearsal of both facilitator and 'mother'. The Cebu experience suggests that the use of the local language is important, particularly in those cases where effective counseling is the major objective. The format of the instructions to both observer and "mother" will need to be revised for greater clarity.

However, it is clear, both from participant and facilitator comments, and from evaluator observation, that these simulations revealed deficiencies in participant knowledge and skills that were not as clear in the written examinations or the facilitators' cumulative assessments. This was particularly true in Cebu where the facilitators had had less opportunity to observe the participants with cases on the wards, and were surprised to see some of the problems the participants were having during the simulations in all three major skill areas: assessment, treatment, and counseling.

3.3 Follow-on activities planned for Part-B

During this visit, arrangements to administer the funding for Part-B of the study were made by Ms. Danielle Grant, Administrative Officer, PRITECH/Washington. The SGV

accounting firm will handle the account and Ms. Evie Reyes will assist in the logistic arrangements. The timetable for the activities and the composition of the teams to undertake the field work are shown in Annex 12. Likewise, these preparations were reviewed with Dr.Sergio Pieche, WHO Medical Officer, Philippines and Dra. Juanita Basilio, MCH/DOH. In addition, they will be shared with WHO/Geneva; the WHO office in Geneva will serve as the contact point for correspondence regarding any changes in the study protocol or logistical arrangements.

As noted in the Annex, Dra. Dayrit suggested that after Part-B has been completed, a consultative meeting be organized in order to prioritize the study recommendations and to plan follow-up action. This meeting is tentatively scheduled for February 7, 1991. It will involve the NCDDP staff at central and regional levels, the DTU trainers and others related to the training and follow-up of case management activities. PRITECH will not fund this activity but will gladly participate in it.

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Above annexes available from PRITECH Information Center

ANNEX I

DTU Course Data Form/Checklist

B. OBSPRAC

COURSE OBSERVER'S CHECKLIST
PRACTICAL SESSION

Participants: _____
 SESSION: _____ Facilitator: _____
 TIME: Beginning: _____ Ending: _____
 NUMBER OF PARTICIPANTS: _____ NUMBER OF TEAMS: _____
 RATIO: Instructor/Participant: _____ RATIO: Instructor/Team: _____

1. Was instructor/facilitator available at least 100% of the time? Y N

2. Did facilitator provide specific** feedback:
 - 2.1 after participants assess and treat? Y N
 - 2.2 after participants talk with mothers? Y N

If yes to either, given an example:

 - 2.3 Was the feedback provided accurate? Y N
 - 2.4 Did facilitator provide feedback in a clear and constructive manner? Y N

3. Number of participants who assess and treat at least one case _____

4. Number of participants who assess and treat at least one case, with:
 - 4.1 no signs of dehydration _____
 - 4.2 some signs of dehydration _____
 - 4.3 severe dehydration _____
 - 4.4 other problems _____

5. Number of participants who practice talking with mothers _____

6. Did participants periodically monitor patients who are on Treatment Plan B and C? Y N

7. Observer's overall assessment: was the quality of the session acceptable (answers to questions 1, 2, and 6 are 'Yes')? Y N

** 'specific feedback' - feedback addresses specific strengths and deficiencies in participant's performance as observed by instructor/facilitator

C,1 ORSPRES

COURSE OBSERVER'S CHECKLIST
CASE PRESENTATION SESSION

SESSION: _____ Facilitator: _____

PLACE: Classroom ___ Ward ___ Participants: _____

TIME: Beginning: _____ Ending : _____

NUMBER OF PARTICIPANTS: _____ NUMBER OF TEAMS: _____

1. Number of participants who make at least one case presentation _____
2. Are actual cases presented? N
3. Did facilitator provide specific** feedback to participants:
 - 3.1 about each case presented? Y N
 - If yes, given an example:
 - 3.2 Was the feedback provided accurate? Y N
 - 3.3 Did facilitator provide feedback in a clear and constructive manner? Y N
4. Observer's overall assessment: was the quality of the feedback acceptable (answers to questions 3.1-3.3 are 'Yes')? Y N

** 'specific feedback' - feedback addressing specific strengths and deficiencies in participant's performance as observed by instructor/facilitator

C.2 OBSERVEX

COURSE OBSERVER'S CHECKLIST
EXERCISE/DEMONSTRATION/RULE PLAY

SESSION: _____ Facilitator: _____

TIME: Beginning: _____ Ending: _____

NUMBER OF PARTICIPANTS: _____

1. Exercise format: (check all that apply)
 - 1.1 individual
 - 1.2 group
 - 1.3 written
 - 1.4 role play, demonstration, presentation (circle one)
2. Did facilitator provide clear directions? Y N
3. Was facilitator available for questions during the exercise? Y N
4. Were necessary materials available to all? Y N
5. Did all trainees participate in the exercise? Y N
6. Were most of the participants able to complete the exercise in the time allowed? Y N NO
7. Did facilitator provide specific* feedback:
 - 7.1 Related to the exercise? Y N
If yes, give examples: _____
 - 7.2. Was the feedback provided accurate? Y N
 - 7.3 Did facilitator provide feedback in a clear and constructive manner? Y N
8. Observer's overall assessment: was quality of the session acceptable (5 or more "yes" answers to questions 2 through 7.3)? Y N

*specific feedback - feedback addressing specific strengths and deficiencies in participant's performance as observed by instructor/facilitator

D. OBSPLAN

COURSE OBSERVER'S CHECKLIST
PLANNING SESSION

SESSION: _____ Facilitator: _____

TIME: Beginning: _____ Ending: _____

NUMBER OF PARTICIPANTS: _____ NUMBER OF TEAMS: _____

- 1. Instructions:
 - 1.1 Were clear instructions given to participants about how to develop and present their plans to improve current practices in their own CDD facilities? Y N
 - 1.2 Did these instructions incorporate the WHO DTU guidelines on improving current practices? Y N
- 2. Does each participant or group draw a floor plan? Y N
- 3. Does each participant or group prepare a plan of action? Y N
- 4. Does each participant or group receive specific** feedback:
 - 4.1 on their plan of action from DTU faculty? Y N
If yes, give an example:
 - 4.2 Was the feedback accurate? Y N
 - 4.3 Did facilitator provide feedback in a clear and constructive manner? Y N
- 5. Observer's overall assessment: was the quality of the session acceptable (answers to questions 1 and 4 are 'Yes')? Y N

* obtain copies for review and future evaluation

** 'specific feedback' = feedback addressing specific strengths and deficiencies in participant's performance as observed by instructor/facilitator

E.2 OBSERVE COURSE OBSERVER'S CHECKLIST
LECTURE

SESSION _____ FACILITATOR: _____

TIME: Session- Beginning: _____ Ending: _____ Total: _____
Discussion, etc.(other than lecture) Total: _____

TEACHING METHOD(S): (Tick all that apply)
 Lecture Practice Video/film
 Q/A Reading
 Group work Role-play
 Discussion Case study
 Demonstration Tour of facility

1. OBJECTIVES presented at the beginning? Y N
Covered?
- 2.1 Objectives for the session (list): Yes No

- 2.2 Were ~~all~~ objectives covered? Y N
3. Number of participants attending: / / Not attending: /
4. Does the instructor speak clearly and loudly? Y N
5. Are slides/overheads clearly visible/legible to all? Y N
6. Is adequate time for discussion provided? Y N
7. Do participants ask questions and/or make comments? Y N
8. How many participants come late (after the lecture started)? /
9. How many participants are ~~not~~ concentrated on the lecture (sleeping, talking, or reading something different from the topic)? Y-N /
10. Is the content of the lecture satisfactorily covered (i.e. according to the WHO DTU guidelines)? Y N
11. If no, describe differences, gaps:

12. Were gaps satisfactorily addressed, either by the lecturer or other DTU faculty, during the session? Y N

13. Observer's overall assessment:

(If 'Yes' answers to questions 2, 4, 5, 6, 10, 12, AND at least 2 of questions 1, 7, and 9) Superior

(If 'Yes' answers to questions 2, 4, 5, 6, 10, 12) Acceptable

(Otherwise) Not acceptable

* Other comments: (e.g., on how the material is presented - with enthusiasm, convincing, boring, etc.)

13. Observer's overall assessment:

	<u>Content</u> **	<u>Method</u> ***
Acceptable	<u> </u>	<u> </u>
Not acceptable	<u> </u>	<u> </u>

** Content
Acceptable if 'Yes' to questions 2, 2 and 10 or, if 'No' to question 10, then 'Yes' to question 12.

*** Method
Acceptable if 'Yes' to questions 4, 5, 6 and 9.

F. DTU Administration and physical arrangements

(Source of information: Interview confirmed by observation. Indicate if data collected by interview (I) and/or observation (O) next to the number of each question)

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------|---|---|
| 44. Is the DTU facility adequately arranged according to WHO DTU guidelines?
(Triage, ORT corner for caretakers, diarrhoea ward) | Y | N |
| 45. Is the classroom adequate, with comfortable seating? | Y | N |
| 46. Is audio-visual equipment available and functioning? | Y | N |
| 47. Is the average number of dehydrated patients seen in a 5 day period: 30 or more? | Y | N |
| 48. Is the DTU adequately* supplied | | |
| a. at the reception/triage area | Y | N |
| b. at the ORT area | Y | N |
| c. at the Diarrhoea Ward | Y | N |
| d. for training | Y | N |
| 49. Is feeding provided to patients as a regular part of treatment?
If yes, describe (regular, on demand, food demonstration etc) | Y | N |
| 50. Are cases with other problems and complications seen and treated? | | |
| a. at the DTU | Y | N |
| b. referred | Y | N |
| If referred, where? | | |
| 51. Does the DTU have a full time manager? | Y | N |
| 52. Does the DTU have a trained director/manager available during training? (trained- in the WHO case management training) | Y | N |
| 53. Does the DTU have adequate nursing staff? | Y | N |
| 54. Is the DTU staff involved in the practical training and in monitoring the participants? | Y | N |
| 55. Do staff give constructive feed-back/ encourage participation? | Y | N |
| 56. Do staff demonstrate a positive attitude towards teaching and towards diarrhoea case management? | Y | N |
- If no to any of questions 51-56, please describe:

*Adequately - according to "Supplies for the Diarrhoea Training Unit, Annex A" copy attached from DTU Director's Guide

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Supplies For The Diarrhoea Training Unit

Supplies for the Reception and Triage Area

- White coats for all participants
- Wall chart on diarrhoea treatment
- Mother's Cards, other health education pamphlets, and other materials for families on prevention and management of diarrhoea, including feeding
- Posters on preparation of ORS solution, home therapy fluid, diarrhoea prevention, etc.
- Forms for record keeping
- ORS packets of the standard size in the area (for demonstrating to mothers)
- Jars and flasks (commonly available sizes and one marked with volume measurements)
- Glasses, cups and spoons

Supplies for the ORT Area

- ORS packets for 5, 10 or 20 litres
- 5, 10 or 20 litre drum with cover and side tap
- ORS packets of the standard size in the area (for demonstrating to mothers)
- Jars and flasks (commonly available sizes and one marked with volume measurements)
- Antibiotics (such as tetracycline capsules) and a suitable antibiotic for dysentery
- Mother's Cards, other health education pamphlets, and other materials for families on prevention and management of diarrhoea, including feeding
- Posters on preparation of ORS solution, home therapy fluid, diarrhoea prevention, etc.
- Baby scales (accurate to 20 grams)
- Thermometers

- 24'

-
- Glasses, cups and spoons
 - Feeding bottles
 - Cotton
 - Gauze
 - Milk powder
 - Towels and other linens
 - Storage cabinet or shelves
 - Forms for record keeping
 - Droppers
 - Syringes
 - Soap
 - Diapers
 - Waste basket/bucket
 - Wash basin and towel rack

Supplies for the Diarrhoea Ward

- Beds or tables with wires above for hanging bottles of IV fluid
- Lactated Ringer with giving sets
- Scalp vein (butterfly) needles
- Antibiotics, such as tetracycline capsules, and a suitable antibiotic for dysentery
- Glucose for injection (20%) - 50ml ampules x 10
- Baby scales (accurate to 20 grams)
- Nasogastric tubes
- Thermometer
- Droppers
- Empty bottles
- Feeding bottles
- Milk powder
- Soap
- Forms for record keeping
- Cupboard
- Syringes and needles
- Alcohol, cotton, gauze
- Glasses, cups and spoons
- One litre and 1/2 litre flasks
- Towels and other linens
- Diapers
- Desk and chair for the nurse
- Tray or cart for supplies
- Waste basket/bucket

ANNEX 1
Pg. 11

- Bedside stools for attending mothers
- All the supplies required for administering ORS
- Health education materials for families and posters

Supplies and Equipment for Training

- 35 mm slide projector and slide sets
- Flip charts and felt pens
- Photocopying machine and supplies
- Automatic stencil cutting and duplicating machine with supplies
- Overhead projector, transparent paper and felt pens
- Film projector and training films
- Other items needed to carry out the training design, such as case record forms
- Paper and pens for participants
- File of additional reference materials for participants to consult

Supplies and Equipment for the Pharmacy

For dry packing 5, 10 or 20 litre packets for hospital use:

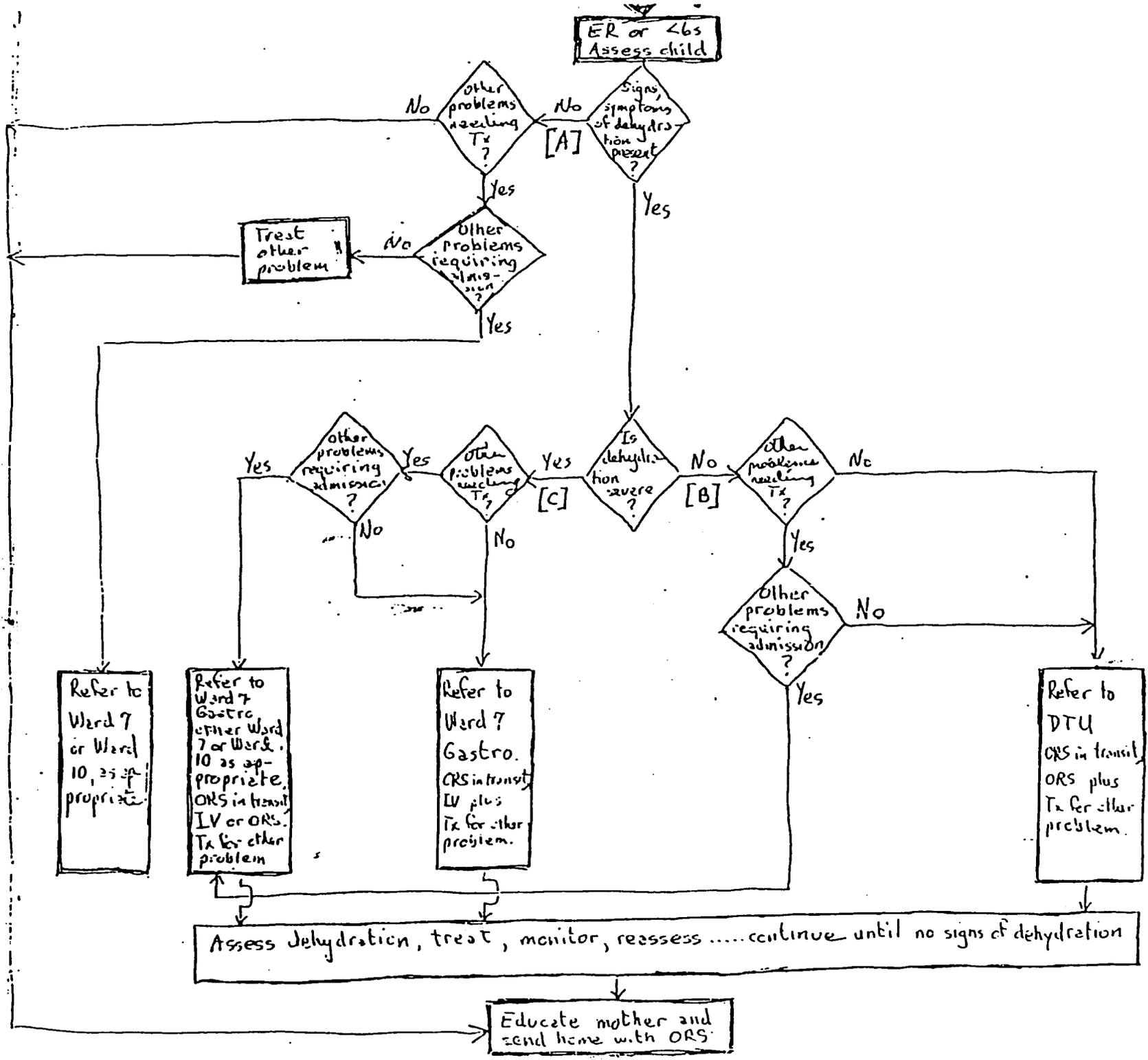
- Stock for 5000 litres

Sodium chloride	17,5 Kg
Trisodium citrate, dihydrate	14,5 Kg
Potassium chloride	7,5 Kg
Glucose	100 Kg

- Polyethylene packaging material and labels
- Sealing apparatus

ANNEX 2

Diarrhea Patient Routing at SIMC



ANNEX 2

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ANNEX 3(a)

DTU Course Schedule

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
6:00-6:30	• REGISTRATION				
8:30-9:00	• OPENING / ORIENTATION	• ETIOLOGY/EPIDEMIOLOGY OF DIARRHEA DRUGS/DYSENTERY (1 Hr)	• SHORT EXAM & DISCUSSION (30 mins.)	• CASE PRESENTATION (30 mins.)	• CASE PRESENTATION (30 mins.)
9:00-9:30		• ACTUAL PRACTICE	• CASE PRESENTATION (30 mins.)	• OTHER PREVENTIVE STRATEGIES (30 mins.)	• LONG EXAM & DISCUSSION (30 mins.)
9:30-10:00	• TOUR OF DTU		• BREASTFEEDING DIFFICULTIES, COUNSELLING MOTHERS: EXERCISE/ROLE PLAY (50 mins.)	• ACTUAL PRACTICE	• ACTUAL PRACTICE
10:00-10:15	MID-MORNING BREAK				
10:15-10:30	• NORMAL GUT PHYSIOLOGY (20 mins.)				
10:30-11:00	• PATHOGENESIS OF ACUTE DIARRHEAS (25 mins.)	ACTUAL PRACTICE	ACTUAL PRACTICE	ACTUAL PRACTICE	ACTUAL PRACTICE
11:00-11:30	• PRINCIPLES OF CLINICAL MANAGEMENT OF ACUTE DIARRHEA (45 mins)				
11:30-12:00					
12:00-1:00	LUNCH BREAK				
1:00-1:30	• DIARRHEA & MALNUTRITION INTERACTION (30 mins.)	• CASE PRESENTATION (30 mins.)	• CASE PRESENTATION (30 mins.)	• CASE PRESENTATION (30 mins.)	• PRESENTATION OF ACTION PLAN & RECOMMENDATIONS
1:30-2:00	• ASSESSMENT OF THE DIARRHEA PATIENT (40 mins)	• ACTUAL PRACTICE	• ACTUAL PRACTICE	• ACTUAL PRACTICE	
2:00-2:30	• CASE MANAGEMENT OF ACUTE DIARRHEA				
2:30-3:00					
3:00-3:15	MID-AFTERNOON BREAK				
3:15-3:30	• CONTINUATION: CASE MANAGEMENT OF ACUTE DIARRHEA (2 Hrs 30 mins)	• ACTUAL PRACTICE	• ACTUAL PRACTICE	• ACTUAL PRACTICE	• PRESENTATION OF ACTION PLAN & RECOMMENDATIONS
3:30-4:00					
4:00-4:30	• INTRODUCTION OF CLINICAL FORMS & REGISTERS	• TALKING TO MOTHERS ON HOME TREATMENT - INTROD. EXERCISE & ROLE PLAY (45 mins)	• IMPROVED WEANING PRACTICES: WHAT, WHEN, HOW (30 mins)	• GROUP WORK: IDENTIFY CURRENT PRACTICES / PLANS TO CHANGE OR IMPROVE (30 mins)	• EVALUATION
4:30-5:00					
5:00-6:30	DINNER BREAK				
6:30-7:00		• CASE PRESENTATION (30 mins)	• CASE PRESENTATION (30 mins)	• CASE PRESENTATION (30 mins)	
7:00-7:30	NO EVENING SESSION	• EXERCISE ON HOME FLUIDS (30 mins)	• GROWTH MONITORING EXERCISE (30 mins)	• FEEDING A.P.E.M. / PERSISTENT DIARRHEA (30 mins)	NO EVENING SESSION
7:30-9:30		• ACTUAL PRACTICE	• ACTUAL PRACTICE	• ACTUAL PRACTICE	
9:30-10:00		• WARD ROUNDS (30 mins.)	• WARD ROUNDS (30 mins)	• WARD ROUNDS (30 mins)	
ASSIGNMENT:	READINGS: ETIOLOGY OF DIARRHEA	READINGS: BREASTFEEDING DIFFICULTIES - EXERCISE	IDENTIFY CURRENT PRACTICES IN YOUR OWN	PREPARE GROUP OUTPUT FOR	

ANNEX 3 (a)

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ANNEX 3(b)

DTU Course Participants Listing

DTU COURSE PARTICIPANTS

<u>Practicum Group Nr.</u>	<u>NAME</u>	<u>AGENCY/LOCATION</u>
I	1. Namfrel G. Serran	- 1st yr Resident SIMC, Cebu City
VI	2. May Dolores Manara, MD	- Asst. City Health Officer Cotabato City
III	3. Salambai Bayan	- Public Health Nurse City Health Office Cotabato City
I	4. Divinagracia Factora, MD	- Integ. Prov. Health Office Isulan, Sultan Kudarat
IV	5. Marcela Zapatos	- Integ. Prov. Health Office Oroquieta/Region 10
VI	6. Alicia Gutierrez	- Resident (Pedia) Negros Oriental Prov. Hospital, Region 7
V	7. Julieta Orias	- Nurse II SIMC, Cebu City
II	* 8. Lambo Macaborod	- Nurse Office of Muslim Affairs, Cebu
II	9. Rovena Daitol, MD	- Resident Physician Family Med., SIMC
III	10. "Boy" Meñosa, MD (DROPPED) OUT	- Resident Physician District Hospital Lapu-Lapu City
III	11. Helen Tero	- Nurse Dinagat District Hospital Surigao del Norte
IV	12. Jesus Amaya, MD	- Medical Officer IV Dinagat District Hospital Surigao del Norte
V	13. Marilou dela Vega, MD	- MOPH, Oroquieta City Misamis Oriental

September 2-6, 1991

* Observer

Facilitators for practicum:

I, III, V Dr. Daisy Sonza

II, IV, VI Dr. Pal Angeles

ANNEX 4

**28th Training Course on Clinical Management
Of Acute Diarrhea Schedule**

28th TRAINING COURSE ON CLINICAL MANAGEMENT OF ACUTE DIARRHEA
 NRITC, San Lazaro Hospital - September 2-6, 1991

TIME	DAY 1 Sept. 2 Monday	DAY 2 Sept. 3 Tuesday	DAY 3 Sept. 4 Wednesday	DAY 4 Sept. 5 Thursday	DAY 5 Sept. 6 Friday
7:30	Registration	Recap of Previous day's activities	PRACTICUM: FOLLOW-UP CASES FROM PREVIOUS-DAY		
8:00	Opening Session	Video Tape Presentation: "Antibiotics"	Recap	Recap	Recap
	Briefing	LECTURE 4: Management of Acute Diarrhea	LECTURE 5: Prevention of Diarrhea	LECTURE 6: Etiology and Epidemiology of Acute Diarrhea	Discussion on Post-Test Completion of requirements
9:00	Pre-Test		Video Tape Presentation: "Prescription for Health"		Presentation of Action Plan
COFFEE BREAK*					
10:15	LECTURE 1: - National CD Program - Cost Effectiveness of ORT - Data Generation for ORT Impact	PRACTICUM**	PRACTICUM	PRACTICUM	Continuation of Action Plan
11:30	Sharing of Experiences on CD/ORT				
LUNCH BREAK					
1:30	Sharing of Experiences on CD/ORT (Continuation)				Case Simulation Session
2:00	LECTURE 2: Pathogenesis of Acute Diarrhea	PRACTICUM	PRACTICUM	Health Teaching Session, PIEES/EDIS Staff	
COFFEE BREAK					
3:15	LECTURE 3: Principles of ORT	Case Presentation	Discussion: Setting of ORT Units	Case Presentation	Case Simulation Session (continuation)
3:30	Video Tape Presentation: "Scientific Breakthrough"	Video Tape Presentation: "Management Module"	Video Tape Presentation: "5 Million Lives"	Post-Test Preparation of Action Plans	Closing Session
EVENING	Class Organization	Follow-up Cases	Follow-up Cases	Follow-up Cases	

*Time for coffee break and lunch break: Flexible
 **When there are no patients, facilitators will prepare other activities during practicum for participants: Health Education

ANNEX 4

ANNEX 5

**28th Training Course on Clinical Management
Of Acute Diarrhea Participants and Team Listings**

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National Rehydration Treatment and Training Center
 NATIONAL TRAINING COURSE ON CLINICAL MANAGEMENT OF ACUTE DIARRHEAS
 September 2-6, 1991

<u>NAME</u>	<u>DESIGNATION</u>	<u>ADDRESS</u>
1. Dr. Myhra C. Correa	Resident Physician	Aurora Memorial Hospital Baler, Aurora
2. Ms. Juliana M. Julio	Chief Nurse	Aurora Memorial Hospital Baler, Aurora
3. Dr. Rodolfo V. Eligio	Resident Physician	Aurora Memorial Hospital Baler, Aurora
4. Dr. Cristina G. Hocson	Resident Physician	Bataan Provincial Hospital Balanga, Bataan
5. Dr. Victoria S. Alarcon	Physician	San Lazaro Hospital Sta. Cruz, Manila
6. Dr. Gilberto P. Ilog	Resident Physician	Andres Bonifacio Memorial Hospital Trece Martires, Cavite
7. Dr. Warlita F. Arayata	Medical Specialist I	Andres Bonifacio Memorial Hospital Trece Martires, Cavite
8. Ms. Teresita A. Perez	Nurse IV	Andres Bonifacio Memorial Hospital Trece Martires, Cavite
9. Dr. Luzviminda Dulnuan	Resident Physician	Ifugao General Hospital Lagawe, Ifugao
10. Dr. Olmaya B. Hiyadan	Resident Physician	Ifugao General Hospital Lagawe, Ifugao
11. Dr. Fernando A. Fernandez	Resident Physician	Kabankalan District Hospital Kabankalan, Negros Occidental
12. Mr. Larry P. Parreño	Nurse II	Iloilo Provincial Hospital Pototan, Iloilo
13. Dr. Ma. Teresa L. Laminero	Resident Physician	Iloilo Provincial Hospital Pototan, Iloilo
14. Ms. Cynthia C. Descallar	Nurse Instructor II	Regional Health Office No. 10 Cagayan de Oro City
15. Dr. Renato M. Matawaran	Medical Officer III	Dinalupihan District Hospital Dinalupihan, Bataan

ANNEX 5

TEAM I

1. Dr. Myra Correa
2. Dr. Cristina Hocson

TEAM II

1. Ms. Juliana Julio
2. Ms. Cynthia Descallar

TEAM III

1. Dr. Hiyadan Olimaya
2. Dr. Ma. Teresa Laminero

TEAM IV

1. Dr. Warlita Arayata
2. Dr. Victoria Alarcon

TEAM V

1. Ms. Teresita Perey
2. Mr. Larry Parreno

TEAM VI

1. Dr. Gilberto Ilog
2. Dr. Luzviminda Dulnuan

TEAM VII

1. Dr. Fernando Fernandez
2. Dr. Renato Matawaran

TEAM VIII

1. Dr. Rodolfo Eligio

FACILITATORS

- TEAMS I, IV & VII - Dr. Perla Alban
TEAMS II, V - Ms. Victoria Garcia
TEAMS III, VI & VIII - Dr. Zoilo Mendoza

ANNEX 6

Diarrhea Case Record Form

DIARRHEA CASE RECORD FORM

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PATIENT'S NAME: _____ REGISTRATION NO.: _____
 ADDRESS: _____ Date of admission: _____
 AGE: ___ years ___ months SEX: M F Date of discharge: _____
 Duration of diarrhea from onset to admission: ___ days = <2wks 7-2 wks
 No. of diarrhea stools in the last 24 hours: ____ Vomiting: None Some
 Very frequent (7-4 / hr)
 Urine: Normal Small amount No urine for 6 hrs. Medicines taken: _____
 Weight: ___ Kg. Temp.: ___ °C Respiratory rate: ___ /min Pulse rate: ___ /min.
 Measles Immunization given at: _____
 Type of food given since onset of diarrhea _____
 Type of feeding _____

ASSESSMENT OF DEHYDRATION

	A	B	C
1. LOOK AT: CONDITION	: Well, Alert	: Restless, irritable	: Lethargic or unconscious
EYES	: Normal	: Sunken	: Very sunken and d.
TEARS	: Present	: Absent	: Absent
MOUTH & TONGUE	: Wet	: Dry	: Very dry
Thirst	: Drinks normally, not thirsty	: Thirsty, Drinks eagerly	: Drinks poorly, unable to drink
2. FEEL: Skin Pinch	: Goes back quickly	: Goes back slowly	: Goes back very slowly

3. ASSESSMENT OF DEHYDRATION: NO SIGNS OF DEHYDRATION SOME DEHYDRATION
 SEVERE DEHYDRATION

Bloody stools: YES NO Abdominal pain: YES NO FEVER (≥39°C): YES NO

Malnutrition (degree): None 1st 2nd 3rd

Other problems: _____

Diagnosis: 1. _____
 2. _____

PROGRESS	: 0 TO 2 HRS	: 2 TO 4 HRS	: 4 TO 6 HRS	: 6 TO 8 HRS	: 8 TO 24 HRS
Number of stools	:	:	:	:	:
Episodes of vomiting	:	:	:	:	:
Urine	:	:	:	:	:
Temperature	:	:	:	:	:
Pulse rate	:	:	:	:	:
ORS consumed (volume in ml.)	:	:	:	:	:
Other fluids taken (ml.)	:	:	:	:	:
IV fluids given (type & volume)	:	:	:	:	:
Food taken/Breast-feeding	:	:	:	:	:
Medicines taken	:	:	:	:	:
CLINICAL SIGNS	: AT 2 HRS	: AT ___ HRS	: AT ___ HRS	: AT ___ HRS	: AT ___ HRS
Condition	:	:	:	:	:
Eyes	:	:	:	:	:
Tears	:	:	:	:	:
Mouth & Tongue	:	:	:	:	:
Thirst	:	:	:	:	:
Skin pinch	:	:	:	:	:
RE-ASSESSMENT OF DEHYDRATION	:	:	:	:	:
TIME OF DISCHARGE	:	:	:	:	:

Body weight: _____ Total amount of fluid: ORS by mouth _____ ml.
 ORS thru NGT _____ ml.
 IV F _____ ml.
 Total of fluid to be given in ~~past~~ 24 hours _____
 next

Other instructions given to mother: _____

History taken and P. E. done by:

 PHYSICIAN/NURSE 40

ANNEX 7

**List of Reference Materials Distributed
During the Course in NRTTC**

REFERENCE MATERIALS DISTRIBUTED DURING THE COURSE IN NRTTC:

1. Department circular no. 88
2. A manual for treatment of diarrhoea. For use by physicians and other senior health workers. WHO/CDD/SER/80.2 Rev.2 1990
3. The management of diarrhoea and use of oral rehydration therapy. A joint WHO/Unicef statement. 2nd ed. 1985.
4. Guidelines on the management of dysentery. DOH/MCH/CDD, Philippines.
5. WHO Update on revision of the diarrhoea treatment chart, 1991.
6. Dialogue on diarrhoea no. 42, September 1990
7. Use of locally available drinking water for preparation of ORS solution. WHO/CDD/SER/81.1 Rev.1.(1985)
8. Prevention module from the WHO CDD Supervisory skills training course.
9. Treatment of 242 neonates with dehydrating diarrhoea with an oral glucose-electrolyte solution. Pizarro et al. J Ped Vol 102, no.1, pp 153-156, Jan 1983
10. The magnitude of the global problem of acute diarrhoeal disease: a review of active surveillance data Snyder et al. Bull WHO 60 (4):605-613 (1982)
11. Oral rehydration therapy - recent advances. Mahalanabis et al. World Health Forum (2) 245-249 (1981)
12. Preventing diarrhoea: what are the policy options? Feachem. Health policy and planning 1986;1(2):109-117
13. Evaluation of oral therapy for infant diarrhoea in an emergency room setting: the acute episode as an opportunity for instructing mothers on home therapy. Pizarro et al. Bull WHO 57(6): 983-986 (1979)
14. Etiologic agents of diarrhoea. Dayrit E, ed. Acute Diarrhoeas: Their management and prevention. In press
15. Oral rehydration therapy for treatment of diarrhoea in the home
16. The role of antibiotics in the treatment of diarrhoea. Kucers et al.

ANNEX 8

**List of Supplies Given to Participants
at the End of the Course in NRTTC
to Set Up ORT Units**

LIST OF SUPPLIES GIVEN TO THE PARTICIPANTS AT THE END OF THE COURSE IN NRTTC, TO SET UP ORT UNITS:

- 10 liter jug
- plastic glasses
- ng tubes
- mothers' pamphlets
- growth chart
- health education poster
- health education flipchart
- two reference books:
 - "Readings on diarrhoea"
 - "Diarrhoeal diseases"

ANNEX 9

90 Day Action Plan Form

90 DAY ACTION PLAN

Objective: To improve diarrhea case management in our hospital

ISSUES/PROBLEMS	SOLUTIONS/ACTIONS/ ACTIVITIES TO BE DONE	T I M E F R A M E	P R O G R E S S I N D I C A T O R S

46

ANNEX 9

ANNEX 10

**List of Videos/Films Shown during the
Training Course in NRTTC**

VIDEOS/FILMS SHOWN DURING THE TRAINING COURSE IN NRTTC:

1. "Scientific breakthroughs", video presentation on pathophysiology of diarrhoea and principles of ORT.
2. "Hard to swallow", video presentation on antidiarrhoeal drugs.
3. "5 million lives", film presentation on CDD programme.
4. "Prescription for health", film presentation on prevention of diarrhoea.
5. "Making things clear", video presentation on communication skills.
6. "Assessment and management of dehydration in children with diarrhoea", video presentation on oral rehydration therapy, prepared by WHO.
7. "Assessment and management of dehydration", video presentation on oral rehydration therapy, prepared by the Philippine Pediatric society.

TABLE 1

Post-Test of Skills

Simulation. Post-test of skills

Percent demonstrating acceptable performance, by major skill area

Case Number	Manila			Cebu			Number of Participants	
	Assm't	Tx	Counsel.	Assm't	Tx	Counsel.	Manila	Cebu
Case 1	100%	100%	NA	58%	67%	NA	15	12
Case 2	100%	100%	NA	83%	58%	NA	15	12
Case 3	100%	93%	NA	NA	NA	NA	15	NA
Case 4	NA	40%	0	NA	42%	17%	15	12
Case 5	NA	43%	0	NA	83%	42%	14	12

ANNEX 11

Participant Evaluation

2/20/23

		Cebu	Manila
Participants' opinions if they:			
a) had the opportunity to treat patients according to	PLAN A	83%	100%
	PLAN B	100%	100%
	PLAN C	17%	40%
b) feel confident in managing	PLAN A	83%	100%
	PLAN B	83%	87%
	PLAN C	83%	87%
c) saw patients with other problems?		83%	93%

100

PARTICIPANTS' EVALUATION ON COURSE COMPONENTS

		Very Useful	Useful	Somewhat Useful	Useless
Lecture I:	Cebu Manila	100% 87%	-- 13%	-- --	-- --
Lecture II:	Cebu Manila	100% 93%	-- 7%	-- --	-- --
Lecture III:	Cebu Manila	92% 53%	8% 47%	-- --	-- --
Lecture IV:	Cebu Manila	75% 47%	17% 53%	8% --	-- --
Lecture V:	Cebu Manila	100% 73%	-- 20%	-- 7%	-- --
Exercises:	Cebu Manila	58% 33%	33% 33%	-- 27%	-- 7%
Clinical practice:	Cebu Manila	92% 87%	-- 13%	8% --	-- --
Case presentations:	Cebu Manila	83% 74%	17% 13%	-- 13%	-- --
Planning session:	Cebu Manila	83% 47%	-- 53%	8% --	-- --

Lecture I: Principles of Clinical Management of Acute Diarrhoea

Lecture II: Management of Acute Diarrhoea

Lecture III: Pathogenesis of Diarrhoeal Diseases

Lecture IV: Epidemiology and Aetiology of Acute Diarrhoeas

Lecture V: Prevention of Diarrhoea

Page 5

PARTICIPANTS' RECOMMENDATIONS ON HOW TO IMPROVE THE COURSE

Cebu

- untighten the schedule
- no everyday evening session
- training should be arranged during peak season
- DTU should have a dormitory and a canteen
- the course should be a live-in course
- the course should be longer
- there should be "ice breakers" between the lectures
- follow-up visits should be arranged after the course

Manila

- lectures should be easier to understand
- there should be only one 24-hour night duty
- facilities in the dormitory should be improved
- there should be more comprehensive lectures
- there should be consensus among the facilitators
- lecturers from the academe and Philippine Pediatric Society should be invited
- there should be more discussion about problems in giving ORT and about limitations of ORT

PARTICIPANTS' EVALUATION ON TIME SPENT

		Too Short	Adequate	Too Long
Lectures:	Cebu Manila	17% 13%	75% 87%	8% --
Exercises:	Cebu Manila	25% --	75% --	-- --
Clinical Practice:	Cebu Manila	58% --	42% 80%	-- 20%
Case Presentations:	Cebu Manila	8% --	92% 93%	-- 7%
Planning:	Cebu Manila	8% 7%	92% 87%	-- --
Entire Course:	Cebu Manila	50% --	42% 93%	8% 7%

**DID PARTICIPANTS FIND SOMETHING ESPECIALLY
DIFFICULT DURING THE TRAINING COURSE?**

Cebu

- too few cases to give enough practical experience
- too tight timetable
- not enough time to read the materials
- meals were not available
- the course was not a live-in course

Manila

- preparation of action plans was difficult
- the facilities in the dormitory were not good (no running water)

ANNEX 12

Part-B - Health Worker Performance Evaluation

PART B Healthworker performance evaluation

January 20-23, ¹⁹⁹² 1991	surveyor training in Manila (San Lazaro Hospital DTU)
January 24-31, ¹⁹⁹² 1991	Teams A,B,and C in the field
February 3-7, ¹⁹⁹² 1991	Data analysis and report writing in Manila
February 10, ¹⁹⁹² 1991	Report given to DOH
February 11, ¹⁹⁹² 1991	Consultative Meeting in DOH

Team A

Dr. Jeanne Newman, QA project
 Dra. Norma Abejar, DOH
 Dr. Scott Endsley, PRITECH
 Provincial CDD co-ordinator

Study Sites

Manila (3 days)
 Lucena
 Batangas
 Santa Cruz

Total 6 facilities

Team B

Dr. Larry Casazza, PRITECH
 Dra. Papa, DOH
 Dr. Tarja Rautanen, consult
 Regional/provincial CDD
 co-ordinator

Study Sites

Cebu (4 days)
 Ilo-Ilo

Total 6 facilities

Team C

Dr. Mariam Claeson, WHO
 Dra. Basilio, DOH
 Dra. Pat Angus, DOH
 Regional CDD co-ordinator

Study Sites

Cagayan de Oro
 Ozamis
 Oroqueta
 Butuan
 Davao

Total 7 facilities

58

Scope of work

SGV will administer and account for local costs associated with PRITECH's CDD Training Assessment, Part B, to be conducted in the Philippines from January 20 - February 1, 1991. Specifically SGV will disperse and account for the funds for the per diem, air fares and local transport costs of Department of Health personnel participating in this assessment. Field work will be conducted by three teams visiting 19 health facilities outside Manila, Cebu/Ilo-Ilo and Mindanao. Additionally, SGV will make payments to the logistical coordinator, Ms. Evelyn Reyes, who will coordinate with Dr. Basilio, DOH, in identifying site visits and arranging travel. Finally, SGV will make payments to data encoders identified by PRITECH to input data collected throughout the study. A list of individuals participating in this study is attached. Also attached is an illustrative budget.

SGV will account for all money dispersed, per AID regulations. At completion of the study, SGV shall submit a final invoice for all actual costs.

CDD Training Assessment
 Budget - Phase II
 January 20 - February 7, ¹⁹⁹²~~1991~~

I. Surveyor Training in Manila - January 20 - 23, ¹⁹⁹²~~1991~~

A. Per Diems

- Dr. Pat Angus - 4 days x 350 per/day	1,400 pesos
- CDD Regional Coordinator (outside Manila) Region IV Mrs. Patrocinio Ferreira 4 days x 350 per/day	1,400 pesos
- CDD Regional Coordinator (Cebu) Region VII Dr. Joy Abellana / Ms. Ofelia Dotillos 4 days x 350 per/day	1,400 pesos
- CDD Regional Coordinator (Ilo-Ilo) Region VI Dr. Marlyn Convocar / Ms. Lydia Simpás 4 days x 350 per/day	1,400 pesos
- CDD Regional Coordinator (Cagayan de Oro) Region X Dr. Ligaya Salcedo / Ms. Cynthia Descallar 4 days x 350 per/day	1,400 pesos
- CDD Regional Coordinator (Davao) Region XI Dr. Jose Pagsaligan / Ms. Ellen Plenos 4 days x 350 per/day	1,400 pesos
Sub-total	8,400 pesos

B. Air Fare

- Dr. Pat Angus - (RT Cebu - Manila)	3,000 pesos
- CDD Regional Coordinator (Cebu) Region VII Dr. Joy Abellana / Ms. Ofelia Dotillos (RT Cebu - Manila)	3,000 pesos
- CDD Regional Coordinator (Ilo - Ilo) Region VI Dr. Marlyn Convocar / Ms. Lydia Simpás (RT Ilo-Ilo - Manila)	3,000 pesos
- CDD Regional Coordinator (Cagayan de Oro) Region X Dr. Ligaya Salcedo / Ms. Cynthia Descallar (RT Cagayan de Oro - Manila)	5,000 pesos
- CDD Regional Coordinator (Davao) Region XI Dr. Jose Pagsaligan / Ms. Ellen Plenos (RT Davao - Manila)	5,000 pesos
Sub-total	19,000 pesos

C. Local Transport

- CDD Regional Coordinator - Region IV Mrs. Patrocinio Ferreira	1,000 pesos
- Transport around Manila	1,000 pesos
	<hr/>
Sub-total	2,000 pesos

II. Field Trips - January 24 - 31, 1991

A. Per Diems

1. Team A (Manila)

- Dr. Abejar - 4 days x 175 per/day	700 pesos
- CDD Regional Coordinator - Region IV Mrs. Patrocinio Ferreira 4 days x 175 per/day	700 pesos
- Driver Region IV - 4 days x 135 per/day	540 pesos

2. Team B (Cebu / Ilo-Ilo)

- Dr. Papa - 8 days x 350 per/day	2,800 pesos
- CDD Regional Coordinator (Cebu) Region VII Dr. Joy Abellana / Ms. Ofelia Dotillos 2 days x 350 per/day	700 pesos
- CDD Regional Coordinator (Ilo-Ilo) Region VI Dr. Marlyn Convozar / Ms. Lydia Simpas 2 days x 350 per/day	700 pesos

- Driver Region VII - 2 days x 135 per/day	270 pesos
- Driver Region VI - 2 days x 135 per/day	270 pesos

SGU will
not be able
to pay

3. Team C (Mindanao)

- Dr. Basilio - 8 days x 350 per/day 2,800 pesos
- Dr. Angus - 8 days x 350 per/day 2,800 pesos
- CDD Regional Coordinator (Davao) Region XI
Dr. Jose Pagsaligan / Ms. Ellen Plenos
2 days x 350 per/day 700 pesos
- CDD Regional Coordinator (Cagayan de Oro) Region X
Dr. Ligaya Salcedo / Ms. Cynthia Descallar
3 days x 350 per/day 1,050 pesos

*SGU will
not be able
to pay*

Driver Region XI 2 days x 135 per/day	270 pesos
Driver Region X 3 days x 135 per/day	405 pesos
Sub-total	14,705 pesos

B. Air Fares

1. Team A (Manila)
no air fares
 2. Team B (Cebu / Ilo-Ilo)
 - Dr. Papa (Manila - Cebu - Iloilo - Manila) 6,300 pesos
 3. Team C (Mindanao)
 - Dr. Basilio (Mla-Davao-Cag. de Oro-Mla) 5,000 pesos
 - Dr. Angus (Cebu-Davao-Cag. de Oro-Cebu) 4,000 pesos
- Sub-total 15,300 pesos

C. Local Transport

1. Team A (Manila)
Gasoline inter-province trip 10,000 pesos
 2. Team B (Cebu/Ilo-Ilo)
Gasoline inter-province trip 10,000 pesos
 3. Team C (Mindanao)
Gasoline inter-province trip 10,000 pesos
- Sub-total 30,000 pesos

*SGU will
not be able
to pay*

III. Data Analysis / Report Writing in Manila - Feb. 2-5, 1991

A. Per Diems		
- Dr. Angus - 4 days x 350 per/day		1,400 pesos
	Sub-total	<u>1,400 pesos</u>
B. Air Fare		
- Dr. Angus - (RT Cebu - Manila)		3,000 pesos
	Sub-total	<u>3,000 pesos</u>
C. Outside Services		
- Logistics Coordinator - Evelyn Reyes 325 pesos/day x 10 days		3,250 pesos
- Data coder 325 pesos/day x 5 days		1,625 pesos
- Data inputter - Evelyn Reyes 325 pesos/day x 10 days		3,250 pesos
	Sub-total	<u>8,125 pesos</u>
D. Other Direct Costs		
- photocopies		3,000 pesos
- office supplies		3,000 pesos
	Sub-total	<u>6,000 pesos</u>
	GRAND TOTAL :	<u>107,930 pesos</u> =====

Republic of the Philippines
Department of Health
Office of Public Health Services
MATERNAL AND CHILD HEALTH SERVICE
Manila

September 23, 1991

Dr. Larry Cassaza
PRITECH
1925 North Lynn St. Suite 400
Arlington, VA 22209
U.S.A.

Dear Dr. Cassaza:

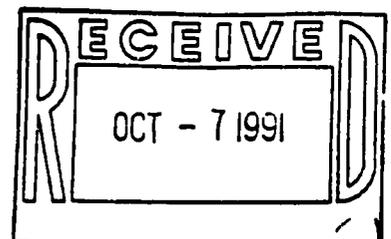
Thank you for your very active participation in the Clinical Management Training (CMT) evaluation, the first phase of which was successfully concluded last September 13, 1991. We found your preliminary report on the evaluation of the courses at Southern Islands Medical Center in Cebu and the National Rehydration Treatment and Training Center at San Lazaro Hospital very informative. It is an excellent job.

Please also thank Drs. Jeanne Newman, Tarja Rautanen and Ms. Danielle Grant for working tirelessly in order to come up with very objective assessments of the CMT course.

We look forward to the second phase of the evaluation on January-February 1992. Thank you.

Very truly yours,


ELVIRA SN. DAYRIT, M.D., MSc. MCH.
Director
Maternal and Child Health Service



PART B Healthworker performance evaluation

January 20-23, 1991	surveyor training in Manila (San Lazaro Hospital DTU)
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 Dra. Norma Abejar, DOH
 Dr. Scott Endsley, PRITECH
 Provincial CDD co-ordinator

Study Sites

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 Lucena
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 Santa Cruz

Total 6 facilities

Team B

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 Dra. Papa, DOH
 Dr. Tarja Rautanen, consult
 Regional/provincial CDD
 co-ordinator

Study Sites

Cebu (4 days)
 Ilo-Ilo

Total 6 facilities

Team C

Dr. Mariam Claeson, WHO
 Dra. Basilio, DOH
 Dra. Pat Angus, DOH
 Regional CDD co-ordinator

Study Sites

Cagayan de Oro
 Ozamis
 Oroqueta
 Butuan
 Davao

Total 7 facilities

Grand total 19 facilities

65