

PDAA T-704
45735

TRIP REPORT OF A CONSULTATION
ON THE MONITORING AND EVALUATION OF THE
ORAL REHYDRATION THERAPY COMPONENT OF THE
USAID PRIMARY HEALTH CARE FINANCING PROJECT
PHILIPPINES

A Report Prepared by PRITECH Consultant:
ROBERT E. BLACK, M.D.

During the Period:
JUNE 13-19, 1985

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT
Supported By The:
U.S. Agency for International Development
AID/DPE-5927-C-00-3083-00

AUTHORIZATION:
AID/S&T/HEA: 12/5/85
ASSGN. NO.: DC 114

CONTENTS

I.	Executive Summary	
	A. Background	1
	B. Purpose of the Consultancy	2
II.	Current Efforts on Monitoring and Evaluation.....	2
III.	ORT Project Monitoring and Evaluation.....	3
IV.	Analysis of the CEBU Project	5
V.	Anticipated Technical Assistance for Monitoring and Evaluation	7
	Tables.....	8
	Appendices.....	10

I. Executive Summary

A. Background

A recent assessment of the Philippine National Diarrheal Diseases Control Program was completed by consultants of the PRITECH Project in 1984 (Rohde, J.E.; Fabricant, S. "Philippines ORT Country Assessment". 4/23-5/4/84, DC25). It was concluded that, in spite of efforts over the previous five years, the use of oral rehydration therapy (ORT) was not as high as expected. The use of anti-diarrheal drugs and IV fluids was still excessive. The Assessment Report identified the following problems:

1. Limited availability and accessibility to an appropriate oral rehydration product;
2. Resistance by medical professionals to practice ORT;
3. Lack of public awareness of the merits of ORT;
4. Limited manpower support within the MOH to manage and coordinate ORT activities.

In response to these identified problems, the Ministry of Health and USAID have initiated a new oral rehydration therapy component of the primary health care financing project in the Philippines. The purpose of this project is to increase the utilization of oral rehydration therapy by the following strategies:

1. Commercialization of ORS products;
2. ORT promotion among medical professionals;
3. Training of paraprofessionals;
4. Public promotion of ORT;
5. Program and staff support.

B. Purpose of the Consultancy

The ORT component of the PHC financing project is being funded by the Child Survival Action Program (CSAP) of AID. CSAP-funded projects have some special information collection and reporting requirements which have been designated Tier 1, Tier 2 and Tier 3. The ORT project in the Philippines was intended to have the type of monitoring and evaluation that would be within Tier 1 and Tier 2. The purpose of this visit was to review and comment on these components of the ORT project. In addition, Tier 3 activities were to be considered for use on data from the Philippines. Specifically examined was the feasibility of the large study being done on Cebu Island by the University of San Carlos and the University of North Carolina to enable study of the variables affecting child survival. If found feasible, the consultant was requested to comment on the importance of this data set for Tier 3 analysis.

II. Current Efforts on Monitoring and Evaluation

During the visit, Ms. Enriqueta Sullesta, CDD Task Force Coordinator, briefed the consultant on the current information collection efforts of the diarrheal diseases control program (CDD). There is a monthly report that should be completed by regional health offices on CDD activities. This includes numbers of diarrheal cases and deaths by age and information on cases and deaths treated with Oresol by location. It also includes information on Oresol supply and distribution. The reporting form for this is attached as Appendix 1. Apparently the information reported is of highly variable quality, and for the country as a whole, incomplete.

A review of the MOH Diarrheal Control Program was conducted in January 1985 by a team from UNICEF, WHO, MOH and USAID. In this review a cluster sample community-based survey was used to generate information on diarrheal disease morbidity and mortality, ORT awareness and usage, and other aspects of the program. This survey was done in the provinces of La Union, Bohol, and Bukidnon. In total, information on 11,129 children was collected. The estimates of diarrheal episodes per year per child ranged from 2.3 to 3.2. Approximately one-third of these episodes were apparently treated with ORS. The total and diarrheal mortality rates for children of five years old varied substantially. These figures are given in Appendix 2. In aggregate, the survey found a diarrheal mortality rate of 9.0 per thousand children of five years old, which was substantially higher than the estimates based on national death reporting (1.0 per 1,000 for 1982). From the survey the percentage of deaths associated with diarrhea ranged from 6.6 to 21.3 in the three provinces. It appears that the survey information provides higher and probably more realistic estimates of total and diarrheal mortality than the previous government figures would indicate.

III. ORT Project Monitoring and Evaluation

It is intended that the Program Monitoring Staff be recruited from the existing personnel of the MOH and be detailed to the office of the director of the Bureau of Health Statistics. During the visit individuals from this Bureau were consulted, along with Ms. Joy Riggs-Perla, USAID Public Health Advisor, and Dr. Rosendo Capul, ORT

Project Manager for USAID, and Ms. Enriqueta Sullesta, CDD Task Force Coordinator. In this discussion it was felt appropriate to collect the information on outputs (Tier 1) and effectiveness (Tier 2) to assess the success of the ORT program. This information would be compiled on an annual basis.

It was expected that the Tier 1 indicators would be available from routine CDD monitoring activities without extensive need for additional data collection. See Table 1 for suggested indicators. These will be reported quarterly.

On the other hand, the indicators for assessment of effectiveness in Tier 2 would take a more active approach with community- or facility-based data collection. See Table 2 for suggested indicators. It was thought that these indicators should be collected by establishing sentinel surveillance units in each of the 12 regions and Metromanila. These units would consist of selected provincial and district hospitals, selected rural health units and selected barangay health stations. The sentinel units would be visited regularly by the central program monitoring staff to collect the necessary information. In addition, data from all regional hospitals and selected other institutions, such as San Lazaro Hospital and Philippine General Hospital, would also be included in the data collection system. These units would be utilized to collect the kind of information now being requested on the monthly report of the diarrheal disease control program. The diarrheal disease morbidity, mortality, and treatment surveys from the three provinces in three regions will serve as a baseline for community data. Within the first few months of project implementation, these same communities

will be re-surveyed to gather additional baseline data which were not included in the earlier assessment. One full community-based survey will also be done at this time in Metro Manila. In this survey, some additional information appropriate to the Tier 2 indicators will be collected. No other community-based surveys will be required at this time; however, the program monitoring staff will provide technical assistance in any other provinces that desire to do such a survey with their own funds. It is anticipated that several may wish to do this and that the information would be useful as a baseline assessment, if the survey methods used were appropriate. It is anticipated that the diarrheal morbidity, mortality and treatment surveys will be repeated after two to three years of program implementation. This will provide information on changes in the levels of the Tier 2 indicators. If ORT coverage improves substantially, these repeat surveys may also demonstrate a downward trend in diarrheal and total mortality rates.

IV. Analysis of the CEBU Project

To assess the appropriateness of the Cebu project to address questions concerning the impact of the Child Survival Action Program, a visit was made to Cebu by Ms. Joy Riggs-Perla, Dr. Capul, Dr. Solon and the consultant. The project was reviewed during extensive discussions with Dr. W. Fliieger and his staff. The project involves data collection on 3,000 mother-infant pairs, which are being followed over a two-year period. The objective of this research project is to evaluate the effects of socioeconomic and demographic

variables at the community, household and individual level on health related behavioral patterns and the effects of these behavioral patterns on morbidity, growth, and mortality of young children.

It is expected that the Tier 3 evaluations will address the relationship between the Child Survival Action Program interventions and cause-specific mortality and growth. For this purpose the Cebu data set is a unique resource for analysis. Although some analyses could be done at this stage, the data collection is still far off and will not be completed until June 1986. Some financial support will apparently be necessary to enable the completion of the data collection and the preparation of data sets for future analysis. In addition, it would be possible to initiate some of the analyses of the patterns found in this study. These analyses could include descriptive analyses of water quality and quantity, fluid use for infants with diarrhea, immunization practices and other data on use of services. Future analyses could also assess the association of these intermediate variables with both their underlying determinants and their impact on growth and mortality. Of this impact evaluation, the most feasible one at the present time is that involving growth. USAID Manila was enthusiastic about the possible support for the Cebu data set.

It may also be possible to utilize some of the Cebu study communities to evaluate changes as a consequence of the ORT program over the next five years. The Cebu data would serve not only as a baseline, but as a rich data source to help determine program success or failure in the perspective evaluation. Thus, it would be desirable to utilize the Cebu area as a sentinel site of a different sort, after the current data collection is completed. USAID/Manila

felt that it would be possible to ensure that the ORT program implementation would begin early in the Cebu area. This would not involve extra program inputs, but rather ensure that Cebu would be early in the phasing of ORT activities. Continued data collection in this area would permit an early evaluation of program progress. This could involve the collection of Tier 2 effectiveness information once or twice a year over the life of the project and one or two special evaluations that would permit analyses considered to be in Tier 3. This would include an evaluation of changes in nutritional status and mortality after several years of program implementation, e.g., 1987 and 1989. Dr. W. Fleiger of the University of San Carlos, Cebu City, indicated his willingness to consider involvement in these future data collection activities for the ORT program.

V. Anticipated Technical Assistance for Monitoring and Evaluation

In discussions with Ms. Riggs-Perla and Dr. Capul, it appeared that USAID/Manila may request short-term technical assistance via PRITECH in support of the monitoring and evaluation activities. This may involve one to two consultant visits per year. The first could be within six months to review the plan for monitoring and evaluation of the ORT program.

TABLE 1

MONITORING EVALUATION OF THE ORAL REHYDRATION THERAPY COMPONENT

TIER I INDICATORS

National Rehydration Center Established

Number of Pediatricians and Trainers trained

Number of MD's, Nurses, Midwives and Others trained

Number receiving News Letter

Number attending conferences on Diarrheal Diseases

Number of households receiving leaflets

Number of Radio, TV, News ads

Number of Ministry of Health Clinics and Hospitals using ORS

Number of Medical School Curricula revised

Number of ORS products privately manufactured in the Philippines
(expected to increase)

Number of ORS products produced by the Government of the
Philippines (expected to decrease)

Management staff in place

Monitoring and Evaluation Plan prepared and staff in place

TABLE 2

MONITORING AND EVALUATION OF
THE ORAL REHYDRATION THERAPY COMPONENTS
TIER 2 INDICATORS

Number of MD's trained by pediatricians and trainers

Percentage of Nurses, Midwives, etc., who can instruct on the use of ORS correctly

Percentage of MD's prescribing ORS correctly (expected to increase to 50%)

Percentage of Mothers who know how and when to use ORS (expected to increase from 23-33% to 70%)

Percentage of commercial outlets stocking ORS products

Percentage of households receiving leaflets

Percentage of households receiving leaflets where the mother can remember specific content

Percentage of households remembering the content of Radio or TV advertisements

Percentage of households aware of ORT and where to get it

Percentage of clinics and hospitals with ORS or other materials e.g., posters for sentinel sites:

 Number of cases of diarrhea by age and treatment received

 Number of deaths associated with diarrhea by age and treatment received

Cost effectiveness studies

MONTHLY REPORT OF THE DIARRHEAL
DISEASES CONTROL PROGRAM
(Oral Rehydration Therapy)
Regional Health Office No. _____

APPENDIX I

1. Agency & Location _____
Barangay RHU PHO/CHO

2. Period covered _____
Month/Year

3. Diarrheal cases attended during the month:

	TOTAL CASES		NO. OF CASES GIVEN ORESOL		NO. OF ORESOL Packets Giv	
	RHU	HOSP.	RHU	HOSPITAL	RHU	HOSPITAL
3.1. Under 1 year	_____	_____	_____	_____	_____	_____
3.2. 1 to 4 yrs.	_____	_____	_____	_____	_____	_____
3.3. 5 yrs & Over	_____	_____	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____	_____	_____

4. Deaths from diarrheal diseases during the month:

	TOTAL DEATHS		NO. OF DEATHS GIVEN ORESOL		NO. OF ORESOL Packets Giv.	
	RHU	HOSP.	RHU	HOSPITAL	RHU	HOSPITAL
4.1. Under 1 year	_____	_____	_____	_____	_____	_____
4.2. 1 to 4 yrs.	_____	_____	_____	_____	_____	_____
4.3. 5 yrs & over	_____	_____	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____	_____	_____

5. Oresol Supply and Distributions:

- 5.1. No. of packets at the beginning of month _____
- 5.2. No. of packets received during the month _____
- 5.3. No. of packets distributed/dispensed during the month _____
 No. of packets distributed to households _____
- 5.4. Balance at the end of month _____
- 5.5. Do you need more Oresol than you are getting? Yes _____ No _____
 If yes to 5.5. how much more per month? _____ packets of Oresol

6. Consolidated: Oresol supply and distribution (to be accomplished by RHUs, PHOs/CHOs and HHOs)

- 6.1. No. of packets at the beginning of month _____
- 6.2. No. of packets received during the month _____
- 6.3. No. of packets distributed/dispensed during the month _____
 No. of packets distributed to households _____
- 6.4. Balance at the end of month _____

7. COMMENTS: - (on problems in the acquisition & distribution of Oresol, on administration and reporting and recommendations to these problems.)

8. Submitted by: _____

 Name/Designation

PLEASE INDICATE PROVINCES/CITIES/HOSPITALS WHICH ARE NOT INCLUDED IN THIS REPORT.

9. Date Submitted: _____

10. Noted by: _____

Table 4. MORBIDITY, MORTALITY AND TREATMENT SURVEY, JANUARY 1965

	La Union	Bohol	Bukidnon	Aggregate
Children under 5 yrs. covered	3766	3659	3704	11,129
Households visited	2678	3303	2725	8,706
Children with diarrhea (past 2 weeks)	335	406	460	1,201
Average child per household	1.4	1.1	1.4	1.3
Diarrhea episode/child/year	2.3	2.9	3.2	2.8
Treatment No. (%)				
None	24(7)	46(11)	72(16)	47(12)
ORS	146(44)	123(30)	123(27)	131(33)
I.V.	15(4)	8(2)	15(3)	13(3)
Others*	247(74)	292(72)	322(70)	287(72)
Mortality rate/1000 - all causes (Children under 5 yrs)	15.9	18.2	43.6	26.0
Mortality rate/1000 - diarrhea - related (Children under 5 yrs)	2.9	4.6	18.3	9.0
Infant Mortality rate (per 1000 LB)	35.8	55.5	94.0	69.0

* includes herbal, anti-diarrheals, antibiotics, etc.

Table 5. FREQUENCY DISTRIBUTION OF CAUSES OF DEATHS BY PROVINCE 1965

CAUSES OF DEATH	LA UNION		BOHOL		BUKIDNON	
	NO.	%	NO.	%	NO.	%
Diarrhea	4	6.6	7	10.3	36	21.3
Measles	3	4.9	8	11.8	35	20.7
Others*	25	41.0	26	38.2	33	19.5
Pneumonias	11	18.0	10	14.7	21	12.4
Unknown	1	1.6	4	5.9	19	11.3
Tetanus	0	0	0	0	8	4.7
Malnutrition	6	9.9	3	4.4	7	4.2
Cough	11	18.0	10	14.7	10	5.9
T O T A L	61	100%	68	100%	169	100%

*includes fever, meningitis, prematurity, accidents and all other causes not listed above.