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FIRST ANNUAL REPORT

1990-1991

for

CHILD SURVIVAL VI

OTR-0500-A-00-0098-0

PAKISTAN



Submitted to

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

Washington, D.C.

by

ADVENTIST DEVELOPMENT AND RELIEF AGENCY INTERNATIONAL

Silver Spring, MD

October, 1991

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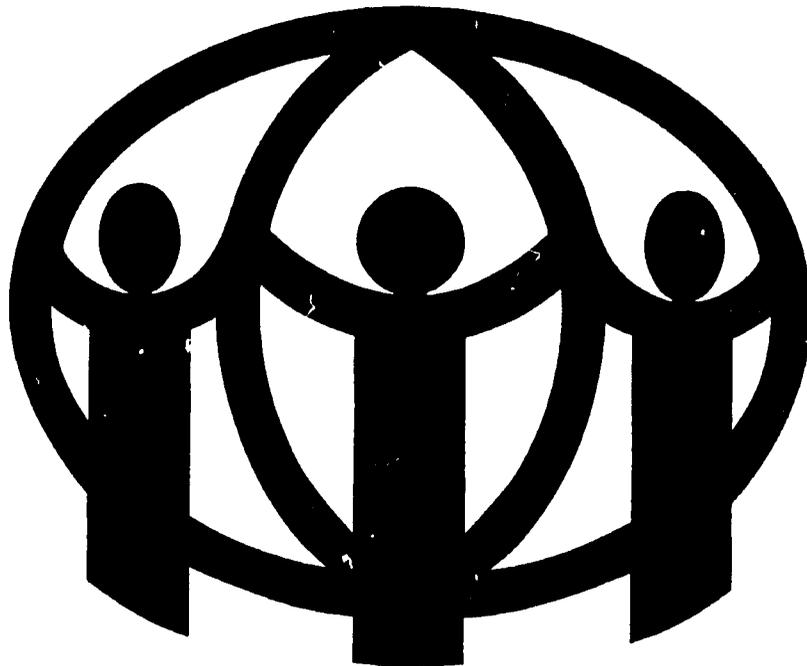
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Due to the legal prohibitions against United States assistance to Pakistan contained in Section 669 of the Foreign Assistance Act, A.I.D. ceased providing funds for this project as of September 30, 1991. Project activities for the month of October 1991, therefore, which include preparation of this report, were severely curtailed. Under these unfortunate circumstances, ADRA International contacted A.I.D. Washington's Mr. John McEnaney and was assured that whatever report on activities the staff managed to produce would be sufficient as an end-of-project report.

ADRA International considers the completeness and detail of this report to be excellent, in light of this circumstance.

ADRA CSP VI ANNUAL REPORT

October 1, 1990 - September 30, 1991

I. CHANGES IN PROJECT DESIGN

A. Statement of Country Project Objectives

After a change of Project Directors in June 1991, the project's DIP was written. According to the objectives defined in this DIP, the project is expected to achieve the following by September 30, 1993:

- a. 70% of villages (250) will have a sustainable system of health education, immunization and referral.
- b. One Community Health Committee for every 300 families (60 CHCs) will be established and functioning.
- c. 60 Community Health Organizers (1 for every 10 Village Health Workers) will be selected, trained and functioning.
- d. Training will be provided to at least one Village Health Worker for every 30 families (or 600 VHWs, approximately half male and half female) who will continue working after project staff leave the area.
- e. At least one Static Health Clinic with staff, supplies and cold chain will be functioning in each of the four target Union Councils, providing all Child Survival Project (CSP) services.
- f. Assure that 75% of under-ones, estimated 2,970 annually, are immunized against BCG, diphtheria, pertussis, poliomyelitis, tetanus, and measles.
- g. Immunize 80% of women of child bearing age (15-45 years) or approximately 19,360 with two doses of Tetanus Toxoid (TT).
- h. 80% of mothers of children under two (approximately 6,160) will be able to present their child's health/EPI record.
- i. 70% of mothers of children under two (approximately 6,160) will be able to explain three benefits of immunization.
- j. Sixty percent of children under five (10,560) who develop symptoms of diarrhea will receive appropriate ORT.

- k. 80% of mothers with children under 5 will be trained in ORT/CDD.
- l. 70% of mothers with children under 5 will be able to demonstrate how to properly prepare ORS, home SSS or cereal-based ORT.
- m. 75% of children under age 5 (13,200) will be weighed and evaluated on a regular basis (at least once every two months) in a growth-monitoring program.
- n. 60% of these (7,920) will show a positive weight gain over three months.
- o. Sixty percent of mothers with children under two (approximately 4,620) will have given them appropriate weaning foods by age 6 months.
- p. 80% of mothers of children under two (6,160) will have received training in appropriate nutrition for weaning.
- q. There will be a 50% decrease in the incidence of second and third degree malnutrition of children under two. (Number of eligibles to be determined after baseline survey.)
- r. 80% of mothers of children under 2 (6,160) will have given their child colostrum.
- s. Seventy percent of pregnant women (3,157) will receive antenatal care (at least two visits with qualified staff at a static health center (SHC) or a home visit with a trained TBA).
- t. Ten percent of CBA married couples in the target areas (1,760 couples) will use appropriate methods for birth spacing.

B. Location and Size of the Priority Population Living in the Child Survival Impact Area

The target populations in the four Union Councils (using a total population of 110,00 from 1981 government census figures) are as follows:

Newborns	5,170/yr	4.7%
0-11 months	3,690	3.6%
12-23 months	3,740	3.4%
2-4 years	9,900	9.0%

Pregnant	4510	4.1%
Women CBA	24200	22 %
Married CBA	17600	16 %

C. Health Problems which the Project Addresses

The Child Survival VI project is a community-based primary health care project designed to reduce the infant, child and maternal mortality and morbidity in the target areas. It will do this by working to make the community more self-sufficient in appropriate health care, by training and utilizing Community Health Committees (CHCs), Community Health Organizers (CHOs) and Village Health Workers (VHWs) for health education and service delivery. Key interventions include immunization (EPI), health and nutrition education, control of diarrheal diseases (CDD), antenatal care, birth spacing (family planning - FP), and growth monitoring.

D. Child Survival Interventions

No change

E. Strategies For Identifying and Providing Service to Individuals at Higher Risk

No Change

II. HUMAN RESOURCES AND COLLABORATION

A. Job Descriptions/Organizational Chart

See organizational chart, job descriptions and resumés in Appendices A, B and C respectively.

Naomi Esau, RN, Project Director, resigned effective June 2, 1991 and Larry Blewett, MPH was immediately appointed to take her place. Ayub Walayat, Community Development Officer, did not return from the ADRA Child Survival Workshop held in the States November 1990. Iqbal P. Gill was appointed Community Development Officer in June 1991. Debra Kachic, Program Coordinator, was out of the country January 17, 1991 - March 18, 1991 due to the Gulf War. Charles Walayat resigned as Business Manager effective August 14, 1991 to pursue his career in dentistry. Jamil Masih took his place with a month overlap for orientation.

B. Technical Assistance**CSP VI Training Programs**

Training: Consolidation on role of CHAP (Christian Hospitals Association of Pakistan) in Primary Health Care Training Projects

Date: September 16-19, 1991

Place: Multan, Pakistan

Trainer: CHAP (Christian Hospitals Association of Pakistan)

Participants: Naomi Esau, Project Director
Ayub Walayat, Community Development Officer
Debra Kachic, Program Coordinator

Training: EPI/CDD

Date: Classroom - October 14-16, 1990
Practical - October 17-21, 1990

Place: Karachi, Pakistan

Trainer: Dr. Imtiaz Moghul (EPI Office, Karachi)

Participants: Anthony Gill, Vaccinator
Arshad Inayat, Vaccinator, Refresher course, already had certificate
Mushtaq Ranja, Vaccinator, had certificate
Bashir Baluch Rasheed, Vaccinator
Mohd Hussain, Vaccinator
Ghulam Mustafa Barijo, Vaccinator, Earned EPI
Munawar Ali Khan Durrani, Vaccinator, Certificates
Javed Noor Jokhio, Vaccinator
Sarfranz Akhtar, Driver

Sarwar Khamoo, LHV Attended Course, but not fully qualified giving vaccinations; no certificate given

Edith Saleem, CHW
Ejaz-ul-Haq, Driver
Tariq Gill, Driver

Training: Survival Workshop

Date: November 7-21, 1990

Place: Washington DC, USA

Trainer: ADRA International

Participants: Kaare Anderson, Country Director
Naomi Esau, Project Director
Debra Kachic, Program Coordinator
Ayub Walayat, Community Development Officer

Training: Project Management

Date: September 9-12, 1991

Place: Mission Christian Hospital, Sialkot, Pakistan

Trainer: Christian Hospitals Association of Pakistan (CHAP)
Primary Health Care Training Project

Participants: Larry Blewett, Project Director
Debra Kachic, Program Coordinator
Iqbal Puran, Community Development Officer
Jamil Masih, Business Manager

Other Assistance:

April/May 1991 - On site visit by ADRA International personnel to assist in writing the DIP

C. Community Activities

Due to the Gulf War in January 1991 and the change of Project Directors in June 1991, the DIP was not completed until June 12, 1991. Project activities have essentially been a continuation of CSP III activities. Three mobile teams each consisting of 3 male vaccinators, 1 female LHV (or RN) and a driver have gone out daily from Karachi Adventist Hospital to deliver EPI, CDD, antenatal care, birth spacing (information, oral pills, injections and condoms were dispensed), growth monitoring and nutrition education. The end of May 1991, CSP VI was advised to scale back activities and staff

pending possible notification of A.I.D. funding cutoff. Late August 1991 ADRA International informed CSP VI that cutoff was eminent and at that time 8 staff were given 30 days notice of layoff. See attached summaries for number of recipients of each CSP intervention activity.

A medical camp was held in Moidan, the project's furthest and most needy area, March 13-14, 1991. CSP staff continued their usual activities as well as assisted doctors from Karachi Adventist Hospital, Civil Hospital and District Council in seeing 312 patients and dispensing medicines.

There are no known, active community health committees which ADRA is currently working with in our project area. CSP VI has been without a Community Development Officer most of the year.

D. Linkages to Other Health and Development Activities

A proposal was submitted to UNICEF in June 1991 for funding for supplies and training of staff in 1992. Mr. Jafri from UNICEF has been very supportive of us and feels confident that our proposal will be approved. Mr. Jafri has been instrumental in helping us develop ideas about community development which we have incorporated into the DIP. As of this date, however, there has been no definite word from UNICEF regarding approval of our proposal or the training they promised to offer.

In May 1991, ADRA along with two other NGO's (HANDS and Baqai Medical Complex) and District Council met together and discussed doing a joint project at a selected site in Gadap (Deh Langheji). Three meetings have taken place, but a firm plan of implementation has not yet been developed. Hopefully cooperation between these organizations will continue and there will be fruit from the meetings which have already taken place. ADRA CSP's input to the joint effort would be EPI services and training of VHWS.

Through ADRA/Sweden, a charity foundation has donated funds to ADRA CSP to provide hospital care at Karachi Adventist Hospital for needy patients in our project area. The funds are to be used by the end of 1991 and new funding for each year can be applied for through ADRA/Sweden. Due to recent changes in the project (change of directors, cut of A.I.D. funding, KAH RMOs unable to arrange schedules to accompany teams, etc.), only three patients from our area have been able to use this charity fund after we were notified of its availability in June 1991. Because of this ADRA/Sweden has allowed the funds to be used for any needy patient at KAH whether from our project area or not. ADRA CSP has also made an agreement with Baqai Medical College, working in Gadap, to take up to five

charity cases/month which they would refer from our project area. This fund is much appreciated as, in the past, we have been hesitant to refer patients to our own hospital as we know they are unable to afford even KAH's concession rates. We hope that our recent slow down in activities will not hinder our chances to continue receiving this much appreciated funding in the future years.

This year ADRA entered into a cooperative agreement with INMED and a local Nestle company to design and produce two nutrition flip charts in Sindhi. They are to focus on nutrition for the pregnant/lactating woman and weaning nutrition. ADRA CSP has drawn preliminary sketches for each of the messages and has consulted Dr. Gaffar Billoo, President of Pakistan Pediatric Association for his input and comments. The charts are now ready for artists to draw samples for field testing. INMED hopes to have one flip chart completed by the end of 1991 for field testing. ADRA CSP's input into this project is chart information, research and design. INMED and Nestle will be responsible for financial outlays. When completed, these charts will be available to other organizations for health education as well as possible translation to other local languages or adaptation for international use.

III. PROGRESS IN HEALTH INFORMATION DATA COLLECTION

A. Baseline Survey

In early September 1990, a thirty cluster survey was conducted with the intention that it would serve not only as the final evaluation of CSP III, but the baseline for CSP VI. Unfortunately the survey was not field tested, CSP staff were not adequately trained in survey methods, local people were not involved in the survey and many questions were either not asked or questions different from the actual intent of the original question were asked/answered. A recheck of many of the villages regarding vaccination status showed that many who were noted "no immunization" in the survey had actually been immunized either by another organization or according to ADRA CSP's vaccination registers. This made this survey of questionable value and not useful for a baseline for CSP VI. Since this was done during CSP III, the cost of the survey came out of CSP III's budget, not CSP VI. Time was spent during CSP VI going back to each of the 259 villages to determine the immunization status at the time of the survey (September 1990) of those originally surveyed. Accurate population figures are still not known for ADRA's project area; however, the immunization coverage as found in the September 1990 30 cluster survey can be considered accurate as the immunization status for each household surveyed was rechecked and appropriate corrections made to the survey results.

During the writing of the DIP in June 1991, a plan was worked out to do a baseline survey village by village as the community development work was taking place in those villages, rather than doing a survey of all of the villages first before beginning any development work. A formal house to house survey/registration will be completed in each of the initial target villages before VHWs are trained in that village to determine baseline statistics and identify individuals eligible for CSP interventions. Local volunteers will be trained to conduct the survey under the supervision of ADRA CSP staff.

A baseline survey was developed in August 1991 and has been translated into Sindhi. It is to be field tested in October 1991. The survey contains only questions pertaining to ADRA's target interventions. When ADRA is able to move on to the next group of villages, then the survey will be conducted there after training local volunteers. In areas where the baseline survey has been completed, this data can be used at midterm and final evaluations. In areas where the baseline survey has not been completed, government population figures and a random household survey will have to be used.

B. Health Information System

Data from the survey will serve as the baseline for any future project evaluations. From the survey, eligible women and children will be registered in the appropriate registers for CSP interventions. In the future these registers will be updated by adding only the names of newborns, newly pregnant women, in/out migrations and deaths. These registers will be maintained by the Volunteer Village Health Workers (VHWs) and Community Health Organizers (CHOs) after training from ADRA staff. Government EPI registers will be maintained by ADRA staff and then by DHO after they assume full EPI delivery responsibility in our areas.

Data for project interventions will be collected on a monthly basis from the VHWs by the CHOs. The CHOs will give this data to the Program Coordinator. It will be input into ADRA's HIS on the computer. Data will be analyzed and interpreted by the Program Coordinator and Project Director so specific recommendations regarding any change in project implementation or strategy can be made to the Management Committee. The Project Director will use these monthly reports to make his quarterly reports to ADRA International, USAID and GOP. Program intervention results will be reported by the Program Coordinator back to the CHOs who will in turn share this information with the VHWs. The VHWs and CHOs

will not be dependent on the computer analysis, however, to determine eligible intervention recipients. They will use their intervention registers to schedule and follow-up participants and drop-outs.

ADRA CSP VI has not initiated an active surveillance system to detect and investigate cases of acute paralysis in children below 15. There are no plans for EPI disease surveillance at this time on ADRA's part, as no health personnel are consistently available in these communities to accurately document diagnosis. Villagers are not able to give reliable causes of death or illness, often stating fever or fits as the problem. When qualified ADRA staff are available to make an accurate diagnosis, appropriate MOH forms will be filled out and submitted to the DHO, EPI and DC for their records.

IV. IMPROVEMENTS IN PROGRAM QUALITY AND TECHNICAL EFFECTIVENESS

Activities have continued as in CSP III without many changes. There has been an increased emphasis on growth monitoring and nutrition education and these activities are now taking place on a more regular basis than before. 1,616 children under five were registered for growth monitoring this year. Out of these, 40% were weighed at least two times during the year; 18% three or more times.

ADRA staff have received teaching on growth monitoring techniques and maternal and weaning nutrition during staff meetings and on site visits by the Program Coordinator. They have been using UNICEF and Aga Khan flip charts to help advise women on proper nutrition. Due to the lack of good flip charts on nutrition, ADRA is in the process of developing two flip charts with INMED and Nestles.

V. WORK SCHEDULE

A. Problems/Constraints

1. CSP III staff were rehired and activities began in CSP III continued without a break. This meant a major amount of time and energy needed to be spent supervising activities and dealing with day to day problems such as vehicle maintenance. Work on the DIP did not begin until April right before ADRA International consultants arrived. Beginning activities before the DIP was written meant that the goal and focus of activities was that of CSP III, not CSP VI. After a change of directors in June 1991, the DIP was written and plans made to stop all activities for the month of October 1991 to orient and retrain staff for CSP VI goals and activities.

2. **ADRA International consultants were originally scheduled to be in Pakistan January/February 1991 to help write the DIP, but due to the Gulf War these plans were delayed until late April 1991. Also during the time of the Gulf War, many field activities had to be suspended due to unrest in Karachi.**
3. **In early November 1990, the Community Development Officer left Pakistan to attend the Child Survival Workshop in the Washington, DC and did not return to Pakistan after that. A new CDO was not appointed until June 1991. Since the groundwork for any community development activities is the responsibility of the Community Development Officer, there has essentially been not much activity in the past year working with local communities to lay the foundation for long term development of their community. The current CDO has been with the project since the beginning (CSP III), knows the target area well and has good relations with people in the community. A firm schedule has been outlined for formation of community health committees and VHW training program to begin as soon as funding is secure. (We have held off on development activities after writing the DIP pending notification of our funding status. We don't want to form community health committees and make promises which we can't keep in the end if we don't have sufficient funding to carry us beyond three months.)**
4. **Due to various reasons, management staff have been out of the country for large blocks of time. The Director, Coordinator and CDO were gone the month of November 1990 for a workshop. The CDO never returned. The Director went on furlough after the workshop, returning to Pakistan early January. The Program Coordinator was then gone for two months (mid January-mid March) due to the Gulf War. This led to poor communication and coordination amongst management personnel as well as sporadic supervision of staff and field activities. The current management team (Director, Program Coordinator, CDO, Business Manager and Director of KAH School of Nursing) works together well and has been having regular weekly meetings to coordinate plans and make decisions.**
5. **Due to irregularities noted in the baseline survey done in September 1990, it was decided at the Child Survival Workshop in November 1990 that instead of redoing the whole survey, the immunization status of each household interviewed should be rechecked on those surveys where the noted information was questionable. Rechecking required a major amount of time from the Program Coordinator and a**

couple other staff members, which took away from time that could have been spent doing other things. Other baseline information will be obtained as noted in III.A and III.B.

6. At the end of CSP III, ADRA CSP was left with four vehicles. Two vehicles (Land Cruiser and tan Suzuki jeep) belong to the government of Pakistan and were given to ADRA to use as we are helping the government through our EPI activities. The Land Cruiser was in the workshop for a major overhaul and repair of much needed body work during September/October 1990. The tan Suzuki is 9 years old and has had a chronic clutch problem requiring it to be in the workshop as much as it is in the field. The other two vehicles (Pajero and white Suzuki) were Karachi Adventist Hospital's match for the CSP III project. Both vehicles have had multiple mechanical problems. The hospital's own vehicles are in poor shape so they have been requesting to have these vehicles back. After completing necessary mechanical and body work on both these vehicles, ADRA CSP will be returning them back to the hospital.

A Land Rover was purchased in January 1991 from ADRA Pakistan with ADRA International matching funds. Soon after its arrival in Karachi, the vehicle was involved in a major accident requiring extensive engine and body repairs. It is still in the workshop as of today. Due to chronic vehicle problems, much time has been wasted in looking after vehicle repairs and in time ADRA staff were unable to complete field activities due to lack of transportation. The Land Cruiser and tan Suzuki are currently in the workshop for mechanical repairs. ADRA CSP plans to continue to use these two vehicles as well as either the repaired Land Rover or a new vehicle bought with funds from selling the Land Rover and ADRA International matching funds which have been set aside for this purpose. ADRA CSP would prefer to use new vehicles in the future because in addition to the frustration and time wasted when schedules and plans have to be changed due to unreliable transportation, maintenance costs of old vehicles is far greater by the end of the year than the cost of a new vehicle. An ideal plan would be to keep each new vehicle approximately two years, selling them before they start having major maintenance costs and while we can still get a good price; and using this money to purchase another new vehicle.

B. Work Plan

September 30, 1991 was the last day that CSP VI will continue its current schedule of activities. This was the last day of work for eight laid-off staff due to the A.I.D. funding cut. Remaining staff will be organized in the following manner: Two vaccinators and a lady community health worker (paid ADRA staff) will continue mobile CSP services to Moidan and Gadap Union Councils, leaving and returning to Karachi Adventist Hospital each day. While covering the Moidan area, the team will stay overnight as needed due to the traveling distance from Karachi.

A community development team consisting initially of two Sindhi speaking female LHV's and two male Health Trainers (chosen from our current vaccinators for their ability to teach as well as communicate in Sindhi) will work closely with the Community Development Officer and Program Coordinator to begin training VHWs in the Konkar Union Council. Two more vaccinators will travel with this team to Konkar and will do vaccinations in Konkar Union Council by motorcycle. The motorcycle will be kept locked in ADRA's center in Konkar and the vaccinators will travel to and from Konkar daily with the community development team.

All CSP activities will be stopped in Songal as ADRA no longer has the resources or staff to continue working in that area for the present. The EPI Project Director, District Council and DHO West have already been informed of this decision.

ADRA has chosen to begin our community development in Union Council Konkar first. This area is closest to Karachi, has a higher general level of education than the other three areas, has several areas with village committees and organizations and already has cold chains established, a hospital, a family planning center and GOP and NGO workers active in the area. Often people who are more highly educated to begin with are easier to train and motivate, and may value and desire more education. This area also has a larger population than the other three Union Councils.

We plan to finish VHW training and turn over EPI responsibilities to the DHO in Konkar by September 30, 1992. The next Union Council entered will be Gadap and ADRA will finish VHW training and turn over EPI responsibility to DHO there by June 30, 1993. Moidan will be the last Union Council entered; it's currently estimated population is less than 4,000. ADRA will finish VHW training and turn over EPI responsibility in Moidan by September 30, 1993

September 1991 - Inform areas of new schedule, Mother card, Child card, antenatal card and family registration folder which have been already designed by ADRA CSP to have art work done by artist and cards/stickers printed and ready for use in field by November 15, 1991.

CDO to begin forming Community Health Committee in Mazar Khan Goth (Deh Darsano Chano, Konkar) - est. population 2200.

October 1-17, 1991 - Staff training at ADRA CSP office, Karachi Adventist Hospital. Training to include content and how to teach VHW curriculum, as well as training in baseline survey method and how to teach this to VHWs. Training will include practice of practical skills, food and ORS preparation demonstrations and making of teaching materials to be used during training sessions. All ADRA field staff as well as some KAH nursing students will participate in this training session.

October 20-25, 1991 - Communication/Health Education Seminar by CHAP PHC Project in Multan to be attended by one LHV and one male Health Trainer. Due to restraints on workshop size, total ADRA staff is unable to attend. The two attending will be responsible to teach ADRA staff what they have learned when they return. Topics include: principles of health education, listening skills, methods of health education, locally available material, producing relevant materials and messages.

October 27-November 7, 1991 - Training of volunteer VHWs in Mazar Khan Goth in baseline survey and conducting survey to include all households in Mazar Khan.

Mobile vaccination team in Gadap/Moidan and on motorcycle in Konkar to begin EPI and CSP activities in these areas again.

November 10-15, 1991 - Refresher in Primary Health Care seminar by CHAP PHC Project in Multan to be attended by ADRA. Topics include: PHC-definition, principles and importance, eight elements of PHC, priorities for Pakistan, community participation, supervisory skills, experience and resource sharing.

Tabulation/analysis of Mazar Khan baseline survey.

November 17-December 5, 1991 - 3 week VHW training session in Mazar Khan.

Formation of Community Health Committee from remaining villages (approx. 18) in Deh Darsano Chano, Konkar excluding Dur Mohd Goth which already has a community health system in place and functioning. Total population of remaining villages estimated to be 3600.

December 9-12, 1991 - Sanitation and Water Supplies seminar by CHAP PHC Project in Multan. ADRA staff attending not determined at this time.

December 15-January 2, 1992 - Training of VHWs in baseline survey and conduction, tabulation and analysis of survey in remaining villages in Deh Darsano Chano, Konkar

January 5-23, 1992 - 3 week VHW training session in Deh Darsano Chano, Konkar.

At this point the community development team will split into two teams, conducting training sessions simultaneously in different locations. In addition to VHW training sessions, there will be one week follow-up/refresher training sessions. It is estimated that a total of 15 sessions will be required to completely cover the Union Council of Konkar. These 15 sessions will include three weeks for baseline survey training, conduction and analysis, three weeks for VHW training and, later on, one week for follow-up/refresher training for each group for a total of 105 working weeks. Since the teams will be splitting in two the end of January, all of Konkar should be completed by October 1, 1992. Another LHV and male Health Trainer may need to be hired at some point in order to accomplish this goal. Also training sessions will only last half the day, so training sessions can be held in one group in the morning and follow-up or other sessions can be held with another group in the afternoon.

ADRA also plans to establish two cold chains in Konkar in addition to the already existing ones covered by other agencies (both NGO and government). One cold chain would be established in Mazar Khan Goth to be staffed by volunteers from Mazar Khan. The vaccinators assigned to cover Konkar with EPI services on motorcycle would be responsible for establishing the cold chain at Mazar Khan and training the volunteer vaccinators in EPI technique. The location of the other cold chain will be determined later.

VI. EXPENDITURES AND JUSTIFICATION FOR BUDGET CHANGES

A. Pipeline

Please see attached Pipeline Analysis, Form A in Appendix D.

VII. SUSTAINABILITY

A. Recurrent Costs

Activities which will require further funding to be maintained after the project ends are: RMO visits, retraining of VHWs or new VHW training, mother/child cards and stickers, family registration cards.

ADRA CSP worked out an agreement with KAH so their RMOs on their days off could accompany ADRA CSP teams to hold clinic in the project areas. ADRA CSP planned to pay each RMO Rs. 150/day for their services. Unfortunately, RMO schedules currently have them all scheduled off on Fridays and Saturdays only, which are the only days CSP does not go to the field. The Director and KAH Medical Director will be working out another plan to involve KAH RMOs in CSP field activities. ADRA CSP plans to charge a nominal fee for consultation with the RMO and medicines which would help recover some of the RMOs salary. After CS project ends, communities would be responsible for arranging the salary and transport of any RMO holding clinic in their community

As far as continuing supplies of mother/child cards, stickers for the cards and family registration cards, it is possible if this tool is proved to be successful, that UNICEF may pick up the cost of reprinting of these materials after ADRA CSP funding ceases.

Training of new VHWs or refresher/ongoing courses for trained VHWs is an activity that will probably cease after CSP funding terminates, unless there is another agency or government department that can take over these activities. It is unlikely anyone else will take over these activities. As far as supervision and motivation to continue activities after ADRA moves on to another area, it is hoped that the involvement of the Community Health Committee will provide the needed encouragement and accountability.

B. Strategies for Reducing Sustainability Concerns

Initially village heads of each village will be approached and asked about their communities needs by our Community Development Officer. We will

then explain who we are as ADRA and what we have to offer, i.e. community development program, not services per se. If the village head feels ADRA can help his community then we will suggest the formation of a Community Health Committee. This committee will be asked to assess their community's needs together and ADRA and the CHC will agree on a plan of action. The CHC will select VHWs for training and ADRA will ask them to consider how they will maintain these VHWs after they are trained - will they pay them from a community fund or will they be volunteers. ADRA doesn't want to train VHWs who will only function for 6 months, then lose interest.

After VHWs are selected ADRA will train them in survey and data collection and these volunteers will conduct a household survey in their community under ADRA staff supervision. The survey will contain questions regarding information relating to ADRA's intended interventions as well as questions regarding the community's felt needs and priorities. ADRA staff will tabulate and analyze the surveys and report back to the CHC. ADRA will try to help the community solve it's top felt need if possible. (e.g. if the top need is water, ADRA will help the community write a proposal for the government matching scheme for a water project or direct the community to someone who can help them write it.) ADRA may help the community find alternative ways to meet their needs. (i.e. suggest the village move to a place where there is a good water supply and help them find the people/funds to do this.)

The CHC and ADRA then will put down on paper what the community's inputs and commitments to the VHW training will be and what ADRA's inputs and commitments are. Putting this down on paper gives a sense of permanency and commitment. ADRA will then plan a VHW curriculum specific for this community's needs (from the basic ADRA VHW training course). After VHWs have completed their training, ADRA will select a CHS from the VHWs and this person will be a member of the CHC. ADRA will encourage the CHC to continue meeting to try and resolve the other problems on their felt needs list. Project intervention data and progress will be reported back to the CHC on a regular basis through the CHS.

A sense of ownership will be fostered because the village heads and community have been involved from the beginning. It has been the CHC and ADRA's plan, not just ADRA's plan.

At the end of this CSP VI grant, sustaining activities will be a demand for health services. The CHC's will continue to function in each community and the system of Volunteer Health Workers will continue their activities to

improve the health of the community. We have the written assurance that cold chains and EPI will be taken over and maintained by the EPI/DHO/GOP.

ADRA has designed both Child Health Cards and Mother Health Cards to use as motivational/teaching tools in the field. Attractive, long-wearing records cards of CSP interventions will be provided for the child's and mother's health record for the family to keep. The child's card will contain information on immunizations given as well as those still needed to complete immunization. The card shows a picture for each injection/oral drops required of a child inflicted with the disease the immunization is to protect against. After the vaccine is given a sticker with a healthy child will be put over the sick child. ADRA plans to use colorful pictures of children from our project area to produce the stickers. A growth monitoring card is included in the child's card. Three panels show how to prepare ORS, SSS and cereal based solution as well as which weaning foods to give at which age. There is a place on the front of the card for a picture of the child and mother. Plastic envelopes will be provided to protect the cards. Having an attractive, sturdy record with the baby's picture will give the mother something to be proud of and hopefully increase demand for immunization and other CSP services even after ADRA is no longer working in the area, as well as serve as an educational tool and reminder for the mother of messages taught by ADRA staff and VHWs.

The mother card is designed similar to the child card with a place for immunization record/stickers, birth spacing record, breast feeding/colostrum education, pictorial reminders of messages on high risk pregnancies, healthy diet for pregnant/lactating mothers and hygiene.

ADRA plans to phase over major program responsibilities to local CHC's from the beginning as soon as village health workers are trained and functioning. Program management skills will be strengthened by monthly and quarterly monitoring, progress reports and retraining as needed until the system is established in each community. The program will become self-sustaining as the health of the community improves and personal benefits are realized by individual program recipients.

C. Cost Recovery Activities

Our village sources tell us that treatment received free is not valued as much as that for which a charge is made. Therefore CSP plans to charge a minimal fee for contraceptives and medications dispensed for minor ailments. This will help replenish funds needed to purchase replacements under the PPWA and UNICEF distribution and replacement policies.

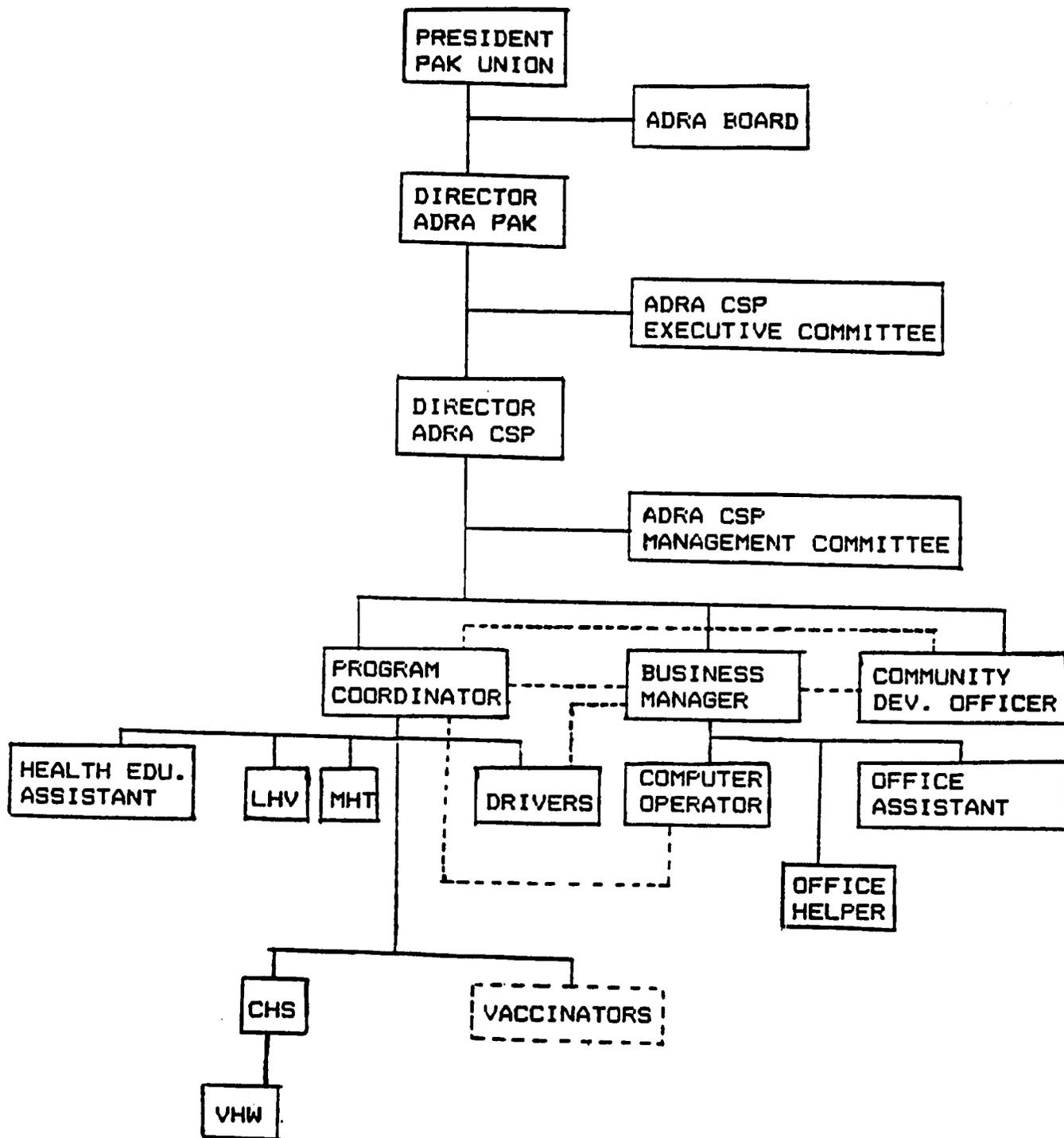
Services of the Drs. who will be participating in one day per week clinics with the ADRA CSP teams will be charged at Rs. 5 per consultation.

At present, for any medicines dispensed by mobile teams, outside of Panadol in connection with EPI, there is a charge of 2 Rs. per patient regardless of the type or amount of medicine(s) dispensed. This has been put in a rolling fund to purchase further medicines. Since October 1, 1990, ADRA CSP has collected 2898 Rs. for medicines and spent 2308 Rs. on medicine purchases. Some medicines dispensed have been given to ADRA free of charge by UNICEF or pharmaceutical companies.

10/10/2020

APPENDIX A: Organizational Chart

ORGANIZATIONAL CHART



APPENDIX B: Project Staff Job descriptions

APPENDIX B

PROJECT DIRECTOR

1. **Chairman of CSP Management Committee.**
2. **Maintain contact and coordinate with other NGO's as well as GOP (e.g. UNICEF, District Council, DHO,etc.).**
3. **Submit trimesterly project activities report to ADRA Interna-tional.**
4. **Coordinate consultant, ADRA International and USAID visits.**
5. **Hold regular staff meetings and weekly CSP Management Committee meetings.**
6. **Make biannual personnel performance report.**
7. **Secretary to CSP Administrative Committee.**

PROGRAM COORDINATOR

1. **Responsible to Project Director.**
2. **Supervises all CSP field activities.**
3. **Updates skills and knowledge of LHV/MHT/VHW/CHO.**
4. **Plans and conducts VHW training sessions.**
5. **Provides minimal curative care in the villages.**
6. **Gives technical advice to LHVs/MHTs.**
7. **Coordinates schedule of LHVs/MHTs.**
8. **Coordinate CSP activities with other NGOs/government.**
9. **Any other job assigned from time to time by Project Director.**

BUSINESS MANAGER/FINANCIAL ADVISOR/ACCOUNTANT

1. Responsible to Project Director.
2. Supervise CSP accounts.
3. Secretary to the CSP Management Committee.
4. Responsible for vehicle maintenance, registration and insurance.
5. Drawing and disbursement of money, including payroll.
6. Arranges for annual financial audits.
7. Supervise office personnel.
8. Any other job assigned from time to time by Project Director.

MIS OFFICER

1. Responsible to Business Manager.
2. Computerize: M.I.S.
 Accounting
 General statistics and generates statistical reports
 Village registration
3. Responsible for computer and software maintenance.
4. Any other job assigned from time to time by Business Manager.

COMMUNITY DEVELOPMENT OFFICER

1. Responsible to Project Director.
2. Establish and maintain good relationship with village chiefs, councillors, chairman and health personnel working in the area.
3. Motivate community people to form village health committees and guide them to discover ways to meet felt needs of community.

4. Assists in planning and conducting VHW training sessions.
5. Coordinate with other NGOs/government agencies.
6. Explore government/NGOs resources for socioeconomic development (SED).
7. Any other job assigned from time to time by Project Director.

VILLAGE HEALTH WORKER

1. Responsible to Community Health Organizer (CHO).
2. Teach basic health principles to his/her community through flip charts, health talks and home demonstration. Must be a good example him/herself.
3. Coordinate with TBA, Councillors, Union Council, CSP, DC, DHO, and any other agency working in area.
4. Responsible to visit 30 families at least once a month.
5. Promote:
 - EP
 - CDD
 - Birth Spacing (Family Planning)
 - Personal & Environmental Hygiene
 - Growth Monitoring
 - Correct Weaning Practices/Breastfeeding
 - Good Nutrition
 - Antenatal Care
6. Responsible for growth monitoring of all children under five in 30 families.
7. Conduct antenatal & postnatal services (if VHW is TBA).
8. Maintain family health records.
9. Maintain records of pregnant women, newborns and deaths.
10. Identify high risk pregnancies & infants.
11. Submit monthly reports to CHO.

COMMUNITY HEALTH ORGANIZER

1. Responsible to Program Coordinator, DC, DHO and Community Health Committee.
2. Supervise and the CSP activities conducted by 10 VHWs.
3. Collect reports from VHWs and submit to Program Coordinator/DC/DHO
4. Maintain and update CSP intervention records.
5. Coordinate schedule of VHWs.
6. Coordinate supplies (i.e family registers, scale, growth monitoring cards, antenatal cards, etc) needed for VHWs CHO is responsible for.
7. Conduct monthly meetings with VHWs.
8. Visit each VHW at least once a month.

VACCINATOR

1. Responsible to Program Coordinator
2. Coordinate/collect supplies from EPI incharge. Report any stock shortage to Program Coordinator.
3. Prepare vaccine carriers.
4. Maintain cold chain at all times.
5. Contact Head person when team arrives at each village and arrange details of team activities.
6. Give vaccinations according to government specifications.
7. Fill out & maintain registers for vaccinations.
8. Give appropriate information about diseases being vaccinated against and inform mothers of possible after effects of vaccinations and any necessary treatment.

9. **Fill out daily and monthly vaccine reports and submit monthly report to CSP office.**
10. **Make sure all equipment is properly maintained. Report any damage to PC.**
11. **Motorcycle Rider is responsible for:**
 - **Making sure all supplies and equipment needed for each day are taken along in adequate amounts**
 - **Checking engine oil of motorbike**
 - **Regularly servicing and maintaining motorcycle in good running condition**
 - **Maintaining motorcycle log book**
12. **Any other job assigned from time to time by Program Coordinator.**

MALE HEALTH TRAINER

1. **Responsible to Program Coordinator.**
2. **Train VHWs in:**
 - a. **Community organization and principles of community development**
 - b. **Village survey and registration**
 - c. **EPI motivation**
 - d. **CDD**
 - e. **Nutrition assessment and growth monitoring**
 - f. **Correct weaning practices**
 - g. **Birth spacing (Family planning)**
 - h. **Personal and community hygiene**
 - i. **Identification and follow up of high risk pregnancies and infants**

- j. **Record keeping**
 - k. **Socioeconomic development techniques**
 - l. **How to teach others in their community**
3. **Keeps daily report and submits monthly report to PC.**
 4. **Submit in writing a report (evaluation/dates/time/place) after every health education session.**
 5. **Look after all the equipment used in the health education session.**
 6. **Assist PC in: planning and conducting VHW training collecting and preparing resource materials arranging health education programs (eg film) for community.**
 7. **Any other job assigned from time to time by PC.**

LADY HEALTH VISITOR

1. **Responsible to Program Coordinator.**
2. **Work with TBAs to teach them to recognize and refer high risk pregnancies and infants.**
3. **Train VHWs in:**
 - a. **Community organization and principles of community development**
 - b. **Village survey and registration**
 - c. **EPI motivation**
 - d. **CDD**
 - e. **Growth monitoring and nutrition assessment**
 - f. **Correct weaning practices**
 - g. **Birth spacing (Family planning)**
 - h. **Personal and community hygiene**

- i. Identification and follow up of high risk pregnancies and infants. Safe delivery methods.
 - j. Record keeping
 - k. Socioeconomic development techniques
 - l. How to teach others in their community
4. Keep daily report of activities. Submit monthly written report to PC.
 5. Submit in writing a report (evaluation/dates/time/place) after each health education session.
 6. Assist PC in: planning and conducting VHW training collecting and preparing resource materials arranging health education programs (e.g. film) for communities.
 7. Minor curative care.
 8. Any other job assigned from time to time by PC

OFFICE ASSISTANT

1. Responsible to Business Manager.
2. Does all secretarial work: typing, filing, bookkeeping, etc.
3. Maintain attendance register.
4. Any other job assigned from time to time by Business Manager.

COOK/HOUSEKEEPER

1. Prepares meals for CSP staff living in field.
2. Keeps a record of food purchased and used.
3. Purchases food as needed.

4. **Washes dishes.**
5. **Keeps team living and working area clean and tidy.**

VER

1. **Responsible to Program Coordinator for daily schedule.**
2. **Daily checks and maintains vehicle in running condition.**
3. **Has vehicles serviced as scheduled.**
4. **Report any vehicle damage or malfunction to Business Manager for decision regarding repair. Should be written in log book also.**
5. **Drive team to/from field and while in field.**
6. **Daily wash outside and clean inside of vehicle.**
7. **Must be properly licensed to drive project vehicles at all times.**
8. **Maintains daily log book.**
9. **Follows vehicle use policy.**
10. **Assists teams while in field.**
11. **Any other job assigned from time to time by Program Coordinator.**

APPENDIX C: Project Staff Curriculum Vitae

CURRICULUM VITAE
of
LARRY EUGENE BLEWETT, M.T. (ASCP), M.P.H.
Prepared 13 May 1991

NAME: Larry Eugene Blewett
Date of Birth:
Place of Birth:
Citizenship: U.S.A.
Spouse: Alta Yvonne (Lake) Blewett
Children: Daughter, age 23, Married-living at Logan, Ut.
Son, age 21, Single, Junior at Southern
College, Collegedale, Tennessee

Education:

Post Graduate: Loma Linda University, Loma Linda, California
Masters in Public Health with emphasis in Health
Administration (Management). (1989)

Graduate: Southwestern Adventist College, Keene, Texas
Bachelor of Science in Medical Technology (1972)

Medical Technology Training

1971-1972 Harris Hospital,
Ft. Worth, Texas (ASCP)

1964-1968 United Medical Laboratories,
Portland, Oregon (AMT)

Work Experience

1989-Present Director of Laboratory and Radiology
Departments, also Director-Instructor of Medical
Laboratory Technician School at Karachi Adventist
Hospital, Karachi, Pakistan

1987-1989 Assistant Administrator at Monument
Valley Hospital in Monument Valley, Utah

1985-1987 Director of Laboratory and Radiology
Departments at Monument Valley Hospital in Monument
Valley, Utah

1980-1984 Director of Laboratory, Radiology, and
Pharmacy Departments at L'Hopital Adventist D'Haiti
in Port-au-Prince, Haiti

1978-1980 Director of Laboratory and Radiology
Departments at Monument Valley Hospital in Monument
Valley, Utah

1976-1978 Directory of Laboratories at Huguley
Memorial Hospital in Ft. Worth, Texas

13 May 1991

Work Experience Continued

1975-1976 Technical Service Representative for
Hycel Corp. in Houston, Texas

1972-1975 Director of the Laboratory at Memorial
Hospital in Beeville, Texas

1969-1972 Laboratory Technologist, Freeland
Clinic in Alvarado, Texas

1968-1969 Director of Laboratory and Radiology
Departments at Santa Anna Hospital in Santa Anna,
Texas

1964-1968 Laboratory Technician at United
Medical Laboratories in Portland Oregon

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RESUMÉ
DEBRA MARIE KACHIC

POSITION DESIRING: PHYSICIAN ASSISTANT

Education: Wichita State University, Wichita, Kansas
Bachelor of Health Sciences, Physician Assistant (July 1984);
First 12 months of this AMA approved program covered basic medical didactics.
Second 12 months spent in clinical rotations which included:
Internal Medicine — Leavenworth VA Hospital, KS (3 months)
Family Practice/ER — Several rural towns in Kansas & Oklahoma (6 months)
Acute Care/Pediatrics — Venice Family Clinic, Venice, CA (7 weeks)
Family Practice — Kaiser Permanente (Drs. Hara & Mittereder) (7 weeks)

UCLA, Los Angeles, California
Bachelor of Science, Psychobiology (June 1982);
Chatsworth High School, Chatsworth, California
Diploma (June 1978);

Experience: Venice Family Clinic, Venice, CA (9/80-8/82)
Volunteer Clinic Assistant
Duties: Patient histories, basic lab tests & procedures, translation (Spanish), patient education

Fuller Theological Seminary, Pasadena, CA (6/82-8/82)
Secretary

Venice Family Clinic, Venice, CA (7/81-6/82)
Secretary, Fundraising

Westwood Convalescent Home, Los Angeles, CA (10/79-8/82)
Volunteer
Duties: Took patients for walks, read to them, wrote letters for them, etc.

1st United Presbyterian Church, Canoga Park, CA (7/80-9/80)
Junior High Intern
Duties: Counseled & supervised junior high youth, organized activities

Hughes Aircraft Company, Canoga Park, CA (7/80-9/80 and 6/79-9/79)
Secretary

Cicoll Corporation, Chatsworth, CA (7/78-1/79)
Secretary/Receptionist

Awards & Honors: Outstanding Student Scholarship from Wichita State University PA Program,
(June 1982)

Dean's Honor Roll, Wichita State University
All semesters attending PA program

Honorable Mention for Kansas Association of Physician Assistants, Sandra Sommers
Memorial Scholarship Award (September 1983)

Treasurer, WSU PA Student Society (2 years)

Venice Family Clinic Volunteer Clinic Assistant of the Year Award (1981)

Intervarsity Christian Fellowship, UCLA

President (June 1981-June 1982)

Steering Committee (June 1980-June 1981)

Dormitory Study Leader (January 1979-June 1980)

Professional Associations: American Academy of Physician Assistants
Kansas Association of Physician Assistants
American Diabetic Association

References: Available upon request

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WORK EXPERIENCE:

Karachi Adventist Hospital
Karachi, Pakistan

July 1990-Present
ADRA Child Survival Project

September 1989-November 1989
Lab Technician Instructor - Anatomy/Physiology
Nursing School Instructor - Microbiology/Physics/Chemistry

January 1989-August 1989
Emergency Room

DeSoto Medical (Advantage Care DeSoto)
Canoga Park, CA 91304
February 1985-March 1987
Industrial Medicine (Work injuries, minor surgery)
Family Practice

Clinica San Marin de Porres
Los Angeles, CA
March 1985-July 1986
Family Practice, primarily Pediatrics

Venice Family Clinic
Venice, CA
August 1984-March 1987
Volunteer in Family Practice/Pediatrics Clinics

FURTHER EDUCATION:

National Institute of Modern Languages
Islamabad, Pakistan
January 1988-December 1988
Certificate and Diploma course in Urdu
(Written and spoken)

CURRICULUM VITAE

NAME: Jamil Masih
FATHER'S NAME: Samuel J. Mall
DATE OF BIRTH:
CIVIL STATUS: Single
NATIONALITY: Pakistani
RELIGION: Christian

ACADEMIC QUALIFICATIONS: Ph.D. (Business Management)
Manuel L. Quezon University
Manila, Philippines, 1990

Dissertation: Production Capacity, Problems
Encountered and Prospects of Selected
Large Scale Export Printing Firm in
Metro Manila: An Assessment

M.B.A.
Southwestern University
Cebu City, Philippines, 1986

Thesis: The Cenapro Chemical Corporation: It's
Management Status, Problems and
Implications to Business Management and
Economic Development of the Community

Bachelor of Commerce
St. Patrick's Government College
Karachi, Pakistan, 1980

Faculty of Science (F.Sc. Pre-Medical)
Government Islamia Science College
Karachi, Pakistan, 1977

Government Mission High School
Sahiwal, Pakistan, 1975

SEMINARS ATTENDED: Organizational Development
August 30-31, 1986, Philippines
Humanizing Relationships in Business and
Service Organizations
March 14-15, 1987, Philippines

35

Modern Innovations in Higher Management
May 21, 1988, Philippines

PROFESSIONAL MEMBERSHIP/

QUALIFICATIONS: Lifetime Member
Graduate School Doctoral Association
Manuel L. Quezon University
Manila, Philippines

Fellow, Society of Business
Practitioners
Greater Manchester, England
Current

Member, Christian Graduate Fellowship
Karachi, Pakistan
Current

WORK EXPERIENCE:

Controller, Examinations
The International University
Karachi, Pakistan
May 1990-Present

Counsellor
Y-Tech Counselling Service
United Nations High Commissioner for
Refugees
Karachi, Pakistan
October 1990-January 1991

Lecturer, BBA and MBA Programs
The International University
Karachi, Pakistan
November 1987-March 1988

Reception/Admission Officer
Karachi Adventist Hospital
Karachi, Pakistan
1979-1984

ADDRESS:

Dr. Jamil Masih
c/o Mr. Wilson Samuel
Karachi American School
K.D.A. Scheme 1
Amir Khusro Road
Karachi, Pakistan

CURRICULUM VITAE

NAME: Iqbal Puran Gill

BIRTHPLACE: Lahore

FAMILY STATUS: Single

EDUCATION: Public Health Education Training
Pakistan Adventist Seminary
June 1986

Business Administration Certificate
Pakistan Adventist Seminary
December 1984

General Studies Certificate
Pakistan Adventist Seminary
September 1983

Matric Certificate (Government)
Pakistan Adventist Seminary
March 1982

Divisional School Leaving Certificate
Pakistan Adventist Seminary
December 1981

WORK EXPERIENCE: ADRA Child Survival Project
Karachi, Pakistan

Project Health Coordinator
February 1988-April 1989

Field Supervisor
May 1989-September 1990

Special Projects
October 1990-June 1991

Community Development Officer
June 1991-Present

Receptionist
Karachi Adventist Hospital
Karachi, Pakistan
November 1987-February 1988

School Teacher
Class 7/8 (Science/Math/English)
Adventist Lodge School
Karachi, Pakistan
January 1987-November 1987

Receptionist
Karachi Adventist Hospital
Karachi, Pakistan
June 1986-January 1987

LANGUAGES:

Punjabi
Urdu
English
Sindhi

APPENDIX D: Pipeline Analysis

FIELD

Actual Expenditures to Date
 (9 / 1 / 90 to 9 / 30 / 91)

Projected Expenditures Against
 Remaining Obligated Funds
 (10 / 1 / 91 to 8 / 30 / 93)

Total Agreement Budget
 (Columns 1 & 2)
 (9 / 1 / 90 to 8 / 30 / 93)

COST ELEMENTS

- I. PROCUREMENT
 - A. Supplies
 - B. Equipment
 - * C. Services/Consultants
 - 1. Local
 - 2. Expatriate
- SUB-TOTAL I
- II. EVALUATION/SUB-TOTAL II
 - A. Consultant/Contract
 - B. Staff Support
 - C. Other
- SUB-TOTAL I
- III. INDIRECT COSTS
 - Overhead/field offices
 - (%) 17%
- SUB-TOTAL III
- IV. OTHER PROGRAM COSTS
 - A. Personnel (list each position & total person months separately)
 - 1) Technical
 - 2) Administrative
 - 3) Support
 - B. Travel (Short Term)
 - 1) In country
 - 2) International
 - C. Other Direct Costs (utilities, printing rent, maintenance, etc)
- SUB-TOTAL III

	AID	PVO	TOTAL
I. PROCUREMENT			
A. Supplies	8,007.69	-	8,007.69
B. Equipment	2,946.84	14,545.45	17,492.29
* C. Services/Consultants			
1. Local	2,182.00	265.37	2,447.37
2. Expatriate			
SUB-TOTAL I	13,136.53	14,810.82	27,947.35
II. EVALUATION/SUB-TOTAL II			
A. Consultant/Contract			
B. Staff Support			
C. Other			
SUB-TOTAL I	-	-	-
III. INDIRECT COSTS			
Overhead/field offices			
(%) 17%	16,682.61	8,513.85	25,196.46
SUB-TOTAL III	16,682.61	8,513.85	25,196.46
IV. OTHER PROGRAM COSTS			
A. Personnel (list each position & total person months separately)			
1) Technical	19,871.64	-	19,871.64
2) Administrative	8,303.32	24,937.00	33,240.32
3) Support	6,166.10	10,000.00	16,166.10
B. Travel (Short Term)			
1) In country	39,701.83	333.67	40,035.50
2) International			
C. Other Direct Costs (utilities, printing rent, maintenance, etc)	10,953.59	-	10,953.59
SUB-TOTAL III	84,996.48	35,270.67	120,267.15
TOTAL FIELD	114,815.62	58,595.34	173,410.96

	AID	PVO	TOTAL
I. PROCUREMENT			
A. Supplies	7,028.31	-	7,028.31
B. Equipment	19,748.16	35,454.55	55,202.71
* C. Services/Consultants			
1. Local	2,416.00	2,759.63	5,175.63
2. Expatriate	22,403.00	1,579.00	23,979.00
SUB-TOTAL I	51,595.47	39,790.18	91,385.65
II. EVALUATION/SUB-TOTAL II			
A. Consultant/Contract			
B. Staff Support			
C. Other			
SUB-TOTAL I	12,000.00	-	12,000.00
III. INDIRECT COSTS			
Overhead/field offices			
(%) 17%	12,000.00	-	12,000.00
SUB-TOTAL III	52,141.39	23,850.15	75,991.46
IV. OTHER PROGRAM COSTS			
A. Personnel (list each position & total person months separately)			
1) Technical	46,423.36	-	46,423.36
2) Administrative	64,358.68	12,716.00	77,074.68
3) Support	17,480.90	21,525.00	39,005.90
B. Travel (Short Term)			
1) In country	75,420.17	66,266.33	141,686.50
2) International			
C. Other Direct Costs (utilities, printing rent, maintenance, etc)	39,436.41	-	39,436.41
SUB-TOTAL III	243,119.52	100,507.33	343,626.85
TOTAL FIELD	358,856.38	164,147.66	523,004.04

	AID	PVO	TOTAL
I. PROCUREMENT			
A. Supplies	15,036.00	-	15,036.00
B. Equipment	22,695.00	50,000.00	72,695.00
* C. Services/Consultants			
1. Local	4,598.00	3,025.00	7,623.00
2. Expatriate	22,403.00	1,576.00	23,979.00
SUB-TOTAL I	64,732.00	54,601.00	119,333.00
II. EVALUATION/SUB-TOTAL II			
A. Consultant/Contract			
B. Staff Support			
C. Other			
SUB-TOTAL I	12,000.00	-	12,000.00
III. INDIRECT COSTS			
Overhead/field offices			
(%) 17%	12,000.00	-	12,000.00
SUB-TOTAL III	68,824.00	32,364.00	101,189.00
IV. OTHER PROGRAM COSTS			
A. Personnel (list each position & total person months separately)			
1) Technical	66,295.00	-	66,295.00
2) Administrative	72,662.00	37,653.00	110,315.00
3) Support	23,647.00	31,525.00	55,172.00
B. Travel (Short Term)			
1) In country	115,122.00	66,600.00	181,722.00
2) International			
C. Other Direct Costs (utilities, printing rent, maintenance, etc)	50,390.00	-	50,390.00
SUB-TOTAL III	328,116.00	135,778.00	463,894.00
TOTAL FIELD	473,672.00	222,743.00	696,415.00

TOTAL FIELD

Excludes Evaluation Costs

8.

APPENDIX E: Health and CSP Questionnaire

1991
USAID Health and Child Survival Project
Questionnaire

with AIDS/HIV Activities Reporting Schedule

PVO Grant

	Pages
Main Schedule.....	1 - 6
Schedule 1 - Demographic.....	7
Schedule 2 - Diarrheal Disease Control.....	8 - 9
Schedule 3 - Immunization.....	10 - 11
Schedule 4 - Nutrition.....	12 - 13
Schedule 5 - High Risk Births.....	14 - 15
Schedule 6 - AIDS/HIV Activities.....	16 - 17
Schedule 7 - Other Health and Child Survival.....	18 - 19

Country Pakistan

Project Title FY 90 Child Survival Grant to ADRA

Project Number 938ADRA.02

Name(s) of Person(s) responding to the questionnaire: Larry E. Blewett/Debra Kachic

Title(s) Project Director/Program Coordinator Date: October 1, 1991

USAID HEALTH AND CHILD SURVIVAL PROJECT QUESTIONNAIRE – FY 91

7. Percentage Attributions to Program Functions

This question should be answered in two steps. First complete Column A, and then complete Column B. This list of program functions is nearly compatible with the "Activity Codes" in the Agency's AC/SI system. If you are reporting attributions in this questionnaire which are different from those reported in the FY 1993 ABS, please note the reason for the discrepancy. The "AC" code corresponding to the USAID Health Information System category is displayed in parentheses for each program function.

This year, the questionnaire includes a new category for **Environmental Health** which does not correspond exactly to any of the activity codes available for attribution through the AC/SI system. In this questionnaire, environmental health refers to activity encompassing those diseases and health problems caused by or aggravated by environmental degradation. Activities in the following areas pursued for specific health objectives may be attributed to **Environmental Health**: wastewater management; solid waste management; air pollution control; toxic radiological and hazardous waste management; occupational health; injury prevention and control, and food hygiene. (Water and sanitation for health and vector-borne disease control should be attributed to the codes established specifically for those activities.)

Step 1 – In Column A write the percent of the Life-of-Project authorized budget (from all USAID dollar funding accounts) that is attributable to each of the functions listed below. The percentages in Column A should sum to 100%.

Step 2 – If the project has a child survival component complete Column B. The entry in Column B should be the percentage of the entry in Column A devoted to Child Survival; for example, if 40% of the project is to Immunization/Vaccination and all of that attribution is for child survival, enter 100% in Column B.

PLEASE REVIEW THE EXAMPLE BELOW BEFORE COMPLETING THE TABLE.

EXAMPLE

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and . . .
a. Diarrheal Disease/Oral Rehydration.....(HEDD)	40%	100%	↓ Schedule 2
-	-	-	-
-	-	-	-
m. Water and Sanitation for Health.....(HEWH)	60%	20%	↓ Schedule 7
-	-	-	-
-	-	-	-
-	-	-	-
TOTAL, All Functions	100%		

↓

This means that 20% of the water and sanitation component of the project is attributed to child survival.

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USAID HEALTH AND CHILD SURVIVAL PROJECT QUESTIONNAIRE – FY 91

9. Life-of-Project Percentage Attributions to Program Functions – Continued (See instruction guide for definitions)

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and. . .
a. Diarrheal Disease/Oral Rehydration.....(HEDD)	15%	100%	♦ Schedule 2
b. Immunization/Vaccination.....(HEIM)	40%	100%	♦ Schedule 3
c. Breastfeeding.....(NUBF)	2%	100%	♦ Schedule 4
d. Growth Monitoring.....(NUGM)	10%	100%	♦ Schedule 4
e. Targeted Child Feeding and Weaning Foods.....(NUGM)	10%	100%	♦ Schedule 4
<hr/>			
f. Vitamin A.....(NUVA)	-	-	♦ Schedule 4
g. Women's Health..... (HEMH)	7.5%	100%	♦ Schedule 7
h. Women's Nutrition (including iron).....(NUWO)	7.5%	100%	♦ Schedule 4
i. Nutrition Mangement, Planning and Policy.....(NUMP)	1.5%	100%	♦ Schedule 4
j. Other Nutrition (e.g., iodine fort. food tech.) _____ (Please Specify)	-	-	♦ Schedule 4
k. Child Spacing/High Risk Births.....(HECS)	5 %	100%	♦ Schedule 5
<hr/>			
l. HIV/AIDS.....(HEHA)	-	-	♦ Schedule 6
m. Water and Sanitation for Health.....(HEWH)	-	-	♦ Schedule 7
n. Environmental Health (See guidance on previous page) _____ (Please Specify)	-	-	♦ Schedule 7
o. Acute Respiratory Infections.....(HERI)	-	-	♦ Schedule 7
p. Malaria.....(HEMA)	-	-	♦ Schedule 7
<hr/>			
q. Other Vector-borne Disease Control... ..(HEVC)	-	-	♦ Schedule 7
r. Health Care Finance.....(HESD)	-	-	♦ Schedule 7
s. Health Systems Development.....(HESD)	-	-	♦ Schedule 7
t. Other Health and Child Survival <u>Essential Drugs</u> (including: aging, prosthetics, essential drugs,orphans) (Please Specify)	1.5%	100%	♦ Schedule 7
u. All Non-Health.....	-	-	♦ None
<hr/>			
TOTAL, All Functions	100%		

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USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY 91

FUNDING INFORMATION

10. What is the total USAID authorized LIFE-OF-PROJECT funding for this project or subproject (authorized dollar funds from ALL USAID funding accounts)? \$ 473,672

11. Does this project receive PL 480 funding (for example, for commodities or ocean freight). 1 - Yes → ANSWER ITEM 12 AND 13
② - No } SKIP NOW TO ITEM 14
9 - Don't Know }

12. In the spaces provided, indicate the total PL 480 funding received by the project or subproject during FY 91 (Oct. 1, 1990 to Sept. 30, 1991).

	AMOUNT
a. PL-480, Title I.....▶	\$ _____
b. PL-480, Title II (including the value of food and monetization).....▶	\$ _____
c. PL-480, Title III.....▶	\$ _____

13. Please describe briefly how the PL 480 funding was used in the project during FY 91. (Use separate sheet if necessary).

14. Activities Involving the Private Sector of the Host Country

a. What type(s) of initiatives to stimulate or support the local private sector are a part of this project?
 (CIRCLE ALL THAT APPLY)

- 1 - Private production of health care goods or commodities.
- 2 - Assistance to privatize public health programs or services.
- 3 - Assistance to regulate private sector health services or commodity production and distribution.
- ④ - Training of private sector health care providers.
- 5 - Involvement of for-profit businesses in project activities.
- 6 - Other _____
 (Please specify)

b. Of the total USAID Life-of-Project funding, estimate the percentage for the activities circled in question 16-a. _____ 1 _____ %

***Codes for "Source": DC: Data Collection System; BG: Best Guess; DK: Don't Know**

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USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY 91

15. Research Activity

a. Estimate the percent of Life-of-Project funds available to this project for research activities related to health and child survival..... 0 % IF 0%, SKIP TO ITEM 18

b. Which program functions does this research address? (CIRCLE ALL THAT APPLY)

- | | |
|--|-------------------------------------|
| 1 - ORT/Diarrheal Disease | 11 - Child Spacing/High Risk Births |
| 2 - Immunization/Vaccination | 12 - HIV/AIDS |
| 3 - Breastfeeding | 13 - Water and Sanitation |
| 4 - Growth Monitoring | 14 - Water Quality Improv. |
| 5 - Targeted Feeding and Weaning Foods | 15 - Acute Resp. Infection |
| 6 - Vitamin A | 16 - Malaria |
| 7 - Maternal Health | 17 - Other Disease Control |
| 8 - Women's Nutrition | 18 - Health Care Financing |
| 9 - Nutrition Mgmt/Planning | 19 - Health Systems Devel. |
| 10 - Other Nutrition | 20 - Other Health |

c. What type(s) of research are addressed? (CIRCLE ALL THAT APPLY)

- | | |
|---|--------------------------|
| 1 - Biomedical | 5 - Epidemiologic |
| 2 - Vaccine Development | 6 - Operational Research |
| 3 - Behavioral/Social Science/Communication | 7 - Other _____ |
| (Please Specify) | |

d. Please list descriptive titles of research being done under this project. For each title, also provide the years of the research and the name, affiliation and address of the primary researcher. (Use a separate sheet if necessary.)

Title: _____

Year: BEG.: _____ END: _____

Name: _____

Affiliation: _____

Address: _____

TRAINING

16. During FY 91 how many persons involved in health services received training through this project?

	SHORT-TERM (< 1 Mo.)	LONG-TERM (> 1 Mo.)	Source of Information
Physicians	0	0	(DC) BG DK
(Students) Nurses	15	0	(DC) BG DK
Community Health Workers	15	0	(DC) BG DK
Traditional Healers	0	0	(DC) BG DK
Community Leaders and Family Members	0	0	(DC) BG DK

TECHNICAL ASSISTANCE

17. How many long-term expatriate advisors, classified by the description of their training, were supported by the project in FY 91? Include individuals supported by this project (A long-term advisor is one assigned to the project for 12 months or longer who was in-country for a part of FY 91.) (WRITE THE NUMBER OF ADVISORS IN THE SPACE PROVIDED)

- | | |
|---|---|
| _____ Physician
<u>1</u> Nurse
_____ Midwife
_____ Nutritionist
_____ Demographer
_____ Epidemiologist
_____ Malariologist
_____ Economist
_____ Social Scientist | Information Management Specialist
_____ Communications/Education
_____ Engineer _____
(e.g. Sanitary) (Please specify)
<u>1</u> Other Physician Assistant

(Please specify) |
|---|---|

18. Local vs. Expatriate Technical Assistance

During FY 91, how many person-months of technical assistance (both short-term and long-term) were provided by local (host country) advisors and by expatriate advisors?

Local Person-Months	*includes 2 expats noted in #17 at Expatriate 12 months each Person-Months
<u>1</u>	<u>27*</u>

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USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY 91

HIGHLIGHTS

19. The primary uses of project highlights are for Congressional and other reporting. Please take a few minutes to make your project come alive for that reporting. Lively descriptions of specific project activities from FY 91 enhance the likelihood that your project will be described in reports such as the annual Report To Congress on Child Survival. Use the examples below as starting points for your description. (Attach additional sheets if necessary.)
- a. **Significant Success Stories:** (Example: Involving a locally based firm with expertise in social marketing strengthened the demand for ORS packets, resulting in an increase in the ORT USE RATE from 10% in 1990 to 25% in 1991...)
 - b. **Lessons Learned:** (Example: An operations research study showed that one incentive to continuing participation in the formal health sector was a "successful" first encounter; therefore, health workers were trained to spend extra time with new clients...)
 - c. **Anecdotes:** (Example: During a visit to a remote village, the young daughter of the village chief interrupted her mother to explain the proper technique for preparing ORS. This reflects the effect of training students in the use of ORS...)
 - d. **Policy Change:** (Example: Data from a major survey showed a shift in dietary practice to less nutritious foods leading the government to modify its pricing policy...)
 - e. **Relation to Country Programs/Strategy:** (Example: The project's major accomplishment is strengthening of the MOH's Family Health Division. In addition to the development of a strong financial control and accounting system, the project supported supervisory training which has facilitated the integration of services in health centers...)

SEE "HIGHLIGHTS" ATTACHMENT

20. Because photographs can often communicate important concepts to busy decision makers much more quickly than words, can you include photographs to supplement the above text? (If yes, please include credit/caption information, including the location and year of the photo on a separate sheet and place picture, slide, or negative in an envelope.) Do not write on photos.

Photographs included? 1 - Yes 2 - No

Schedule 1 DEMOGRAPHIC CHARACTERISTICS/PVO SCHEDULE

- 1-1 What is the geographical area in which this project is delivering and/or promoting health or child survival services? (CIRCLE ONE ANSWER)
- 1 - The entire country
 - ② - A geographical area smaller than the entire country
 - 3 - None. The project does not deliver or promote services
 - 9 - Don't Know
- } COMPLETE ITEMS
1 - 2 THROUGH 1 - 7
- } SKIP NOW TO NEXT SCHEDULE

- 1-2 What is (are) the particular name(s) of the major or political subdivisions (for example, St. John's Province or Isatoyl Department) in which project activities are being carried out? (If entire country, write "ALL".)
- 1 - Union Council Konkar, Karachi East
 - 2 - Union Council Gadap, Karachi East
 - 3 - Union Council Moidan, Karachi East
 - 4 - Union Council Songal, Karachi West
 - 5 - _____

- 1-3 To which of the following subgroups are services targeted? (CIRCLE ALL THAT APPLY)
- ① - Children < 12 mos.
 - ② - Children 12 - 23 mos.
 - ③ - Children 24 - 59 mos.
 - 4 - Other children
 - ⑤ - Lactating or pregnant women
 - ⑥ - Other women of reproductive age
 - 7 - All other women
 - 8 - Men
 - 9 - The elderly (age 60 & older)
 - 10 - Other _____ (Specify)

- 1-4 Does this project attempt to serve all members of the targeted subgroups that live within the project area? (CIRCLE ONE)
- ① - Yes, attempts to serve all members of targeted subgroups in project area.
 - 2 - No, attempts to serve only a portion of the targeted subgroups that live within the project area. (COMPLETE COLUMN B IN ITEM 1 - 5 BELOW)
 - 3 - Other (Please explain) _____

1-5 Population

In Column A, enter the number of people in the following subgroups who live in the entire project area. In Column B, enter the number of people in each subgroup that the project is actually targeting. If it is the same as Column A, write "same" in Column B.

	Column A Entire Project Area	Source of Information*	Column B Target Population	Source of Information*
a. Total Population.....	110,000	DC ⑥ DK	SAME	DC ⑥ DK
b. Number of children aged < 12 months.....	3,960	DC ⑥ DK	SAME	DC ⑥ DK
c. Number of children aged 12 - 23 months.....	3,740	DC ⑥ DK	SAME	DC ⑥ DK
d. Number of children aged 24 - 59 months.....	9,900	DC ⑥ DK	SAME	DC ⑥ DK
e. Number of children 0 - 6 years (0 - 72 months).....		DC BG DK		DC BG DK
f. Women aged 15 - 19 years.....		DC BG DK		DC BG DK
g. Women aged 35 - 49 years.....		DC BG DK		DC BG DK
h. Women aged 15 - 49 years.....(15-44 years).....	24,200	DC ⑥ DK	SAME	DC ⑥ DK
j. Approximate number of births during FY 1990.....	5,170	DC ⑥ DK	SAME	DC ⑥ DK

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

BG = 1981 Government of Pakistan Census

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Schedule 1 DEMOGRAPHIC CHARACTERISTICS/PVO SCHEDULE

(Continued)

1 - 6 Is the population served living primarily in an urban or rural environment? (CIRCLE ONE)

1 - Primarily urban
(If project serves primarily urban population or peri urban, please describe strategies employed).....▶

② Primarily rural

3 - Mixed

4 - Don't know

1 - 7 If you use a demographic data collection system, please describe how data are collected and analyzed.

SEE "DEMOGRAPHIC CHARACTERISTICS" ATTACHMENT

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Schedule 2 DIARRHEAL DISEASE CONTROL

Important: Complete this schedule only if this project provides funding or otherwise supports activities in Diarrheal Disease Control.

COMMODITIES

- 2-1 During FY 91, were project funds committed for the purchase of ORS packets with the intention of distributing them to consumers? (CIRCLE ONE)
- 1 - Yes → COMPLETE ITEM 2-2
 ② - No } SKIP NOW TO ITEM 2-3
 9 - Don't Know
-
- 2-2 If yes, write the number of packets purchased with USAID funds.
- No. of Packets

 *DC BG DK PACKET SIZE
 Source of information (in CCs or Liters)
-
- 2-3 Did the project support or promote the distribution of ORS packets (USAID, gov't or other donor purchased) through the national CDD program or through some other diarrheal disease control project or program?
- ① - Yes, the national CDD } COMPLETE ITEM 2-4
 2 - Yes, an independent program }
 3 - No }
 9 - Don't Know } SKIP NOW TO ITEM 2-5
- *ADRA works with the GOP on a provincial and local level although none of our staff are government employees
-
- 2-4 As part of that program, have packets been sold or are there plans to sell them?
- 1 - Have been sold } PLEASE DESCRIBE IN ITEM 2-12
 2 - Plans exist for sales }
 ③ - Sales not envisioned }
 9 - Don't Know
-
- 2-5 Did the project sponsor or promote the production of ORS packets within the participating country?
- 1 - Funds have been committed } COMPLETE ITEM 2-6
 2 - Promoted, but funds not committed }
 ③ - No involvement with production } SKIP NOW TO ITEM 2-7
 9 - Don't Know
-
- 2-6 Did the project sponsor or promote production of ORS packets by any of the following organizations or businesses? (CIRCLE ALL THAT APPLY)
- 1 - Governmental organizations
 2 - Private, commercial businesses
 3 - Joint governmental/commercial ventures
 4 - Other organizations

TRAINING

- 2-7 During FY 91, were project funds committed to support training in the control of diarrheal disease?
- ① - Yes → COMPLETE ITEM 2-8
 2 - No }
 9 - Don't Know } SKIP NOW TO ITEM 2-9
-
- 2-8 Which of the following types of people received training as a consequence of project support? (CIRCLE A RESPONSE FOR EACH CATEGORY)
- | | YES
Substantial
Activity | YES
Minor
Activity | NO | DONT
KNOW |
|--|--------------------------------|--------------------------|----|--------------|
| a. Physicians..... | 1 | 2 | ③ | 9 |
| b. Nurses.....(Students) | 1 | ② | 3 | 9 |
| c. Community Health Workers..(ADRA Staff) | 1 | ② | 3 | 9 |
| d. Traditional Healers..... | 1 | ② | 3 | 9 |
| e. Community Leaders and Family Members..... | 1 | ② | 3 | 9 |
| f. Others (specify)..... | 1 | 2 | ③ | 9 |

***Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know**

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Schedule 2 DIARRHEAL DISEASE CONTROL

(Continued)

STRATEGIES

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
2-9 During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities designed to prevent or treat diarrheal diseases or dehydration? (PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW.)				
a. Free distribution of ORS packets through the public sector.....	1	②	3	9
b. The selling of ORS packets through the public sector.....	1	2	③	9
c. Marketing of ORS packets through commercial outlets or private health care providers.....	1	2	③	9
d. Promotion of sugar/salt solution prepared in the home.....	1	②	3	9
e. Promotion of other home-based solutions.....	1	②	3	9
f. Promotion of continued breastfeeding during diarrhea.....	1	②	3	9
g. Promotion of other appropriate feeding during and after diarrhea.....	1	②	3	9
h. Hygiene education.....	1	②	3	9
i. Improved water or sanitation.....	1	②	3	9
j. Modification of curriculum in medical or nursing schools.....	1	2	③	9

TECHNICAL ASSISTANCE

2-10 During FY 91, did the project provide technical assistance for improving diarrheal disease control programs? (CIRCLE ONE)	1 - Yes, Substantial Activity	③ - No
	2 - Yes, Minor Activity	9 - Don't Know

CHILD SURVIVAL INDICATORS

2-11 What is the ORT Use Rate (see the Instructions for Information on definitions) in the project area?	
a. ORT Use Rate.....	42 %
b. Date (mo/yr) data was collected.....	September 1990
c. Source of the data used to make the estimate.....	① DC BG DK
d. If a data collection system was used, please describe it. If possible, please include in the description the agency responsible for the system (MOH, WHO, UNICEF), the scope of the system (national or project area specific), the permanence of the system (special study or ongoing monitoring system), the methodology of collection (sample survey, clinic-based statistics, village-based statistics), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.). (Attach additional sheets if necessary.)	
ADRA CSP III staff conducted a thirty cluster survey in September 1990. Out of 594 households interviewed, 205 had a positive history of a child under 5 with diarrhea in the last 2 weeks; 42% of these stated using ORS.	

ADDITIONAL BACKGROUND INFORMATION

2-12 Please provide any other background information which would enable us to understand better the unique nature of the diarrheal disease control component of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary.)

SEE ATTACHED

Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 3 IMMUNIZATION

Important: Complete this schedule only if this project provides funding or otherwise supports activities in Immunization.

COMMODITIES

3-1 During FY 91, were project funds committed for the purchase of vaccines? (CIRCLE ONE ANSWER)
 1- Yes → COMPLETE ITEM 3-2
 ②- No } SKIP NOW TO ITEM 3-3
 9- Don't Know

3-2 How many doses of each vaccine were purchased with USAID funds?

	BCG	DPT	Polio	Measles	Tetanus
Source of information (CIRCLE ONE)	*DC BG DK				

3-3 Did the project support or promote the distribution of vaccines (USAID, gov't or other donor purchased) through the national EPI program or some other vaccine distribution program or project? (CIRCLE ONE)

①- Yes, the national EPI } COMPLETE ITEMS 3-4 THROUGH 3-6
 2- Yes, another program or project } *ADRA works with the GOP on a provincial and local level to provide EPI in our area using gov't supplied vaccines, syringes & registers
 3- No } SKIP NOW TO ITEM 3-7
 9- Don't Know

3-4 During FY 91, how many children were vaccinated as part of that program?

	BCG	DPT1	DPT3	Polio1	Polio3	Measles
a. Children of all ages.....	2068	2199	1759	2199	1761	1692
b. Infants under one year.....	1546	1640	1240	1639	1238	1378
c. Source of information.....	①DC BG DK					

3-5 During FY 91, how many women were vaccinated with tetanus toxoid as part of that program? 2347

Source of information (CIRCLE ONE) ①DC BG DK

3-6 At any time during FY 91, were fees charged for vaccinations during that program?
 1- Yes → PLEASE DESCRIBE IN ITEM 3-12
 ②- No
 9- Don't Know

TRAINING

3-7 During FY 91, were project funds committed to support training in immunization? (CIRCLE ONE)

①- Yes → COMPLETE ITEM 3-8
 2- No } SKIP NOW TO ITEM 3-9
 9- Don't Know

3-8 Which of the following types of people received training as a consequence of project support? (CIRCLE A RESPONSE FOR EACH CATEGORY)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Physicians.....	1	2	③	9
b. Nurses.....(Students).....	1	②	5	9
c. Community Health Workers.....	1	②	3	9
d. Traditional Healers.....	1	②	3	9
e. Community Leaders and Family Members.....	1	②	3	9
f. Others <u>ADRA Staff (Vaccinators</u>	①	2	3	9

(Please Specify) LHS Drivers)

Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

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Schedule 3 IMMUNIZATION (Continued)

STRATEGIES

3-9 During FY 91, did the project sponsor, promote or participate in any of the following vaccination strategies or activities?

(CIRCLE THE CHOICE THAT MOST NEARLY APPLIES FOR EACH STRATEGY)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Mass Immunization Campaigns.....	1	2	3	9
b. Fixed Immunization Center(s).....	1	2	3	9
c. Mobile Vaccination Team(s).....	1	2	3	9
d. Social Marketing to Stimulate Demand.....	1	2	3	9
e. Local Production of Vaccines.....	1	2	3	9

TECHNICAL ASSISTANCE

3-10 During FY 91, did the project provide technical assistance for improving immunization programs? (CIRCLE ONE)

- 1 - Yes, Substantial Activity
2 - Yes, Minor Activity
3 - No
4 - Don't Know

CHILD SURVIVAL INDICATORS

3-11 a. What is the vaccination coverage rate (see instruction guide for information on definitions) in the project area?

	BCG	DPT3	Polio3	Measles	Tetanus
Percent of fully vaccinated children, 12 - 23 mos. of age...	69%	49%	49%	57%	N/A
Date (mo/yr) data was collected.....	9/90	9/90	9/90	9/90	N/A
Source of information (CIRCLE ONE).....	DC BG DK				

b. If a data collection system was used, please describe it. If possible, please include in the description the agency responsible for the system (MOH, WHO, UNICEF), the scope of the system (national or project area specific), the permanence of the system (special study or ongoing monitoring system), the methodology of collection (sample survey, clinic-based statistics, village-based statistics), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc). (Attach additional sheets if necessary.)

These statistics are from the baseline survey done of 594 households in September 1990. The immunization status of all children under 2 and CBA women as of September 1990 was verified by cross checking ADRA records and those of other organizations working in our area.

ADDITIONAL BACKGROUND INFORMATION

3-12 Please provide any other background information which would enable us to understand better the unique nature of the immunization component of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. Due to the newly announced measles initiative, we are particularly interested to hear about any measles activity undertaken through this project. (Attach additional sheets if necessary.)

SEE ATTACHED

Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

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Schedule 4 NUTRITION

Important: Complete this schedule only if this project provides funding or otherwise supports activities in Nutrition.

COMMODITIES

4-1 During FY 91, were project funds committed for the purchase of any of the following:

(CIRCLE THE CHOICE THAT MOST NEARLY APPLIES)

	YES	NO	DONT KNOW
a. Food.....	1	(2)	9
b. Vitamin A.....	1	(2)	9
c. Iron.....	(1)	2	9
d. Weighing Scales.....	1	(2)	9
e. Growth Monitoring Charts.....	1	(2)	9
f. Other (specify) <u>B Complex, Vitamin C, Calcium</u>	(1)	2	9

STRATEGIES

4-2 During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities designed to improve nutrition?

(PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Infant and Child Feeding Practices				
1. Increased duration of breastfeeding.....	1	(2)	3	9
2. Exclusive breastfeeding.....	1	(2)	3	9
3. Proper weaning and child feeding.....	(1)	2	3	9
4. Hospital practices supporting breastfeeding.....	1	?	(3)	9
5. Other approaches promoting initiation of breastfeeding.....	1	(2)	3	9
6. Modification of curriculum in Medical or Nursing Schools.....	1	2	(3)	9
b. Breastfeeding in the context of other interventions				
1. Breastfeeding during diarrhea.....	(1)	2	3	9
2. Contraceptive practices that preserve breastfeeding.....	1	2	(3)	9
c. Growth Monitoring				
1. Community-based.....	(1)	2	3	9
2. Clinic-based.....	1	2	(3)	9
3. Promoting the concept.....	1	(2)	3	9
d. Nutrition Surveillance				
1. Identification of nutrition problems.....	1	(2)	3	9
2. Monitoring the impact of economic policy.....	1	2	(3)	9
e. Vitamin A				
1. Assessment of levels of deficiency.....	1	2	(3)	9
2. Supplementation (capsules or liquid).....	1	2	(3)	9
3. Food fortification.....	1	2	(3)	9
4. Home and community gardens.....	1	2	(3)	9
f. Private Sector				
1. Commercial production/marketing of weaning foods.....	1	2	(3)	9
2. Commercial production/marketing of Vitamin A.....	1	2	(3)	9
3. Other (specify).....	1	2		
g. Supplementary Feeding Programs				
1. Food for work.....	1	2	(3)	9
2. Food in support of Maternal Child Health Programs.....	1	2	(3)	9
3. Emergency Food Relief.....	1	2	(3)	9
4. Other (specify).....	1	2		

4-3 If the project sponsored supplemental feeding during FY 91, which groups were targeted? (CIRCLE ALL THAT APPLY)

Children:	5 - Lactating women
1 - Under 12 mos.	6 - Pregnant women
2 - 12 - 23 mos.	7 - Other _____
3 - 24 - 35 mos.	(8) - None
4 - 36 - 60 mos.	9 - Don't know

Schedule 4 NUTRITION

(Continued)

TRAINING

- 4-4 During FY 91, were project funds committed to support training in infant and child feeding practices and/or growth monitoring? (CIRCLE ONE)
- 1 - Yes → COMPLETE ITEM 4 - 5
 2 - No } SKIP NOW TO ITEM 4 - 6
 9 - Don't Know

4-5 Which of the following types of people received training as a consequence of project support? (CIRCLE ALL THAT APPLY)

	Infant and Child Feeding Practices				Growth Monitoring			
	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Physicians	1	2	<input checked="" type="radio"/> 3	9	1	2	<input checked="" type="radio"/> 3	9
b. Nurses (Students)	1	<input checked="" type="radio"/> 2	3	9	1	<input checked="" type="radio"/> 2	3	9
c. Community Health Workers	1	2	<input checked="" type="radio"/> 3	9	1	2	<input checked="" type="radio"/> 3	9
d. Traditional Healers	1	<input checked="" type="radio"/> 2	3	9	1	<input checked="" type="radio"/> 2	3	9
e. Community Leaders and Family Members	1	<input checked="" type="radio"/> 2	3	9	1	<input checked="" type="radio"/> 2	3	9
f. Other ADRA Staff	1	<input checked="" type="radio"/> 2	3	9	1	<input checked="" type="radio"/> 2	3	9

TECHNICAL ASSISTANCE

- 4-6 During FY 91, were project funds committed to the provision of technical assistance in support of nutrition activities? (CIRCLE ONE ANSWER)
- 1 - Yes, Substantial Activity 3 - No
 2 - Yes, Minor Activity 9 - Don't Know

CHILD SURVIVAL INDICATORS

- 4-7 a. What is the rate of malnutrition (see instruction guide for clarification of definitions) in the target group served by the project?

	Group 1	Group 2	Group 3	Group 4
Target Group	Children 0-11 mos.	Children 12-23 mos.	Other Under 5 (Specify)	Other (Specify)
Estimated Rate of Malnutrition			48%	
Date (mo/yr) of estimate			1985-87	
Source of Information (CIRCLE ONE)	*DC BG DK	*DC BG DK	<input checked="" type="radio"/> *DC BG DK	*DC BG DK

- b. If a data collection system was used, please describe it. If possible, please include in the description the agency responsible for the system (MOH, UNICEF, WHO), the scope of the system (national or project area specific), the permanence of the system (special study or ongoing monitoring system), the methodology of the collection (sample survey, clinic-based statistics or village-based statistics) and the computation procedures (weighting in a sample, weighting of data from clinics or villages, etc.) (Attach additional sheets if necessary)

1991 UNICEF report using statistics from 1985-87. This number represents the percent of children under 5 which are moderately or severely underweight (below 80% weight for age) in Pakistan.

ADDITIONAL BACKGROUND INFORMATION

- 4-8 Please describe any other background information which would enable us to understand better the unique nature of the nutrition component of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary.)

SEE ATTACHED

Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 5 HIGH RISK BIRTHS

Important: Complete this schedule only if this project provides funding or otherwise supports activities to prevent High Risk Births.

COMMODITIES

- 5-1 During FY 91, were project funds committed for the purchase of contraceptives with the specific intention of distributing them to prevent high risk births? Please refer to page 3 of the instruction guide for the definition of high risk births. (CIRCLE ONE)
- ① - Yes
2 - No
9 - Don't Know
-
- 5-2 Did the project support or promote the distribution of contraceptives to prevent High Risk Births (USAID, Government or other donor purchased) through a national program or some other program or project? (CIRCLE ONE)
- ① - Yes, a national program } COMPLETE
2 - Yes, another program or project } ITEM 5-3
3 - No }
9 - Don't Know } SKIP NOW TO ITEM 5-4
-
- 5-3 At any time during FY 91, were fees charged for contraceptives during that program? (CIRCLE ONE ANSWER)
- ① - Yes → PLEASE DESCRIBE IN ITEM 5-11
2 - No
9 - Don't Know

TRAINING

- 5-4 During FY 91, were project funds committed to support training focused on the high risks of closely spaced births, births to very young or old women, or to high parity women in the project area?
- ① - Yes → COMPLETE ITEM 5-5
2 - No }
9 - Don't Know } SKIP NOW TO ITEM 5-6

5-5 Which of the following types of people received training as a consequence of project support? (CIRCLE A RESPONSE FOR EACH CATEGORY)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Physicians.....	1	2	③	9
b. Nurses..... (Students)	1	②	3	9
c. Community Health Workers.....	1	2	③	9
d. Traditional Healers.....	1	②	3	9
e. Community Leaders and Family Members.....	1	②	3	9
f. Others <u>ADRA Staff</u>	1	②	3	9

(Please Specify)

STRATEGIES

5-6 During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities for the purpose of delaying conception or spacing births? (PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Breastfeeding.....	1	②	3	9
b. Other Natural Family Planning.....	1	2	③	9
c. Sterilization.....	1	②	3	9

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

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Schedule 5 HIGH RISK BIRTHS (Continued)

5 - 7	Did the project sponsor or participate in activities to promote child spacing or family planning specifically directed at one or more of the following high risk groups? (CIRCLE A RESPONSE FOR EACH CATEGORY)	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW	
		a. Women under age 18.....▶	1	(2)	3	9
		b. Women age 35 or older.....▶	1	(2)	3	9
		c. Women who have given birth within the previous 15 months.....▶	1	(2)	3	9
		d. Women with 3 or more children.....▶	1	(2)	3	9

TECHNICAL ASSISTANCE

- 5 - 8 During FY 91, did the project provide technical assistance for improving high risk birth programs? (CIRCLE ONE ANSWER)
- 1 - Yes, Substantial Activity
2 - Yes, Minor Activity
(3) - No
9 - Don't Know

CHILD SURVIVAL INDICATORS

- 5 - 9 What is the Contraceptive Prevalence Rate (see instruction guide for information on definitions) in the project area.
- | | |
|---|-------------|
| a. Contraceptive Prevalence Rate in area.....▶ | 8 % |
| b. Date (mo/yr) data was collected.....▶ | 1984/85 |
| c. Source of the data used to make the estimate.....▶ | *DC (BG) DK |
- d. If a data collection system was used, please describe it. If possible, please include in the description the agency responsible for the system (MOH, WHO, UNICEF), the scope of the system (national or project area specific), the permanence of the system (special study or ongoing monitoring system), the methodology of collection (sample survey, clinic-based statistics, village-based statistics), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc). (Attach additional sheets if necessary.)

1991 UNICEF report based on GOP statistics

- 5 - 10 a. Estimate the percentage of total births in your project area during the reporting period that were high risk (see definition on page 3 of instruction guide.)
- _____ 55 _____ %
- b. Please indicate the source of the data.
(CIRCLE ONE)
- *(DC) BG DK
- 523 women were registered for antenatal checks during FY 91. 287 of them were high risk.

ADDITIONAL BACKGROUND INFORMATION

- 5 - 11 Please provide any other background information which would enable us to understand better the unique nature of the high risk births component of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. Please give special attention to activities designed specifically to the identification of candidates for high risk pregnancies and any particular steps taken to avert those pregnancies. (Attach additional sheets if necessary.)

SEE ATTACHED

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

Schedule 6 HIV/AIDS ACTIVITIES

Important: Complete this schedule only if this project provides funding or otherwise supports activities in HIV/AIDS prevention.

- 6-1 During FY 91, if the project sponsored, promoted or participated in HIV/AIDS activities, please provide a brief description of the objectives and methodology of those activities. (Attach additional sheets if necessary.)

- 6-2 Please summarize the lessons learned from the AIDS activities funded under this project. (Attach additional sheets if necessary.)

- 6-3 From the organizations listed on page 1 of the Main Schedule, please indicate which organizations were involved in HIV/AIDS prevention activities supported under this project, and list a contact person for each. (Note: this information will be used to identify which PVOs and NGOs are involved in USAID HIV/AIDS prevention activities and to compile a listing of US Government-sponsored international AIDS activities which will be disseminated to facilitate inter-agency coordination.)

	ORGANIZATION	CONTACT PERSON
1-	_____	_____
2-	_____	_____
3-	_____	_____
4-	_____	_____
5-	_____	_____
6-	_____	_____
7-	_____	_____
8-	_____	_____
9-	_____	_____

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Schedule 6 HIV/AIDS ACTIVITIES

6 - 4 The table below is to be used to summarize the scope of the HIV/AIDS activities supported under this project.

The following are guidelines to be applied for completing information in the columns in the table starting with Column A.

- Column - A. Use Activity codes listed below to describe the nature of the HIV/AIDS activities.
- Column - B. Show the percent of total AIDS activity, as reported in question 9, of the Main Schedule, attributed to each activity reported in Column A. Column B should add to 100%.
- Column - C. Estimate the percent of resources supporting research for each activity reported in Column A.
- Column - D. List the organization(s) by number from question 6 - 3 on page 16 which support each activity listed in Column A.
- Column - E. Cite target population for each activity listed in Column A. Use Population Code(s) listed below as appropriate for each activity.
- Column - F. Indicate by Y or N (Yes or No) whether activities listed in Column A are community-based with target community involvement in the design, implementation, and /or evaluation of the activities.
- Column - G. Please cite the number of individuals reached by prevention efforts in each activity area and indicate in Column H the source of the data by circling one of the the following: DC (Data Collection), BG (Best Guess), or DK (Don't Know).

A Activity	B % of AIDS Attribution	C % Research	D Organizations Supported	E Population Targets	F Comm. Based	G Nos. Reached FY91	H Data Sources
BTS							DC BG DK
CSP							DC BG DK
CPD							DC BG DK
HSV							DC BG DK
PNR							DC BG DK
STD							DC BG DK
PDM							DC BG DK
OA1	100%						DC BG DK

ACTIVITY CODES:

Blood Transfusion Screening..... BTS
 Condom Supply..... CSP
 Condom Promotion and Distribution..... CPD
 HIV Surveillance..... HSV
 Partner Number Reduction..... PNR
 STD Diagnosis Treatment Services..... STD
 Policy Dialogue/Modelling..... PDM
 Other..... OA1

(Please specify)

TARGET POPULATION CODES:

General Public..... GPU
 Children (0-8 years)..... CHI
 Youth (9-14 years)..... YUO
 Female Sex Workers..... FSW
 Male Sex Workers..... MSW
 Other Women at Risk..... OWR
 Other Men at Risk..... OMR
 IV Drug Users..... IDU
 Clinic/Hospital-based
 Health Service Providers..... HSP
 Traditional Healers..... TRH
 Other Service Providers..... OSP
 Community Leaders..... CML
 Other..... OTH

(Please specify)

6 - 5 What percentage of the condoms being supplied by USAID are used for AIDS prevention (rather than family planning)? _____%

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Schedule 7 OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

This schedule is designed to record information about health and child survival interventions other than those identified in schedules 2 through 6.

IDENTIFICATION OF OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

- 7-1 What type(s) of "other" health and child survival interventions received funding or other support through this project? (CIRCLE ALL THAT APPLY)
- | | |
|--|--------------------------|
| 1 - Acute Respiratory Infections | 5 - Maternal Health |
| 2 - Health Care Financing (answer 7-6) | 6 - Elderly/Adult Health |
| 3 - Water and Sanitation | 7 - Other _____ |
| 4 - Malaria (answer 7-7) | (Please Specify) |
- 7-2 Please describe each of these "other" health and child survival interventions; for example, "The malaria program is supporting the development of surveillance based on passive case detection in health clinics and using data from the surveillance to target spraying in areas of high endemicity." (Attach additional sheets of necessary.)

COMMODITIES

- 7-3 During FY 91, were project funds for any of the interventions circled in item 7-1 above committed to the purchase of any of the following? (PLEASE CIRCLE THE LETTER PRECEDING EACH TYPE OF COMMODITY FOR WHICH FUNDS WERE COMMITTED.)
- | | |
|--|-----------------------------------|
| a. Essential drugs | h. Audio-visual equipment |
| b. Laboratory equipment | i. Computers—hardware or software |
| c. Medical equipment | j. Prosthetics |
| d. Clinic/office furnishings | k. Other _____ |
| e. Construction materials for water/sanitation and other activities. | (Please Specify) |
| f. Vehicles or other transport equipment | m. Other _____ |
| g. Educational materials | (Please Specify) |

TRAINING

- 7-4 During FY 91, were project funds committed to support training in any of the types of interventions circled in item 7-1?
- 1 - Yes → COMPLETE ITEM 7-5
 2 - No
 9 - Don't Know } SKIP NOW TO ITEM 7-6

7-5 Which of the following types of people received training as a consequence of project support? (CIRCLE A RESPONSE FOR EACH CATEGORY)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Physicians.....	1	2	3	9
b. Nurses.....	1	2	3	9
c. Community Health Workers.....	1	2	3	9
d. Traditional Healer.....	1	2	3	9
e. Community Leaders and Family Members.....	1	2	3	9
f. Others (specify) _____	1	2	3	9

STRATEGIES

PLEASE ANSWER 7-6 ONLY IF YOU CIRCLED "2 - Health Care Financing" IN RESPONSE TO ITEM 7-1.

7-6 Health Care Financing Strategies

During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities in the area of Health Care Financing? (PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Cost containment.....	1	2	3	9
b. Public sector cost-recovery or cost-sharing.....	1	2	3	9
c. Demand analysis for health activities.....	1	2	3	9
d. Private insurance companies or other pre-paid health providers (e.g. HMOs).....	1	2	3	9
e. Social insurance funds provided through the public sector or parastatal organizations.....	1	2	3	9
f. Other _____	1	2	3	9

(Please Specify)

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Schedule 7 OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

(Continued)

PLEASE ANSWER 7 - 7 ONLY IF YOU CIRCLED "4 - Malaria" IN RESPONSE TO ITEM 7 - 1.

7 - 7 Malaria Strategies.
 During FY 91, did the project sponsor, promote or participate in any of the following strategies or activities for the purpose of malaria control?
 (PLEASE CIRCLE A RESPONSE FOR EACH OF THE STRATEGIES LISTED BELOW.)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Malaria surveillance and/or treatment.....	1	2	3	9
b. Surveys for chloroquine sensitivity/resistance.....	1	2	3	9
c. Mosquito control:				
1. Against adult mosquitos.....	1	2	3	9
2. Against larvae.....	1	2	3	9
3. Environmental modification..... (including source reductions)	1	2	3	9
d. Public education to promote:				
1. Anti-malarial treatment.....	1	2	3	9
2. Anti-mosquito measures.....	1	2	3	9
3. Impregnated bednets.....	1	2	3	9
4. Other _____ (Please Specify)	1	2	3	9

TECHNICAL ASSISTANCE

7 - 8 During FY 91, did the project provide technical assistance in any of the types of interventions circled in item 7 - 1?

1 - Yes → COMPLETE ITEM 7 - 9
 2 - No
 9 - Don't Know } SKIP NOW TO ITEM 7 - 10

7 - 9 For each type of intervention circled in item 7 - 1 above, indicate the level of technical assistance provided.
 (CIRCLE ONE RESPONSE FOR EACH INTERVENTION)

	YES Substantial Activity	YES Minor Activity	NO	DONT KNOW
a. Acute Respiratory Infection.....	1	2	3	9
b. Health Care Financing.....	1	2	3	9
c. Water and Sanitation.....	1	2	3	9
d. Malaria.....	1	2	3	9
e. Maternal Health.....	1	2	3	9
f. Elderly/Adult Health.....	1	2	3	9
g. Other _____ e.g. ophans, etc. (Please Specify)	1	2	3	9

ADDITIONAL BACKGROUND INFORMATION

7 - 10 Please provide any other background information which would enable us to understand better the unique nature of any or all of the other health and child survival components of the project including a description of any activities not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc.
 (Attach additional sheets if necessary.)

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APPENDIX F: CDD Curricula

APPENDIX F: CDD Curricula

ADRA stresses and trains VHWs to promote the following:

- Continued breast-feeding during diarrhea;
- Continued feeding for weaned infants during diarrhea;
- Use of ORS (commercially available), home SSS and cereal based ORT;
- Supplemental feeds during the week following an episode of diarrhea;
- Discourage use of bottle for anything, including water;
- Encourage use of cup/spoon for ORS and other feedings;
- Encourage good family and environmental hygiene;
- Encourage full EPI coverage by age one;
- Immediate referral in case of severe dehydration or bloody stool;
- Discourage use of inappropriate medicines.

Main focus of VHW training is:

- Causes of diarrhea
- Prevention of diarrhea
- How to prepare and administer ORT
- How to recognize signs of dehydration
- When and where to refer
- How to teach parents about CDD through use of flip charts and home demonstrations

Each volunteer VHW is expected to visit each family under their care once a month and continuously reinforce CDD messages. In addition to this, VHWs and CHOs will maintain monthly logs of cases of diarrhea, duration of each episode, use of ORS/other remedies and outcome of each diarrheal episode.

Up until April 1991, ADRA/CSP had been provided ORS packets free of charge by UNICEF to give beneficiaries. UNICEF is no longer supplying these except for training purposes so ADRA has been heavily promoting home SSS and cereal-based ORT since then. Locally produced ORS packets are available in markets for 4-5 rupees. During VHW training, in addition to encouraging home SSS and cereal-based ORT, ADRA will show samples of all locally available ORS packets so VHWs and mothers will know they are the same as the UNICEF packets ADRA has been promoting in the past. ADRA plans to approach local pharmaceutical companies about supplying shops in the area we are working and asking for samples for training to be included in the VHW kits. This will be beneficial to the company by increasing their market and to the community by assuring a continuously available supply of ORS.

The cereal based ORT ADRA promotes uses rice. Rice is available in Pakistan, but is not normally kept in village homes since it is considered a specialty item to be eaten at festivals and weddings. Good quality rice is more expensive than the wheat purchased for everyday use. There is a wheat-based cereal eaten in this area, but again only on special occasions. CSP will experiment with the use of the wheat based cereal as well as suggesting use of less expensive, broken rice instead of good quality, stressing the importance of these cereals for the health of their children. It is felt villagers will accept this method and can be encouraged to keep essential ingredients in the home. Home demonstrations will also be done.

ADRA's health education messages include improvement of personal and environmental hygiene to decrease the incidence of diarrhea as well as other diseases. MOH and ADRA do not currently encourage (nor do we discourage it) boiling water due to expense and unavailability of fuel, as long as it is "clean." (i.e from a hand pump well or pipe). GOP has recently started a matching grant scheme where they will match 50% for community initiated improvement projects, including potable water projects. UNICEF also has a project to provide hand pumps to communities as well as supplies to build hand dug latrines. ADRA will help communities develop plans/proposals for the UNICEF and GOP projects and explore funding sources for the community's matching portion of the GOP.

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APPENDIX G: CDD Messages

APPENDIX G: CDD Messages

ADRA CSP staff stresses and trains VHWs to promote the following messages about diarrhea and its control:

Children at "high risk" for management of diarrheal diseases are those which are:

- Not fully immunized, especially against measles and polio
- Any child who recently had measles
- Infants on bottle feeding or mixed feeding, especially age 0-4 months
- Malnourished
- Drinking contaminated water supply
- Live in poor family or poor environment hygiene
- Weaning age children
- Premature children

To prevent diarrhea or lessen the severity of diarrhea and its after-effects, the following things are advocated:

- Continued breast-feeding during diarrhea;
- Continued feeding for weaned infants during diarrhea;
- Use of ORS (commercially available), home SSS and cereal based ORT;
- Supplemental feeds during the week following an episode of diarrhea;
- Discourage use of bottle for anything, including water;
- Encourage use of clean cup/spoon for ORS and other feedings;
- Encourage good family and environment hygiene;
- Encourage full EPI coverage by age one;
- Immediate referral in case of severe dehydration or bloody stool;
- Discourage use of inappropriate medicines.

Main focus of training is:

- Definition of Diarrhea
three or more loose, watery stools per day
Often children which are breast fed and not given any solid food will have several soft stools in a day; this is not diarrhea.
- Causes of Diarrhea
 1. Milk other than breast milk (i.e. buffalo, cow, goat, powdered formula, etc.) Since buffalo milk is made for baby buffalos, often human babies have difficulty digesting it. Ask what milk the baby is drinking or if these was a recent switch in milk type.

2. **Bacteria (e.g. shigella) or parasites (e.g. amoeba) often cause bloody diarrhea. If the child has bloody stool, in addition to ORS advise the patient be seen by the doctor for appropriate medicines.**

3. **Virus (e.g. Rotavirus)
Causes 85% of acute diarrhea
Usually lasts 4-5 days
Antibiotics do not work on viruses. Antibiotics kill bacteria, both good and bad which are in our body. If we take antibiotics when we don't need them, this can cause diarrhea instead of stopping it.**

- **Prevention of diarrhea
ADRA's health education messages include improvement of personal and environmental hygiene to decrease the incidence of diarrhea as well as other diseases. ADRA does not currently encourage (nor do we discourage it) boiling water due to expense and unavailability of fuel.**
- **How to recognize signs of dehydration**
- **When and where to refer**
- **How to teach parents about CDD through use of flip charts and home demonstrations**
- **How to prepare and administer ORT
Up to this point ADRA/CSP has been provided ORS packets free of charge by UNICEF to give beneficiaries. UNICEF is no longer supplying these except for training purposes. Locally produced ORS packets are available in markets for 4-5 rupees. ADRA will show samples of all locally available ORS packets so VHWS and mothers will know they are the same as the UNICEF packets ADRA has been promoting in the past. ADRA plans to approach local pharmaceutical companies about supplying shops in the area we are working and asking for samples for training to be included in the VHW kits. This will be beneficial to the company by increasing their market and to the community by assuring a continuously available supply of ORS. As some communities do not have ready access to markets, CSP will not only encourage the use of these locally available packets, but cereal-based ORS and SSS as well.**

CSP promotes the use of home SSS using the following formulas:

4 glasses (standard metal drinking glass) water
 or 4 piyalis (bowls)
 or 1 liter, 1 kilo or 1 ser
 8 teaspoons sugar
 1 teaspoon salt

OR

4 glasses water
 1 fistful sugar
 1 pinch salt

All these ingredients are readily available at low cost (less than one rupee) and are kept in the homes on a regular basis. MOH/EPI's current recommendation is that the water does not need to be boiled, as long as it is "clean" (i.e from a hand pump well or pipe).

Rice based ORS:

1. Wash and soak one fistful of dry rice grain in some water until soft.
2. Grind soaked rice until it becomes a paste.
3. Add 2.25 glasses (600 ml) water to rice paste and boil until first bubbles appear. Cool.
4. Add one pinch (up to first crease of finger) salt and stir well.
5. Discard after 6-8 hours.

ADRA CSP mainly uses Nirali Kitaben's flip chart entitled "Daston Ki Bimari" (Diarrhea and Dehydration) to teach about CDD. Nirali Kitaben also has a booklet form of the flip chart. An English translation of the information is included. A copy of the booklet in Urdu is with ADRA International. The numbers in circles correspond to the page number in the flip chart. Only the printing in the slightly larger, bolder type appear on the flip charts. Translation in parenthesis is for information found written in the booklets only (not the flip charts), but this information is given verbally when the flip charts are used.

This is your child: laughing, playing, healthy.

Protect your child's health. Save him from diarrhea and dehydration. (In the following lessons we will tell you how diarrhea can be dangerous for a young child. What are the reasons for this? Why is dehydration dangerous? What is Nimkol (ORS)? How is ORS prepared, etc.? Besides this, there are

three causes of diarrhea and dehydration. You will also learn about signs, prevention, diet and precautions during diarrhea and how to stop diarrhea.)

1. Diarrhea can take away a child's strength or his life. (When a child has diarrhea, he starts to have thin, watery stools several times during the day. After many such stools, the child's condition begins to deteriorate. Sometimes in just a short time his condition can become very serious.)
2. Each year, innumerable children die of diarrhea. (This is because many people consider diarrhea to be such a common disease prevention and treatment measures are not taken until the child is dying.)
3. Diarrhea is caused by a dirty environment. (Germs are spread by flies, dirt and wind which touch the baby's food or drink can cause diarrhea.)
4. Causes of Diarrhea - Number 1
 Dirty bottles or pacifiers. (Use of bottles and pacifiers is the most common cause of diarrhea in young children. Often, after feeding, the milk bottle or pacifier falls on the dirty ground. In this way, many germs from the dirt or flies get on the bottle/pacifier. The child cries and the fallen bottle or pacifier is picked up off the ground and put back in the child's mouth. In this way, the diarrhea germs reach the baby's stomach.)
5. Causes of Diarrhea - Number 2
 Dirty dishes or food. (Besides bottles and pacifiers, uncovered eating, drinking and cooking utensils can become contaminated by flies sitting on them or dirt falling on them. Germs from these contaminated things can easily cause the child to become sick.)
6. Causes of Diarrhea - Number 3
 Open area for passing stool. (In many households, children use an open gutter for passing stool. Children who are sick have germs in their stool. These germs can reach our food, drink or utensils by flies, dirt or wind. In many cities, water pipes to houses pass through the gutter. If the pipe racks, then germs from the gutter's dirty water causing diarrhea get into the drinking water.)
7. Causes of Diarrhea - Number 4
 Malnourished, weak or sick children get diarrhea over and over. (Because their bodies don't have the strength to overcome dangerous germs, if they

have diarrhea over and over or it lasts for many days, then they become malnourished. Malnourished, weak children are attacked over and over by illnesses and then they take a long time to become well again.)

8. Why is diarrhea dangerous?

With diarrhea, water and salts leak quickly out of the child's body. Just like water leaks out of a crack in a water jug.

9. Why is diarrhea dangerous?

If you do not give a plant water, then it will die.

If the body becomes dehydrated, then the child can die too.

10. Some signs of dehydration

Urine stops or is very little or becomes dark yellow

Weight loss of greater than 10%

Stool looks like water

Skin which is pinched remains puckered

Pulse fast, but weak

Sunken, dry eyes

Sunken fontanelle

Thirst; dry lips and tongue

Vomiting

This child's condition is dangerous - Start giving him ORS drink.

11. How to prepare ORS drink from packet

1 large packet ORS

Boil water and cool it (we do not currently recommend this)

1 liter or 1 seer water

(we do not have small packets as pictured on left in karachi, so we ignore this part of this picture)

(To replace water which the child has lost from his body, give child one type of rehydration solution such as "Nimkol." You can usually find Nimkol packets in hospitals or drug stores.)

12. Homemade method for preparing ORS

2 pinches salt
1 pinch baking soda (We don't usually recommend this)
1 fistful sugar
1 liter water

Mix all ingredients with water and let set. (If you don't have baking soda, then just use salt and sugar to make ORS. If available, orange, lemon or tangerine juice can be squeezed into the mixture.)

13. ORS Drink

Only put the ORS drink in a mixing container. (If there is ORS drink left after 24 hours, then throw it out and make fresh ORS drink.)

For each episode of diarrhea, give the child ORS drink again. (Chart number 23 show a child less than 3 months old should be given ORS drink one time and boiled water the next time. A 3-12 month old child should receive ORS drink 2 times, then boiled water the next time. We so not give this advice in parenthesis.)

14. Dehydration

Again and again give ORS drink so the body does not become dehydrated. (Because just as much water and salt that is lost due to diarrhea, it needs to be replaced by mouth.)

In this manner a cracked jug will not become empty if it is continuously filled with water. (Because lost water is being replaced from above.)

15. Diarrhea and dehydration

After giving ORS drink, the baby's condition has been taken care of. Just like watering a plant makes it fresh again.

16. Three stages of diarrhea and dehydration**First Stage**

Diarrhea less than four times
Normal thirst
Tongue, lips and eyes moist
Normal amount and color of urine

Pinched skin immediately returns to normal
Little or no vomiting
Fontanelle not sunken

Condition: Appears normal
Slight weight loss

17. Treatment for first stage

Keep breastfeeding/ giving usual milk or formula and keep feeding food. Give extra liquids. (e.g. water, rice water, anise seed water, barley water, etc.)
Watch for signs of dehydration

(If using milk other than breast milk, until diarrhea has slowed down, use half milk and half water.)

18. Second Stage

Pinched skin slowly returns to normal
Decreased urine with darker color
4-10 episodes of diarrhea
Rapid pulse
Thirst more than normal
Lips and tongue dry
Slight Fontanelle depression
Eyes slightly sunken
Slightly rapid breathing
Vomiting 1 time

Condition: Lethargic
Weight 5-10% loss

19. Treatment for Second Stage

Give ORS after every loose stool (see chart 23) Keep breastfeeding /other milk and feeding food(Mix milk other than breastmilk 1 part milk to 1 part water until diarrhea has slowed down)(If the baby vomits after taking ORS, wait a few minutes and try again). Try to take the child to a doctor

20. Third Stage

Very fast, weak pulse
Pinched skin very slowly returns
No urine for 6 hours

More than 10 loose stools
Thirsty but unable to cry
Tongue and lips dry
Eyes sunken and no tears
Fontanelle sunken
Breathing very rapid and deep
Vomiting several times
High fever

Condition: Lapsing in and out of consciousness
Weight loss of more than 10%

21. Treatment for Third Stage

Child's life is in danger. Take him quickly to a hospital.
If you can't take him to the hospital immediately, then continue giving ORS as shown in chart 22.

(Take ORS along and continue giving on way to hospital.)

(For high fever, put cold cloth on head and body. Keep giving ORS until the baby is unable to drink.)

(After treating for dehydration, start giving milk and food.)

22. How much ORS drink to give the first 4-6 hours

23. How much ORS drink to give for each loose stool

24. What food to give after treatment of dehydration

25. How to prevent Diarrhea

Rule number 1 - Breastfeed child up to two years old (because breastfed babies have less incidence of illness - breastmilk is free from germs.)

Rule number 2 - After 4 months, along with breastmilk, begin giving child solid food (e.g. sooji, firni, dahlia, mashed banana, mashed potato, kitchri, etc. so that the child will build up his strength and will not quickly become sick.)

26. Rule number 3 - Do not give the baby bottles or pacifiers (because both things are difficult to get clean. Germs breed on the dirt left on bottles and pacifiers and can cause the child to become sick.)

- Rule number 4 - If using milk other than breastmilk, use bowl and spoon to give to child (then slowly start feeding child from glass or cup. These things are very easy to keep clean.)
27. Rule number 5 - Give child only fresh, clean food. Protect food from dirt and flies. (Pay close attention to the cleaning of child's dishes. After washing cooking dishes, store carefully so flies and dirt don't fall on them. Wash fruit and vegetable before preparing or eating. Wash your and child's hands well with soap before feeding child.)
28. Rule number 6 - Give children under 2 years old only water that has been boiled and cooled. (Boiling water kills any remaining germs in the water. Put the water in a clean container to store.)
29. Rule number 7 - Have your child weighed regularly. (If the child's weight is right for his age according to the growth monitoring care, this means the child is healthy and he is getting enough to eat. Today every country has mother/child centers and hospitals with growth monitoring cards being used. You also can make your child's weight card.)
30. Rule number 8 - Do not allow children to pass stool in open gutters. (In this manner, germs causing illness are spread to others. Remember not to use pipes near open gutters, because if the pipe is cracked or broken, germs from the dirty gutter water can get into the pipe water.)
- Build and use a latrine. (If child does pass stool on the open ground, then bury the stool in the dirt.)
31. Rule number 9 - A child becomes weak from fever or illnesses. Get him treated quickly (because a weak child very quickly gets other illnesses.)
- Do not stop feeding or liquids while a child is sick. (By stopping feeding a child, he will become even weaker.)
- (Make sure the child has all his immunizations so he is protected against those illnesses.)
32. Rule number 10 - If in one day a child has more than 4 loose stools, then start giving him water and ORS (so he does not become dehydrated. Most children who die from diarrhea, die because of dehydration.)
33. Healthy children can overcome sicknesses. During pregnancy, mothers need to eat a healthy diet so that her child will be healthy when born.

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Breastfeeding mothers need to eat a healthy diet so she can give her child good breast milk.

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