

A TRIP REPORT ON THE EVALUATION
OF
THE TEN STEP CHECK SYSTEM FOR ALL SICK CHILDREN:
A CHILD SURVIVAL INTERVENTION DEVELOPED AND IMPLEMENTED BY
THE CHILD SURVIVAL SUPPORT PROJECT
USAID Project 492-0017-C-00-0073-00
IN PAPUA NEW GUINEA

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LIST OF ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AIDAB	Australian International Development Assistance Bureau
ARI	Acute Respiratory Infections
APO	Aid Post Orderly
ASH	Provincial Assistant Secretary for Health
CAHS	College of Allied Health Services
CDD	Control of Diarrhoeal Diseases
CHW	Community Health Worker
COP	Chief of Party
CS	Child Survival
CSP	Child Survival Program of the NDOH
CSSP	Child Survival Support Project
EHP	Eastern Highlands Province, PNG
EPI	Expanded Program for Immunizations
FAS	First Assistant Secretary
GPNG	The Government of Papua New Guinea
HEO	Health Extension Officer
HRD	Human Resources Development
ISP	Interim Support Project proposed for funding by AIDAB
JSI	John Snow, Inc., the U.S. Contractor for the CSSP
LMA	Logistics Management Advisor
LOP	Life of Project
MCH	Maternal and Child Health
NCD	National Capital District
NDOH	National Department of Health
OIC	Officer in Charge of a health center/subcenter
OPHN	Office of Population, Health and Nutrition
ORT	Oral Rehydration Therapy
PACD	Project Activity Completion Date
PHC	Primary Health Care
PHS	Primary Health Services
PHD	Provincial Health Division
PNG	Papua New Guinea
POM	Port Moresby, Papua New Guinea
PROAG	Project Agreement
RDO/SP	U.S. Agency for International Development/Regional Development Office for South Pacific located in Suva, Fiji
RSU	Regional Support Unit
SOW	Scope of Work
TA	Technical Assistance
TOT	Training of Trainers
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VBA	Village Birth Attendant
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

The Papua New Guinea Child Survival Support Project (PNG CSSP) was designed in 1989 by USAID with the government of PNG (GPNG), to improve the quality, efficiency and effectiveness of the delivery of maternal and child survival services in rural areas of PNG. John Snow, Inc. (JSI) was awarded the CSSP in September 1990. The original PACD was August 31, 1997, with a projected USAID LOP contribution of \$9.4 million.

The project activities were designed to be implemented in two phases. In August-September 1993 plans for Phase II were being developed. In November 1993, the USAID South Pacific program was designated to be closed out in FY94. The PNG CSSP would therefore be terminated early, with a LOP funding reduction to \$6.407 million and a new PACD of March 31, 1995.

The focus of the redefined Phase II would be on a comprehensive child survival (CS) and maternal health training package for district level health personnel, which would be implemented and field tested in two provinces, with needed modifications and improvements made prior to project completion. The training centered around an excellent, well-developed 10-Step Check System for all sick children, which was integrated with community education flipcharts, posters and pamphlets.

In the short time remaining, the USAID-funded CSSP completed the training of trainers and district in-service training of health workers in the two pilot provinces, but did not have adequate time to properly monitor and evaluate the program implementation post-training. The CSSP staff have done a remarkable job in coordinating child survival activities with other donors and PNG agencies since 1990 which I'm sure has helped in securing support from the Australian International Development Assistance Bureau (AIDAB) for a follow-on CSP project.

Recommendations

In general, the proper use of this 10-Step Check system will enable health workers -- especially the lower level health staff in rural areas, but also doctors and nurses in the urban clinics and hospitals -- to correctly identify priority child survival diseases and problems and provide the proper treatment, health education and referral if necessary, thereby improving the health care provided to infants and children in PNG.

I feel that the use of this 10-Step Check, as a teaching and diagnosis/treatment tool or methodology could be of value to health care providers here in the Philippines, as well as in other countries where USAID or other donors supports health programs.

I. BACKGROUND

A. Introduction

The Papua New Guinea Child Survival Support Project (PNG CSSP) was designed in 1989 by USAID with the government of PNG (GPNG), to improve the quality, efficiency and effectiveness of the delivery of maternal and child survival services in rural areas of PNG. The South Pacific Regional Development Office (RDO/SP) of the United States Agency for International Development (USAID), in Suva, Fiji, awarded the PNG CSSP to John Snow, Inc. (JSI), through a competitive contract in September 1990. The original PACD was August 31, 1997, with a projected USAID LOP contribution of \$9.4 million.

The project activities were designed to be implemented in two phases, with Phase I, lasting approximately three years, serving to supply the organizational, programmatic and technical foundation for Phase II. An interim evaluation of the CSSP in PNG was conducted in early 1993, which was used by the GPNG National Department of Health (NDOH), USAID and the TA contractor, in developing the plans for Phase II in August-September 1993.

In November 1993, the RDO/SP was told that the South Pacific program was one of 21 USAID missions worldwide which would be closed over the next three years, with the RDO/SP closing in FY94. The PNG CSSP project Phase II plans were not yet finalized at this time, and, as this project too would be terminated early, implementation plans were necessarily changed to meet the new decisions regarding the program and remaining life of the project. On May 26, 1994, the GPNG signed ProAg Amendment No.7, which was also then signed by the RDO/SP Acting Regional Director on June 3, 1994. The USAID LOP funding had been reduced from \$9.4 million to \$6.407 million. The PACD was changed from August 31, 1997 to March 31, 1995 -- a two years and 5 months reduction in project duration.

Due to early termination, the redefined Phase II activities of the shortened project could not be implemented in depth country-wide, while other activities were discontinued completely or cutback. The focus of Phase II would be on a comprehensive child survival (CS) and maternal health training package for district level health personnel, which would be implemented and field tested in two provinces, with needed modifications and improvements made prior to project completion. It was noted that time would be greatly decreased for necessary activity follow-up and adjustments in monitoring and training tools, due to the early project termination. By the end of project, it was planned that the training package and materials could be utilized by the GPNG wherever it saw fit, using various funding sources.

B. Statement of Work

As part of the consultant's SOW for the end-of-program evaluation of the Child Survival Project in the Philippines, a short visit to Papua New Guinea (PNG) was scheduled to assess the child survival "10-Step Check" system developed and implemented under the USAID-funded Child Survival Support Project (CSSP) in PNG. The evaluation would assess the effectiveness of the 10-Step Check, and also determine if this new methodology could be introduced in the Philippines (or elsewhere), or be used by other donors, in the delivery of child survival interventions.

During the post-PNG trip review with USAID/Manila OPHN staff, the evaluator was also asked to comment on the overall implementation of the PNG CSSP since June 1994 and present closeout status of the project.

C. Methodology

The evaluation was conducted by an external consultant contracted under a purchase order. She arrived in Port Moresby, PNG on 5 FEB 95 and went the same day to Goroka, Eastern Highlands Province (EHP) for six days, to attend the Planning Workshop for the Child Survival Training Programme. She accompanied the CSSP Chief of Party/Logistics Management Advisor (COP/LMA), Mr. Allan Bass and the CSSP MCH Physician, Dr. Keith Edwards. During this workshop, she was able to meet or hear from many national, provincial or district health officers, plus others who had an interest and involvement in child survival/training.

A one day field trip was made to the Gulf Province to assess the implementation status of the 10-Step Check system. A list of people contacted appears as Appendix B. Document review was conducted both in PNG and Manila, and the list of documents reviewed is Appendix C. Upon arrival in Manila, the consultant presented her preliminary findings to the OPHN Project Officer. Based on that debriefing, a format for the written report was outlined, and the report completed on 24 FEB 95.

II. THE PNG CSSP - PHASE II OF THE PROJECT

With the decision for early close-out of the PNG-CSSP, the project focused on achieving the ability to use a comprehensive training "package" covering a variety of child survival services for district level health workers. It would include training of trainers in two provinces, utilizing materials developed and field tested during this time period, with necessary modifications and improvements being made in the training package by the end of project. This set of materials could then be used country-wide by the GPNG.

Coordination activities at the central level would continue with various organizations involved in the national "Child Survival Crash Program," in which the government and NDOH focused attention and also resources on child survival interventions.

No new studies or research would be initiated - those already begun by November 1993 would be completed. Also, the project no longer focused on the institutional development of the Regional Support Units (RSUs) as of September 1993.

In order to establish in-country capabilities among the national staff for utilizing the outputs/products of the CSSP project, a "Child Survival Fellows" training program was instituted where personnel were selected to be a counterpart to a long-term advisor to work together on project activity implementation. This replaced the overseas short-term training activity from Phase I of the CSSP.

A. Project implementation since June 1994

1. Training.

The choice of the comprehensive training package in child survival services as the major focus of Phase II of the PNG CSSP proved to be most beneficial for the health workers in the health system as well as the women and children in PNG.

Two separate Training of Trainers (TOT) workshops were held in two provinces during this last 7 month period -- in Gulf and New Ireland provinces. The first TOT Workshop covered the use of the 10-Step check list and deskchart; introduction of the New Pediatric Standard Treatment Book; use of community education flipcharts and diagnosis, treatment and prevention of diarrhoea. The second TOT workshop was held after two months and covered additional problems of malnutrition, malaria, pneumonia and immunization issues.

Two health workers from every district in the province as well as selected provincial staff were trained at the TOT Workshops. They in turn provided district training on the selected topics to all levels of health workers, including the health center and aid post health workers during four health center-based in-service courses.

The goal of training all levels of health workers in Gulf and New Ireland provinces was met, with 308 and 477 health workers trained respectively. All received the complete package of training and community education materials. The implementation of this programmed approach to diagnosis and treatment with the integration of community health education messages and strategies proved successful.

2. Coordination of Child Survival Program Activities.

From my relatively short 11 day evaluation in PNG observing the CSSP program, I believe one of the major reasons for the success of the USAID-funded CSSP and the NDOH's CSP status is the present TA team - the COP/LMA, Allan Bass and the MCH Physician, Dr. Keith Edwards. As is usually the case, the success or failure of a program is dependent on its leadership, and their ability to interact with program staff and other agencies' personnel.

Both Allan Bass and Dr. Edwards have the enthusiasm, dedication and commitment necessary to promote CSP activities in general and their program specifically. More importantly, they are respected by their national staff, as well as by staff of other organizations with an interest or involvement in child survival.

The successful child survival activity coordination efforts are due to a mixture of personalities which clicked -- Dr. Hamid Houssaini, the UNICEF Country Representative; the honorable Peter Barter, the PNG Minister of Health; high level NDOH National staff; plus Allan and Keith -- and the combined commitment of them all towards a strong national Child Survival Program. The experiences of the USAID-funded PNG CSSP project provided some basis and impetus for the formation and coordination of the GPNG's Child Survival Crash Program which was initiated in October 1993 and launched country-wide in February 1994.

Because of the involvement of both the CSSP COP and MCH Physician with several NDOH and other GPNG groups involved with child survival, and their liaison with other health sector donors (AIDAB/ADB/WHO/UNICEF), positive groundwork was laid for the continuation of the CSSP in some form/activities when USAID funding ceases in March 1995. Being physically located in the same building with the NDOH has been advantageous for CSP coordination and communication.

The Primary Health Services (PHS) Division of the NDOH allocated a national counterpart Training Coordinator, to work with the MCH Physician and he became one of the Child Survival Fellows. Two other PHS employees were also allocated to assist in materials production for the training unit, which allowed for increased production and transfer of skills necessary for program sustainability. In August 1994, the COP/LMA began counterpart training in logistics management for CS and Primary health Care (PHC) for the newly appointed NDOH Family Health Logistics Officer.

B. A Planning Workshop for the Child Survival Training Programme, Goroka, Eastern Highlands Province, February 6-10, 1995

As a final coordination effort, a Planning Workshop for the Child Survival Training Programme was held in February 1995, in Goroka, EHP, which was attended by a cross-section of over 120 participants, from the NDOH, Provincial Health Divisions, UNICEF, CSSP, church/women's groups, NGOs, the National Department of Education and other GPNG personnel.

This workshop set the stage for the country-wide district in-service training of health personnel and the planning for health patrols for the provinces. It introduced the CSP Health Worker training and Health Promotion materials to the Provincial Health Coordinators, who would then have the responsibility to communicate this information to their fellow staff and implement the training in their provinces.

I was extremely impressed with the organization of this well-attended workshop and the focus on participation of the attendees in both the presentations and learning experiences. The quality of the training and health promotion materials was exceptional, as was the simplified algorithmic system of the 10-Step Check, with the integrated community education flip charts, posters and pamphlets.

A much needed addition to the health training program was the inclusion of training with a simplified financial planning and management system, which addressed the problems of weak managerial skills, accountability and numeracy both at provincial and district levels.

With all the key Child Survival players together, coordinated planning was possible for the upcoming year, for both district training in 10 provinces, plus the scheduling of MCH/Immunization patrols during the same period in all 19 provinces.

C. Constraints to project implementation

During this final phase of the CSSP project, finances remained a major constraint. The PNG government changed in September 1994, and a new Minister of Health took office. There was a freeze on

government expenditures along with a 12% devaluation of the PNG currency. Money previously allocated for restoration of rural health outreach patrols (two million kina) was lost. The government decided to operate on a continuing appropriation supply bill rather than submit the 1995 budget to Parliament in 1994. This action stopped new International Bank funding which included the Asian Development Bank Human Resource Development (ADB HRD) Project, which the CSSP had hoped would provide continuation of present training activities in the future.

Limited capability and space for materials production was a constraint, with periodic printing company backlogs. Purchase of additional equipment rectified some of these problems, but a major push will be on now (February 1995) to keep up with the production of materials necessary for the 20 new provincial TOT Workshops which are scheduled to be held one every three weeks from now through December 1995.

A major constraint to program implementation is communication and transport capabilities to training sites, in a country where both are difficult in most provinces. The radio systems are in disrepair, with non-functioning equipment. Proper supervision and monitoring of programs require transportation, by boat, air or land, depending on the district. With the financial crisis, money for transport became non-existent, which effectively stopped travel.

The decision to close out the CSSP program early in itself was a constraint to program implementation, especially waiting during the period while the final plans were being made, as it slowed the rate of on-going activities. Afterwards, there was not enough time remaining in the program to adequately monitor and supervise the training program implementation, in order to make the necessary modifications for final preparation of training materials before the project ended. This activity fortunately will be continued in the follow-on project, which will be funded by AIDAB.

D. Sustainability - Interim Support Project (ISP)

As soon as the final decision was made for early termination of the CSSP project, the TA team began seeking funding from other donors to continue project activities, especially the training of trainers and district in-service training of health personnel.

The USAID-funded CSSP project ends March 31, 1995. During the LOP, its experiences provided some basis and impetus for the GPNG's Child Survival Crash Program, initiated in October 1993 and launched country-wide in February 1994. Task forces at the provincial and national levels manage the program, which covers three main activities - assistance to MCH services, advocacy and multi-sectoral collaboration.

Due to the government's financial crisis, in November 1994, the GPNG requested assistance from the Australian International Development Assistance Bureau (AIDAB) to meet the CSP needs on an interim basis. In response, the Interim Support Project (ISP) was developed which is planned to cover the period between February/March 1995, after which the USAID-funded CSSP will end, and early 1996, when the AIDAB Maternal and Child Health (MCH) Project is planned to begin. This longer-term MCH project hopefully will continue many of the actions implemented in the CSP.

The ISP's objective is to provide interim support to the GPNG's CSP, in order to prevent illness and promote better health in women and children, and reduce childhood mortality. Activities will include delivery of MCH services through fixed facilities and mobile patrols to fully immunize children and give ante-natal care to women, including tetanus immunizations.

The ISP will also support increased competence of health personnel through training, by providing TA, in-service training courses, resource materials productions and distribution costs. Support will also be provided for a team leader and a trainer to provide technical assistance. It is planned that the inputs from Australia, estimated at a cost of AUS\$ 5 million, will be managed through UNICEF in PNG.

E. Closeout status

At the time of this visit (February 5-15, 1994) close out activities were on schedule as per the monthly close-out plan submitted to USAID. Plans were being finalized between USAID/OPHN and CCSP PNG regarding the disposition plan for non-expendable fixed assets.

III. THE 10-STEP CHECK SYSTEM FOR ALL SICK CHILDREN

A. Overview

The 10-Step Check System for all Sick Children, along with the integrated community education flip charts, posters and pamphlets is an extremely innovative training methodology, made effective because of its simplicity. This package of materials was designed to aid in training as well as provide health education to patients and family.

The program centers on the 10-Step Checklist for All Sick Children deskchart, which enables the health worker to remember to ask about 10 important topics for each child, as well as the corresponding 10 pertinent areas to examine or check on the child, in order not to miss serious illnesses. If a problem area is detected, the third section in the deskchart provides information on the necessary actions to take. With every topic, the important parent education section is included.

This 10-Step Check is not meant, by any means, to replace a normal systematic check of body systems and history taking, which most medical personnel are taught to perform. What it does provide is an excellent screening tool for identifying childhood illnesses, which may go undetected during a clinic visit because the parent doesn't mention the problem, or the health worker may not remember to question the parent about anything besides the chief complaint.

The 10-Step Check desk chart provides continuous reinforcement of the important questions to ask, examinations to perform, and needed actions to take, and health education to give. The flipchart is placed on the desk with the instructions facing the health worker. On the opposite page, facing the parent/child, is a health promotion picture and message.

When a problem area is identified, the chart is flipped to the appropriate step, where the correct treatment and actions are given on the health worker's side, and the appropriate health messages and pictures linked to the disease are shown on the mother's side.

This training package also includes additional flipcharts, posters and pamphlets regarding important childhood diseases, such as Acute Respiratory Infections (ARI), diarrhoea, malaria, etc., which can then be used to further educate the parent about warning signs and preventive measures. A complete listing of the training and health education materials developed by the CSSP and which are available for health workers is shown in Appendix C. (Note: A training module for "The Role of the Aid Post Worker in Village Delivery", plus a "Care of the Mother and Baby After Village Child

Birth" flip chart have been developed by the CSSP. Neither were given out at the TOT Workshops of the Planning Workshop, as the priority focus for the initial district in-service training phase was first on the major global child health issues and target diseases.

B. Practical experience during the Goroka Workshop

In talking with the participants attending this workshop, it was gratifying to hear how so many people have only positive things to say about the 10-Step Check system. Dr. Bob Danaya, the Senior Pediatrician at POM Hospital and Senior Lecturer at the University of PNG stated that all medical students are taught the use of the 10-Step Check in their residency programs in Port Moresby. Matron Kathy Arttu, from Kavieng General Hospital in New Ireland Province, stated that the training program with the 10-Step Check was very successful. She said that "it was an eye-opener for all of us.... The hospital staff use this system, and even the doctors were now finding problems which were not identified for the patients before."

It was extremely interesting to observe the various participants practicing the use of the 10-Step Check system. Our 120+ attendees ranged from doctors, Health Extension Officers, nurses, non-medical health department personnel to non-health related participants.

We spent two mornings, rotating between a large urban clinic and the provincial hospital pediatric ward, working in groups of 5-8 with a preceptor/trainer. Utilizing the 10-Step Checklist desk chart was awkward at first, because we were not familiar with the questions or exam system, and the coordinated treatment located in the Standard Pediatric Treatment Book. By the third patient the first morning, the attendees were more comfortable with the process and system.

The second morning, I remember vividly one participant, a male nurse, who was so unsure of himself the day before, but now exuded confidence in his questions, exams and treatments this day. It was quite evident that he had reviewed the system the night before, and knew how to use the desk flipchart and Standard Pediatric Treatment Book. I found the same thing true of myself.

The best thing about the 10-Step Check system is that it provides all the questions and answers for the health worker, especially the aid post orderlies (APOs) in the PNG who may have been in service for 10-15 years, but who have received no in-service training during that time. These APOs, as well as the PNG Community Health Workers (CHWs), work in the periphery, by themselves, without the close supervision and contact with other health personnel. For them, it takes the guesswork out of diagnosing and treating children with 10 major health problems or

conditions. By asking the questions and doing the exams in a systematic way, the health worker cannot forget to inquire about these 10 problems, and also has the information needed to know how to treat the child and when to refer to another health facility.

C. Implementation status in Gulf Province

The Planning Workshop in Goroka, Eastern Highlands Province, was extremely timely and important, as it gave me an overview of the entire CSSP training program and the training and health education materials available. What I needed now was to evaluate health workers out in the field who had been previously trained in the use of the 10-Step Check System. I had only one day before I left PNG in which I flew round-trip to the Gulf Province, which was one of the two pilot provinces for the district in-service training.

The Gulf is a difficult province in which to travel. Accompanied by the NDOH MCH Coordinator, we went by vehicle to visit an APO and a health center. I wanted to see the APO actually doing an exam while using the 10-Step Check, but unfortunately, the tidal river was too high to cross in the morning, and by the afternoon, there were no more patients. The APO was an older gentleman who's been in service for 15 years. The APO did have the blue Standard Pediatric Treatment Book in his clinic, which was located in the small seaside village of Uami, but I did not see the pink 10-Step Check deskchart, which he said he had brought to his home. Some of the health posters were hung on the walls.

We next went to a district center clinic, with an inpatient capacity of 10, which was in the village of Malalaua. There were 3 nurses aids -- older women -- who worked in the pediatric clinic and community education room; a female midwife who was out in the district; and one male nurse. The Officer in Charge (OIC) was a Health Extension Officer (HEO), a 3 year-trained medical person, with skills below those of a doctor.

There were 2 copies of the pink 10-Step Check deskchart in the clinic area. There were no additional flipcharts or pamphlets on the various diseases which were supposed to be used for health education. There were health education posters on the walls.

The HEO OIC repeatedly stated what a wonderful system this was, and that all his staff knew how to use the 10-Step Check. He chose one of the nurses aides to demonstrate the use of the check. Unfortunately, this older woman had attended the in-service 7 months before, but had not practiced these skills as she did not have responsibility for examining and diagnosing. She only dispensed medicines when ordered. Therefore, out of fairness to her, the HEO should not have had her try to demonstrate this skill, as it was out of the realm of her regular duties.

8. I support and would advocate the use of this 10-Step Check system. Its effectiveness will only be as good as the concomitant monitoring and supervision of the health worker learning and utilizing the system. As was observed in the field in the PNG, due to a variety of circumstances -- early program closure, government financial crisis, etc. -- adequate follow-up monitoring and supervision was not done for the pilot district in-service training in the Gulf Province. I feel that this will not be the case in the follow-on project, because the same CSSP training staff, who are committed to the success of the program, will be involved, and they realize this deficiency and the priority to rectify it.

9. In general, the proper use of this 10-Step Check system will enable health workers -- especially the lower level health staff in rural areas, but also doctors and nurses in the urban clinics and hospitals -- to correctly identify priority child survival diseases and problems and provide the proper treatment, health education and referral if necessary, thereby improving the health care provided to infants and children in PNG.

IV. RECOMMENDATIONS FOR USAID AND OTHER DONORS

1. I feel that the use of this 10-Step Check, as a teaching and diagnosis and treatment tool could be of value to health care providers here in the Philippines, as well as in other countries where USAID supports health programs. I have not had the opportunity to observe the midwives here in a barangay health station (BHS) in a rural area out in the periphery. It is here in the BHSs where I would judge this system would be the most beneficial, as these health workers work alone, without daily contact with other health personnel.

Again, this system does not take the place of regular systematic history-taking and examination routines -- it provides an additional reinforcement to remember to check 10 priority areas for sick infants and children. Therefore, it would not contradict whatever standard diagnosis and treatment systems were in place. It would only enhance them.

2. What would be necessary for USAID or other donors, such as UNICEF, to consider, would be the adaptation and modification of the 10-Step check to reflect a country's local conditions, as well as the treatment regimes/protocols supported by the agency or government. Donors may also have specific guidelines for diagnosis and treatment of various disease entities which they must follow and advocate. These, by necessity, would have to be considered in the modification of the 10-Step Check if it were supported.

V. LESSONS LEARNED

1. People make programs happen. They also make the difference in the success of program implementation. The special mix of the present players coordinating and advocating the Child Survival programs in PNG -- in the NDOH, GPNG, CSSP and UNICEF -- enabled the CSP to succeed.

Because this group had all "bought into the system" of Child Survival activities, and believed in what they were doing, they were able to instill the same feelings in other groups -- other government departments, women's and church groups, NGOs, etc -- thereby redirecting the orientation of health supporters towards primary health care and preventive measures rather than curative care.

2. Community participation and involvement is essential to the success and sustainability of child survival activities. The PNG communities were very active in the form of women's groups, church groups and local government groups - all were resources which agencies tapped to support child survival interventions. Village outreach patrols, a former PNG health intervention, are again a priority in the present CSP activities and are successful because of the cross-sector community support.

3. If a program is to be effective and successful, as much emphasis as is placed on materials production and training must be placed on supervision and monitoring, which are also vital aspects of program implementation .

4. The USAID decision to close out their RDO/SP program, with resultant closure of the CSSP project stimulated a positive change. New funding and donors were found for child survival activities, and continuation of former USAID-funded training program activities was insured.

SCOPE OF WORK FOR EVALUATION IN THE PNG

From the Public Health/Service Delivery Specialist's scope of work:

F. Level of effort: Specific Tasks

7. "On the way to the Philippines, the Public Health/Service Delivery specialist will make a short visit to Papua New Guinea (PNG) to assess the child survival system developed and implemented under the USAID-funded program in (PNG). The new system is called the "Ten Step Check." The Ten Step Check is a new methodology in the diagnosis and treatment of sick infants and children. The system also - importantly - includes a related health education program for the community. This new system has been implemented in PNG over the last year. No literature has been published on the system; however, the Contractor has written (and the cognizant project officer agreed) that "The Ten Step Check material... opens an important new tool in diagnosis and treatment of sick children with (possible) world-wide application..." The evaluator - an expert in this field - will assess the effectiveness of the Ten Step Check and, as the Philippine CSP is being conducted, s/he will determine if this new methodology can be introduced to the Philippines in the delivery of child survival interventions. Although the evaluator will spend a small amount of time in the PNG, this aspect of the evaluation is for the benefit of the Philippines."

MAJOR DOCUMENTS REVIEWED

Asia Development Bank

Draft Report of a Project Preparatory Technical Assistance on Human Resource Development in the Health Sector in Papua New Guinea. May 1994

Australian International Assistance Bureau (AIDAB)

Papua New Guinea Child Survival Program Interim Support Project (Draft Design Document). February 1995

Department of Health (PNG)

Standard Treatment for Common Illnesses of Children in Papua New Guinea. A Manual for nurses, health extension officers and doctors. 6th edition 1993

Department of Health and the Child Survival Support Project

Training Materials for Health personnel

The 10-Step Checklist for All Sick Children. A desktop flipchart for health personnel.

The 10-Step Checklist for All Sick Children. Module. An In-service Course for District Health Workers.

The Diagnosis, Treatment and Prevention of Diarrhoea in Children. An In-service Course for District Health Workers.

Pneumonia (ARI) Diagnosis, Treatment and Prevention. Module. An In-service Course for District Health Workers.

Malnutrition Diagnosis, Treatment and Prevention. Module. An In-service Course for District Health Workers.

Trainers Workbooks for TOT Workshops 1 and 2.

Program Coordinator's Workbook for the Planning Workshop for the Child Survival Training Programme.

The Role of the Aid Post Worker in Village Delivery. An In-service Training Module for Aid Post Workers.

Mid-Upper-Arm-Circumference (MUAC) Tape with treatment regime.

Training Materials for Community Education:

A Happy Health Family in PNG. Flipchart, poster and pamphlet.

Diarrhoea and Your Family. Prevention and Treatment. Flipchart, poster and pamphlet.

Cough and Fast Breathing Sickness in Children (Pneumonia/ARI). Prevention and treatment. Flipchart, poster and pamphlet.

Good Food for Mothers and Children in PNG - The Six Nutrition Messages. Flipchart; and More Food More Often Every day will make Your Child Strong and Healthy. Flipchart, plus nutrition poster and pamphlet.

Malaria and Your Family. Prevention and Treatment. Flipchart, poster and pamphlet.

Injection Poster.

Immunizations to Protect Your Family. Flipchart, poster and pamphlet.

Care of Mother and Baby after Village Child Birth. Flipchart.

Department of Health and UNICEF

Crisis in Paradise. The State of Papua New Guinea's Children. A call to action. Port Moresby. 1993

John Snow, Inc.

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