ISN 83478

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PDABG452

AGA KHAN FOUNDATION U.S.A.

ANNUAL REPORT TO THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT ON A MATCHING GRANT FOR

STRENGTHENING THE EFFECTIVENESS, MANAGEMENT AND SUSTAINABILITY OF PRIMARY HEALTH CARE/MOTHER AND CHILD SURVIVAL PROGRAMS IN ASIA AND AFRICA

FOR THE FISCAL YEAR ENDING JUNE 30, 1993

COOPERATIVE AGREEMENT NUMBER: PDC-0158-A-00-1102-00

JULY 30, 1993

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LIST OF ATTACHMENTS

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FREQUENTLY USED ABBREVIATIONS AND ACRONYMS

ADRA	Adventist Development and Relief Agency
A.I.D./USAID	United States Agency for International Development
AIHD	ASEAN Institute For Health and Development
AKCHP	Aga Khan Community Health Programme, Dhaka, Bangladesh
AKDN	Aga Khan Development Network
AKES	Aga Khan Education Services
AKF(B)	Aga Khan Foundation (Bangladesh)
AKF(K)	Aga Khan Foundation (Kenya)
AKF USA	Aga Khan Foundation U.S.A.
AKHN	Aga Khan Health Network
AKHS	Aga Khan Health Services
AKHS(K)	Aga Khan Health Services (Kenya)
AKU	Aga Khan University
AKU/CHS	Aga Khan University/Dept. of Community Health Sciences
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
APHA	American Public Health Association
ARI	Acute Respiratory Infection
BSH	Bangladesh Society of Hypertension
CBDD	Community-based Drug Distributor
CBDS	Community-based Drug Supply
CBPHC	Community-based Primary Health Care
CBHW	Community-based Health Worker
CBMIS	Community Based Management Information System
CCDB	Christian Commission for Development in Bangladesh
CEO	Chief Executive Officer
CHD	Community Health Doctor
CHN	Community Health Nurse
CHO	Community Health Organizer
CHV	Community Health Volunteer
CHW	Community Health Worker
CMT	Community Management Team
CMV	Community Mother Volunteer
CS	Child Survival
DANIDA	Danish International Development Agency
DHMT	District Health Management Team
DPT	Diphtheria Polio Tetanus
EDI	Economic Development Institute
EPI	Expanded Programme of Immunization
ENHR	Essential National Health Research
FHP	Family Health Project

FREQUENTLY USED ABBREVIATIONS AND ACRONYMS
(Continued)

FP	Family Planning
HKI	Helen Keller International
KARI	Kenyan Agricultural Research Institute
KMC	Karachi Metropolitan Corporation
IMR	Infant Mortality Rate
LBW	Low Birth Weight
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MIS	Management Information System
MMC	MAP Management Committee
MPHC	Mombasa Primary Health Care Programme
NCDDP	National Control for Diarrheal Disease Programme
NCIH	National Council for International Health
NGO	Non-governmental Organization
NSP	Nutritional Surveillance Project
OMB	Office of Management and Budget
OPP	Office of Planned Parenthood
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAMM	Program Against Micronutrient Malnutrition
PGC	Project Governing Council
PHC	Primary Health Care
PHC MAP	Primary Health Care Management Advancement Programme
PHO	Public Health Officer
PHT	Public Health Technician
PIC	Project Implementation Committee
PICT	Programme for The Introduction of Contraceptive Technology
POS	Pregnancy Outcome Study
PRA	Participatory Rural Appraisal
PRICOR	Primary Health Care Operations Research
PRITECH	Technologies For Primary Health Care
PTA	Parent-Teacher Association
PVO	Private Voluntary Organizations
RNP	Regional Network Programme
SHD	Safe Home Delivery
TAC	Technical Advisory Committee
TBA	Traditional Birthing Attendant
TL	Tubal Ligation
TOT	Training of Trainers
TSG	Technical Support Group

FREQUENTLY USED ABBREVIATIONS AND ACRONYMS
(Continued)

TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
UPHC	Urban Primary Health Care Programme
U5MR	Under 5 Mortality Rate
URTI	Upper Respiratory Tract Infection
VAC	Vitamin A Capsule
VHC	Village Health Committee
VHSS	Voluntary Health Services Society

EXECUTIVE SUMMARY

A.I.D.'s Current three-year Matching Grant to the Aga Khan Foundation U.S.A. (AKF USA) for Strengthening the Effectiveness, Management and Sustainability of Primary Health Care/Mother and Child Survival Programs in Asia and Africa has just completed its second year. Through this Matching Grant, AKF USA is building upon PHC projects previously funded by A.I.D. to increase their operational efficiency, strengthen management, expand service provision and outreach, develop new PHC management tools, test new models and approaches to PHC sustainability and local financing, and facilitate the sharing of PHC strategies. The main purposes of the Matching Grant are: (i) to expand coverage, increase effectiveness and test new organizational models for community-based PHC in three projects serving the health needs of more than 200,000 urban and rural residents by strengthening the capacities of local communities and NGOs to deal with their own health problems; (ii) to strengthen management, information systems, and the social, organizational and financial sustainability of 10 PHC projects involved in RNP and PHC MAP activities; (iii) to produce, begin to distribute and promote the use of 13 field-tested PHC MAP modules and related training and resource materials.

The heart of the AKF approach is the cross-fertilization of ideas among projects through both technical assistance and a continuing learning process. AKF USA's institutional ties with the Aga Khan Health Network, composed of the Aga Khan University (AKU) in Pakistan, the Aga Khan Health Services (AKHS) and AKF's offices in Kenya, Pakistan, Bangladesh and Geneva, offer a unique opportunity for developing and testing participatory development approaches which can capitalize upon and synthesize the knowledge of both the developed and the developing world.

The $1.2 million Matching Grant from A.I.D. supports five AKF USA-sponsored health projects over three years (July 1991-June 1994). AKF USA's contribution to the project funding will increase from an original projection of $1,400,000 to $1,513,000 (56 percent match). Three of the projects funded under this Matching Grant are community-based primary health care projects: (i) the Mombasa Primary Health Care Project (MPHC) in Kwale District of Kenya, implemented by the AKHS,Kenya; (ii) the Aga Khan Community Health Programme (AKCHP) in the Dhaka Municipality in Bangladesh, implemented by the Silver Jubilee Commemoration Society (SJSC), and whose management is soon to be turned over to the Society for Urban Health (SUH), a local NGO; and (iii) the Urban Primary Health Care Programme (UPHC) in the squatter settlements and lower income areas of Karachi, Pakistan, implemented by the Aga Khan University's Department of Community Health Sciences (AKU/CHS).

The two other projects supported by this grant are targeted toward strengthening the management capacity of local PHC managers. They are: (i) the Regional Network Programme (RNP), coordinated by AKU; and (ii) the Primary Health Care Management Advancement Programme (PHC MAP), coordinated by AKF Geneva. The first provides

a forum for the exchange of strategies and "best practices" among PHC projects. The second aims to improve the quality and use of health information, enabling PHC managers and local communities to use information more effectively for planning purposes.

The three PHC projects concentrate on improving maternal and child health by providing community-based primary health care services, outreach, and education. At the same time, these projects are experimenting with new strategies for improving PHC sustainability through community participation, more appropriate and effective services that meet local needs, demands and constraints, and new methods of local financing. By the end of the current Matching Grant, MPHC, AKCHP and UPHC are expected to serve approximately 200,000 rural and urban residents, with a target population of over 65,000 women of childbearing age and children under age five.

All five projects also contribute on a broader scale to development through: training of medical and nursing students at the AKU; development of local human resources in the project areas in the form of trained Community Health Workers (CHWs) and other health volunteers; leadership development; mobilization of communities and strengthening of local institutions for the provision of community-based PHC and other community development activities which can directly affect health status; development of low-cost PHC models that can be replicated in collaboration with local governments and NGOs; synthesis of strategies for alternative PHC financing, including local resource-pooling; and improvement of PHC management capacity by providing PHC managers with flexible and adaptable management tools for collecting and analyzing PHC data.

The five PHC projects under the current Matching Grant have established PHC services and systems in place which have helped to improve the overall health of the communities they serve. Targets for improvements in the infant mortality rate, immunization levels, community mobilization and participation, local human resource development, community outreach and education activities, and water and sanitation improvements, have been for the most part, met consistently. Although many of the challenges reported in last year's annual report still exist, the projects have taken positive steps toward surmounting those.

During the second year of AKF USA's current Matching Grant, several cross-cutting and project specific lessons have been articulated by the project's themselves, particularly concerning: community participation; the use of information management systems and operations research to better target services, improve community outreach and education activities, and more effectively address the more difficult and persistent constraints to health improvements; and PHC sustainability. In some cases, these lessons learned have resulted in adjustments in project strategies and allocation of resources. More detailed information on each project's progress and lessons learned is contained in the report. Highlights of each project's progress over the last year are enumerated below.

The Mombasa Primary Health Care Project (MPHC):

- increased village participation from 65 percent in June 1992 to 71 percent. Forty-one of the 58 villages in the project area have identified PHC leaders, developed health action plans and put them in place, and maintain at least 40 percent villagers' participation in ongoing PHC activities;
- organized Project Implementation Committees (PICs) at all three village sites, as well as Village Health Committees (VHCs), Parent-Teacher Associations (PTAs), and women's groups;
- conducted school health programs in 26 primary and 2 secondary schools throughout 1992, and reached 14 additional schools in the first half of 1993;
- continued training-of-trainer courses for community leaders and PHC/CBHC training for PTAs, VHCs and women's groups;
- continued facilitation of family planning focus groups and realized a dramatic increase in family planning knowledge (from a 36.8 percent baseline to 77.6 percent);
- trained 19 community-based drug distributors to improve home-based management of illness;
- cultivated 80 trial plots with local farmers to demonstrate alternative agricultural practices for improving yields;
- completed a household survey of the project area;
- continued water and sanitation improvements in collaboration with communities, and with local resources.

The Aga Khan Community Health Programme (AKCHP) in Dhaka:

- continued community mobilization and outreach activities in the new project service areas of South Khilgaon and Bagicha;
- organized one Community Mother Volunteer (CMV) basic training course and seven refresher courses, bringing the total active CMVs to 143;
- developed health education curricula for school teachers, trained 52 new school teachers in 5 schools, and a total of 1,159 students in 12 schools;
- carried out other health education and community awareness activities, including a School Health Workshop with school administrators, an International Training Course on Primary Health Care, a course on Epidemiology and Biostatistics, TBA training, and NGO training;
- implemented a new fee structure and policies in the clinics which increased clinic revenues without compromising clinic attendance;
- provided maternal services to 1,868 pregnant mothers and 72 postnatal mothers, and strengthened systems for referrals to secondary care, making 102 referrals for pregnancy-related problems;
- maintained a high TT immunization rate (97 percent) for pregnant women, strengthened TBA training and support systems, and increased TBA's timely reporting of births from 33 percent to 50 percent;

- took progressive steps to turning over the management of the project to the Society for Urban Health (SUH), a local NGO, and to diversify AKCHP's funding base.

The Urban Primary Health Care Programme (UPHC) in Pakistan:

- maintained PHC services established in 7 communities;
- increased efforts to identify low birth weight babies and other children at higher risk for malnutrition;
- studied family planning practices and conducted family planning workshops, concentrating especially on the promotion of birth spacing;
- collected and analyzed information on causes of death among children under age five to better deal with the highest-risk cases by developing specific strategies;
- continued dialogue and planning activities with the Karachi Metropolitan Corporation (KMC), the World Bank's Family Health Project, local NGOs, communities and other health services for the Macro PHC Project;
- carried out a community assessment in the Macro PHC Project areas to analyze pertinent socioeconomic, health, and demographic issues, and to evaluate the availability and quality of health services, which will be used for further planning.

The Regional Network Programme (RNP):

- held the Annual RNP Workshop in Kathmandu in March 1993 to discuss Women in Health and Community Development, Alternative Approaches to Financing, and Health Systems Development;
- published and distributed the 1992 RNP Workshop Report, "Growing Together";
- trained 20 RNP participants in TOT methods for community-based PHC during a workshop held in March 1993 in Bangladesh;
- sponsored RNP members' participation in the AKU's annual Preceptor Orientation Program, a rigorous, six-week, field-based course designed to prepare new preceptors for community-based PHC programs;
- conducted a session on "Principles of Ethics", and how they can be applied in the work situation at the Aga Khan Health Services, Pakistan (AKHS,P) in April 1993.

The Primary Health Care Management Advancement Programme (PHC MAP):

- completed final drafts of all 9 PHC MAP modules, including user's guides, facilitator's guides, reference materials and diskettes;
- developed an additional module on *Surveillance of Morbidity and Mortality* (Module 4), as recommended at the May 1992 International Conference;
- held a PHC MAP Orientation Workshop in December 1992, introducing the materials and gaining feedback from approximately 40 U.S. PVOs, health consulting firms and donors;

- held a review meeting of Modules 8 and 9 on *Cost Analysis* and *Sustainability* with staff from the World Bank's Economic Development Institute (EDI) in February 1993;
- introduced 52 participants from PVOs, NGOs, government ministries, universities and consulting firms to PHC MAP during a one-day workshop in June 1993 which was held in conjunction with the National Council for International Health (NCIH) Annual Conference;
- presented PHC MAP to 40 participants at a Workshop on the "Future of Microcomputers in Epidemiology" at the Centers for Disease Control (CDC), Atlanta.

Overall, the multi-country, five project program is 4 percent below budget through Year 2: a total of $1,952,700 ($815,000 from A.I.D, and $1,137,700 from AKF USA) has been expended as of June 30, 1992 against an approved budget of $2,038,800. The overall forecast for the three year program has been adjusted from $2,680,000 to $2,713,000, and the increase of $33,000 will be funded entirely from an additional AKF USA contribution of the same amount. A.I.D.'s contribution will remain unchanged, at the previously approved level of $1,200,000, and AKF USA's share will be increased to $1,513,000. In Year 3, a total of $760,300 will be expended against an original forecast of $641,200. Of this amount, $385,000 (51 percent of total costs) is from A.I.D., and the remaining $375,300 will be funded by AKF USA.

As noted in the financial section of this Annual Report, savings are projected for the MPHC projects, mainly because of a major devaluation of the Kenyan shilling and some program underspending. The savings for the overall three-year program amounts to $127,400. Of this amount, AKF USA proposes to apply $36,000 to support new activities under the MPHC (described in sections 4.1 and 6.3), which have been included in the revised MPHC budget. The overall three year budget for the project has been reduced from $483,800 to $392,400, a reduction of $91,400. In addition, AKF USA proposes to reallocate the balance of approximately $91,000 (3% of the total revised budget) to other projects under the Matching Grant program. Approximately $89,000 will be applied to cover costs associated with the production, promotion and dissemination of materials developed under the PHC MAP project. These costs were contained in AKF USA's original proposal to A.I.D. for the Matching Grant, but remained unfunded because the total Matching Grant approved by A.I.D. was less than the amount requested. The balance of approximately $2,000 will be reallocated for the costs of an external evaluation of the Matching Grant program.

I. BACKGROUND TO GRANT AND PROJECT CONTEXT

1.1 Introduction

The Aga Khan Foundation U.S.A. (AKF USA) is part of a nondenominational international development network established to promote social development through innovative approaches to problems in health, education, and rural development. Cross-cutting concerns include the role of women in development, the environment, sustainability, community participation, human resource development, and the strengthening of nongovernmental organizations (NGOs). New areas of interest include small-enterprise development and the rural built environment.

The social development institutions within the Aga Khan Development Network (AKDN) include the Aga Khan Foundation (AKF), the Aga Khan Health Services (AKHS), the Aga Khan Education Services (AKES), and the Aga Khan University (AKU). Service facilities include approximately 500 health care and education units operated by AKHS and AKES. The Aga Khan University (AKU) in Pakistan includes a Faculty of Health Sciences, made up of Schools of Medicine and Nursing, a teaching hospital, and the Department of Community Health Sciences (AKU/CHS). AKF, with offices in ten countries, is essentially a funding agency, but it involves itself in the genesis and evolution of its projects, as well as in learning from the experiences it funds. AKF works closely with its grantees in the design, implementation, and evaluation of projects. The heart of the AKF approach is the cross-fertilization of ideas among projects through both technical assistance and a continuing learning process.

AKF's health activities in recent years have focused on innovative approaches to the development of community-based primary health care. Commitment to community participation in project management and decision-making increasing access to services and resources have been central features of all AKF's health projects. Increasing emphasis has been given to improving management and management information systems (MIS), including the use of clearly defined indicators for monitoring and evaluation of progress. AKF's health strategies are increasingly addressing issues directly related to financial, social, and organizational sustainability of community-based programs and the relation of primary health care (PHC) initiatives to existing health services and public health systems to ensure relevance and applicability.

The three community-based PHC projects in this Matching Grant and the two supporting projects build upon AKF's experience in these areas.

The geographical areas selected have endemic poverty and high rates of infant and maternal mortality, morbidity, and malnutrition, inadequate water and sanitation, and poor housing conditions. People are forced to live under conditions of social and often political instability and environmental degradation. Where health and social services are available, they are usually understaffed, underfunded, and poorly managed. Inadequate attention is given to

preventive and promotive care for common local health problems. Community organizations and self-reliance are usually limited, and people are unaware of even simple health measures which are within their means, such as Oral Rehydration Therapy (ORT). In poorer communities, there are inadequate internal financial resources to maintain even a rudimentary local health care system. At the same time, enclaves within these communities with an Infant Mortality Rate (IMR) of more than 100 per one thousand are entering a health transition, moving beyond the diseases of poverty to the diseases of industrialized societies. In some instances, entire communities are in the midst of such a transition. The PHC projects funded under this Matching Grant have been designed to take some of these changes into account while dealing with the traditional priorities of Maternal and Child Health (MCH).

AKF USA's previous Matching Grant (1988-91) for *Strengthening the Management, Monitoring and Evaluation of PHC and Mother and Child Survival Programs in Selected Countries of Asia and Africa* enabled the Aga Khan Health Network (AKHN), composed of the AKU, AKHS, and AKF, to make substantial progress in PHC implementation and management. The current Matching Grant (1991-94) builds on these gains and addresses recurrent and emerging issues and gaps in health systems development, management, and information support. These PHC projects have become increasingly concerned with evolving into health programs which can be supported, in part, by locally available resources. This requires a long-term institutional base, which clearly exists in AKHS and AKU, further development of local human resources, acceptable and cost-effective services and activities, and new mechanisms for local financing of PHC. AKF's programs are continuing their emphasis on PHC/MCH, strengthening implementation, program analysis, and management, and focusing more on cost and sustainability issues.

The current AKF USA Matching Grant program has five components, including three community-based PHC projects in Kenya, Bangladesh, and Pakistan. These projects aim to strengthen these communities' participation by increasing their responsibilities in effective and efficient PHC planning and management and by testing new approaches and strategies for organizing and financing PHC/MCH projects to ensure long-term financial and organizational sustainability.

1.2 Mombasa Primary Health Care Project (MPHC): Kenya

The MPHC project areas were identified for support by Kenya's District Health Management Team (DHMT) and AKHS, Kenya in 1987. The Kwale district in the Coastal Province of Mombasa was found to be in greatest need because of the population's poor health status, inadequate access to health services, and low socioeconomic status. During the problem identification stage, MPHC communities identified the following as their priority health problems: frequent childhood death; inadequate and unsafe water; poverty; poor food harvests; high morbidity because of malaria, bilharzia, worms, measles, and diarrhea; aches and pains; high illiteracy; lack of service units such as dispensaries, hospitals, schools, and markets; and the effects of a harsh climate. As project implementation has

progressed, MPHC has observed that the lack of access to safe water and adequate food is one of the major factors that continues to impede the communities' ability to improve their health status. The continued efforts of MPHC's water development projects and farmer "demonstration plots" are designed to overcome these obstacles by improving the economic and food production potential of these communities.

1.3 Aga Khan Community Health Programme (AKCHP): Bangladesh

AKCHP was established in 1984 in Dhaka by the Silver Jubilee Commemoration Society. This PHC/MCH project, operating since 1985, has surpassed its operational targets. However, a large segment of the population remains vulnerable to malnutrition, disease, and poor health. AKCHP is continuing the expansion of its services and transforming itself in order to sustain the shift from that of a "project-led" approach to a "community-led" approach.

AKCHP has successfully begun to diversify its funding resources beyond AKF and has developed strong collaborative relationships with other local and international NGOs and Private Voluntary Organizations (PVOs), as well as the Government of Bangladesh (GOB). In October 1992, a proposal was submitted to the Danish International Development Agency (DANIDA) for project funding (1993-1995). DANIDA has since visited the project site and has given the project a very positive review. In her report, the consultant stated, "...So it is highly recommended that this programme be continued, and encouraged to continue developing and testing better ways to provide PHC in urban settings. AKCHP successfully realized its targeted coverage and provision of services to the community. It has succeeded in reaching the community [through] relevant, cost effective delivery of services....". Prospects for funding appear hopeful based on the positive assessments received thus far.

1.4 Urban Primary Health Care Programme (UPHC): Pakistan

In 1983, a five-year PHC project was designed by AKU/CHS to address the two issues of health human resources development and health systems development. The project developed a series of seven PHC modules, each serving a population of 8,000 to 10,000, with primary beneficiaries being mothers and children. The modules were designed to provide effective and affordable services, and to serve as prototypes for PHC systems that could be replicated by municipal and provincial governments. The field sites also provide training for AKU's medical and nursing students and Community Health Workers (CHWs), preparing them to deal with the major health problems of Pakistan.

The aim of the 1991 Matching Grant is to maintain services for the 54,700 people served by the seven micro-PHC modules located in the following areas: Orangi, Chanesar Goth, Grax, Essa Nagri, Azam Basti, Baba Island and Karimabad. From the experience gained through these micro sites, AKU/CHS has embarked upon the development of a Macro PHC Project by collaborating with local communities, nongovernmental organizations (NGOs) and local governments. The Macro PHC Project is intended to serve as a model for the

provision of PHC services to populations of 50,000 or more. AKU/CHS will manage and facilitate the development process, collaborating with communities, government, and other NGOs to mobilize financial and institutional resources to support the project.

1.5 Aga Khan Regional Network Programme (RNP)

RNP, established under AKF USA's 1988 Matching Grant, provides PHC practitioners and managers from AKF-supported projects in Kenya, Pakistan, and Bangladesh the opportunity to share their experiences and address cross-cutting issues in PHC service delivery and management through workshops and information exchange. As the PHC systems of member projects mature, the agenda of RNP has expanded to include health systems development, alternative health financing, community organization, and ethics in PHC. Under AKF USA's current Matching Grant RNP has already expanded from five PHC projects in three countries to 10 PHC projects in four countries (Pakistan, Bangladesh, India, and Kenya).

1.6 PHC Management Advancement Programme (PHC MAP)

To overcome the management information gap in the health sector, the AKHN and Primary Health Care Operations Research (PRICOR) have developed the Primary Health Care Management Advancement Program (PHC MAP) to provide local managers with simple tools that they can use to gather useful information for program management and evaluation. The modules are designed to help managers identify management information needs; assess community health needs and coverage; help plan and assess health worker activities: increase the quality of surveillance of morbidity and mortality reporting; improve program monitoring and evaluating procedures; evaluate the quality of PHC services and of PHC management; perform cost analyses; and assess the sustainability of PHC programs. These tools have been designed and field-tested in consultation with local PHC managers and practitioners in Africa, Asia, and Latin America to fit local conditions and are now ready for broad dissemination and application in the developing countries. The PHC MAP materials have also drawn the attention of urban-based PHC programs in the United States, where it is expected that the PHC MAP modules will also be applicable, offering new opportunities for "technology transfer" from developing to developed countries.

II. PROJECT METHODOLOGY

The overall goal of the Matching Grant project is to contribute to improving the equity, effectiveness, efficiency, and sustainability of primary health care projects in developing countries of Asia and Africa. The three main purposes are to expand coverage, increase effectiveness, and test new organizational models for community-based PHC in three health projects. By the end of the project funding, they will serve more than 200,000 urban and rural residents by strengthening the capacities of local communities and NGOs. The projects will also strengthen the management, information systems, and the social, organizational and financial sustainability of 10 PHC projects involved in RNP and PHC MAP activities.

2.1 Program Objectives

The objectives of the Matching Grant continue to be the following:

- Improving the survival, health, and safety of young children and women of childbearing age, who are most vulnerable to the afflictions related to extreme poverty. All three PHC projects (MPHC, AKCHP, UPHC) are targeted toward serving this group.

- Mobilizing communities in support of PHC. The three PHC projects are seeking to inspire and maintain community participation in all aspects of planning and implementation to enhance long-term sustainability.

- Using Management Information Systems (MIS) to chart changes in demographics and health statistics and improving PHC management, planning, efficiency, and long-term sustainability.

- Providing flexible management tools for PHC managers and practitioners that are easily adapted to fit local situations. The management tools that are provided by PHC MAP are designed to help managers gather and use information for program management and evaluation.

- Maintaining and expanding a working group, RNP, from various PHC projects to meet and discuss issues and ideas related to PHC. Experiences are shared to assist local PHC managers in providing maximum benefits to their communities and in optimizing limited resources.

Mombasa Primary Health Care: Kenya

The overall mission of the MPHC is to improve the health and socioeconomic status of the poor in rural Kenya. The project area in Kasemeni, Mtaa, and Mwavumbo in the Kinango Division of Kenya's Kwale District has a population of 44,435, with a target group of 10,423 women of childbearing age, and 12,563 children under the age of five. Earlier population figures (48,000) have been adjusted this year based on recent surveys.

The MPHC's strategy is to enable community members to undertake those activities which will bring about sustainable improvements in their health. Communities have been mobilized to build upon local structures which can empower leaders, train Community Health Volunteers and Workers, CHVs and CHWs, and develop PHC skills and capacity. In order for MPHC to implement a successful PHC program in the rural areas of Kenya, MPHC has first had to act as a catalyst in mobilizing village institutions. MPHC has brought the capabilities of various community organizations together to encourage a cooperative effort.

Various strategies have enabled community members to bring about sustainable improvements in their health status. These include: continued community participation and involvement at all project levels; building upon existing village groups and organizations as entry points for Community-Based PHC (CBPHC), and improving their leadership skills for future sustainability; developing capacity and skills in the community through training of CHWs and other volunteers; continuing various community outreach services; and improving the quality and accessibility of water.

Activities are managed through both a quarterly review process and an Annual Review by an intersectoral team composed of representatives from the community; AKHS,Kenya; Kenyan Ministries of Health, Education and Social Services; the Local Administration; AKF; and UNICEF.

Because of the very difficult and vulnerable environment in which MPHC operates, a need to improve the communities' access to basic necessities of food and water has become apparent to improve health status. MPHC has responded by organizing activities for clean water sources, demonstration plots for alternative farming methods, and sanitation activities.

Aga Khan Community Health Programme: Bangladesh

The total project area consists of more than 70,000 low-income residents of Paltan, Shantinagar, Farkirapul, South and North Shajahanpur, and Arambagh of Wards 60, 61 and 62 of the Dhaka municipalities. The target population consists of more than 25,000 women of childbearing age and children under five years of age. In this poor urban setting, AKCHP is aiming to make the transition from a "project-led" approach to a "community-based" approach by recruiting and training CHWs, promoting active community involvement, and establishing alternative methods of financing. The involvement of illiterate women in this process has been a major goal. Community Mother Volunteers (CMVs) will be the principal action-agents for reaching this goal. Community participants have been serving under trained CHWs, and consistency and quality of care have been checked through regular monitoring and field visits by management staff.

Urban Primary Health Care: Pakistan

UPHC aims to create replicable, effective, community-led, and community-financed PHC projects in urban areas. The project area includes six urban squatter settlements (katchi abadis), and one lower-middle class community in Karachi with a total population of 58,500. Decreases in population are partially attributed to the continued migration of families in and out of the project area. UPHC's target group is 9,305 children under age five, and 7,872 women of childbearing age in the katchi abadis. Medical students from AKU, who gain valuable field experience in Community-based Health Care (CBHC), are also direct beneficiaries of the project.

Although the major causes of deaths have not changed (they are still diarrhea, malnutrition, low birth weight (LBW), and Acute Respiratory Infection (ARI)), a shift in project methodology has addressed the weaker areas within the program. Areas in which the original program methodology faced the greatest difficulty were: (i) decreasing the percentage of children who suffered from malnourishment; (ii) maximizing the use of clinical services; and (iii) increasing the number of traditional birth attendants (TBAs) reporting births so that high-risk infants could be identified early on.

An effort is being made by the field teams to address the above problems by focusing more on the causes of these problems and trying to establish new strategies to deal with them. Efforts are being made to focus more on children under three, rather than all under five. Greater emphasis is now being placed on promoting breastfeeding and better nutritional practices of mothers, identifying reasons for residual mortality, focusing especially on the children who die in the early months of life, and identifying reasons for the drop in the use of clinical services. UPHC has also had success in initiating a new ARI program and will soon be implementing new programs that will increase community participation and involvement in UPHC activities.

A Macro PHC Project is being established to provide a viable model of PHC that will be suitable for replication within the general framework of the national health care system. In collaboration with local communities, nongovernmental organizations (NGOs), and government, the Aga Khan University has organized a prototype Macro PHC Project to facilitate the development of an effective, affordable, and replicable health care program at the sub-district level.

The project aims to develop a network of PHC programs for well-defined, underserved populations of up to 50,000. Linkages with NGOs and community organizations leading to greater community participation are to receive priority attention. Other major objectives of the Macro PHC Project are to work for collaborative linkages with various levels of government to integrate the project with already existing infrastructure, and to explore the possibilities of linking the program with urban components of the World Bank's Family Health Project (FHP) in Pakistan.

Regional Network Programme

RNP has been designed to strengthen AKF-sponsored PHC projects through information exchange between PHC projects. The focus of RNP continues to be on promoting equity, efficiency, effectiveness, and long-term sustainability of PHC projects. RNP participants include PHC managers from projects in Pakistan, India, Bangladesh, and Kenya. This target group and the populations they serve have benefitted through expanded access to information about various PHC methods. RNP functions through a series of annual meetings, field visits, a newsletter, and workshops attended by representatives from various PHC projects. During the past year, workshops in Health Systems Development, the Health Transition, Alternative Approaches to Financing, Ethics, and Women in Health and

Community Development have allowed project teams to pool information to gain new perspectives and advice.

With the additional information gained through the various workshops, field visits, and meetings, RNP is now ready to go beyond the procedural questions to those of institutional implementation. In the coming year, the focus of RNP activities will include issues dealing with the impact, costs, and effectiveness of health programs. Understanding the larger purpose, usefulness, replication, and the development of new partners in PHC will be addressed.

Primary Health Care Management Advancement Programme

The purpose of the PHC MAP project is to assist local PHC managers in the collection, processing, and analysis of useful management information. The target group is local PHC managers who might not have access to reliable methods of information gathering and analysis but who would like to improve planning and management capacity. The modules are designed to help managers identify management information needs through the identification of strengths, and weaknesses, in local PHC programs. To ensure its relevance to PHC management issues in the developing world, PHC MAP adopted a strategy of involving PHC managers and practitioners in Asia, Africa, and Latin America in the development, field testing, and review of PHC MAP materials.

2.2 Program Inputs and Outputs

The total three-year budget (1991-94) for the five components of the project is $2,713,000. It includes a contribution of $1,200,000 (44 percent of the total) from AID and $1,513,000 (56 percent of the total) from AKF USA, which is an increase of $113,000 in AKF USA's contribution over the original three year budget. Project management costs and administrative overheads incurred by AKF USA and its affiliates in the AKDN, estimated to be $1 million, are not included in the grant budget but comprise a further AKF contribution. The inputs and outputs for each project during the reporting year July 1, 1992 - June 30, 1993 are outlined below.

Mombasa Primary Health Care Project: Kenya

Financial inputs totaled $115,400. Organizational inputs included 9 full-time staff and 2 Public Health Technicians (PHTs), seconded to the project by the Ministry of Health. The following outputs were targeted: establish or strengthen organizational structures for PHC at the village level, for an increase from 44 percent to 50 percent by the end of 1992 and up to 75 percent by the end of 1993 (so far these targets have been exceeded); strengthen the existing MIS; train 7 Community-based Health Workers; provide health services to the target population; and provide technical assistance for improvements in water and environmental sanitation.

Aga Khan Community Health Programme: Bangladesh

Financial inputs under the Matching Grant totaled $64,800. Targeted outputs were to increase the availability of individual primary health care components, such as immunization, vitamin A capsule supplementation, nutrition, maternity care, and water and sanitation. By the end of June 1993, the AKCHP had 41 staff members, 143 Community Volunteers, and 210 Traditional Birth Attendants. AKCHP would like to continue to train greater numbers of volunteers and TBAs in order to increase services. The issues of sustainability, and increasing the amount of revenue from individual services and training, are being addressed seriously within the present framework. Collaboration with government and nongovernmental organizations has continued and been strengthened, especially in the areas of ARI, nutrition, TBA training, and research. Cooperation with the PHC programs within the RNP in Pakistan, India, Kenya, and the Aga Khan University continues.

Urban Primary Health Care Programme: Pakistan

Financial inputs totaled $312,800. Targeted outputs were to maintain the 33 percent reduction in IMR and a 25 percent decrease in Under 5 Mortality Rate (U5MR) at reasonable costs; to maintain the 33 percent improvement in grade II nutritional status and the 6 percent improvement in grade III nutritional status; to develop human resources by training CHWs and Community Health Nurses (CHNs); and to apply lessons learned under the micro PHC modules to develop macro PHC models which will provide health services to populations of 50,000 or more at affordable costs.

Regional Network Programme

Financial inputs totaled $128,800. Other inputs were significant staff time and communications costs from participating institutions including UPHC, MPHC, AKCHP, and AKU. Outputs for RNP consisted of workshops, meetings, and field visits in Karachi, Gilgit, Dhaka, Kathmandu, and Mombasa, and the publication of the RNP newsletter. Because of the political situation in India, the 1993 RNP Annual Workshop was held in Kathmandu instead.

Primary Health Care Management Advancement Programme

Financial inputs totaled $164,900. Organizational inputs included staff time from and consultations with AKHN; Ministries of Health and other government agencies; NGOs; UNICEF; WHO; universities in India, Bangladesh, Indonesia, Thailand, the United Kingdom, and Canada; and, the Rockefeller Foundation and other foundations.

Outputs include the nine PHC MAP modules listed below. Each of the nine PHC MAP modules includes a User's Guide, a Facilitator's Guide, and related computer programs (EPI-Info); tne series is completed by three Manager's Guides and a computerized version of the PRICOR Thesaurus.

PHC MAP MODULES

Module 1. *The PHC MAP Framework for Assessing Information Needs.*
Module 2. *Assessing Community Health Needs and Coverage.*
Module 3. *Planning and Assessing Health Worker Activities.*
Module 4. *Surveillance of Morbidity and Mortality.*
Module 5. *Monitoring and Evaluating Programs.*
Module 6. *Assessing the Quality of Service.*
Module 7. *Assessing the Quality of PHC Management.*
Module 8. *Cost Analysis of PHC Programs.*
Module 9. *Sustainability Analysis for PHC Programs.*

MANAGER'S GUIDES

Better Management - 100 Tips: A helpful-hints book that describes effective ways to help managers improve what they do.

Problem Solving: A guide to help managers deal with common problems.

Computers: A guidebook providing useful hints on buying and operating computers, printers, and other hardware and software.

The Computerized PRICOR Thesaurus: A compendium of PHC indicators.

III. MONITORING AND EVALUATION

3.1 External Evaluation of the Matching Grant Program

AKF USA's Matching Grant agreement requires that an evaluation be conducted prior to the end of the program. This evaluation will help both A.I.D. and the Foundation in assessing the effectiveness of their grants, and will help the Foundation to refine its development strategy, guide future decisions, and meet reporting and evaluation requirements. An external evaluation is to take place in September 1993, early in the third year of the Matching Grant.

Evaluations of health care programs funded by AKF and its partners (such as A.I.D.) are particularly important, as the AKF Board has expressed its strong interest in learning generic lessons from major grants in the health sector which collectively aim to improve the effectiveness, management, and sustainability of health care programs of the Aga Khan Health Network (AKHN).

The overall purposes of the evaluation are to:

- assess the progress made to date by the various projects;

- document improvements in the projects' performance and the health infrastructure for delivering services (in the case of the PHC/MCS projects); and
- evaluate the overall accomplishments of the Matching Grant.

The evaluation will address the following general areas of interest to AKF USA and A.I.D.:

- the primary focus and use of funding;
- the NGOs' organizational development;
- the project design and implementation plans;
- effectiveness and impacts of services;
- PVO/NGO-host government cooperation;
- sustainability strategies;
- project finances; and
- lessons learned by the Matching Grant projects.

A.I.D.'s Office of Foreign Humanitarian Assistance/Private Voluntary Cooperation (FHA/PVC) has reviewed and approved the Terms of Reference and the evaluation team. In addition, a preliminary schedule of events has been planned, along with guidelines for the evaluators. The evaluation is scheduled to begin on September 11, 1993, with the final Evaluation Report due on November 15, 1993.

3.2 Mombasa Primary Health Care Project (MPHC): Kenya

MPHC is using the information from its October 1990 Community Survey (conducted under the previous Matching Grant) as its baseline data.

Program Targets and Indicators for the Calendar Year 1993

MPHC's plans for 1993 were developed, based on the 1992 performance, during the December 1992 quarterly review. (See Attachment 1: MPHC 1993 Plan of Action) Overall objectives with quantitative targets were articulated. Each community or village PHC project drew up its plans based on these objectives and their own health priorities. The main 1993 targets and indicators are described below.

Community Process. Increase active village participation in all 58 villages from 69 percent (38 villages) in 1992 to 75 percent (42 villages) in 1993. Indicators used to monitor the process will be the number of villages with ongoing community-based health care (CBHC) activities and the number of villages planning and implementing their Plans of Action.

Training. The development of knowledge and skills among CBHWs will be promoted by training 12 Village Health Committees (VHCs), 15 Parent-Teacher Associations (PTAs), 6 women's groups, 2 youth groups, 5 churches and mosques, 28 schools, 56 CBDDs, 100 men and women for Safe Motherhood, 5 Community-Based Training of Trainers (TOTs) and 30 TOTs from government organizations, 60 community leaders, as well as MPHC staff.

Indicators that will be used to determine the success of training will be the number of persons trained per category and the effectiveness of those trained based on assessment results.

Intersectoral Collaboration. Intersectoral and interagency collaboration in planning, implementing, and evaluating project activities will be actively encouraged and facilitated. In the past MPHC has worked closely with UNICEF, the Ministry of Health, the Kenyan Agricultural Research Institute (KARI), Kenya Red Cross, The Centre For Development and Population Studies (CEDPA) and Technologies For Primary Health Care (PRITECH).

Information Gathering and Utilization. MPHC will improve the management of PHC/CBHC activities at the community level by developing systems for information collection and use with all 3 Project Implementation Committees (PICs) and at least 30 of the 56 villages. The Community Based Management Information System (CBMIS) has been designed specifically for this and will act as a self-monitoring device. The indicators used will be the number of villages collecting and using information and the availability of records and reports at the community level.

Immunization. MPHC will maintain immunization coverage for children between the ages of 12 and 23 months above 75 percent and raise tetanus toxoid coverage for women to 85 percent. The indicators used to monitor immunization coverage will be the percentage of children aged 12-23 months who are fully immunized, and the percentage of women with children below the age of 1 who were immunized against tetanus.

Food Production, Nutrition, and Growth Monitoring. Overall nutritional status of children aged 0-35 months will be improved by monitoring those who measure in the normal weight-for-age and low-weight-for-age categories. In addition, crop yield per unit area in the test plots will also be used as an indicator of the potential for increased food production or output.

Family Planning (FP). MPHC will improve the health of women aged 15-49 years by increasing awareness and practice of family planning. By the end of 1993, at least 25 percent of women or their spouses will be using a reliable family planning method. The indicators used will include the percentage of women using a reliable family planning method and the percentage of men and women who can name at least three reliable family planning methods.

Community-Based Drug Supply. The purpose of the CBDS program is to improve home case management of common diseases by improving access to information and common pharmaceutical drugs at the village level. The ratio of trained Community Based Drug Distributors (CBDD) to the total population, the percentage of cases that are properly managed at home, and the percentage of mothers who know the correct symptoms and treatment for common diseases will be the indicators used to monitor the success rate of the CBDS program.

Water and Sanitation. MPHC, through mobilizing local and external resources, will complete work on the Kasemeni-Miyani and Mavirivirini pipelines, construct 6 new water pans, improve and expand 10 existing water pans, and collect and analyze water samples to test quality. MPHC will also collect information related to water use and accessibility -- the time it takes to get from a household to a water source and the average amount of water used daily by households in the project area. This will be done to monitor the impacts that changing water supply may have on average consumption.

Monitoring Plan

Project progress is monitored through data collection at the community level, including an annual survey. In addition, every MPHC staff member and government extension worker in the project area is required to keep a daily record of activities. Monthly forms or tally sheets are now completed for certain activities. CBHWs also evaluate their own performance regularly.

This information is reported during the weekly planning meetings. It is summarized monthly by the Assistant Information Officer and is aggregated quarterly for discussion during the Quarterly Review Meetings. During the Quarterly Review Meetings, progress is compared to the targets for the year. The Annual Plan of Action, drawn up in November-December of each year based on the annual survey results, forms the basis for planning future activities and monitoring.

3.3 Aga Khan Community Health Programme (AKCHP): Bangladesh

AKCHP has been working rigorously on two information systems, the Health Information System (HIS) and the Clinic Information System (CIS), both of which will provide data and an analytical framework for monitoring, evaluation, and operations research. Many of the surveys and surveillance systems that were initiated in the last reporting period have now been absorbed by the HIS, the CIS, and Operations Research.

During the past reporting period, HIS personnel have been involved in developing and reviewing data systems from three rounds of data collection, including demographic, morbidity, and service indicator surveillance system for April 1992 to December 1992. Continuous feedback and training to the CHWs and Community Health Organizers and Field Supervisors was facilitated by the HIS. Household listings and identification of target groups for various project activities, such as immunization lists, were produced.

AKCHP has used the HIS to analyze teenage health profiles, develop TBA profiles, identify at-risk low-birth weights babies, identify reasons for lack of maternal Tetanus Toxoid (TT) immunization during pregnancy, collect education and occupation profiles of the AKCHP population, develop hypertension protocols, collect Nutritional Surveillance Project (NSP)

data, perform water and sanitation surveys, and do verbal autopsies. Among other things, HIS personnel have also been involved in providing EPI-INFO training to students of the Epidemiology and Biostatistics course, held at AKCHP.

To improve the quality of data and feedback, the CIS was reviewed. Standard tables and graphs will be produced to provide disease profiles of AKCHP's target population, children under the age of five and mothers, both in the prenatal and postnatal stages. Reports will be produced monthly and data will be aggregated and compiled quarterly for the six-month reports. A new clinic data form was developed that will be used for data collection.

Operations Research

Since the formation of the Research Cell in January 1992, several operations research projects have been carried out to monitor and provide feedback to PHC providers on PHC activities. Among the reasons for having a strong operations research team is the need to provide adequate information to both the local and central managers of PHC programs. This information helps continuously in the monitoring, evaluation, and planning process. An example is the demographic profile recently completed by AKCHP. Baseline data was analyzed, and a profile of the target population by age, sex, and community was produced. The population was also analyzed by CHW. This information was important to the workers in identifying target groups for various activities. (See Attachments 4 and 6)

3.4 Urban Primary Health Care Programme (UPHC): Pakistan

The Management Information System (MIS) is a vital part of the PHC program and helps monitor progress through quarterly and yearly evaluations. Results from periodic monitoring help to guide teams and overall PHC programs in making informed decisions. Through this system, the teams have been able to address issues concerning the breadth of coverage and the provision of equitable and effective services.

In 1992, some data recording instruments were revised and new instruments developed to improve the value and relevance of data provided for monitoring and planning purposes.

MIS Workshop

In November 1992, a workshop was held to review the overall program goals and objectives. In addition, AKU/CHS also considered how the MIS might be better adapted to fit the current information needs. Based on the identified endpoints, a critical evaluation of current indicators was undertaken to decide which of these had practical relevance to the program and should be retained. New indicators were proposed where needed, and existing instruments for data collection were reviewed.

MIS Manual for Health Workers and the MIS Training Manual. The drafts for the two manuals have been prepared and are currently being updated in light of the changes suggested during AKU/CHS's November 1992 workshop on MIS.

Data Instruments.

The data collection instruments in use are the family folder, the child health card, the maternal health card, the daily activity register, the pregnant women's register, the TBA reporting forms, the clinical morbidity forms, and the death report forms. Modifications and additions that have been carried out over the past reporting period are as follows. (See Attachment 26)

MCH Card. In the past, two child health cards were being completed; one remained with the mother and the other with the CHW. An additional maternal health card also remained with the mother. The new Pictorial MCH card will replace all three cards. (See Attachment 27) The card is valid for the mother until she becomes pregnant again, and for the children until they reach three years of age. The purpose of the new card is to identify and monitor high-risk women and children. The new MCH card has been field-tested and will be introduced beginning in July 1993.

Verbal Autopsy. The verbal autopsy form for children under the age of five has recently undergone revision. The new form is based on a series of rules that facilitate diagnosis and identification of the appropriate cause of death. The form and the decision rules have been field-tested in the northern areas of Pakistan and have now been introduced on an experimental basis in the PHC micro field sites.

Meeting/Training Register. This is a new register that will be developed and will help monitor the number of meetings and training sessions held for TBAs, CHWs, and other PHC staff workers. It will track the number of people participating in PHC programs and help monitor lane meetings and other interactions with the community.

Rehabilitation Workers Activity Register and Community Coordinators Activity Register. These registers will be developed to help workers better monitor and plan their activities. In 1993, a clinical services register and a lab register will be developed. Some changes may also be made to the current clinical records and the maternal register. Once household risk factors have been identified, the family folders will be replaced by simpler household profile cards.

3.5 Aga Khan Regional Network Programme (RNP)

The monitoring and evaluation of the RNP project includes interpreting the extent to which AKF's standardized indicators are being used by the field-based projects. The standardized indicators are measures of morbidity and mortality in target populations and are used to better extract data for assessing, planning, and implementing PHC projects. Mid-term and

final evaluations will be carried out to assess progress, and informal evaluations undertaken by AKU/CHS and other RNP members will examine results of meetings and training programs.

Because RNP will now address broader issues concerning health systems, rather than specific PHC programs, new AKF indicators will have to be formulated that will eventually be passed on to the projects in Kenya, Bangladesh and Pakistan.

3.6 PHC Management Advancement Programme (PHC MAP)

Various workshops and meetings have already been held in the past reporting period to disseminate information, receive feedback on the material, and receive evaluative comments and suggestions for the dissemination and use of modules. Of particular importance were the hands-on workshop at the National Council For International Health's (NCIH) Annual Conference (July 1993), the American Public Health Association's (APHA) Annual Conference (November 1992), and the Orientation Seminar (December 1992) held in Washington, DC.

Besides disseminating information on PHC MAP, post-workshop questionnaires have provided provocative insights into the efficacy of the material. These evaluations will be used to assess the usefulness of the materials and to further target promotion and dissemination activities.

3.7 Aga Khan Foundation U.S.A. (AKF USA)

Quarterly reports are submitted by the individual projects and reviewed by AKF USA, AKF Geneva, AKU, and AKHS. Other occasional, special activity reports, such as workshop reports from RNP and PHC MAP, are also reviewed by AKF USA and AKF Geneva.

Dr. Pierre Claquin, Health Program Officer, and Dr. Ron Wilson, Director of Health Programs, both with AKF Geneva, also make regular visits to the project areas to observe progress and provide technical advice.

The AKF units in Kenya, Pakistan, and Bangladesh also play an important role in providing project monitoring, evaluation, and technical assistance to the projects in their respective countries.

IV. REVIEW AND ANALYSIS OF PROGRAM RESULTS BY COMPONENTS

4.1 Mombasa Primary Health Care (MPHC): Kenya

Overview

Major activities this year were community participation and involvement in PHC at the

village level, strengthening community-based organizational structures, developing capacity and skills in the community, providing health services to target populations, and improving the quality of, and accessibility to, water.

Community Participation and Involvement

MPHC's target for July 1992 through June 1993 was to increase self-reliance for all 58 villages in the project areas and to raise the level of participation in the PHC project area from 69 percent (38 villages) to 75 percent (42 villages). Substantial progress toward these targets has been made. Of these, 41 villages (71 percent), have identified their problems, drawn up plans of action, and started implementation by becoming actively involved in community-based PHC.

A village is classified as actively participating or involved when:

- problems have been identified and prioritized by village residents;
- a Plan of Action to address the priority problems has been drawn up;
- at least part of the Plan of Action is being implemented;
- CBHC/PHC leadership has been identified and is working;
- at least 40 percent of the families in the village are involved in the ongoing CBHC activities.

PHC Organizational Structures

MPHC ensures that village organizational structures evolve independently -- each village decides which organizational structure might best address their community needs. Two distinct organizational structures are currently in operation, the Village Health Committee (VHC) and the Project Implementation Committee (PIC). The VHC deals with activities on the village level and the PIC deals with issues within a broader locational jurisdiction.

MPHC has designed training for Village Health Committees (VHCs), Parent Teacher Associations (PTA), women's groups, and other community structures engaged in PHC/CBHC. The reason for training village level organizations is to make information available to the decision makers at the PIC level. Five of the seven sessions have been completed.

At each PHC location, a PIC is organized and chaired by the village chief. PIC membership is drawn from village representatives, extension workers, politicians, and others. The PIC draws up plans, mobilizes resources, oversees implementation, and increasingly takes on the role of PHC monitoring and assessment. Each of MPHC's three project locations now has an active PIC.

Currently, each of the three PICs has systems and structures in place, and at least 30 percent of the community-based structures, such as schools, PTAs, and women's groups, will be

generating information for PHC/CBHC activities by the end of 1993.

The challenge of involving women at the PIC level has not yet been met because of cultural barriers and low literacy. There are only one or two women at this level, who are government extension workers. MPHC will continue to work with the communities to overcome such barriers to women's participation, however, this is a slow process. Women are active at other levels such as health education, improved food production, and water source protection. Data on female participation at the village level is being compiled.

Developing Capacity and Skills in the Community

MPHC views training as a crucial factor influencing the long-term sustainability of PHC projects. The six-month (January 1993-June 1993) targets were to train 50 community members for Safe Motherhood, 5 extensions workers as TOTs, 26 persons for community based drug distribution and 7 sessions of PHC/CBHC training for PTAs, VHCs, women's groups, and so on.

Safe Motherhood. Both MPHC and UNICEF are involved in providing training for Safe Motherhood. The programs are similar, but MPHC's Safe Home Delivery (SHD) program was the first of its kind in the region. MPHC is hoping that by increasing the number of trained birth attendants at the village level, prenatal care will improve. Consequently, an improvement in Safe Home Delivery (SHD) will have a positive impact on the health of the target population. Sixty-seven villagers have been trained in Safe Motherhood since the beginning of 1993, exceeding the six-month target.

Extension Workers and TOTs. Three out of the five extension workers targeted have been trained as trainers as of June this year.

Community-Based Drug Distribution. Nineteen of the 26 workers were trained for drug distribution. CBDD training for the remaining villagers will continue.

School Health. PHC education activities have been implemented in all the 26 primary schools and 2 secondary schools in the project area. Fourteen additional schools were targeted for additional programming and those training sessions completed. MPHC has developed expertise in this area, so much so that it led, with AKHS,K, an RNP workshop on Health Through Schools, in August 1993 at Karachi. All RNP members participated in this workshop, including Junagadh PHC, Sidhpur PHC, AKCHP Dhaka, AKHS Pakistan, as well as other non-AKF affiliated NGOs. They will be using the lessons learned from the MPHC experience to improve and expand their own school health programs.

A summary of targets and achievements for this reporting period is shown in Attachments 2 and 3. The variance in the numbers trained in each category has been for two reasons. First, participation in the sessions is voluntary and therefore cannot be enforced. Second, it seems that enough people do register, but when the actual training is scheduled, more

important issues such as food and water shortages, illness, and family emergencies, prevent them from participating.

PHC Service Delivery

Maternal and Child Health. The objective for the 1993 calendar year is to maintain child immunization coverage through the second year of life above 75 percent. So far, 82.2 percent of the children aged 12-23 months have been fully immunized. TT targets were to be raised to 85 percent. However, there has been a decrease (from baseline) in Tetanus Toxoid coverage for pregnant women to 78.1 percent. According to AKF's standardized indicators, a woman is fully immunized against tetanus when she has received two TT injections. The project has continued to use these criteria to judge TT coverage. However, different organizations, including the Ministry of Health, have different criteria. Because some of their data is used in reporting, it has been difficult to assess TT coverage, a fact that may, in part, explain the slight decrease.

Most of the immunization services are provided by the government's static units, but the project complements this effort through three mobile clinics at Mazeras, Mtaa, and Mwabila village. Sixteen out of the 18 mobile clinics were held by June 1993. It is estimated that the project provides 20 to 30 percent of the MCH and FP clinical services in these villages. However, all the information, community education, and training activities for MCH and FP services in the project area are provided by MPHC.

Family Planning. For the 1993 calendar year, the overall FP target is to have at least 25 percent of the women or their spouses use a reliable method of family planning. In the project areas, use of modern FP methods is among the lowest in the country. Although MPHC had planned to improve the use of FP by increasing the number of service outlets, concerns about the feasibility and potential impacts of this approach were raised. As a result, MPHC has been conducting focus group discussions on FP with community members. At least four sessions per village are conducted with the following target groups: males over age 35; males ages 15-35; females over age 40 with no child under age 5 years; and females ages 15-40. The project team has developed FP training modules for use at the village level. Five out of the targeted 15 sessions have been completed for this year.

Discussions at FP meetings have shown that men generally make final child-bearing decisions. The men in the project area have limited access to FP information, education, and services and have vague ideas about modern contraception, largely through rumors. They however, have been generally positive about FP but have many unanswered questions. Women, on the other hand, seem to know more about modern FP but lack support from their spouses.

A recent survey showed that 77.6 percent of women of childbearing age could name at least one family planning method. This is a marked improvement over 36.8 percent from the baseline survey in 1989. Unfortunately, only 16.9 percent of the women questioned actually

used a reliable family planning method. This demonstrates that cultural norms will change slowly, and points to a greater need for education programs for both men and women.

Nutrition and Growth Monitoring. Growth monitoring is conducted at mobile clinics and village or school-based growth-monitoring sites. The number of monitoring outlets involved in regular growth monitoring and nutrition education has increased from 3 sites in 1988 to 19 sites, including 12 schools, 4 villages and 3 dispensaries, in addition to 3 mobile clinics. Children below the age of 2 years have not been weighed consistently. The statistic that uses four weighings per year as a benchmark has declined in the past year, from 61.5 percent in 1990 to 40.6 percent in 1992. This decline is due to the failure of mothers to use the monitoring services offered because of the very difficult economic and physical conditions that prevailed in the project area through most of the year. Nutrition status has remained poor over the period, with 40 percent of children between 0 and 59 months classified as underweight. MPHC has currently drawn up plans and implemented projects that strike at the heart of malnutrition -- introducing simple, efficient agricultural technology on trial farm plots and improving access to water. This suggests a shift in emphasis from PHC services to broader health systems that address issues of malnutrition and access to safe water.

Curative Services. Minimal curative services are offered at mobile clinics. Most of the community-based curative care is provided by community-based drug distributors who were trained in October 1991. The CBDD program was established to improve home-case management of common health problems. This includes prevention and control measures. Information on the success of the CBDD program is being compiled and reviewed.

For a summary of progress on key service indicators. (See Attachment 3) Many variances can be attributed to the economic and climatic conditions prevalent in the project area over the year. Decreasing cash-crop prices, coupled with decreasing yields because of drought, have significantly eroded the economic base of this region. In addition, stringent structural adjustment measures, and the fact that aid to Kenya has decreased, led to a rapid increase in the cost of living and unemployment. Service decreases in PHC and curative care can be explained by the fact that two mobile clinics were not dispatched because of impassable roads, and project transport difficulties following.

Staff Enhancement Training

Staff development is seen as an important ingredient in providing an efficient PHC delivery system. The following staff and management enhancement programs have been carried out since June 1992.

- All technical staff, including seven TOTs, attended a two-day Management and Leadership workshop.
- All technical staff received an introductory course in Participatory Rural Appraisal (PRA).
- The Project Manager, Public Health Officer (PHO) and Assistant Information

Officer attended the introductory course on Epidemiology in Nairobi.

- The Project Manager attended a Community Based Development Course at ASEAN Institute for Health and Development (AIHD), Mahidol University, Bangkok.

Water, Sanitation And Environment

The baseline survey and the health needs priority list both point to the need for safe and accessible to water. Water sources for the project area are mainly polluted rivers and ponds which often dry up during the dry season, forcing families to travel long distances in search of water. Many of the health problems mentioned by the community in their priority list are related to the limited availability of water and, more specifically inadequate sanitation.

Many households in the project area do not have adequate human waste disposal methods. The most common method used is the pit latrine. During the rainy season, the latrines have a tendency to collapse, owing to their poor construction and the nature of the soil. Therefore, the need for adequate water and sanitation is something that MPHC has been aware of but could not exactly quantify until the appropriate data on water use and access was collected and analyzed.

Water and Sanitation Survey. A water and sanitation survey was conducted in June 1992 and covered villages along the proposed Kasemeni-Miyani pipeline and Kaphingo-Mavirivirini pipeline. Results show that the majority of the people living in the project area take anywhere from less than 15 minutes, to 30 minutes, to collect water during the dry season. Only in the case of Kasemeni does the water collection take more than 30 minutes per day. The implications of this study are being reviewed.

Water, Pipelines, Tanks and Latrine. This year's target was to lay 17 km. of water pipes and construct 13 demonstration latrines. To date, 13.5 km of pipeline have been laid. Because of the increase in the cost of living, the community has found it hard to raise funds to support the technical experts in the field. After repeated efforts, the National Pipeline Corporation recently authorized the connection to the main pipeline.

Out of the 10 demonstration latrines targeted for 1993, seven were completed as of June 1993. The objective for the demonstration latrine is to reduce morbidity caused by diarrhea, bilharzia, and intestinal worms by improving human and household waste disposal.

Having completed the six roof catchment water tanks and realizing that they only provided water for around three to four months of the year, MPHC is currently undertaking water pan improvements to enhance current water sources. No more roof catchment water tanks are planned.

Mtaa Dam. The dam was built in the 1950s and normally serves four villages. In the past, small projects on the dam have been initiated by MPHC and carried out solely by the local community. However, silt buildup has reduced its output capacity. Most of the work done

on the dam has not ameliorated the situation. The desilting and re-embankment of the Mtaa Dam, an expensive but necessary activity, is currently not part of MPHC's plans. The project may consider a role in the dam's rehabilitation as part of its strategy in Phase III (after June 1994), if other agencies do not undertake this activity.

Strengthening MIS

As a result of the 1992 survey on appropriate health indicators for CBMIS, 16 CBMISs were targeted for 1993, and 11 have been put in place. The implementation of CBMIS has been slower than targeted. This is partly attributed to low levels of literacy. Other experiences point to cultural differences in how information is recorded, processed, and communicated. Realizing this, the project team is using Participatory Rural Appraisal (PRA) methodology in this undertaking. Anecdotal evidence from the field has suggested that women have shown more interest than men.

Diarrhea and Malnutrition Study. MPHC received a small grant from the African Medical and Research Foundation's (AMREF) Health Education and Behavior Department to conduct an in-depth study of community-level understanding and management of diarrhea and malnutrition. The study began in March 1992 and was recently completed. Various signs of dehydration were mentioned by mothers, such as sunken eyes, limb collapse, skin pinch, dry mouth, and so on. However, 20 percent of the mothers were unaware of any dehydration symptoms. MPHC is still developing a plan of action to deal with the results of this survey. MPHC recently received a grant of US $4,600 from CEDPA which will be used to conduct a follow-up study on Home Case Management of Diarrheal Diseases.

Household Survey. MPHC has also completed a household survey of the area, recording the following information:

- names, sex, and age of the head of the household;
- residents of the household by name, sex, and age;
- date of birth of all children under five years in the household;
- births which occurred in the household for the 1992 year; and
- deaths in 1992 by age and cause.

Local people from the villages were involved in data collection. It is estimated that 5-7 percent of the households were not covered, because of the unavailability of a household member despite repeated visits in the span of a week.

Mortality data were hard to collect. Because of cultural considerations, villagers resist giving the MPHC information about deaths. Most of the under-reporting occurred in the areas of child mortality. MPHC is still processing this data.

Performance Constraints

Since the last annual report, there have been numerous problems in the MPHC project area that have hindered progress. The most striking problem has been the economic performance of the region. In the wake of a structural adjustment program and falling agricultural prices, household-level purchasing power and investments have weakened further. The economic situation, coupled with drought and consequent food shortages, has adversely affected families.

Families have been unable to meet basic needs, such as food, education, health care, and so on. Increasing burdens have been put onto women to collect water from distant sources, markedly decreasing the amount of time they could spend improving the living conditions of their children and their families.

To further aggravate the situation, one project vehicle was stolen, while the others suffered from continual breakdowns. In addition, two mobile clinics were grounded because of impassable roads. This severely hampered project workers from achieving their targets.

Other constraints include literacy problems in establishing the CBMIS, seed shortages at the Kenya Grain Grower's Cooperative Union, approval delays by the National Pipeline Corporation for connecting to the Mombasa water mains, and lack of local fundraising activities to support water-related projects.

Budgetary Issues

Because MPHC covers a large portion of the Kenyan coastline, transportation is of the utmost importance in providing targeted services. The project's Toyota Land Cruiser was stolen early in January 1993, and the four-year-old Land Rover suffers from mechanical problems frequently. Thus, MPHC has failed to meet some of its targeted services and consequently its budget has been underspent. In addition, the continuous devaluation of the Kenyan shilling has caused a significant net dollar savings in the budget.

The vehicle must be replaced if PHC services are to be continued at previous levels and if planned targets are to be reached. The funding for the vehicle will come partially from AKHS Kenya's insurance, which will not cover the full replacement costs, and from a portion of the underspent budget. AKF USA proposes that the remainder of the savings be allocated to:

- a study which will attempt to identify income generating activities that might help generate local incomes to invest in and sustain PHC services in the Coastal region of Kenya. Technoserve, a U.S. PVO with experience in small-scale enterprise and economic development in Kenya, has agreed to undertake this study through its Kenya branch; and

- the promotion, distribution, and dissemination of materials produced under the PHC MAP. The budget for these activities had been reduced earlier because the total funding available from A.I.D. under the Matching Grant was considerably less than the amount which AKF had requested.

4.2 Aga Khan Community Health Programme (AKCHP): Bangladesh

Overview

During this reporting period, AKCHP continued to fine-tune its urban PHC program. (See Attachment 5) Efforts have been made in strengthening training capability, further developing an effective and efficient health information system (HIS), addressing difficult issues in community participation, facing new problems in the service delivery system, and developing research capability for promoting a sound and scientific approach to issues evolving around urban health and development. New ideas and innovations in various components of the project meant that the program has operated in a proactive manner to address health needs in the slums of Dhaka. Finally, a continuous effort was made to diversify AKCHP's financial resources for future funding of the project.

In AKCHP's plan of action, immunization, routine health check-ups and first aid facilities were included as service priorities for 1993. Year-round health education on hygiene, nutrition, common infectious diseases (diarrhea, pneumonia, and skin conditions), and environmental health will be included as the major health education activities for 1993. Hygiene education, ensuring safe water, and installing sanitary latrines are other activities planned in 1993.

Community Mobilization and Participation

Initiatives. AKCHP organized a one-day workshop on February 15, 1993 to discuss community participation in its two experimental areas, Khilagaon and Bagicha. In these two communities, AKCHP is attempting to maximize community participation by involving highly motivated groups of young community activists in the provision of community-based PHC services. The objectives of the workshop were to: (i) review the present status of community participation in these areas; (ii) examine community participation in accordance with World Health Organization (WHO) guidelines; (iii) identify problems faced by the volunteers and their solutions; and (iv) develop an action agenda for 1993. The Visualization in Participatory Program (VIPP) method, introduced by UNICEF in Bangladesh, was used in the workshop to ensure maximum participation and to provide instantaneous and interactive feedback on workshop proceedings to participants.

This year, the community volunteers continued their Expanded Program of Immunization (EPI) and vitamin A capsule (VAC) distribution activities. Volunteers also actively took

part in the national EPI workshop in November 1992. They distributed car stickers and organized a rally carrying placards with EPI messages.

Female volunteers played an active role in targeting women for TT immunization. With the help of AKCHP, they made household visits to motivate women, especially unmarried women and students, for TT immunization. The volunteers distributed Vitamin A capsules to all one through six-year old children in their locality.

Bagicha. In Bagicha, the volunteers decided to conduct a survey to find the VAC and immunization coverage rates in their area. They developed a data collection form and started the survey. However, because some of the more active female volunteers moved out of the project area, the survey has not yet been completed. Plans for completing the survey and recruiting additional volunteers are under way.

Volunteers in Community Participation. AKCHP has made the following observations about volunteers in CBPHC:

- Volunteers are instrumental in developing the necessary awareness for promoting community participation among local people.
- They are good points of contact in reorganizing and orienting existing social organizations into health promotion activities.
- They are instrumental in mobilizing resources from the community for primary health care activities.
- The volunteers, with support from local NGOs, can continue as agents for local health awareness-building and perform minimum preventive health care activities such as immunization, VAC distribution, and periodic social mobilization activities related to health (e.g. organizing a rally, street campaigns, attending workshops, etc.), without any remuneration.

Problems Associated with Volunteers. AKCHP has observed the following problems about using volunteers in CBPHC:

- Lack of pay reduces volunteers' incentives to continue their services.
- Elderly people in the community do not see voluntary work as a useful way to build a career, and as a result, they discourage their children from taking part in volunteerism.
- Female volunteers are criticized by their families and the community if they work with male volunteers.
- The high volunteer turnover rate is compounded by the difficulty in finding replacements.
- Communication among volunteers is poor and needs to be strengthened.
- There is a tendency toward less follow-up by AKCHP on volunteer activities.

Training. Training continued to be one of AKCHP's, major primary health care activities. (See Attachments 7 and 10) Curriculum development, extension of TBA training to other NGOs, and materials development were the major activities during this reporting period. At the same time, Community Mother Volunteer (CMV), TBA and schoolteachers' training continued.

Three training brochures have been developed and circulated to various institutions. The brochures are on Schoolteachers' Training, CMV Training, and CHW Training. A special brochure on TBA Training has also been developed and distributed.

This period was highlighted by the School Health Workshop, the International Training Course on Primary Health Care, the course on Epidemiology and Biostatistics at AKCHP, and TBA training. Several training sessions were conducted for other NGOs. AKCHP thus became an NGO which proved its capacity to provide training on a fee basis to other organizations.

CMV Training. One CMV basic course was organized during this period to replace volunteers who had dropped out. Fourteen CMVs participated. As a result, the total number of active volunteers is now 143. Seven CMV refresher courses were organized for 67 CMVs. Six CMV meetings were organized, with 133 CMVs participating.

Schoolteachers' Training. The schoolteachers' curricula were completed. Pre- and post-test questionnaires were developed, and 52 schoolteachers in 5 different schools were trained.

Health Education. A total of 1,159 students received health education in 12 different schools on the subjects of hygiene, immunization, ARI, and diarrhea. Health education for mothers in the communities was initiated this year by the CHWs and the CMVs in the areas of nutrition, ARI, diarrhea, environment, hygiene, prenatal and postnatal care, and first aid. The discussion on diarrhea was particularly relevant, as an epidemic broke out in December 1992. (See Attachment 8)

Community Health Workers Training. A needs assessment for CHW training needs was completed in March 1993 using the VIPP method. The following CHW training needs were identified: (i) hypertension; (ii) ARI; (iii) family planning; (iv) supervision; (v) prenatal check up; (vi) overview of PHC (history, background, strategy, principles, etc.); and (vii) developing presentation and public-speaking skills. Instruction on the above topics will be initiated in the next quarter.

PHC Service Delivery: Clinics

Strengthening Services. During this reporting period, the Health Information System (HIS), formerly called the Management Information System (MIS), worked to finalize a newly computerized PHC information system, design forms for various PHC activities, and analyze data for reports. The HIS is a first of its kind for PHC in Bangladesh. This unique system

will be able to provide all the required health indicators for the communities served by AKCHP at any point in time. The data base will also be used for providing feedback, monitoring progress, and conducting relevant operations research.

Satellite Clinics. During this reporting period, satellite clinics were facing problems arising from the dynamics and instability of community organizations. As these satellite clinic sites are donated by the communities and community organizations, any changes in the organization's leadership, management, or locale may affect the operation of these satellite clinics. For example, the clinic in South Shajahanpur had to be moved from its previous location. The clinic property had been donated by the Railway Diploma Engineers Samity. They asked for funding from AKCHP in order to renovate their premises for more space. Unable to oblige, AKCHP was forced to move the clinic to a nearby club, the Meetaly Bahumukhi Samabaya Sangstha. Because of the close proximity to its previous location, however, patrons have not been inconvenienced by the relocation.

In the last reporting period, several of the problems (lack of furniture, local politics, inability to function daily) of the Nabarabi satellite clinic were mentioned. AKCHP field workers found an alternative location on the premises of Pabna Samity, a local voluntary organization. The new clinic was opened in December 1992.

The Gonoshikha satellite clinic is located in a school for adult literacy. Financial strains of the latter forced them to impose rent obligations on the AKCHP clinic. Because AKCHP was unable to accommodate their financial demands, the AKCHP clinic is in the process of searching for an alternative site. The other satellite clinics at Bijoy Nagar and North Shajahanpur are running well. The Central Health Clinic is being maintained with minimum inputs, mainly as a referral center.

Acquired Immunodeficiency Syndrome (AIDS). Building public awareness about AIDS is an initiative AKCHP is trying to incorporate into its PHC programs. AKCHP is also cooperating with other agencies in this regard. Sessions on AIDS with the clinic teams are planned for the upcoming quarter. Recently, ICDDR,B has taken steps to implement programs and distribute materials on AIDS. AKCHP is also collaborating with the Voluntary Health Services Society (VHSS) and the Christian Commission for Development in Bangladesh (CCDB) on AIDS-awareness activities.

Patient Fees. Because of the increase in service charges instituted in January 1992, a fee policy was articulated and circulated to the satellite clinics and the community. No charge will be taken for EPI immunization for registered or nonregistered families. If the clinic team determines that a patient is unable to pay fees because of extreme poverty, the patient will be given clinical services regardless of his ability to pay. Nonetheless, every attempt will be made to earn at least partial service fees to cover a higher proportion of costs.

A comparative analysis was conducted using the rate of fees, the number of clinic days, and the money earned as fees for service in 1991 and 1992. The results showed that the increase

in clinic fees did not negatively affect attendance. Rather clinic attendance increased by 3.2 percent, while revenues from fees increased by 34 percent. (See Attachment 9)

Post-Transition Diseases: Hypertension. Hypertension was chosen as a case study in post-transition diseases. A prevalence survey was conducted and a strategy was outlined. The primary objective of the study was to identify strategies for decreasing morbidity and mortality related to hypertension. The study yielded substantial outputs. AKCHP established a referral network with the Bangladesh Society of Hypertension (BSH). AKCHP also succeeded in developing health education messages related to hypertension. The study simultaneously allowed for training AKCHP workers in blood pressure measurement.

Maternity Care. A register is now maintained for keeping track of pregnant women's scheduled visits. The pregnant women's visit information is given to the field workers. This feedback system was introduced to increase mothers' visits to the clinic during pregnancy. Referral of high-risk pregnant mothers to secondary care has been strengthened during this period. (See Attachment 11) From July 1992 to June 1993, 62 high-risk pregnancies were referred to different hospitals. (See Attachment 12) A total of 1,868 pregnant mothers and 72 postnatal mothers were seen in different clinics during this period, and 102 referrals for pregnancy-related problems were made. (See Attachment 13)

In the upcoming quarter, all new pregnancy cases will be encouraged to go to the clinic for urine tests for detecting sugar or albumin, and each will be urged to go to the clinic once per trimester. CHWs, CHOs, Field Supervisors and clinic teams have been trained for these tests.

Maternal Nutrition. The CHWs have been trained on the measurement of arm circumference for evaluating mothers' nutritional status. Data on maternal nutrition have been collected and are being processed. A report will be prepared in the upcoming quarter.

Safe Delivery. A protocol was initiated to find reasons for unsafe delivery. In addition, a protocol on delivery costs was started in January 1993, which will be used to document and analyze delivery expenses.

ARI. ARI interventions were instituted in the clinics in January 1993. All physicians and workers have been trained in the treatment and management of ARI according to WHO guidelines. Data on ARI have been analyzed and shared with WHO, UNICEF, and the ARI directorate of the Government of Bangladesh (GOB). During this period, 664 children under five years attended the satellite clinics, of which 225 came for ARI treatments.

Diarrhea Curriculum. AKCHP has been working closely with the National Control for Diarrheal Disease Programme (NCDDP) in developing a national curriculum for diarrhea control designed for health workers. AKCHP's flip charts and messages were used extensively in designing these materials.

EPI Disease Surveillance. New cases of EPI diseases are reported monthly by the Field Supervisors. Quarterly reports are sent to the EPI director. The first National EPI Week was observed from September 26 through October 1, 1992. AKCHP's nine years of experience in managing a community-based urban PHC program was shared with the EPI Directorate, UNICEF, and WHO.

PHC Service Delivery: Field Activities

Field Problems. Community health workers have been facing problems in their service areas. Monthly eviction and slum demolition policies hinder the workers from providing consistent services and locating households. Migration into other slum areas has become a factor for volunteer and TBA drop out. The growing number of working women has also had some negative impacts on AKCHP's activities. The absence of women in the home makes it difficult for the CHWs to visit mothers and their children.

Maternal Care. Monthly TBA and CMV meetings have strengthened the maternity care activities sponsored by the workers. A total of 496 TBAs attended 30 meetings held over the duration of the reporting period. These activities have increased interest among TBAs. A TBA identification survey was conducted and completed. Currently, there are 210 TBAs working in the AKCHP areas. CHWs and Community Health Organizers (CHOs) continued providing active care and liaison (nutrition education, motivation for TT and clinical visits) at the household level to pregnant and postnatal mothers. Clear links between clinic visits by pregnant mothers and care in the field have been established. Criteria for determining high-risk pregnancy were also developed. A high rate of TT coverage of pregnant mothers (99 percent) has been maintained. The incidence of TBAs providing birth information within 72 hours has also increased from 33 percent to 50 percent during this period. Despite all these efforts, pregnant mothers' attendance records in satellite clinics for prenatal checkups still remain poor. Reasons for these poor attendance trends will be explored in the upcoming quarter.

The prenatal card has been reviewed and necessary changes have been made. The new card was field tested and has been in use since April 1993. Postnatal surveillance was introduced in maternity care during this period. It will provide information about postnatal morbidity in the population.

Childhood Nutrition. During this period, 10,650 children were weighed for growth monitoring. Relevant growth promotional activities (nutrition education, referral, etc.) were carried out during the growth monitoring session. (See Attachment 14) Because of the high prevalence of malnutrition, mothers and children were invited for monthly evaluations. The children were weighed and clinically examined while mothers were interviewed. Mothers were counseled on feeding. AKCHP also participated in developing a booklet on nutrition and breast milk with the Programme for the Introduction of Contraceptive Technology (PICT). AKCHP has also begun to collect and analyze data on breastfeeding practices to evaluate the feeding practices for children under three years old.

Immunization. Beginning in January 1993, the target group for childhood immunization in the AKCHP area became children up to one year of age. This has been decided by the national EPI Directorate. During this period AKCHP continued its usual immunization activities, maintaining a high immunization coverage. AKCHP runs 40 immunization sessions in 23 clinics per month. Of them, 14 are fixed centers and the rest are mobile camps. During this period, 41 children received Oral Polio Vaccine (OPV) zero within two weeks of birth while 177 received OPV four (one dose of OPV with measles vaccination). The high coverage (97 percent) of TT immunization during pregnancy has been maintained. No case of neonatal tetanus has been reported in 1992. AKCHP thus achieved one major goal of EPI, which is the virtual elimination of neonatal tetanus by 1995.

VAC distribution to children one to six years old continues and has been maintained at 99 percent. During this period, VAC strategy was reviewed and decisions regarding supplementation during the postnatal period and illness were made.

Water, Sanitation, and Environment. A survey was conducted to gather baseline information on water, sanitation, and environment. The findings of the water, sanitation, and environment survey were shared with CARE for future development of a joint sanitation program in the Dhaka slum areas. In a second collaboration, AKCHP and ICDDR,B joined to initiate a study on childhood defecation practices in Dhaka slums and develop strategies for promoting better health practices with children.

Community deliberation and contributions led to the installation of a tubewell in Hussain Bastee in ward 60 of AKCHP area. The community provided the funds while the Adventist Development and Relief Agency (ADRA) supplied the hardware. Two individuals, nominated by the community, received training and instruction on the maintenance of the tubewell.

Operations Research

AKCHP, through its PHC services, has been collecting demographic, disease occurrence, and nutritional status data on its target population. (See Attachment 4) These data are collected from 26,311 urban poor, living in 5,231 households in the Wards 60 and 62 of the Dhaka City municipalities. The data are collected by trained staff using carefully designed methods to ensure quality. After collection, the data are entered into a computerized management information system for purposes of monitoring the field work of various health workers, periodic evaluations of progress, and analysis of data for research.

The above-mentioned HIS allows for various epidemiological and operations research activities in an urban setting. Since January 1992, an internal research group of junior trainee investigators under the Project Director has been responsible for the execution of research initiatives in different areas, including: acute respiratory tract infections; low birthweight; nutrition in pregnant women; water, sanitation, and environment; surveillance of infectious and communicable diseases which can be prevented by vaccinations; reasons

for which people drop out from scheduled courses of vaccination; safe delivery by TBAS; quality of services; determination of causes of death by verbal autopsy; and the sustainability of PHC programs.

Staff Development

Several measures were taken under the staff development program during this reporting period. A core of qualified, multi-disciplinary instructors provides training. A number of staff members were sent abroad as well to attend training courses, workshops, seminars, and meetings. In-house presentations were also an integral part of staff development strategies. AKCHP organized an international training course, "Trainers for Trainees (TOT)," under the aegis of the RNP. It was designed to help people better understand the concept of PHC. Similarly, AKCHP also organized a 15-day course on "Epidemiology and Biostatistics" for the Essential National Health Research (ENHR). Several training materials were developed and circulated.

Sustainability

AKCHP has started a pilot program in the slum area of Bagicha of Motijheel Thana of Dhaka City. The objective of the project is to empower women by enhancing their functional education, providing training on PHC, and improving their access to credit for income generation activities. Part of the income produced through these income generation activities will be used to develop a collective fund for PHC services and thus will contribute in part to the population's economic ability to demand PHC services and to longer-term sustainability of the PHC program. Five women's groups have been formed, and training to improve the members' functional education has begun. Savings have been generated through weekly subscription fees. Some PHC activities, such as health education and VAC distribution, have begun.

AKCHP has successfully begun to diversify its funding resources beyond AKF, and has developed strong collaborative relationships with other local and international NGOs and PVOs, as well as the GOB. In October 1992, a proposal was submitted to the Danish International Development Agency (DANIDA) for project funding (1993-1995). In May 1993, the Counsellor of the Royal Danish Embassy visited AKCHP. Upon the counsellor's departure, a consultant was appointed to provide an appraisal which was then submitted in June 1993. Prospects for funding appear hopeful given the positive assessment AKCHP received in the appraisal report.

4.3 Urban Primary Health Care Program (UPHC): Pakistan

Overview

In 1983, a five-year PHC project was designed by the Aga Khan University/Department of Community Health Sciences (AKU/CHS) to address the issues of human resources

development and health systems development. The project has developed a series of PHC modules in the urban squatter settlements (katchi abadis) and other low-income settlements of Karachi. (See Attachment 15) Each module serves a population of about 10,000. The primary beneficiaries are mothers and children because they are the most vulnerable group in the population and are at the highest risk of morbidity and mortality. The modules of primary health care in the katchi abadis are designed to provide effective and affordable services and to serve as prototypes for PHC systems that could be replicated by municipal and provincial Governments. In addition, these field sites provide training for AKU's medical and nursing students and trainers in community health.

The guiding principles of these prototypes are related to WHO's goal of Health for All: that health care should be available, affordable, accessible, and acceptable to all. In addition it should be relevant and appropriate to the major health problems of the area and be a part of the total human development. These are reflected in the overall program design.

Five PHC modules follow the AKU design of community-oriented PHC program. These are the modules in Orangi, Chanesar Goth, Grax, Essa Nagri, and Azam Basti. The PHC components currently being implemented at these five field sites are immunization, growth monitoring, prenatal care, management of diarrhea, health education, family planning, basic curative care, school health programs and training of TBAs. Interventions for ARI, drug abuse, and childhood disabilities are also being introduced in phases.

The PHC module in Baba Island is explicitly community-managed. This is a departure from the earlier five sites. Since September 1988, one Community Health Doctor, one Community Health Nurse, and a Community Organizer have been collaborating with members of a local NGO, the Fisherman Welfare Association, in identifying problems and in developing the PHC program.

Another PHC module is in a middle-class area, Karimabad, and emphasizes health promotion and disease prevention in a community that already has well-established curative services. In collaboration with the community and the local health care providers, the project aims to: (i) develop mechanisms for early identification of risk groups; (ii) improve awareness of existing diseases; (iii) bring about appropriate behavioral changes in the attitude and practices of the population; and (iv) improve understanding among area health care providers of diseases and the methods of prevention.

Overall Progress and Achievements

The primary indicators of young child mortality, IMR and U5MR, have decreased substantially between the baseline surveys and the current report. Decreases have been 33 percent and 25 percent for IMR and U5MR, respectively, on average for the five field sites. These decreases have been achieved at the cost of about Rs. 93 ($3.70) per person (using total population in the project area as the denominator). The fact that such extensive

mortality reduction has been achieved consistently among several communities at costs affordable in Pakistan represents the development of prototypes that could be important for government and other NGOs.

Child Mortality. (See Attachment 16) Data from the field sites suggest that the decrease in mortality rates seen over the past few years may now be leveling off. UPHC's emphasis has now shifted toward maintaining this rate and developing strategies to deal with the highest risk cases. This shift is further provoked by recent data showing a slight increase in IMR over the past year. The average IMR of the five field sites, which had decreased over a period of three years (1989-91) to 63.8 in 1991, has now risen to 73.8 infant deaths per 1000 live births in 1992. The U5MR followed a similar pattern, with a rise to 97.5 from 83 under 5 deaths per 1000 live births recorded in 1991. The pattern of decrease was more or less similar in all the field sites. The major causes of under five deaths still continue to be diarrhea, malnutrition, low birthweight (LBW), and ARI. Further analysis of the mortality data is under way.

This regression in IMR has given rise to speculation regarding a "residual mortality". The department is currently laying emphasis on the identification of the causes of stagnating improvements in mortality levels, as well as strategies to deal with this trend. This may be an opportunity to review programmatic focus vis-a-vis health related issues such as sanitation, safe drinking water, and literacy. The collaboration of CHS in the PHC Macro Project with the Karachi Metropolitan Corporation may help in addressing these problems.

Immunization. Immunization continues to be a successful program component. Immunization coverage from July 1992 targets infants in order to determine whether the program is working well. Of the infants in the combined field sites (except Baba Island), 75 percent are either completely or appropriately immunized. A major achievement has been the high proportion of married women (89 percent) with at least two doses of tetanus toxoid. The current status of immunization of women and children is presented in Attachments 17 and 18.

Immunization clinics are held once a week in all PHC field sites. Initially, all teams targeted children under five, in addition to married women in the 15-49 year age group. Since July 1992, the target group for children has changed from under-fives to infants. The reason for the change in the target group among the pediatric population is to determine whether newborns are being immunized according to the recommended age schedule from the Expanded Program for Immunization (EPI). However, other children requiring immunization are also encouraged to attend this clinic.

Birthweight Monitoring. With the exception of Orangi, the percentage of newborns weighed within 48 hours of birth is steadily increasing. Overall, the percentage has increased from 53 percent in the quarter October-December 1991 to 64 percent in the period July-December 1992. As the percentage of children weighed increases, the proportion of newborns with low birthweight is decreasing.

Nutritional Status. (See Attachments 19 and 20) Nutritional status of children under five has remained more or less stable over the past three years. Essa Nagri and Grax were the only two field sites in which the nutritional status of children seems to have improved slightly. The larger increase occurring in Essa Nagri where the percentage of children in the normal category has increased from 58 percent in December 1991 to 61 percent in 1992.

In all field sites more emphasis is being given to the indicator "change in weight" rather than nutritional status, as it helps to identify the children with faltering growth. All teams have started intensive follow-ups of those children who are either losing weight or not gaining weight, and each site has developed a visual growth monitoring system to aid in this follow-up process.

A wholesome, nutritious diet will be emphasized in addition to the continued focus on weaning and breastfeeding practices. A group of field directors and other AKU staff has also been formed in the department of Community Health Sciences (CHS) including the field directors to identify strategies for further improvement in nutrition status of children. The percentage of children who gained weight in December 1992 as compared to December 1991 has increased in all field sites.

TT Immunization. (See Attachment 18) Comparison of December 1991 figures with March 1993 figures shows that the tetanus toxoid (TT) immunization coverage of married women has increased in all field sites except Azam Basti. The overall immunization coverage of women who delivered during the period remained about the same as last year.

Prenatal Care. During the past one and a half years, special efforts and attention have been given to prenatal care, safe deliveries, and the general well-being of the mother and the newborn. However, now that the Pregnancy Outcomes Study has ended, the average number of prenatal contacts with the PHC program has decreased from 2.5 during the July-December 1991 quarter, to an average of 1.7 contacts recorded between July-December 1992 in the combined field sites. The number of prenatal or antenatal care (ANC) visits to the center by the clients has decreased in all field site except Chanesar Goth. Although the reason for the overall drop in ANC contacts is not known, the field teams sense it is because the strategy of providing home-based care has decreased the need for pregnant women to come to the clinic.

Traditional Birth Attendants. (See Attachment 21) TBAs have been trained in all field sites, as they are, in many cases, the only viable alternative health-care providers that pregnant women consult. The percentage of deliveries done by trained TBAs has dropped in all field sites, but more deliveries are being conducted by other trained health workers.

Family Planning. (See Attachments 22 and 23) Family planning prevalence by method was aggregated in December 1992 to determine the more popular contraceptive methods in the community. Data showed that tubal ligation (TL) was the single most frequently used

method, with 45 percent of couples employing this method. This shows that efforts have concentrated largely on family curtailment. More emphasis needs to be given to birth spacing. For the 1,861 married couples practicing family planning, condoms are the most popular of the temporary methods, at 28 percent of the total family planning methods used in the field sites.

This issue has already been discussed during the planning workshops at the field sites. All field teams have decided to put their efforts into targeting both newly married couples and those who have not yet completed their families for child spacing. Percentages of pregnant women have also decreased in all field sites. An overall reduction of 6 percentage points, from 14 percent in December 1991 to 8 percent in December 1992, was noted. The crude birth rate, however, has remained the same. The reason for this is not clear.

Clinic Attendance. Clinic patients are predominantly female. Visits from patients in the one to five years of age and 15 to 50 years of age categories are the greatest. Children under five constitute about 40 percent of the patients seen at the centers. Baba Island on the other hand shows a majority of male patients, with a large proportion belonging to the age group of 15 years and above.

In 1992 the five most prevalent diseases were skin problems, upper respiratory tract infections (URTI), diarrhea/dysentery, gynecological problems, and musculoskeletal problems. Skin diseases and URTI were the most common problems seen in those less than 15 years of age.

Causes of Death. (See Attachment 16) Although the mortality rates have dropped, the major causes of death in children under five years of age are still diarrhea, malnutrition, LBW & ARI. Diarrhea accounted for 37 percent of the main causes of death, followed by ARI/Pneumonia (9.8 percent), Prematurity/LBW (6.5 percent), and birth injury/asphyxia (4.6 percent). When main and associated causes are combined, diarrheal syndromes still account for most deaths, followed by malnutrition.

Further analysis of the data shows that 50 percent of the diarrhea deaths in the three years from 1990-1992 occurred in under five-month-old children and malnutrition deaths in under four-month-old children. More focus needs to be given to reducing LBW. In addition, further study needs to be conducted to identify what is causing otherwise healthy children to be consumed by malnourishment or diarrhea during the first five months of life. The field teams will also try to address some of the social and environmental problems, as well as improve program management to further reduce mortality levels.

Staff Development.

One of the basic purposes of the PHC project is to address the issues of health human resource development and health systems development. The establishment of functioning PHC modules was considered to be critical in order to provide opportunities for AKU's

medical and nursing students to proceed through a program of community and health services assessment, planning for PHC programs, and implementation and evaluation of PHC systems. The members of Community Health Sciences Department (CHS) work closely with other departments of the University in order to ensure a viable productive curriculum, fulfilling both the needs of the community and the students. The general goals and purposes for the development of the program, aside from the establishment of a PHC prototype, are to continue to increase teaching and learning opportunities for medical and nursing students on three levels:

- relating to communities;
- assessing community problems and needs;
- participating in planning, implementing, managing, and evaluating PHC systems, particularly for the more deprived populations.

Program Costs and Sustainability

The total annual cost of the program in five of the seven CHS-led field sites was Rs. 5,494,457 (approx. $184,000 at an exchange rate of Pk.Rs.29.85 to $1.00) for an aggregate population of 48,050 in 1992. Of the total cost, 81 percent was for running the program up to the PHC field team level. Another 19 percent was for supporting the field teams. As compared to 1991, the 1992 costs have increased by about 12 percent. This increase is presumably due to inflation. (See Attachments 24 and 25)

The average field cost per person per year of the five CHS-led field sites is Rs.93 or $3.70 per person per year. One of the field sites, Azam Basti, is also a referral site providing lab services and secondary care; its cost is Rs.144 or $5.70 per person per year. Excluding this figure, the average annual per capita cost for PHC in remaining field sites is Rs.83.3 or $2.30.

Note that in the above figures, annual cost per capita is calculated with the total population as the denominator, whereas services are targeted mainly to mothers and children under age five. This is not, however, an exclusive focus of the programs. Other members of the family receive relevant and applicable care, which are routinely curative services. Thus, cost per capita has also been calculated for the target population (married women and children under five for outreach services and total population for curative services). The average field cost per capita for target population is Rs. 292 or $11.50 per person per year.

Macro PHC Project

Overview. The micro PHC program sites are extremely useful for gaining field experience and enhancing human resource development; however, the limited application of the micro PHC program becomes apparent when one is faced with managerial issues on a larger scale. AKU/CHS has determined that the micro PHC modules are inappropriate for application as organizational components for replication in larger public systems. AKU/CHS feels that

it is necessary to upscale in population size to the sub-district or district level to achieve system efficiencies in management. This would also engage the interest of other organizations, such as NGOs, and their resources. With this strategy, the success of the Macro PHC Project is conceivable but has not yet been achieved. As AKU/CHS became aware of the limitations of these micro PHC prototypes, it embarked upon the development of a Macro PHC Project in collaboration with local communities, NGOs, and the government. The main objective of the Macro PHC Project is to develop an effective, affordable, and replicable health system prototype at the subdistrict level.

The Macro PHC Project aims at developing a network of PHC programs for well-defined, underserved populations totalling about 50,000. Linkages with NGOs and community organizations, precipitating greater community participation, are to receive priority attention. The Macro PHC Project is seeking to integrate the program along various levels of government, where infrastructure already exists and has proven sustainable.

Organization and Management. The project is being developed in District South of Karachi This region was chosen for the following reasons:

- the AKU-CHS micro PHC programs, Chanesar Goth and Azam Basti, are within this boundary and are considered important strategic sites from which activities can be initiated;
- a tertiary care facility and the proposed site for the development of a secondary care facility by local health authorities are in close proximity;
- the Karachi Metropolitan Corporation (KMC) dispensary (Urban Health Care Center) is situated in the geographical center of this area;

The Macro Project Oversight Team is responsible for initiating active dialogue with NGOs and communities for their participation in the program. The team also maintains liaison with the municipal health authorities for a more integrated approach.

Through a series of regular meetings, senior KMC officials were briefed and updated on the urban component of the Family Health Project (FHP) and on the Macro PHC Project. Updates on the Macro PHC Project were regularly provided to the Health Services directors at KMC. The importance of establishing a symbiotic relationship between the urban FHP and the Macro PHC Project was discussed in detail with KMC officials. The urban FHP will be able to provide resources and training in the District South, and the Macro PHC Project carries the potential for developing an optimum sub-district-level prototype for FHP. The basic requirements for the successful realization of a replicable large-scale prototype are greater community participation leading to community control, shifts toward lower costs, and the availability of alternative resources.

Overall Progress. To plan the health care system, it was essential to make a total community assessment by identifying pertinent socioeconomic, health, and demographic issues, and by preparing evaluations of available health services. This was the first step in

identifying and prioritizing the health problems and needs in the target area.

The Macro Project Oversight Team has initiated a process which will help realize an optimum level of community participation. At the same time, the team has also started to operationalize a plan for the implementation of various health care activities. Community assessments provided valuable information on factors that might impede broad-based community participation. A general lack of cohesiveness in the project area because of cultural and linguistic differences, a shortage of skills among the local groups, and the fact that the local NGOs operate in complete isolation from one another are constraints. Other social problems such as the high prevalence of heroin abuse, particularly among the youth in the area, and low female literacy compound the already difficult situation.

Although it is difficult to achieve community participation in urban areas, the involvement of communities from the very beginning of the planning process has improved participation. Developing the program with the community, rather than asking the community to participate in a program after its implementation, has obvious advantages.

Constraints. The Macro PHC team has concluded that difficulties in actually getting KMC medical and health services involved in the planning, implementation, and management of the Macro PHC Project occurred because the health authorities concerned were not involved in the initial planning processes. This uninvolvement has caused a lack of understanding on the part of the AKU/CHS about the nature of health care provision and its management by KMC. In addition, it is causing problems for KMC in trying to understand the process and activities of the Macro PHC Project and the integration of various component services. This experience points to the need to begin integration and coordination of various programs while they are still in similar phases of planning and implementation to better achieve "scaled up" programs.

4.4 Aga Khan Regional Network Programme (RNP)

Overview

RNP has continued to provide a forum for representatives of member PHC projects in Bangladesh, India, Kenya, and Pakistan to meet, share experiences, discuss common issues, and explore new ideas that might be incorporated into their projects. RNP has been successful in building productive and professional relationships among its members. More recently, RNP has been shifting its focus from the more general questions related to PHC implementation to health systems management development and other broader uses. A summary of the major activities which RNP has completed during this Matching Grant is shown in Attachment 28.

Overall Progress

Newsletter. The articles for the fourth issue of the newsletter have been collected and are now being edited. Because of a shortage of articles, the newsletter could not be published on time. This is an area in RNP that needs to be strengthened.

Workshops. The 1993 workshop was held on March 2-6 in Kathmandu, Nepal. It was the first time a field trip had been organized in a non-AK field site and was greatly appreciated by the participants. Members met to discuss progress on issues addressed during the 1992 workshop namely, the Role and Effectiveness of CHWs, Growth Monitoring, and Community Participation. New topics such as Women in Health and Community Development, Alternative Approaches to Financing, and Health Systems Development were addressed. The 1992 RNP Workshop Report, "Growing Together", was distributed in March 1993.

In Mombasa last year, the AKCHP had requested colleagues from the PHC projects in Kenya to run a Training of Trainers (TOT) course in Bangladesh. The TOT course is designed to help people better understand the concept of PHC, its relation to other sectors and communities, and, above all, the principles and strategies involved. It also attempts to facilitate learning through participatory methods. The course was organized in Dhaka just before the RNP international workshop to save costs of the trainers coming twice to this part of the world. A total of 20 participants attended the workshop, including individuals from AKHS, Pakistan, AKHS, India, and AKU.

The Preceptor Orientation Program (POP) is a rigorous, six-week, field-based course held annually at AKU and designed to prepare new preceptors for community-based PHC programs held every year. The course fulfills training needs in the areas of management, epidemiology, statistics, management information systems, health planning, and components of PHC (growth monitoring, maternal care, etc.). The participants found POP effective as it gave them exposure to basic epidemiology, helped sharpen their analytical skills, and provided a forum for interaction with people from other programs.

In April 1993, two faculty members from AKU/CHS went to Islamabad to run a session on ethics in PHC. The session focused on the principles of ethics and how they can be applied in the work situation at AKHS,P. After the 1993 Annual RNP Workshop, the RNP Steering Committee decided that each program was prepared to pursue ethics in their programs both at the grassroots and policy levels.

RNP is a unique instrument for the development of PHC. The dynamics of the program allow for continuous evolution. RNP is now shifting its focus from the basic questions of what to implement to deeper questions of implementation strategies with an eye toward future needs and optimum efficiency. Health issues such as PHC impacts, costs, effectiveness, larger purposes, replication, scaling-up, development of new partners, and operational research will now fill the RNP agenda.

Future Activities

RNP is anticipating the 1994 Workshop to be held in the Junagadh Project area in India. Topics to be discussed include: Inter-sectoral Collaboration, Traditional Healers, Ethics, Women in Health and Community Development, and Mental Health. If time allows, PHC-MAP Module 2, entitled *Assessing Community Health Needs and Coverage*, will also be discussed.

4.5 PHC Management Advancement Programme (PHC MAP)

Overview

PHC MAP has been focusing its efforts on completing the final revisions of the PHC MAP modules, actively convening workshops in order to introduce and gain feedback on the materials, and disseminating the PHC MAP modules to institutions involved in PHC.

Overall Progress

During the last 12 months, an additional module on *Surveillance of Morbidity and Mortality* (Module 4) was developed and added to the PHC MAP series. Based on the feedback from the Bangkok Conference in May 1992, participants felt it was necessary to address morbidity and mortality surveillance as part of this series. PHC MAP staff also developed an accompanying Facilitator's Guide for Module 4.

During August - September 1992, the University Research Corporation Center For Human Services (URC/CHS) staff developed indicators, checklists and questionnaires for several new PHC components while others were revised and modified. The new components include: accidents and injuries; chronic and noncommunicable diseases; childhood disabilities; and sexually transmitted diseases such as human immunodeficiency virus and acquired immunodeficiency syndrome, HIV/AIDS.

Module 9, *Sustainability Analysis,* also went through extensive revisions as a result of participant feedback from the Bangkok Conference.

All nine modules of PHC MAP were finalized during the September 1992 - January 1993 period. Each module was edited, reviewed, and formatted. In addition to the User's Guides, an accompanying Facilitator's Guide was developed for each module. These were finalized during the same period and submitted for final desktop publishing and printing.

The PHC MAP staff also completed a computerized version of each of the modules. The programs are developed using the Hyperpad program and will accompany the entire set of PHC MAP series. Each is a self-guided, interactive tutorial which PHC MAP users can utilize to familiarize themselves with each module.

The PHC MAP series also includes four manager's guides, or reference materials. Each of these was finalized during the last 12 months. *Better Management: 100 Tips* and *The Problem-solving Guide* were begun during the previous year. These two guides were revised based on suggestions from the May 1992 conference participants and finalized in December 1992. Work on the *Computer Guidebook began in September 1992 and was revised and completed in January 1993. The Computerized PRICOR Thesaurus* was developed in February 1993. The program is menu-based and gives the user an opportunity to print sections or alter the text to fit their local needs.

During the Orientation Seminar held in December 1992, it became clear that Module 1, *Assessing Information Needs,* was not quite appropriate for a general introduction or overview of the PHC MAP series, specifically in a seminar setting. Although Module 1 does introduce all other modules, it has a very different purpose, which is to help the user conduct an information audit and determine which modules are most needed. Therefore, it was decided to develop an *Orientation Package,* which was completed in April 1993.

Modules 1,5,6,7,8, and 9 are already off the press while Modules 2, 3, and 4 will be printed by the second week of August. For a brief description of each module see the PHC MAP brochure. (Attachment 29)

PHC MAP Promotion and Training Activities

Orientation Workshops. In November 1992, URC/CHS staff presented a brief overview of the PHC MAP materials at the Annual Conference of the American Public Health Association. Approximately 25 participants attended the presentation.

In December 1992, URC/CHS, in collaboration with AKF USA and AKF Geneva, conducted a day-long "Orientation Seminar" to introduce participants from U.S. PVOs, health consulting firms, and donor agencies to PHC MAP and to identify institutions that might be interested in collaborating with AKF USA and URC/CHS in dissemination and promotion of the materials. The seminar was attended by 40 participants, including representatives from Management Sciences for Health, Family Health International, the National Council for International Health, Family Care International, the National Institutes of Health, the Johns Hopkins University, Save the Children USA, Technologies for PRITECH, PRAGMA, INMED, the National Association of Community Health Centers, and Vector Biology Control Project, among others.

Feedback from the participants on the PHC MAP materials was very positive. Most of the participants thought not only that the materials were "right on target", but that they could use them in their work. For example, the Cambridge Consulting Corporation plans to use the modules in its Urban EPI Project, which covers 88 municipalities in Bangladesh. The Johns Hopkins School of Public Health and the George Washington University are interested in integrating the materials into their curriculum. The Vector Biology Control Project expects to use the materials in its malaria control projects in Africa. The National

Association of Community Health Centers is interested in using the materials in its domestic work.

In June 1993, URC/CHS, in collaboration with AKF USA, conducted a one-day workshop in conjunction with the National Council for International Health (NCIH) Annual Conference. This workshop was designed to go into more detail for each module. The workshop started with a plenary session and an introduction to the PHC MAP conceptual framework. Following that, the 52 participants were divided into three groups. Each group was introduced to each of the nine PHC MAP modules and given some time to comment and ask questions. The participants gained hands-on experience with the PHC MAP computer programs which accompany Module 2 *Assessing Community Health Needs and Coverage*, Module 8, *Cost Analysis*, and Module 9, *Sustainability Analysis*. The participants were quite impressed with the PHC MAP materials and applauded the efforts of AKF USA and URC/CHS in developing and promoting these materials. Since the workshop, several groups have contacted URC/CHS and AKF USA to provide training and technical assistance for introducing the PHC MAP into their programs. Workshop participants also provided AKF USA with very useful and specific suggestions concerning the dissemination of the materials and the targeting of institutions. All of the 50 participants in the June 1993 workshop requested a full set of the PHC MAP modules following the workshop.

Other PHC MAP Promotional Activities. In October 1992, Dr. Neeraj Kak of URC/CHS, presented a course on Rapid Surveys and Monitoring for the Program Against Micronutrient Malnutrition (PAMM) at the Centers for Disease Control, Emory University, in which he used several of the PHC MAP modules. There were 15 participants from 9 countries. They all requested complete sets of the PHC MAP modules.

In February 1993, AKF USA and URC/CHS presented an overview of the PHC MAP Module 8 on *Cost Analysis* and Module 9 on *Sustainability Analysis* to the staff of the World Bank's Economic Development Institute (EDI).

In March 1993, Dr. Neeraj Kak presented the PHC MAP series at a Workshop on the Future of Microcomputers in Epidemiology at the Centers for Disease Control. There were approximately 40 participants.

Dissemination

PHC MAP materials were disseminated at each of the workshops mentioned above, and most of the participants requested copies of the final PHC MAP modules, when available in August. These workshops generated interest in PHC MAP, and as a result URC/CHS and AKF USA have responded to numerous requests for more information and orders over the past several months.

The Samboon Vachrotai Foundation in Thailand has volunteered to act as the distributor of the PHC MAP materials. They will be prepared to distribute materials by mid-August.

Three additional workshops have been planned this will be instrumental in further disseminating PHC MAP materials.

The PHC MAP workshops have been attended by staff of health ministries, NGOs/PVOs, private commercial groups from various countries (Bangladesh, India, Indonesia, Pakistan, the People's Republic of China, Thailand, Bolivia, Colombia, Guatemala, Honduras, Mexico, Peru, Kenya, Senegal, Zaire, Nigeria), and researchers and consultants from universities and technical assistance groups in both the U.S. and developing countries. The U.S.-based institutions that have participated in workshops or received PHC MAP materials include FHI, JSI, MSH, US A.I.D., the World Bank, the Johns Hopkins University, the George Washington University, Harvard University, and the University of Washington, among others.

Future Activities

A three-week Master Trainers' Training Course has been scheduled at the ASEAN Institute for Health and Development (AIHD) in Bangkok, Thailand. Starting on August 2, the course will train three to four Master Trainers each from AIHD, AKU/FHS, AMREF, BRAC and McMaster University, who would then establish PHC MAP Training of Trainer (TOT) courses that will benefit both NGOs and government health services in their respective regions.

United Nations Children's Fund (UNICEF)/EAPRO is currently working with AIHD and the Samboon Vachrotai Foundation to plan and conduct a regional course to train PHC MAP trainers from Bangladesh, Indonesia, and from universities, government health services, and NGOs in the countries of Southeast Asia and the Pacific. UNICEF in Bangladesh has also expressed a strong interest in promoting PHC MAP in that country and is likely to sponsor participants from Bangladesh.

Finally, McMaster University has made a formal proposal to be the "PHC MAP Center of Excellence" for Canada. It will collaborate with institutions under the University Partnerships Project, reaching 18 universities in 13 countries, and introduce PHC MAP to the Network of Community-Orientated Educational Institutions for Health Sciences (INCLEN).

V. MANAGEMENT: REVIEW AND ANALYSIS OF SUPPORT FUNCTIONS

5.1 Organization and Management

While AKF USA is responsible for administering the Matching Grant and is accountable to A.I.D., each of the five projects funded under this project is managed autonomously by the collaborating/implementing agency within the AKHN. Program planning, principally

the responsibility of each implementing institution within the network, benefits from this inter-institutional collaboration, which enables cross-fertilization of ideas and inputs into various components of the project.

The Mombasa PHC Project is being implemented by the AKHS, Kenya. The project is managed by Esther Sempebwa Nagawa and is assisted by a technical team, administrative support staff, and short-term consultants as needed. Ms. Nagawa is under the administrative direction of the Program Director and Chairman of AKHS, Kenya Dr. Nizar J. Verjee. Mr. Mirza Jahani, CEO, AKF (Kenya), and the Administrator of the Aga Khan Hospital in Mombasa, Mr. Sadru Dhala, also provide technical assistance and oversight. The Program Development Committee (a subcommittee of AKHS, Kenya has responsibility and authority for all aspects of the project requiring major policy decisions. The MPHC Project receives technical assistance and support from AKHS, Kenya including its Kisumu PHC Project, and from AKF's Geneva-based health professionals. The Government of Kenya's Ministry of Health also provides logistical and technical support. The AKF unit in Kenya plays an important role in providing oversight of the project on behalf of the Foundation. In addition, Health and Development Committees have been established at various levels in the community.

The Aga Khan Community Health Programme which provides health services, training, and outreach to communities in the Dhaka slums, was established by the Silver Jubilee Commemoration Society and receives oversight from the Society's Board of Management. AKCHP is under the direction of Dr. S. Mizan Siddiqui, Program Director, and supported by medical doctors, health workers, and administrative and support staff. AKF (Bangladesh) provides oversight and technical assistance to the project on behalf of the Foundation.

The Urban PHC Programme in Karachi, Pakistan is being implemented by the AKU/CHS. The program was previously under the direction and supervision of Dr. John (Jack) Bryant, the Chairman of AKU/CHS. Dr. Bryant retired at the end of June 1993, which was also the end of the second fiscal vear of the Matching Grant. Dr. Joseph McCormick, formerly with the Centers for Disease Control in Atlanta, is the new Chairman of the CHS Department. He will provide the leadership and direction for the program as part of his new responsibilities, as well as oversee a highly qualified team of health professionals. The project benefits from the in-house experience and expertise at the AKU, and from collaboration with AKF's health professionals.

The Primary Health Care Management Advancement Programme is coordinated by AKF Geneva, with technical support from Dr. Ronald Wilson and Dr. Pierre Claquin. Dr. Jack Reynolds, of URC/CHS, is the Project Director and Dr. Paul Richardson of URC/CHS has designed and managed field tests of the materials. A Steering Committee composed of representatives from each participating project and a PHC MAP Management Committee have also served to provide direction to the project.

The Regional Network Programme is being coordinated by AKU/CHS and is based there. Ms. Khatidja Husein, a graduate of Harvard's School of Public Health, serves as the Coordinator of the RNP, again under the direction of Dr. Joseph McCormick. A Steering Committee that has representatives from each of the participating institutions gives direction to the RNP. The Chair of the Steering Committee rotates every year. The Director of the PHC project that hosts the annual workshop becomes the chairperson for that year. The support functions of the RNP will continue to draw heavily on the resources of the AKU as the most appropriate and accessible site for access to specialized knowledge, library facilities, and other network resources. Six technical teams have been formed to lead the work of the RNP. These teams are headed by staff of the different projects in the network and will function in a decentralized manner, with coordination efforts being undertaken by the various projects involved in each team.

5.2 Financial Management

AKF USA's financial management and accounting systems conform to generally accepted accounting policies and procedures.

Annual budgets are submitted to the AKF USA National Committee for review. These comprehensive budgets include estimates of revenue, program and administrative expenditures, source and uses of funds, balance sheets, and other schedules and information pertinent to the financial activities of the Foundation. Approved budgets are submitted to the AKF USA Board of Directors for final review and approval. The Chief Executive Officer (CEO) is responsible for implementing the approved budgets and for monitoring their day-to-day progress. A computerized financial reporting and accounting system is maintained by a professional accountant and other support staff.

Accounting books are maintained at the project level. Financial reports and requests for reimbursement are prepared on a quarterly basis at the project level and forwarded to AKF USA for review and submission to A.I.D. Performance against budget is carefully analyzed, and explanations for variances against budget are obtained and conveyed to A.I.D. in periodic reports.

All of AKF USA's subrecipients are audited annually, and A-133 audits are performed and coordinated at AKF USA. Audits of AKF USA under Circulars A-110 and A-133, performed by Coopers and Lybrand, have been positive and have not resulted in any questioned costs under previous or existing agreements with A.I.D.

VI. FINANCIAL REPORT

6.1 Financial Overview

The financial schedules that follow compare the actual expenditure of A.I.D.'s and AKF USA's funds with the budget for the second fiscal year of the Matching Grant Program, as

well as the projected budget for the remaining year of the grant. Financial profiles of projects, and of AKF USA, prepared in accordance with A.I.D.s' format, precede the financial schedules.

Overall, the multi-country, five project program is 4 percent below budget through Year 2: a total of $1,952,700 ($815,000 from A.I.D, and $1,137,700 from AKF USA) has been expended as of June 30, 1992, against an approved budget of $2,038,800. The overall forecast for the three year program has been adjusted from $2,680,000 to $2,713,000, and the increase of $33,000 will be funded entirely from AKF USA sources. A.I.D. contributions will remain at the previously approved level of $1,200,000, and AKF USA's share will be increased to $1,513,000. In Year 3, a total of $760,300 will be expended against an original forecast of $641,200. Of this amount, $385,000 (51 percent of total costs) is from A.I.D., and the remaining $375,300 will be funded by AKF USA.

This cost sharing analysis, however, reflects only the allocation of expenditures between the two sources of funds, i.e., A.I.D. and AKF USA. In reality, because the receipt of A.I.D.'s funds is based on requests for reimbursement from the projects, the actual funds disbursed by AKF USA exceed the 58 percent of the total costs allocated to AKF USA as of the end of the second year of the Matching Grant (June 30, 1993). This disbursement arrangement is necessary to provide working capital to the projects. Other than direct project costs, the costs do not include the value of time and material resources provided by various Aga Khan Development Network (AKDN) institutions collaborating in this program, nor will these indirect costs be charged to the projects.

The principal cause of underspending to date has been the devaluation of the Kenya shilling, and the consequent impact on project expenditures, as expressed in dollars, at the Mombasa PHC project in Kenya.

6.2 Project Expenditures

The following is a summary of the actual expenditures for the second Grant Year and of the revised budget for the remaining year of the Matching Grant Program, by project:

a. Mombasa Primary Health Care Project. On a cumulative basis, the project is underspent by approximately $45,600 for the first two Grant Years ($18,500 A.I.D. and $27,100 AKF). Of this amount $22,800 relates to Program Expenditures and $22,800 relates to Procurement. As noted above, a substantial portion of this underspending relates to the devaluation of the Kenya shilling. Original budgets were based on an exchange rate of KES 30 to $1. Current exchange rates approximate KES 75 to $1. This rate has been used to forecast costs for Grant Year 3, which have been reduced from $165,800 to $120,000. The proposed application of savings under the Matching Grant program is discussed in section 6.3.

b. Aga Khan Community Health Programme, Dhaka Bangladesh (AKCHP). Funding for the project has been used, as scheduled, and there are no further costs to be incurred in Grant Year 3. There are no variances from the two-year budget submitted to A.I.D. because the Matching Grant has provided only a portion of AKCHP's costs, the remainder being direct funding that AKCHP has received from other donors.

c. Urban Primary Health Care. Some line-item variances from the revised Grant Year 2 budget have been recorded, including personnel costs. Overall spending during Grant Year 2 and forecasts for total spending through Grant Year 3 remain unchanged, however. All funds for the project are provided by AKF USA because of A.I.D.'s current policy toward Pakistan.

d. Regional Network Programme. On a cumulative basis, the project is underspent by approximately $17,400 ($15,700 A.I.D. and $1,700 AKF). In view of increased projections during Grant year 3 for personnel costs and for travel and other costs associated with various workshops planned during the year, the three-year project budget remains unchanged.

e. Primary Health Care Management Advancement Programme. A modest underspending against budget of approximately $11,400 was realized during Grant Year 2. This was due primarily to the deferral of certain activities related to the dissemination of PHC MAP materials from Grant Year 2 to Grant Year 3. The budget for the overall project has been increased from $671,000 to $793,300, in part because of revised projections for production and distribution of the PHC MAP materials. This modification will not represent an increase in the funding requirements from A.I.D. for the overall Matching Grant Program, and financing plans are discussed in Section 6.3 below.

f. Headquarters. Funds budgeted for use during Grant Year 2 were not utilized, due in part because of revised projections for the evaluation scheduled for the fall of 1993. The overall budget has been increased from $40,000 to $42,000, to be expended during Grant Year 3. The additional costs of $2,000 will be provided by AKF USA.

6.3 Underspending and Reallocation

AKF USA is proposing that some of the funds from the underspending in the MPHC Project and the currency devaluation in Kenya be applied to new activities at the Mombasa MPHC Project and to cover the unfunded costs for the production and dissemination of PHC MAP materials.

It is proposed that the savings from MPHC be applied to cover the costs of a study on the opportunities and constraints on economic development in the Coastal areas in Kenya. The study is estimated to cost $16,000, which will be derived from AKF USA's matching funds. The results of the study will have a direct bearing on the future strategies of the Mombasa MPHC Project because the lack of income among the local poor is a major constraint to

improvements in health status. The Kenya branch of Technoserve, a U.S. PVO, has agreed to do this study. In addition, funds provided by AKF USA will be used to cover the partial replacement costs of a stolen vehicle. The absence of the vehicle is making it difficult for project staff to carry out activities in remote areas.

Additional savings will be reallocated to the PHC MAP project in order to provide adequate funding for the production, promotion, and dissemination of PHC MAP materials. The original PHC MAP budget had been reduced by approximately $200,000, based on the funds available under the Matching Grant program. In view of the extremely favorable reaction to the PHC MAP products, it is proposed that savings be applied to cover, in part, additional forecast costs totaling $122,300 during Grant Year 3, in order to maximize the availability of these materials. AKF USA's additional contribution of $33,000, noted above, will also be allocated in part to cover these costs.

These additional costs and proposed reallocation have been reflected in the revised budgets for Grant Year 3 and will not increase the contribution required from A.I.D. for the overall Matching Grant Program.

6.4 A.I.D. Funding

AKF USA receives funds from A.I.D. on the basis of requests for reimbursement submitted to A.I.D. once each quarter. These requests are based on the financial reports received from the various projects. In some instances, AKF USA has advanced funds to the collaborating agencies to provide working capital to facilitate field operations.

6.5 AKF USA's Share of Project Costs

AKF USA's share of project costs is largely funded by donations from a large number of small donors. Donors are kept abreast of project development through regular activities such as presentations, meetings, and where possible, site visits. AKF USA's volunteer National Committee and a network of other volunteers play an active role in these endeavors, as well as in the actual raising of funds. AKF USA does not foresee any difficulty in meeting its cost share under the Matching Grant program.

6.4 Financial Profile of Projects
Funded Under Grant Agreement PDC-0158-A-00-1102-00
July 1, 1991 - June 30, 1994
YEAR 2

(IN $'000s)

A. BUDGET VS. ACTUALS	AID		AKF	
Project Elements	Budget	Expend	Budget	Expend
KENYA - Mombasa PHC				
Total Program	119.8	91.8	0.3	0.0
Total Procurement	19.6	23.6	43.7	0.0
Ongoing Evaluation	-	-	-	-
BANGLADESH - AKCHP				
Total Program	51.9	51.9	12.9	12.9
Total Procurement	-	-	-	-
Ongoing Evaluation	-	-	-	-
PAKISTAN - Urban PHC				
Total Program	-	-	255.3	277.9
Total Procurement	-	-	37.4	16.4
Ongoing Evaluation	-	-	20.0	18.5
MULTI-COUNTRY - RNP				
Total Program	71.9	63.9	39.7	39.7
Total Procurement	28.2	20.5	6.4	4.7
Ongoing Evaluation	-	-	-	-
MULTI-COUNTRY - PHC MAP				
Total Program	149.5	120.0	6.8	4.9
Total Procurement	20.0	40.0	-	-
Ongoing Evaluation	-	-	-	-
HEADQUARTERS				
Total Program	-	-	-	-
Total Procurement	-	-	-	-
Ongoing/Final Eval.	9.5	0.0	2.3	0.0
TOTAL PROGRAM	470.4	411.7	424.8	375.0

B. SOURCES OR PROJECT FUNDS (IN '000s)

AID Matching Grant	411.7
Private	
Cash	375.0
In-kind	0.0
Host and Other Governments	
Cash	0.0
In-kind	0.0
Other AID Grants/Contracts	0.0
Other U.S. Government	0.0
Other	0.0
TOTAL SOURCES	786.7

6.4 Financial Profile of Projects
Funded Under Grant Agreement PDC-0158-A-00-1102-00
July 1, 1991 - June 30, 1994
YEARS 1 AND 2

(IN $'000s)

A. BUDGET VS. ACTUALS

Project Elements	AID Budget	AID Expend	AKF Budget	AKF Expend
KENYA - Mombasa PHC				
Total Program	202.3	179.8	22.0	21.7
Total Procurement	19.7	23.7	74.0	47.2
Ongoing Evaluation	-	-	-	-
BANGLADESH - AKCHP				
Total Program	110.1	110.1	52.1	52.1
Total Procurement	-	-	-	-
Ongoing Evaluation	-	-	-	-
PAKISTAN - Urban PHC				
Total Program	-	-	520.4	543.0
Total Procurement	-	-	65.7	44.7
Ongoing Evaluation	-	-	38.0	36.5
MULTI-COUNTRY - RNP				
Total Program	114.6	106.6	92.1	92.1
Total Procurement	32.9	25.2	12.1	10.4
Ongoing Evaluation	-	-	-	-
MULTI-COUNTRY - PHC MAP				
Total Program	307.0	277.5	289.3	287.4
Total Procurement	72.1	92.1	2.6	2.6
Ongoing Evaluation	-	-	-	-
HEADQUARTERS				
Total Program	-	-	-	-
Total Procurement	-	-	-	-
Ongoing/Final Eval.	9.5	0.0	2.3	0.0
TOTAL PROGRAM	868.2	815.0	1,170.6	1,137.7

B. SOURCES OR PROJECT FUNDS (IN '000s)

AID Matching Grant	815.0
Private	
Cash	1,137.7
In-kind	0.0
Host and Other Governments	
Cash	0.0
In-kind	0.0
Other AID Grants/Contracts	0.0
Other U.S. Government	0.0
Other	0.0
TOTAL SOURCES	1,952.7

6.5 Financial Profile of Aga Khan Foundation U.S.A.
Year Ended December 31, 1992

		January 1 - December 31, 1992
A.	**Program Expenditures:**	
	Small Project Grants	$1,519,326
	Training	
	Sectoral Strategy Development	
	Disaster Relief	
	Evaluation	
	Program Management	
	Indirect Costs	
	TOTAL WORLDWIDE PROGRAM	$1,519,326
B.	**Sources of Funds:**	
	AID Matching Grant	$423,912
	Private	
	Cash	1,033,955
	In-kind	
	Hosts/Other Governments	
	Cash	
	In-kind	
	Other AID Grants or Contracts	61,459
	Other U.S. Government	
	Other	
	TOTAL	$1,519,326

6.6 AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Consolidated Program Summary
BUDGET VS ACTUALS - GRANT YEAR 2

(In $'000s)

Direct Costs	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
KENYA - Mombasa PHC									
* Total Program	119.8	0.3	120.1	91.8	0.0	91.8	28.0	0.3	28.3
* Total Procurement	19.6	43.7	63.3	23.6	0.0	23.6	(4.0)	43.7	39.7
* Ongoing Evaluation	-	-	0.0	-	-	0.0	-	-	0.0
Sub-Total	139.4	44.0	183.4	115.4	0.0	115.4	24.0	44.0	68.0
BANGLADESH - AKCHP									
* Total Program	51.9	12.9	64.8	51.9	12.9	64.8	0.0	0.0	0.0
* Total Procurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
* Ongoing Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sub-Total	51.9	12.9	64.8	51.9	12.9	64.8	0.0	0.0	0.0
PAKISTAN - Urban PHC									
* Total Program	-	255.3	255.3	-	277.9	277.9	-	(22.6)	(22.6)
* Total Procurement	-	37.4	37.4	-	16.4	16.4	-	21.0	21.0
* Ongoing Evaluation	-	20.0	20.0	-	18.5	18.5	-	1.5	1.5
Sub-Total	0.0	312.7	312.7	0.0	312.8	312.8	0.0	(0.1)	(0.1)
MULTI-COUNTRY - RNP									
* Total Program	71.9	39.7	111.6	63.9	39.7	103.6	8.0	0.0	8.0
* Total Procurement	28.2	6.4	34.6	20.5	4.7	25.2	7.7	1.7	9.4
* Ongoing Evaluation	-	-	0.0	-	-	0.0	-	-	0.0
Sub-Total	100.1	46.1	146.2	84.4	44.4	128.8	15.7	1.7	17.4

6.6 AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Consolidated Program Summary - Continued
BUDGET VS ACTUALS - GRANT YEAR 2

(In $'000s)

Direct Costs	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
MULTI-COUNTRY - PHC MAP									
* Total Program	149.5	6.8	156.3	120.0	4.9	124.9	29.5	1.9	31.4
* Total Procurement	20.0	0.0	20.0	40.0	0.0	40.0	(20.0)	0.0	(20.0)
* Ongoing Evaluation	-	-	0.0	-	-	0.0	0.0	0.0	0.0
Sub-Total	169.5	6.8	176.3	160.0	4.9	164.9	9.5	1.9	11.4
HEADQUARTERS									
* Total Program	-	-	0.0	-	-	0.0	-	-	0.0
* Total Procurement	-	-	0.0	-	-	0.0	-	-	0.0
* Ongoing/Final Evaluation	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8
Sub-Total	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8
Total Direct Costs	470.4	424.8	895.2	411.7	375.0	786.7	58.7	49.8	108.5
Indirect Costs	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL MG PROGRAM	470.4	424.8	895.2	411.7	375.0	786.7	58.7	49.8	108.5

6.6 AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Consolidated Program Summary
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

(In $'000s)

Direct Costs	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
KENYA - Mombasa PHC									
* Total Program	202.3	22.0	224.3	179.8	21.7	201.5	22.5	0.3	22.8
* Total Procurement	19.7	74.0	93.7	23.7	47.2	70.9	(4.0)	26.8	22.8
* Ongoing Evaluation	-	-	0.0	-	-	0.0	-	-	0.0
Sub-Total	222.0	96.0	318.0	203.5	68.9	272.4	18.5	27.1	45.6
BANGLADESH - AKCHP									
* Total Program	110.1	52.1	162.2	110.1	52.1	162.2	0.0	0.0	0.0
* Total Procurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
* Ongoing Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sub-Total	110.1	52.1	162.2	110.1	52.1	162.2	0.0	0.0	0.0
PAKISTAN - Urban PHC									
* Total Program	-	520.4	520.4	-	543.0	543.0	-	(22.6)	(22.6)
* Total Procurement	-	65.7	65.7	-	44.7	44.7	-	21.0	21.0
* Ongoing Evaluation	-	38.0	38.0	-	36.5	36.5	-	1.5	1.5
Sub-Total	0.0	624.1	624.1	0.0	624.2	624.2	0.0	(0.1)	(0.1)
MULTI-COUNTRY - RNP									
* Total Program	114.6	92.1	206.7	106.6	92.1	198.7	8.0	0.0	8.0
* Total Procurement	32.9	12.1	45.0	25.2	10.4	35.6	7.7	1.7	9.4
* Ongoing Evaluation	-	-	0.0	-	-	0.0	-	-	0.0
Sub-Total	147.5	104.2	251.7	131.8	102.5	234.3	15.7	1.7	17.4

6.6 AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Consolidated Program Summary - Continued
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

(In $'000s)

Direct Costs	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
MULTI-COUNTRY - PHC MAP									
* Total Program	307.0	289.3	596.3	277.5	287.4	564.9	29.5	1.9	31.4
* Total Procurement	72.1	2.6	74.7	92.1	2.6	94.7	(20.0)	0.0	(20.0)
* Ongoing Evaluation	-	-	0.0	-	-	0.0	0.0	0.0	0.0
Sub-Total	379.1	291.9	671.0	369.6	290.0	659.6	9.5	1.9	11.4
HEADQUARTERS									
* Total Program	-	-	0.0	-	-	0.0	-	-	0.0
* Total Procurement	-	-	0.0	-	-	0.0	-	-	0.0
* Ongoing/Final Evaluation	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8
Sub-Total	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8
Total Direct Costs	868.2	1,170.6	2,038.8	815.0	1,137.7	1,952.7	53.2	32.9	86.1
Indirect Costs	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL MG PROGRAM	868.2	1,170.6	2,038.8	815.0	1,137.7	1,952.7	53.2	32.9	86.1

6.7 AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Consolidated Program Summary
GRANT YEARS 1 TO 3 - REVISED BUDGET

(In $'000s)

Direct Costs	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
KENYA - Mombasa PHC												
* Total Program	88.0	21.7	109.7	91.8	0.0	91.8	65.1	-	65.1	244.9	21.7	266.6
* Total Procurement	0.0	47.2	47.2	22.0	0.0	22.0	15.0	36.0	51.0	37.0	83.2	120.2
* Ongoing Evaluation	0.1	-	0.1	1.6	-	1.6	3.9	-	3.9	5.6	0.0	5.6
Sub-Total	88.1	68.9	157.0	115.4	0.0	115.4	84.0	36.0	120.0	287.5	104.9	392.4
BANGLADESH - AKCHP												
* Total Program	58.2	39.2	97.4	51.9	12.9	64.8	-	-	0.0	110.1	52.1	162.2
* Total Procurement	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
* Ongoing Evaluation	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
Sub-Total	58.2	39.2	97.4	51.9	12.9	64.8	0.0	0.0	0.0	110.1	52.1	162.2
PAKISTAN - Urban PHC												
* Total Program	-	265.1	265.1	-	277.9	277.9	-	267.0	267.0	-	810.0	810.0
* Total Procurement	-	28.3	28.3	-	16.4	16.4	-	23.3	23.3	-	68.0	68.0
* Ongoing Evaluation	-	18.0	18.0	-	18.5	18.5	-	19.0	19.0	-	55.5	55.5
Sub-Total	0.0	311.4	311.4	0.0	312.8	312.8	0.0	309.3	309.3	0.0	933.5	933.5
MULTI-COUNTRY - RHP												
* Total Program	42.7	52.4	95.1	63.9	39.7	103.6	128.6	-	128.6	235.2	92.1	327.3
* Total Procurement	4.7	5.7	10.4	20.5	4.7	25.2	25.0	1.7	26.7	50.2	12.1	62.3
* Ongoing Evaluation	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
Sub-Total	47.4	58.1	105.5	84.4	44.4	128.8	153.6	1.7	155.3	285.4	104.2	389.6

6.7 AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Consolidated Program Summary - Continued
GRANT YEARS 1 TO 3 - REVISED BUDGET

(In $'000s)

Direct Costs	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
MULTI-COUNTRY - PHC MAP												
* Total Program (Note 1)	157.5	282.5	440.0	120.0	4.9	124.9	28.8	3.0	31.8	306.3	290.4	596.7
* Total Procurement	52.1	2.6	54.7	40.0	-	40.0	80.9	21.0	101.9	173.0	23.6	196.6
* Ongoing Evaluation	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
Sub-Total	209.6	285.1	494.7	160.0	4.9	164.9	109.7	24.0	133.7	479.3	314.0	793.3
HEADQUARTERS												
* Total Program	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
* Total Procurement	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
* Ongoing/Final Evaluation	-	-	0.0	-	-	0.0	37.7	4.3	42.0	37.7	4.3	42.0
Sub-Total	0.0	0.0	0.0	0.0	0.0	0.0	37.7	4.3	42.0	37.7	4.3	42.0
Total Direct Costs	403.3	762.7	1,166.0	411.7	375.0	786.7	385.0	375.3	760.3	1,200.0	1,513.0	2,713.0
Indirect Costs	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTAL MG PROGRAM	403.3	762.7	1,166.0	411.7	375.0	786.7	385.0	375.3	760.3	1,200.0	1,513.0	2,713.0

VII. LESSONS LEARNED

7.1 Cross-Cutting Lessons

- *Having in place appropriate processes for volunteer selection has been found to be a factor in program management, community participation, and organizational sustainability.*

Setting selection criteria and performance standards for CHWs and other health volunteers helps, in part, to improve volunteer retention and effectiveness. Mixed results have been achieved through the use of cash or in-kind incentives. Often, the local social and cultural norms and perceptions of the role of the volunteers must be addressed at the community level before volunteers can be used effectively for PHC.

- *As MIS capacity is developed, the addition of operations research components to projects can provide them with the ability to use health data to analyze and understand community health profiles, practices, and indicators. Such information can allow PHC managers to develop strategies specific to a community's changing needs, to target services better and to evaluate results. A further benefit can be the sharing of knowledge and expertise with other NGOs and government agencies that might result.*

For example, AKCHP and UPHC have been able to perform short-term studies on such issues as breastfeeding practices, water and sanitation, TBA profiles and health knowledge, attitude and practice (KAP) surveys, disease prevalence, and causes of death. MPHC recently completed a study, funded by a small grant from AMREF in March 1992, on diarrheal disease prevalence and mothers' ability to diagnose symptoms. This year, MPHC received a small research grant ($4,600) from the Centre for Development and Population Activities (CEDPA) to conduct a follow-up study on Diarrhea Disease Home Case Management.

- *In evaluating and planning for sustainability in PHC and other development programs, PVOs, NGOs and donor agencies need to consider financial and nonfinancial (or strategic) factors, and the linkages that often exist between the two.*

During the development of the PHC MAP Module 9, *Sustainability Analysis*, it became apparent that sustainability analysis should encompass financial and non-financial factors. Thus, Module 9 was designed to allow PHC managers to analyze ten strategic and financial factors to sustainability: (i) target population size; (ii) target group knowledge, attitudes and practice (KAP); (iii) PHC service quality; (iv) management support; (v) organizational capacity; (vi) political commitment; (vii) personnel resources; (viii) revenues; (ix) expenditures; and (x) environment. For each of these factors, Module 9 provides: definitions; lists of key indicators that project managers can use for measurement; suggested strategies for addressing associated problems and opportunities; and lists of the possible financial implications that the project manager should consider during a sustainability analysis.

- *To improve sustainability of PHC programs, PHC managers will need access to flexible and adaptable management and analytical tools to perform sustainability and cost analysis.*

Each of the PHC service projects under the current AKF USA Matching Grant program is concerned with improving the sustainability of its PHC programs. However, each of these projects, MPHC, UPHC and AKCHP, is faced with a different operational environment and is at a different stage in reaching its sustainability goals. AKF is encouraging each of these PHC projects to carry out sustainability analyses of their programs and to develop plans of action which incorporate steps to address both strategic and financial factors. For this purpose project managers are being encouraged to use the PHC MAP Module 9 materials. some cases better familiarization and training with the Module 9 materials and concepts will be required before PHC managers can effectively go through such a process.

7.2 Mombasa Primary Health Care Project (MPHC)

- *Until external factors affecting the communities' health are addressed, community-based PHC programs are less likely to fully achieve sustainable health impacts in the communities they serve.*

MPHC has been successful in mobilizing and organizing communities for community-based PHC, including developing a replicable model for recruitment and training of CBHWs and other health volunteers in the East African Coastal region. As a result, community knowledge of good health practices has improved, as have immunization rates and access to basic preventive services. At the same time, the communities in the project area continue to be plagued with widespread childhood and maternal malnutrition, and general poor health. The primary contributing factors to continued poor nutrition, susceptibility to disease, and general poor health are thought to be the overall underdevelopment in these communities, particularly the lack of access to year-round water sources and adequate food.

- *The Community organizations that have been mobilized, and the institutional capacity that has been developed for community-based PHC can also be used to facilitate the introduction of other development initiatives which might positively affect health status.*

To address the problem of inadequate food supplies (and hence poor nutrition), MPHC has facilitated contact between the Ministry of Agriculture and farmers, and has helped introduce new farming techniques for improving yields on a trial-plot basis. This has helped to demonstrate to the communities some possible alternative agricultural methods which might help to improve local food supply.

- *Primary health care practice can reasonably build upon the knowledge, local human resources, and skills developed within programs such as MPHC as models for community-based recruitment, training, volunteer-management, and health information management.*

MPHC has become a resource for other health programs and agencies in the region by

providing training to UNICEF-sponsored projects and the Lamu District Health Management Team. In some instances, the provision of training and technical assistance to other health agencies can provide a means for generating project income. However, it is very unlikely that such activities, in and of themselves, could be a sufficient source of revenues to make the PHC program self-supporting.

- *In some instances, improving access to certain types of health services is not sufficient to increase the communities' use of the same. Health services related to culturally sensitive issues are more likely to be adopted by communities, and sustained, if participatory approaches, community outreach and education are coupled with service provision.*

The value of time spent by the MPHC project team in understanding community perceptions was reinforced by its experiences in organizing and conducting family planning focus groups in 1992. These focus groups opened the way for further exploration and action in an area which has been regarded as taboo. Villages are now arranging for family planning education sessions, and the number of family planning clients is beginning to increase.

- *Collaboration between government and nongovernmental agencies is particularly important in resource-poor regions, such as Kwale District, to address the myriad factors affecting health, and to maximize resources.*

MPHC has continued to build its collaborative relationships with both government and nongovernmental agencies active in the health sector in the MPHC project area and beyond, including: the Ministries of Health, Education, Agriculture, Water Development, Local Administration, and Culture/Social Services; the Mombasa Municipality; KARI; Kenya Red Cross; AMREF; GTZ/GASP Lamu; UNICEF; CEDPA; and PRITECH. The above agencies have contributed to the progress of the project in various ways, such as provision of technical skills, human resources, and materials.

- *The participation of women in program leadership at the local level remains a major challenge for MPHC.*

Only female government extension workers from outside of the village have, thus far, penetrated the PICs. No local women have, as yet, participated in PICs. Other leadership groups, such as PTAs and VHCs, usually average one to two local women representatives out of an average membership of 12. Some younger women leaders have begun to emerge, however. One of the youth groups (Mazeras) is led by a young woman with excellent skills in community mobilization and organization, offering hope that with the younger generation, women may take their proper roles as leaders.

7.3 Aga Khan Community Health Programme (AKCHP)

- *Attaining local management and sustainability of PHC programs may often entail numerous processes and government approvals, requiring NGOs to have an understanding of*

local regulations, and adequate communications, institutional resources, and support services.

The management of AKCHP, established by the Silver Jubilee Commemoration Society, will be taken over by the Society for Urban Health (SUH), a local NGO in Bangladesh, before the end of the current Matching Grant. Over the past year, SUH has successfully completed the two major steps in that process: (i) received authorization from the government to receive foreign donations; and (ii) received approval to take over the management of AKCHP. At the same time, AKCHP has taken positive steps to diversify its funding base. A proposal to DANIDA for funding of AKCHP has been reviewed favorably and is expected to result in continued funding of AKCHP.

- *In designing fee-for-service structures, a CBPHC programs should: (i) develop a clear statement of its fee policies and communicate the same to the community; (ii) set criteria for identifying patients who cannot afford to pay and make provisions for continuation of services to those people on a needs basis; (iii) develop systems for monitoring the impact of fees on clinic attendance, especially within the target population, to insure that PHC coverage is not forgone to income generation.*

In January 1992, AKCHP instituted a change in its fee structure at all its clinics. Following this, some confusion arose in the community regarding clinic fees. This confusion encouraged AKCHP to develop a clear statement of its fees policies and circulate it to all satellite clinics and the community. AKCHP's new fee policy includes specific guidelines for registered and nonregistered families and special exceptions for extremely needy cases. AKCHP carried out a comparative analysis of clinic visits and total clinic revenues from fees between 1991 and 1992. The results of this analysis showed that overall clinic attendance, which increased by 3.2 percent, was not negatively affected by the change in policy. At the same time, a 34 percent increase in clinic revenues from fees was attained. (See Attachment 9)

- *In high-poverty, urban areas, local conditions often act as impediments to the provision of consistent PHC services, and follow-up remains a challenge. PHC programs working in urban slum environments will need to identify these barriers and develop specific strategies to overcome them to ensure that consistent PHC services are provided on a sustainable basis.*

In the AKCHP project area, outmigration to other slum areas is high because of housing conditions and government policies of "razing" slum areas from time to time. This has affected the retention of health volunteers. More mothers are working outside of the home as low-paying job opportunities crop up around the slum neighborhoods. Often, volunteers are not able to follow up with children as they are left unattended at home or accompany their mothers to work.

7.4 Urban Primary Health Care Programme

- *AKU/CHS has determined that the micro PHC modules are inappropriate for*

application as organizational components for replication in larger public systems. Rather, AKU/CHS feels that it is necessary to upscale in population size to the subdistrict or district level to achieve system efficiencies in management. As AKU/CHS became aware of the limitations of these micro PHC modules, it embarked upon the development of a Macro PHC Project in collaboration with local communities, NGOs and the government.

The micro PHC modules developed by AKU/CHS have been extremely useful as "social laboratories" for teaching purposes, helping AKU's medical and nursing students gain practical field experience, and enhancing human resource development in the health sector. At the same time, the communities in the seven micro PHC sites have benefited through improved access to clinical services, health outreach, and education, which has resulted in an overall improvement in health status, especially in the target population of mothers and children under age five.

- *Integrating government and nongovernment health services for purposes of upscaling health programs requires that all concerned organizations and agencies become involved in the early planning processes of such programs.*

The difficulties which AKU/CHS encountered in getting the Karachi Metropolitan Corporation (KMC) and the Zonal Municipal Committees of Karachi (ZMC) medical and health services involved in the planning, implementation and management of the Macro PHC Project were partially because concerned health authorities were not involved in the planning process from the very beginning. These major health service providers were contacted after AKU/CHS had developed a framework and plan for a subdistrict level system. This caused a lack of understanding on the part of the CHS department about the complex nature of health care provision and its management by the KMC. Additionally, it is causing problems for KMC and ZMC in understanding the process and activities of the project, and how various component services might be integrated.

- *In planning integrated health care systems an essential first step is community assessment. Such an assessment should identify pertinent socio-economic issues, evaluate health demographics, and collect information on the availability and quality of existing health services.*

Over the past year, AKU/CHS conducted a community assessment in site selected for implementation of the Macro PHC Project, District South of Karachi. The community assessment identified the target population, evaluated environmental factors which affect health, including housing conditions, water and sanitation, and socio-economic profiles, assessed the health services available in the area, and reviewed the existing institutional framework whereby community participation might be encouraged. This community assessment was a first step towards identification of health and health services problems in the area. The results of the assessment found: (i) inadequate water supply and poor sanitation throughout the area; (ii) low female literacy; (iii) social problems, among which, heroin addiction is the most serious; (iv) under-utilization of the KMC dispensary and maternity home; (v) no secondary care available; (vi) no outreach services available; (vii)

a high-rate of home deliveries, most of which involve TBAs who are untrained and unsupervised; and (viii) no interaction between private, government and the micro-PHC health services. This assessment is providing AKU/CHS and the PHC Macro Project Oversight Team with valuable information for planning and prioritizing health services for health systems development.

- *In multi-linguistic and multi-ethnic communities where local NGO structures may be weak, community control of PHC programs will be difficult to accomplish until community leadership, cohesiveness, and organization is improved.*

Greater community participation leading to community control, shifts toward lower costs, and availability of alternative resources are basic tenets for developing a replicable model for large-scale health delivery systems. However, AKU/CHS's community assessment found that the communities in the project area were highly fragmented and that local groups are institutionally weak. In light of this, the Macro PHC Oversight Team has decided that community development is a crucial step toward community participation and control of the program. Community development activities will deal with the lack of cohesiveness among various parts of the community, lack of leadership and management skills in local groups, and the tendency for local groups to work in complete isolation from one another. It is hoped that these activities will lay the groundwork for stronger community organizations which can act as conduits for increasing participation, local management and pooling of resources.

7.5 Regional Network Programme

- *Regional networks, such as the RNP, can play a key role in helping to disseminate "best practices" in PHC, and facilitate the genesis of new strategies for health systems development.*

The RNP has been successful in facilitating the sharing of health strategies among its members. In Kenya, Child-to-Child Health Education and Health Through Schools programs have been shown to improve children's and their families' knowledge and health practices. In August 1992, MPHC conducted a workshop on "Health Through Schools" for other members of RNP in Karachi. After learning more about this intervention at the RNP Workshop, AKCHP has taken a further step to improving children's health, by coupling its Health Through Schools programs with efforts to encourage schools to improve the learning environment and its impact on children's health, including better water, sanitation, and health and hygiene practices. Such health education programs are particularly relevant and essential in countries and communities where many children do not attend school beyond the primary level.

7.6 Primary Health Care Management Advancement Programme

- *The availability and relevance of health program data, and its effective use for meeting program monitoring and evaluation needs, can be improved through the use of specially-*

designed management tools, such as PHC MAP, which integrate MIS concepts and processes with health program management systems.

A major goal of the present Matching Grant has been to increase the effectiveness and sustainability of PHC programs by increasing their capacity to collect, process, and use information related to their program management and impacts. During the past year, all of the programs have taken steps to reassess their management information systems, with the purpose of identifying those data which can best serve their management needs and of improving data quality. In the cases of AKCHP and UPHC, this led to revising the types of data which are being collected, developing new data collection instruments, and streamlining health information processes and data use by the management team, CHWs, and the community. These efforts were accomplished largely because of these PHC programs' exposure to PHC MAP materials and their participation in the RNP.

- *The participatory design and development approach of PHC MAP, to field-test the materials in PHC programs in developing countries, and to involve PVOs/NGOs, universities, district-level health agencies and multilateral and bilateral donors in the review, promotion and dissemination process, has helped to create an effective demand for the PHC MAP materials. As more organizations are exposed to PHC MAP, it is expected that this demand will continue to grow.*

URC/CHS recently conducted a survey of programs where PHC MAP materials have been tested over the last three years. Overall, the results of the survey show that the PHC MAP modules were useful, well organized, and very adaptable to local situations. PHC MAP modules provided a mechanism for the manager to determine information priorities. Most of the programs surveyed were in the process of incorporating the PHC MAP tools into their MIS. Many of the respondents said that use of the PHC MAP modules resulted in improved management assessment skills, helping them to improve service quality. At the same time, respondents stated that use of PHC MAP helped them to reduce the knowledge gap and to better identify program strengths and weaknesses.

Likewise, promotional and training activities, such as the June 1993 PHC MAP Workshop at the NCIH Annual Conference, have generated more interest in PHC MAP. Fifty-one of the 52 participants in the June workshop requested copies of the PHC MAP modules when they become available in August 1993. Most of these participants were able to cite specific plans of action for how they might use PHC MAP, either in project implementation, PHC management training programs, or within the context of university-level public health curricula.

VIII. RECOMMENDATIONS

- In extremely underdeveloped communities with a shallow economic base, such as the communities in the MPHC project area, integrated or parallel programs designed to improve conditions contributing to the general economic and health environment should be

implemented to realize sustainable improvements in a community's health status. PHC programs might, in a limited way, integrate program components which can address some of these needs, and for which they have a demonstrated comparative advantage. For example, water and sanitation, improved farming methods, human resource and technical skills development, and women's education programs might be integrated into PHC programs. Alternatively, NGOs working in the health sector might assist communities to further use their organizational skills to implement integrated community development activities, identify and liaise with other NGOs to provide such services, or act as an intermediary between the communities and government agencies to better demand and gain access to public services and investments.

- To begin to address the above, AKF has developed terms of reference for the completion of a study to explore more fully the potential for agricultural and entrepreneurial-based development in Kenya's Coastal area. The study will investigate current agricultural activities and sources of income, constraints in the natural resource base, and appropriate technologies, and risk sensitivity. Outcomes of the study will be used to further the development of AKF and other NGO strategies and programs, which have the potential to complement AKF's health programs in the region. AKF is planning to collaborate with Technoserve on such a study and recommends that this important program be supported through savings in the MPHC budget.

- PHC programs serving populations in temporary and extremely poor and unstable environments may need to develop alternative strategies for service delivery and follow-up. Integrating childcare and outreach to working mothers with PHC may help to improve opportunities for more consistent service delivery as well as child nutrition programs and healthier and safer living conditions.

- School curricula should be further expanded to include more PHC elements. PHC program managers could target local and national education officials, decision makers and teachers for dissemination of education materials and awareness-raising activities to encourage a broader-scale integration of health education materials in primary education and to improve the environmental conditions, water, sanitation, and health practices in the schools themselves.

- PHC MAP, the management tools developed and field-tested under this Matching Grant, should be further promoted and disseminated, and training programs should be held to assist PHC managers in improving their program's capacity to effectively manage and evaluate information. Dissemination of the PHC MAP materials should be along a four-pronged approach: (i) directly target NGOs, district-level health programs, universities, and other organizations involved in the implementation of health programs that can immediately apply the PHC MAP materials in their projects; (ii) target intermediary organizations and health networks or associations that might assist in disseminating and supporting the use of PHC MAP, such as UNICEF, PVOs, NGOs and their networks, and multilateral and bilateral donor agencies; (iii) identify training institutions and conduct training and training-

of-trainers programs which will encourage the establishment of PHC MAP "Centers of Excellence"; and (iv) integrate PHC MAP materials into Public Health curricula in universities both in the U.S. and in developing countries. Through such a process, a broader body of knowledge and PHC information management practices could be developed.

- PHC programs which have developed health information systems and expertise should consider the cost-effectiveness of adding operational research components to their programs to improve their capacity to respond to community health needs and develop more effective strategies and targeted services. To the extent possible, operations research should be carried out, and/or results shared, in collaboration with other NGOs, networks of PHC projects (such as RNP), government agencies, and universities, so that costs and expertise are shared, and coordinated service and referral systems can be developed.

1993 PLAN OF ACTION

MOMBASA PRIMARY HEALTH CARE PROJECT

COMMUNITY PROCESS

Status by end of 1992:

LOCATION	NUMBER OF VILLAGES	VILLAGES REACHED	VILLAGES ACTIVE
MTAA	14	14	11 (78%)
KASEMENI	16	15	13 (81%)
MWAVUMBO	28	27	16 (57%)
TOTAL	58	56	40 (69%)

1993 Objective:

To increase self-reliance by continuing to raise Primary Health Care awareness in all 58 villages and thereby increase active participation from 69% to 75% overall.

Indicators:

1. number of villages with on-going CBHC activities;
2. number of villages planning and implementing their Plans of Action (POA).

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Village level awareness meetings and barazas	*	-	-	-	-	-	-	-	-	-	-	*	PIC/TOTs
. Contact and plan with leaders in slow villages	*	-	-	-	-	*							"
. Identify training needs of various CBHWs and plan action		*	-	-	-	-	*						TOTs
. Follow up implementation of Village level 1993 POA	*	-	-	-	-	-	-	-	-	-	-	*	PIC/TOTs
. PIC meetings	*	.	.	.	.	.	.	.	.	.	.	*	Chiefs
. PIC exchange visits			*						*				Chief/TOTs
. Mobilize resources for:													
Mtaa Dispensary	*	-	-	-	-	*							Chief
Mwatate Disp.	*	-	-	-	-	*							"
Miyani Water Phase2		*	-	-	-	-	-	-	-	*			"
. Monitor and supervise	*	-	-	-	-	-	-	-	-	-	-	*	PIC
. Assessment and feedback			*			*			*				PIC/Fred
. Plan for 1994 at village level						*	-	-	*				PIC/TOTs

ASSUMPTIONS

1. Once a village becomes active, it will remain so.
2. The social and economic situation in the area will be conducive to participation

2. TRAINING

Status by end of 1992

CATERGORY	TOTAL TRAINED	TOTAL ACTIVE
SHD/TBAs	89	*
VHC/PTAs/WGs	21	8
Community Leaders	26	20
Teachers	33	28
Schools	22	22
TOTs	17	17
TOFs	2	2
CBDDs	52	26**

* too early to assess level of activity

** new group of 26 was trained at the end of 1992 so had not starte dispensing.

1993 Objective:

To enhance community based health care sustainability by developing knowledg and skills among the following catergories:

100 people for Safe Home delivery
15 Schools PTAs for CBHC management
20 Women Groups for health and development
20 villages for health education
52 CBHWs for drug distribution
5 Community TOTs
30 Community Leaders
Staff and other extension workers in the project area for:

- management
- cost efficiency and analysis
- proposal writing
- epidemiology
- AIDS and STDs

ASSUMPTIONS

1. People at community level will volunteer for training
2. The people who start training will complete the courses

3. After the acquiring of knowledge and skills people will put these in practice at community level

4. People who have acquired knowledge and development will pass these on to others (multiplying effect).

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Continue registration for Safe Home Delivery (SHD)	*	-	-	-	-	*							PIC/TOTs
. Train 1st SHD Groups: Mtaa		*											Janet
Kase: *													Eva
Mwav:		*											Mwau
. VHC Training Kase:		*		*			*			*			Eva
Mwav: *	*						*						Mwau
Mtaa		*			*								Janet
. PTAs/Women Grps training				*				*	-	-	-	*	PIC/TOTs
. Refresher for Comm Leaders					*								"
. New Comm Leaders training				*									Peter
. TOT Refresher						*							Manager
. TOT 3-phases	*				*			*					Manager
. TOF			*			*			*				Manager
. Nutrition w/shop		*											Peter
. Management/Cost Effect's	*												Manager
. Epidemiology w/shop							*						Manager
. Proposal writing						*							Manager
. Counselling Refresher									*				Manager
. Improved farming	*	-	-	-	-	-	-	-	-	*			TOTs
. Latrine construction	*	-	-	-	-	-	-	-	-	-	-	*	Peter
. District Heads Orientation		*											MOH/Manager

3. **FOOD PRODUCTION, NUTRITION & GROWTH MONITORING**

Nutritional status by end of 1992 (weight for age):

	Normal	MALNOURISHED 1st Degree	2nd Degree	3rd Degree
0-11 months	81%	16%	3%	
12-23 months	45%	39%	9%	7%
24-35 months	51%	42%	6%	1%

Overall low weight for age = 40.7%.

1993 Objective:

To achieve sustainable improvements in the nutrition status of children 0-3[illegible] months of age (weight for age) by improving food quantity and variety.

Indicators:

1. food yield per unit area;
2. children 0-35 months with normal weight for age.

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Awareness barazas (farming)	*--*												Chief/TOT
. Recruitment of farmers	*-----*												"
. Baseline information from volunteer farmers	*-----*												Fred/ESN
. Training of farmers		*----------*											KARI/MOA/TO
. Develop and test technology for rain water harvesting:													
- Contact NGOs/MOA	*-----*												Manager
- Discuss with community	*------*												TOTs
- Trials	*------*												PIC/TOT
. Set up scheme for supply of seeds, fertilizer and technical support		*------*											PIC/TOT
. Information and education for nutrition and GM Teachers/TOT	*.....*												
. Carry out GM and follow-up of kids at risk	*.....*												"
. Food preparation and child feeding demonstrations	*.....*												"
. Monitor and supervise	*.....*												PIC/TOTs
. Assess food harvest							*---*						KARI/MOA/P[illegible]
. Monitor cost of activities	*.....*												TOT/PIC
. Assess nutritional status									*				PIC/Fred
. Feedback and replan					*		*			*			"

ASSUMPTIONS:

1. There will be sufficient rain for crop production

2. Required inputs and technical assistance will be readily available from the MOA, KGGCU and KARI

3. Farmers will use the food first and foremost to feed the family rather than sell it

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4. FAMILY PLANNING

Status by end of 1992:

- % of women who know at least 1 family planning method = 77.6%.
- % of eligible women using a reliable family planning method = 17%.

1993 Objective:

To improve the health of women 15-49 years by increasing awareness and practice of family planning. By the end of 1993, at least 25% of the women will be using a reliable method of family planning.

Indicators:

1. % of eligible women using a reliable family planning method;
2. % of men/women who know at least 3 reliable family planning methods.

ACTIVITIES	J F M A M J J A S O N D	ACTOR
. Analyse reports of 1992 Focus Group discussions	*--*	Esther
. Feedback and replan	*	TOTs
. FP Focus Group discussions	*.....*	TOTs
. Respond to needs arising from Focus Group discussions	*.....*	TOTs
. Set up FP Cinema Centres	*------*	PICs
. Finalise FP training modules	*	TOTs/PM
. FP information and educ at village level	*.....*	TOTs
. Train FP Motivators/Distributors	*------*	TOTs/PIC
. Acquire FP Kit, materials & Supplies	*--*	MOH/PM
. Provide FP services at H.Units	*.....*	ECNs
Community	*----------*	PIC/TOT
. Set up monitoring system	*----------*	PIC/Fred
. Assess progress	* * "	
. Feedback and replan	* * "	

5 IMMUNIZATION

Status by end of 1992:

- Fully immunized children under 2 years = 82.2% (Crude data)
  43.3% (Valid data)
- Tetanus toxoid coverage = 78%

1993 Objective:

To maintain immunization coverage in the second year of life above 75% and raise TT coverage to 85%.

Indicators:

1. % of children 12-23 months fully immunized; (crude & valid data)
2. % of women with a child under 1 year who were immunized against tetanus.

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Staff KEPI refresher		*--*											P.Manager
. Awareness barazas		*-----*											TOTs
. Information & education		*.....*											TOTs/CBHWs
. Mobile clinics		*.....*											"
. Equip Mazeras for MCH/FP	*-----*												MOH/PM
. Improve service quality	*-------*												"
. Immunization campaigns (subject to need)			*.....*										PICs/TOIr
. Tracking defaulters	*.....*												PIC/Schoolr
. Assess coverage					*				*				PICs/Fred
. Feedback and replan						*				*			"

ASSUMPTIONS:

1. Parents will continue to utilize MCH services
2. MCH service clients will be willing to sit through 30 minutes of health education per mobile clinic
3. Pre natal care clients will be able to pay ten shillings each month for iron and folate tablets
4. Improvements in service quality will lead to higher valid data coverage for immunization.

6. WATER

Status by end of 1992:

- % of households with water supply within: (dry season)
  - 15 minutes walk = 39%
  - 30 minutes walk = 42%
  - > 30 minutes walk = 19%

1993 Objective

To work with the community towards improving quality and accessibility of water by undertaking the following :

- complete work on Kasemeni-Miyani and Mavirivirini pipelines;
- construct more water pans (mitsara);
- improve/expand existing water pans;
- mobilize local and external resources;
- sample for biological and chemical analysis.

Indicators:

1. % of households with water supply within 15, 30, 31 or more minutes;
2. ammount of water used in a household in one day.

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Information and education on water protection and use	*	-	-	-	-	-	-	-	-	-	-	*	PICs/Peter
. Facilitate community organization for water source development	*	.	.	.	.	.	.	.	.	.	.	*	"
. Mobilize for resources	*	.	.	.	.	.	.	.	.	.	.	*	"
. Construct new pans	*	-	-	*				*	-	-	-	*	"
. Improve old pans	*	-	-	*				*	-	-	-	*	"
. Complete work on pipelines	*	-	-	*									MOW/Peter
. Water quality tests		*	-	-	*			*	-	-	-	*	"
. Assess water accessibility and utilization					*					*			Peter/Fred
. Feedback and replan						*					*		"

ASSUMPTIONS:

1. Community will able to raise finances at their level to pay skilled workers
2. There will be a regular supply of water in the pipelines once completed

7. SANITATION

Status by end of 1992:

- 61% of households had pit latrines;
- diarrhoea disease prevalance among under five year old = 6.25 episodes
- three demonstration VIP latrines constructed.

1993 Objective:

To reduce morbidity due to diarrhoea, bilharzia and intestinal worms by improving human and household waste disposal.

Prevalance of bilharzia and intestinal worms to be established during the year.

Indicators:

1. % of households having access to and using pit latrines;
2. diarrhoea disease prevalance; (5.6 by end of 1992)
3. number of VIP latrines constructed.

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Bilharzia and worms prevalence survey and treatment of those affected					*-----*				*-----*				MOH/TOTs
. Set criteria for assisting individuals for latrine construction		*--*											PICs/PHO
. Awareness barazas			*--------*										PICs/TOTs
. Information and education		*----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------*	TOTs/CBHWs
. Identify sites for demo and training		*-----*											PIC/PHTs
. Mobilize local resources		*----------	----------	----------*									PICs/Chief
. Construct demo latrines and rubbish pits		*---*				*-------*							PHO/PHTs/PI
. Train community members in latrine construction		*---*					*-------*						"
. Monitor activities		*----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------*	PICs/TOTs
. Assess progress					*			*					PICs/Fred
. Feedback and replan						*			*				"

ASSUMPTIONS

1. MOH will provide technical skills for prevalence surveys
2. Community will be willing to build improved latrines and use them

8. SCHOOL HEALTH

Status by end of 1992:

- 24 of 26 primary schools involved in at least 1 CBHC activity;
- 27 teachers trained for the Child to Child approach;
- 7 teachers trained in Counselling and CDD - Home Case Management.

1993 Objective:

To develop Community Based Health Care skills among school pupils and teachers in the 26 primary schools within the project areas.

Indicators:

1. % of pupils and teachers trained and active in CBHC.
2. Reduction of malaria, diarrhoea, bilharzia and ARI morbidity among school pupils.

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Return results of School Health assessment	*												TOTs
. Review school Plans of Action with teachers	*--*												"
. Child-to-Child workshop				*									P. Manager
. Health education and Information e.g GM, treatment	*----------											*	TOT/Teachers
. Provide scales, cards etc	as will be needed												TOTs
. Finalise development of record keeping system	*-----*												Fred/TOTs
. Growth and immunization monitoring	*----------											*	Teacher/Pupils
. Food production, preparation and demostrations	*----------											*	"
. Monitoring and supervision	*----------											*	Teachers/TOTs
. Treat minor ailments	*----------											*	Teachers
. Malaria, Bilharzia treatment and control	*----*			*-------*				*-----*					Teachers/TOT
. AIDS information and education	*------*			*-------*				*-----*					"
. Head Teachers orientation			*										P. Manager
. Oral health promotion	*----------											*	TOTs
. School health assessment					*								Fred
. Assess progress								*					TOTs/Fred

ASSUMPTIONS

1. CBHC/PHC trained teachers will not be transferred from project area
2. Schools will find time/incorporate CBHC activities in the curriculum
3. Head masters will provide adequate support to the teachers and pupils

9. COMMUNITY BASED DRUG SUPPLY

Status by end of 1992:

- 26 people trained and supplying drugs
- 26 more people trained in October

1993 Objective:

To improve home case management of common diseases by improving accessibility of information and common drugs at village level.

Indicators:

1. ratio of trained CBDD to population
2. % of cases which were properly managed at home level (malaria, diarrhoea, worms).
3. % of mothers who know correct signs, symptoms and treatment for malaria, diarrhoea, worms, ARI and malnutrition.

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Monitor and supervise CBDDs	*	-	-	-	-	-	-	-	-	-	-	*	TOTs
. Ensure drug supplies	*	-	-	-	-	-	-	-	-	-	-	*	"
. Information and education at village level for proper Home Case Management		*	-	-	-	-	-	-	-	-	-	*	TOTs/CBDDs
. Train CBD Committess: Kas:					*	-	-	-	-	*			Eva
Mtaa:	*	-	-	-	*								Janet
Mwav:		*	-	-	*					*	-	-	Mwau
. Monitor morbidity and CBDDs treatment		*	-	-	-	-	-	-	-	-	-	*	
. Malaria parasite surveys		*	-	-	*								MOH/DVBI
Train for malaria control				*	-	-	-	-	*				TOTs
. Train 52 more CBDDs							*						TOTs
. Establishment of Community Pharmacies	*	-	-	-	-	-	-	-	-	-	-	*	PIC/TOT
. Monitoring and supervision	*	-	-	-	-	-	-	-	-	-	-	*	"
. Data aggregation and feedback			*			*			*				"/Fre
. Refresher training										*			P.Manage
. Assess CBDDs and system								*					

ASSUMPTIONS:

1. Drugs will continue to be available from UNIC; =

10. ENVIRONMENTAL PROTECTION AND ENERGY CONSERVATION

1993 Objective:

To enhance environmental protection activities in 30% of the 58 village within the project areas.

ACTIVITIES	J F M A M J J A S O N D	ACTOI
. Create awareness about energy conservation and environmental protection	*----------*	TOTs/CBH
. Identify groups for skills development	*--------*	"/PI(
. Discussions to identify Appropriate technology	*--------*	"
. Train for approp tech:	*----------* "	
. Implement activities at village level e.g:	*.....* "	
- tree planting		
- plant nurseries		
- soil erosion control		
- Maendeleo jiko		
. Monitor activities	*----------*	"
. Assess progress	*	"
. Feedback and replanning	*	"

ASSUMPTIONS:

1. Technical advice and skills will be readily available from releva government departments

2. Climate will be favourable

3. Logistic support e.g transport will be adequate

11. INFORMATION GATHERING AND UTILIZATION

1993 Objective:

To improve management of PHC/CBHC activites at community level through developing information gathering and utilization systems with all 3 PICs and at least 30 of the 58 villages.

Indicators:

1. number with villages collecting and utilizing information;
2. availability of records and reports at community level.

ACTIVITIES	J	F	M	A	M	J	J	A	S	O	N	D	ACTOR
. Create awareness among PIC members and villages	*-----*												TOTs/Chiefs
. Identify Information needs		*------*											"/Fred
. Identify who will collect the Information needed			*---------*										"
. Train Information Collectors				*-------*									Fred/TOTs
. Develop information collection formats with community				*-------*									"
. Collect information					*----------*								PICs
. Analyse and produce reports						*	*	*					"/Fred
. Feedback							*	*	*				"
. Assess system									*				"
. Feedback and replanning										*			"

ASSUMPTIONS:

1. Community needs information for various purposes
2. There are people in the community who can collect and utilize information
3. Community know the type of information they need

Accomplishments Versus Targets

Activity	1992 Target	1992 Achieved	Jan - June 1993 Target	Jan - June 1993 Achieved
1. % of villages participating	50.0	69.0	75.0	71.0
2. Monthly PIC meetings (3PICs)	36	21	18	13
3. Train for Safe Motherhood	60	24	50	67
4. Train Community leaders	30	26		
5. TOTs*	15	10	5	3
6. Community Based Drug Distributors; training	30	26	26	19
7. PHC/CBHC training for PTAs, VHCs, Women, etc groups	10	5	7	5
8. Improved food production with volunteer farmers	10	10	100	80
9. FP Focus Group Discussions	23	19		
10. FP education (village level)			15	5
11. MCH/FP Mobile clinics	36	36	18	16
12. Involve 26 Primary and 2 Secondary schools in CBHC	28	28	14	14
13. Lay 17 km of water pipes (3 projects)	17	10	17	13.6
14. Construct Demonstration latrines	13	3	10	7
15. Establish CBMIS	18	12	16	11

Summary of Progress on Key Indicators

		1989	1990	1992
1.	% mothers breastfeeding over 18 months	64.6		84.2
2.	% of babies being given supplementary foods by 6 months of age	30.9		81.3
3.	% of children <2yrs weighed at least 4 times a year		61.5	40.6
4.	% of pregnant women who received ante-natal care at least once	87.3		97.6
5.	% of women receiving delivery care by a trained attendant	18.1		34.4
6.	% of newborns with a sibling under 2 years born to the same mother	10.1		4.4
7.	% of women delivering who were immunized against tetanus	84.8		78.1
8.	% of children 12-23 months fully immunized (crude data)	79.5	79.9	82.2
9.	% of households with clean water supply within:			
	15 minutes walk			
	30 minutes walk			
	over 30 minutes walk	35.1		28.0*
10.	% of households with pit latrines	33.1	40.2	61.0
11.	% of children 0-59 months who are low weight for age	34.7		40.7
12.	% of mothers aware of all the six childhood immunizable diseases	1.2	10.1	7.5
13.	Average annual episodes of diarrhoea	6.2		5.6
14.	% of women of child bearing ages using reliable family planning method	9.8		16.9
15.	% of women of child bearing ages naming at least one family planning method	36.8		77.6

* Distance to water source during the dry season.

See figures 1-5 as well.

DEMOGRAPHIC SURVEILLANCE SYSTEMS
AKCHP

AKCHP Demographic Surveillance System.
Active Household and Population on by Month

	<--------Slum----------> # Population				<--------Mohalla--------> # Population				<--------Total--------> # Population			
Month	# H. Hold	M	F	Total	# H. Hold	M	F	Total	#H. Hold	M	F	Total
Jan'92	1022	2713	2671	5384	1097	2729	2677	5406	2199	5442	5348	10790
Feb'92	1560	4032	3987	8019	2226	5434	5286	10720	3786	9466	9272	18739
Mar'92	2515	6107	6160	12267	2991	7398	7125	14523	5506	13505	13285	26790
Apr'92	2566	6222	6289	12511	3018	2466	7192	14658	5584	13688	13481	27169
May'92	2521	6106	6185	12291	3023	7451	7213	14664	5544	13557	13398	26955
Jun'92	2488	6040	6102	12142	2974	7324	7105	14429	5462	13364	13207	26571
Jul'92	2440	5947	6010	11957	2947	7272	7059	14331	5387	13219	13069	26288
Aug'92	2390	5855	5918	11773	2912	7213	6981	14194	5302	13068	12899	25967
Sep'92	2374	5829	5889	11718	2865	7122	6887	14009	5239	12951	12776	25727
Oct'92	2336	5759	5807	11566	2853	7095	6877	13927	5189	12854	12684	25538
Nov'92	2282	5630	5671	11301	2827	7050	6820	13870	5109	12680	12491	25171
Dec'92	2259	5585	5621	11206	2818	7025	6811	13836	5077	12610	12432	25042

AKCHP Demographic Surveillance System
Demographic Status by Area as of June 1993

	Slum	Mohalla	Total
# active households	2036	2786	4822
# active members	10244	13705	23949
# live births	348	363	711
# deaths	81	50	131
# immigrations	2305	2523	4828
# out migrations	4240	3274	7514

AKCHP Demographic Surveillance System
Demographic Status by CHW as of June 31, 1993

CHW #	# active households	# active members	# live births	# deaths	# in migrants	# out migrants
1	353	1735	45	7	288	350
2	344	1956	60	10	267	228
3	363	1616	59	10	646	1059
4	332	1644	44	4	306	321
5	341	1655	68	8	427	976
6	428	2030	49	10	358	541
7	408	2022	45	9	473	488
8	372	1722	60	14	369	573
9	391	1870	51	6	306	594
10	359	1870	38	13	284	455
11	402	1981	63	10	401	926
12	352	1760	68	12	283	469
13	377	2034	61	18	420	534
Total	4822	23949	711	131	4828	7514

AKCHP Demographic Surveillance System
Number of Population in Different Target Group at 31/12/93

CHW	<2 yrs		<3 yrs		<5 yrs		1-6 yrs		15 - 49 female		Total Population
#	N	%	N	%	N	%	N	%	N	%	
1	90	5.3	138	8.1	238	13.9	193	11.3	429	25.1	1707
2	118	6.1	173	8.9	301	15.4	256	13.1	462	23.7	1949
3	102	5.1	163	8.2	293	14.8	255	12.9	551	27.8	1982
4	83	5.1	126	7.8	212	13.1	169	10.4	447	27.6	1622
5	111	5.5	171	8.5	289	14.3	243	12.0	541	26.7	2023
6	92	4.6	173	8.7	298	15.0	263	13.2	505	25.4	1991
7	119	5.9	184	9.1	305	15.0	234	11.5	525	25.9	2030
8	122	7.0	174	9.9	293	16.8	239	13.7	442	25.3	1749
9	89	4.8	136	7.3	243	13.1	212	11.4	512	27.6	1854
10	96	5.0	161	8.4	284	14.9	237	12.4	481	25.2	1911
11	102	5.0	174	8.5	302	14.7	254	12.4	512	24.9	2055
12	98	5.6	152	8.7	260	14.9	207	11.9	443	25.4	1745
13	110	5.4	167	8.2	289	14.1	243	11.9	504	24.6	2048
Total	1332	5.4	2092	8.5	3607	14.6	3005	12.2	6354	25.8	24666

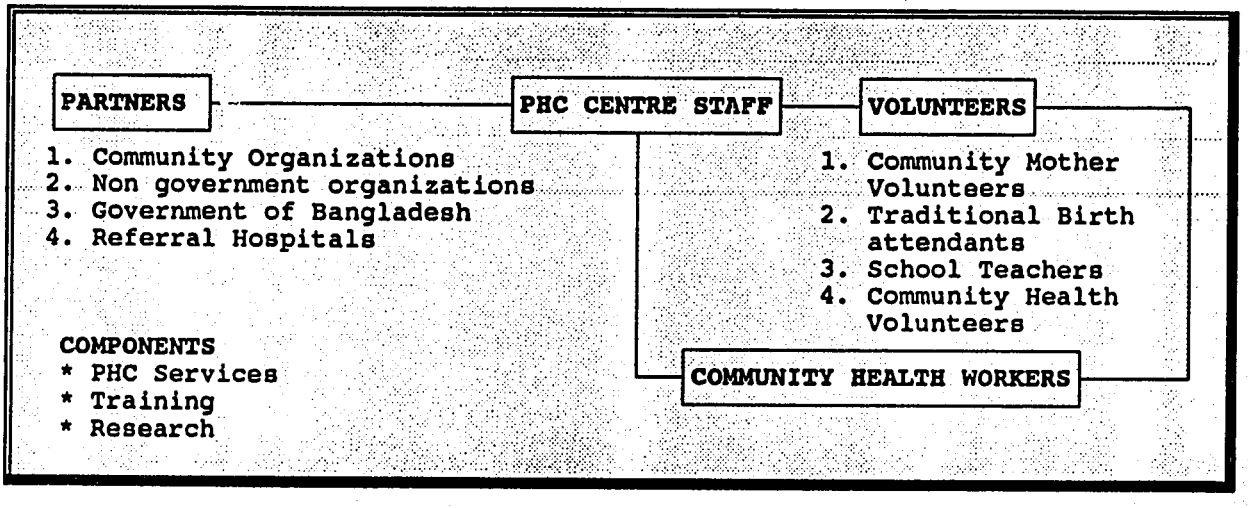
AKCHP Demographic Surveillance System
No. of New Born with Siblings Under 2 Years
Year of Reporting : 1992

of live outcome . . . . . : 550

with siblings < 2 yrs . . . : 59

% with siblings < 2 yrs . . . : 10.7

AKCHP PRIMARY HEALTH CARE MODEL



SOCIO-ECONOMIC DATA
AKCHP

Data on the socio-economic conditions in slums of ward 60 & 62 of Dhaka City (February 1992, April 1992, October 1992, December 1992)

		N	No.hab 100 Spft	House Rent / month (Taka)	Female Ed. * (%)	Male Ed. * (%)	Rick-shaw van-cart Puller (%)	Previous Week's Salary (Taka)	Distress Sale (%)	Value (Taka)	Food Loan (%)	Food Expense (Taka)
Feb' 90	Dhaka-60	365	5.5	407	10.2	20.1	43.9	463	0.3	600	1.9	166
	Dhaka-62	136	5.2	543	19.4	30.6	16.9	404	0.0	0	0.0	178
Apr '90	Dhaka-60	398	6.1	408	8.9	17.4	36.7	394	0.0	-	0.8	174
	Dhaka-62	143	6.0	516	17.6	24.5	19.6	414	0.0	-	1.4	194
Oct' 90	Dhaka-60	394	6.5	456	11.6	19.5	40.1	329	0.3	2500	0.0	180
	Dhaka-62	134	6.5	566	8.5	21.6	18.7	298	0.0	-	0.0	199
Dec '90	Dhaka-60	438	6.6	487	14.5	24.5	36.5	329	0.0	0	0.2	183
	Dhaka-62	106	6.3	746	19.8	28.8	17.9	460	0.0	0	0.0	201

* One year or more of formal education.

TRAINING SUMMARY
AKCHP

Training summary
for the period July'92 - June'93)

Sl. No.	Training Programme	No. of Courses	No. of Attended
1.	CMV Basic Training	3	44
2.	CMV Refresher's Training	12	122
3.	CMV Meetings	23	477
4.	School Teacher's Training	6	52
5.	School Health Education	23	1996
6.	TBA Refresher Training	6	46
7.	TBA Meetings	30	496
8.	CHW/CHO Refresher Training	1	30
9.	Health Education by CMVs	1389	9859
10.	School Teacher's Workshop	1	44
11.	International TOT course	1	18
12.	Applied Epidemiology and Biostatistics course	1	15

THE AGA KHAN COMMUNITY HEALTH PROGRAMME

HEALTH MESSAGE FOR SCHOOL STUDENTS

1. Take vaccine to prevent Tuberculosis, Diphtheria, Tetanus, Pertussis, Polio and Measles
2. Take everyday green leafy vegetables, yellow fruits (eg. a pumpkin, carrot, ripe papaya, ripe mango) and Mola fish to keep your eyes healthy.
3. Start taking oral saline solution (ORS) as soon diarrhea starts and continue until diarrhea stops.
4. Take half liter of Tubewell / Tap water and mix a handful of molasses / sugar in it. Add one pinch of three fingers salt to the solution. The oral saline is ready to drink.
5. Wash your hand with soap or ash before meal and after defecation.
6. Keep your nail short and clean. Take shower daily and wear clean cloths.
7. Do not spit. It spreads diseases.
8. Wash your teeth after getting up from bed in the morning and before going to bed at night.
9. Do not defecate here and there. It spreads diseases. Always use latrine.
10. Plant tree for healthy environment.

আগা খান কমিউনিটি হেলথ প্রোগ্রাম, ছাত্র-ছাত্রীদের স্বাস্থ্য বার্তা

AKCHP PERCENTAGE CHANGE IN EARNINGS 1991 AND 1992

Number of patients, money earned and percentage change in earning in 1991 and 1992

Year	1991	1992	Change (%)
Number of patients	6919	7147	228 (3.2)
Taka earned	54,072	72,628	18,556 (34)

TYPES OF BIRTH ATTENDANTS IN AKCHP AREAS
AKCHP

Types Birth attendant in AKCHP target population (Ward 60 & 62 of Dhaka City Corporation) March 1993

	Number	Percent
AKCHP Trained TBA	293	35.5
Other Trained TBA	40	4.8
Hospital staff (Nurse, Doctor)	190	22.0
Non Trained TBA	292	35.4
Self	10	1.2
Total	825	100

REFERRAL PLACES OF PATIENTS OF SECONDARY CARE AKCHP

Referral places for secondary and tertiary care of the Aga Khan Community Health Programme curative health care delivery system

Sl. no.	Name of hospital	Government/ Non Government	Type:general/specialized
1	Azimpur maternity	Government	Specialized (pregnant and delivery)
2	Dhaka Medical College	Government	General
3	Sir Salimullah Medical College	Government	General
4	Railway Hospital	Government	General
5	Institute of Cardiovascular Diseases	Government	Specialized (heart diseases)
6	Institute of Post Graduate Medicine and Research	Government	General (renal failure cases)
7	Dhaka Shishu Hospital	Non Government	Specialized (Pediatric cases)
8	International Center for Diarrhoea Disease Hospital	Non Government	Specialized (Family Planning methods)
9	Mohammadpur Fertility Center	Non Government	Specialized (Family Planning method)
10	Children Nutrition Unit (SCF, UK)	Non Government	Specialized (malnourished cases)

QV

REFERRAL PLACES
AKCHP

Referral places for pregnant women (April-September'92) N=31

A. Government Hospitals	N	Percent
Dhaka Medical College Hospital	15	48.3
Azimpur Maternity Hospital	11	35.4
Institute of Post graduate Medicine & Research Hospital	3	9.6
Police Hospital	3	9.6
B. Private Clinics		
Rawshan Ara clinic	5	16.1
Lutfunnessa Clinic	3	9.6
Dhaka Maternity	1	3.2
Total	31	100

REASONS FOR REFERRAL
AKCHP

Reasons for referral of pregnant women to different hospitals/clinics (April-September 1992) N=31

Referral Reason	n	Percent
Breech presentation	4	12.9
Absent foetal heart sound	6	19.3
Severe edema	5	16.1
History of caesarian section	2	6.4
History of still born	4	12.9
History of child death	1	3.2
Jaundice	2	6.4
History of tuberculosis	1	3.2
Per vaginal bleeding	1	3.2
Per vaginal discharge	1	3.2
Expected date of delivery overdue	1	3.2
Ultrasonogram for IUD	2	6.4
Pregnancy test	1	3.2
Total	31	100

SUMMARY REPORTS OF MALNOURISHED CASES AKCHP

Summary report of the severe malnourished cases (Oct '92 - March '93)

Nutritional Status	Oct	Nov	Dec	Jan	Feb	Mar	Total
Improved	49	53	48	40	28	33	251
Not improved	13	11	10	8	10	4	56
Deteriorated	9	3	3	1	3	3	23
Malnourished	14	7	7	7	7	3	45
Death	1	1	4	1	0	1	8
Migration out	4	5	2	4	4	2	22
Referred	0	0	0	0	0	0	0
New case	0	7	1	6	4	4	5
Absent	11	3	3	3	1	1	24
Age > 36 months	0	0	1	2	2	1	26
Total	102	90	79	72	59	52	460

AVERAGE REGISTERED FAMILIES MONITORED PER MONTH

FIELD SITE	1989 Regtd	1989 Montd	1989 %	1990 Regtd	1990 Montd	1990 %	1991 Regtd	1991 Montd	1991 %	1992 Regtd	1992 Montd	1992 %
Orangi	1450	1266	87	1480	1167	79	1506	1375	91	1500	1330	89
Chanesar Goth	1670	1408	84	1686	1477	88	1850	1650	89	1913	1698	89
Orax	1285	1188	92	1317	1141	87	1323	1205	91	1353	1203	89
Essa Nagri	1683	1560	93	1720	1396	81	1786	1652	92	1801	1600	89
Azam Basti	1246	1165	93	1316	1121	85	1274	1145	90	1270	1097	86
Total	7334	6587	90	7518	6302	84	7739	7029	91	7837	6928	88

CONSOLIDATED° DEATH STATUS: BY AGE

(MAIN PLUS ASSOCIATED CAUSES)

AGE	MAIN AND ASSOCIATE CAUSE	1989 (n= 43)		1990 (n= 56)		1991 (n= 35)		1992 (n= 45)		TOTAL (n = 179)		
		#	%*	#	%*	%*	%*	%*	%*	#	%*	%**
<1 MONTH	PREMATURITY/LBW	16	37.2	17	30.4	16	45.7	20	44.4	69	38.5	29.9
	BIRTH INJURY/ASPHYXIA	7	16.3	9	16.1	6	17.1	5	11.1	27	15.1	11.7
	DIARRHOEAL SYNDROMES	5	11.6	3	5.4	1	2.9	6	13.3	15	8.4	6.5
	ARI/PNEUMONIA	2	4.7	3	5.4	1	2.9	5	11.1	11	6.1	4.8
	CONGENITAL MALFORMATION	1	2.3	3	5.4	3	8.6			7	3.9	3.0
	JUNDICE/HEPATITIS	3	7.0							3	1.7	1.3
	ACUTE ABDOMEN/INTESTL. OBST.	1	2.3			1	2.9			2	1.1	0.9
	MALNUTRITION	1	2.3							1	0.6	0.4
	BRAIN INFECTION			1	1.8			3	6.7	4	2.2	1.7
	OTHERS	15	34.9	7	12.5	2	5.7	2	4.4	26	14.5	11.3
	EPI PREVENTABLE DISEASES:	2	4.7	1	1.8			1	2.2	4	2.2	1.7
	Neonatal Tetanus	*2*	*4.7*	*1*	*1.8*			*1*	*2.2*	*4*	*2.2*	*1.7*
	UNKNOWN OR ILL-DEFINED SYNDROMES:	19	44.2	18	32.1	14	40.0	11	24.4	62	34.6	26.8
	Unknown	*14*	*32.6*	*17*	*30.4*	*8*	*22.9*	*8*	*17.8*	*47*	*26.3*	*20.3*
	Breathing Problem	*4*	*9.3*	*1*	*1.8*	*5*	*14.3*			*10*	*5.6*	*4.3*
	Unknown & Fever	*1*	*2.3*			*1*	*2.9*	*3*	*6.7*	*5*	*2.8*	*2.2*
	TOTAL	72	167.4	62	110.7	44	125.7	53	117.8	231	129.1	100.0
1 MONTH TO <1 YEAR		(n= 57)		(n= 82)		(n= 57)		(n= 64)		(n = 260)		
	DIARRHOEAL SYNDROMES	26	45.6	51	62.2	31	54.4	38	59.4	146	56.2	34.6
	MALNUTRITION	11	19.3	34	41.5	20	35.1	23	35.9	88	33.8	20.9
	ARI/PNEUMONIA	5	8.8	13	15.9	15	26.3	11	17.2	44	16.9	10.4
	PREMATURITY/LBW	3	5.3	11	13.4	10	17.5	18	28.1	42	16.2	10.0
	ACCIDENT/INJURY	1	1.8	1	1.2	1	1.8			3	1.2	0.7
	CONGENITAL MALFORMATION	1	1.8	2	2.4			2	3.1	5	1.9	1.2
	JAUNDICE/HEPATITIS					1	1.8			1	0.4	0.2
	RHEUMATIC/CONGL. HEART DIS.	2	3.5							2	0.8	0.5
	BIRTH INJURY/ASPHY.	1	1.8							1	0.4	0.2
	ACUTE ABDOMEN/INTESTL. OBST.											
	BRAIN INFECTION							2	3.1	2	0.8	0.5
	OTHERS	16	28.1	5	6.1	5	8.8	4	6.3	30	11.5	7.1

° Note that numbers refer to number of diagnoses, not numbers of patients.

* Percent of cases (denominator, n) dying with the given cause (totals exceed 100%)

** Percent of consolidated diagnoses (main plus associated) due to the given cause (total= 100%)

CONTD...

CONSOLIDATED° DEATH STATUS: BY AGE
(MAIN PLUS ASSOCIATED CAUSES)

AGE	MAIN AND ASSOCIATE CAUSE	1989 (n=40)		1990 (n=29)		1991 (n=28)		1992 (n=35)		TOTAL (n = 132)		
		#	%*	#	%*	%*	%*	%*	%*	#	%*	%**
	EPI PREVENTABLE DISEASES:							2	5.7	2	1.5	1.1
	Measles							*2*	*5.7*	*2*	*1.5*	*1.1*
	UNKNOWN OR ILL-DEFINED SYNDROMES:	12	30.0	7	24.1	10	35.7	7	20.0	36	27.3	19.0
	Unknown	*7*	*17.5*	*7*	*24.1*	*6*	*21.4*	*2*	*5.7*	*22*	*16.7*	*11.6*
	Breathing Problem	*3*	*7.5*							*3*	*2.3*	*1.6*
	Unknown & Fever	*2*	*5.0*			*4*	*14.3*	*5*	*14.3*	*11*	*8.3*	*5.8*
	TOTAL	60	150.0	33	113.8	43	153.6	54	154.3	189	143.2	100.0

° Note that numbers refer to number of diagnoses, not numbers of patients.

* Percent of cases (denominator, n) dying with the given cause (totals exceed 100%)

** Percent of consolidated diagnoses (main plus associated) due to the given cause (total= 100%)

CONTD...

CONSOLIDATED° DEATH STATUS: BY AGE
(MAIN PLUS ASSOCIATED CAUSES)

AGE	MAIN AND ASSOCIATE CAUSE	1989 (n= 57)		1990 (n= 82)		1991 (n= 57)		1992 (n= 64)		TOTAL (n = 260)		
		#	%*	#	%*	%*	%*	%*	%*	#	%*	%**
	EPI PREVENTABLE DISEASES:			4	4.9	1	1.8			5	1.9	1.2
	Measles			*4*	*4.9*					*4*	*1.5*	*0.9*
	Pertussis					*1*	*1.8*			*1*	*0.4*	*0.2*
	UNKNOWN OR ILL-DEFINED SYNDROMES:	18	31.6	12	14.6	9	15.8	14	21.9	53	20.4	12.6
	Unknown	*8*	*14.0*	*9*	*11.0*	*5*	*8.8*	*9*	*14.1*	*31*	*11.9*	*7.3*
	Breathing Problem	*6*	*10.5*						*0.0*	*6*	*2.3*	*1.4*
	Unknown & Fever	*4*	*7.0*	*2*	*2.4*	*4*	*7.0*	*5*	*7.8*	*15*	*5.8*	*3.6*
	Haemorrhage			*1*	*1.2*					*1*	*0.4*	*0.2*
	TOTAL	84	147.4	133	162.2	93	163.2	112	175.0	422	162.3	100.0
1-<5 YEARS		(n= 40)		(n= 29)		(n= 28)		(n= 35)		(n = 132)		
	DIARRHOEAL SYNDROMES	17	42.5	16	55.2	10	35.7	20	57.1	63	47.7	33.3
	MALNUTRITION	10	25.0	4	13.8	9	32.1	12	34.3	35	26.5	18.5
	ARI/PHEUMONIA	6	15.0	3	10.3	3	10.7	2	5.7	14	10.6	7.4
	ACCIDENT/INJURY	1	2.5	1	3.4	4	14.3	2	5.7	8	6.1	4.2
	RHEUMATIC/CONGL. HEART DIS.	2	5.0							2	1.5	1.1
	ACUTE ABDOMEN/INTESTL. OBST.	1	2.5							1	0.8	0.5
	PREMATURITY/LBW					1	3.6	1	2.9	2	1.5	1.1
	JAUNDICE/HEPATITIS											
	BRAIN INFECTION			1	3.4							
	CANCER	1	2.5							1	0.8	0.5
	OTHERS	10	25.0	1	3.4	6	21.4	8	22.9	25	18.9	13.2

° Note that numbers refer to number of diagnoses, not numbers of patients.
* Percent of cases (denominator, n) dying with the given cause (totals exceed 100%)
** Percent of consolidated diagnoses (main plus associated) due to the given cause (total= 100%)

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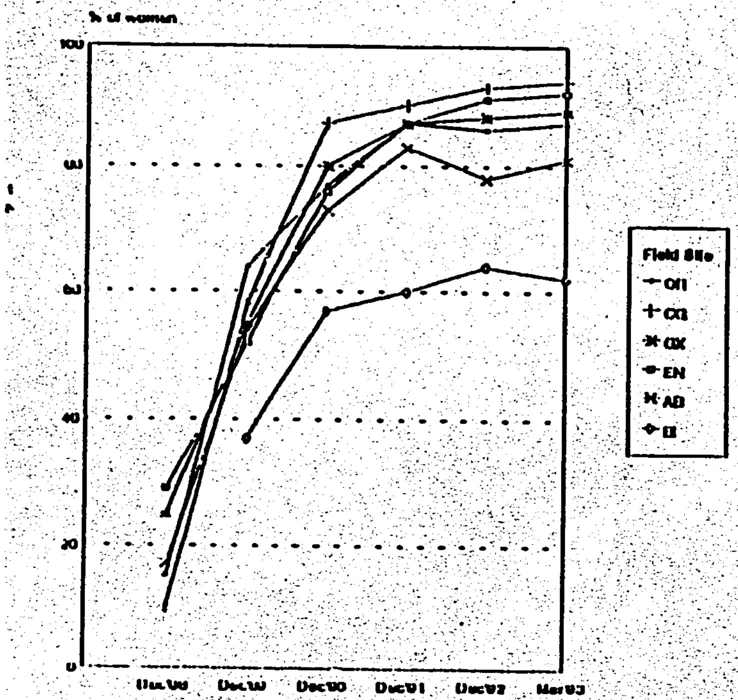
IMMUNIZATION COVERAGE
Under 5 children

		<5 children				<1 children		
		Dec 1988	Dec 1989	Dec 1990	Dec 1991	Sep 1992	Dec 1992	Mar 1993
ORANGI	Total (#)	1481	1563	1511	1389	247	255	246
	Complete (%)	74	82	73	76	11	19	18
	Appropriate (%)	7	7	13	13	43	49	50
	Incomplete (%)	10	6	9	7	30	16	18
	None (%)	9	5	5	4	16	16	14
CHANESAR GOTH	Total (#)	1813	1817	1801	1875	380	350	328
	Complete (%)	63	70	68	70	15	9	13
	Appropriate (%)	9	12	17	13	68	68	66
	Incomplete (%)	26	13	11	13	9	10	15
	None (%)	2	5	4	4	9	13	6
GRAX	Total (#)	1328	1417	1332	1297	244	265	260
	Complete (%)	65	70	69	72	16	12	18
	Appropriate (%)	9	11	11	10	34	42	47
	Incomplete (%)	18	12	15	13	34	26	20
	None (%)	8	7	5	5	16	20	14
ESSA NAGRI	Total (#)	1811	2055	1993	2000	463	438	406
	Complete (%)	51	60	66	67	20	24	15
	Appropriate (%)	10	12	16	17	57	56	64
	Incomplete (%)	25	14	13	11	6	8	8
	None (%)	14	14	5	5	17	13	14
AZAM BASTI	Total (#)	1202	1419	1361	1255	268	272	256
	Complete (%)	51	71	78	79	26	24	21
	Appropriate (%)	13	12	11	12	55	59	57
	Incomplete (%)	22	11	7	7	13	10	17
	None (%)	14	6	4	2	6	7	5
TOTAL	Total (#)	7635	8271	7998	7816	1602	1580	1496
	Complete (%)	63	70	70	72	18	18	17
	Appropriate (%)	9	11	14	13	54	56	58
	Incomplete (%)	20	11	11	11	16	13	15
	None (%)	8	8	5	4	13	14	11
BABA ISLAND	Total (#)		782	632		148	133	100
	Complete (%)		33	43		3	9	3
	Appropriate (%)					9	12	5
	Incomplete (%)		32	39		56	53	62
	None (%)		35	18		32	20	30

Note: Immunization coverage was being calculated for <5 children till June 1992.
From September 92 it is being calculated for <1 children.

T.T. IMMUNIZATION COVERAGE WOMEN 15 - 49 YEARS

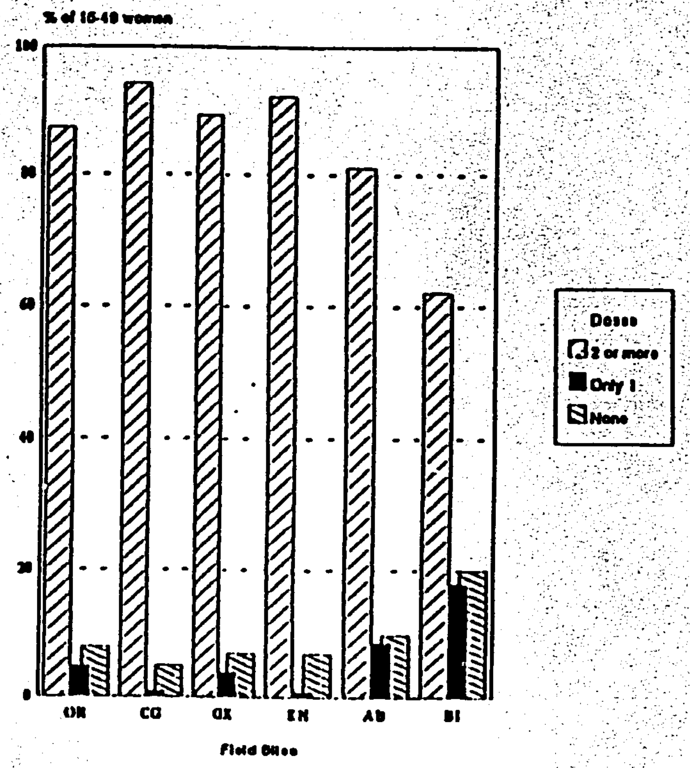
TRENDS FOR COMPLETE CATEGORY



[illegible] data is only for married women
[illegible] in Mar'93. OR=1099, CG=1514, GX=1119, EN=1505, AB=1199 & BI=1379

BY COVERAGE CATEGORIES

MARCH 1992



Total married women in March 1993:
OR=1099, CG=1514, GX=1119, EN=1505, AB=1199 & BI=1379

101

NUTRITIONAL STATUS
UNDER 5 CHILDREN

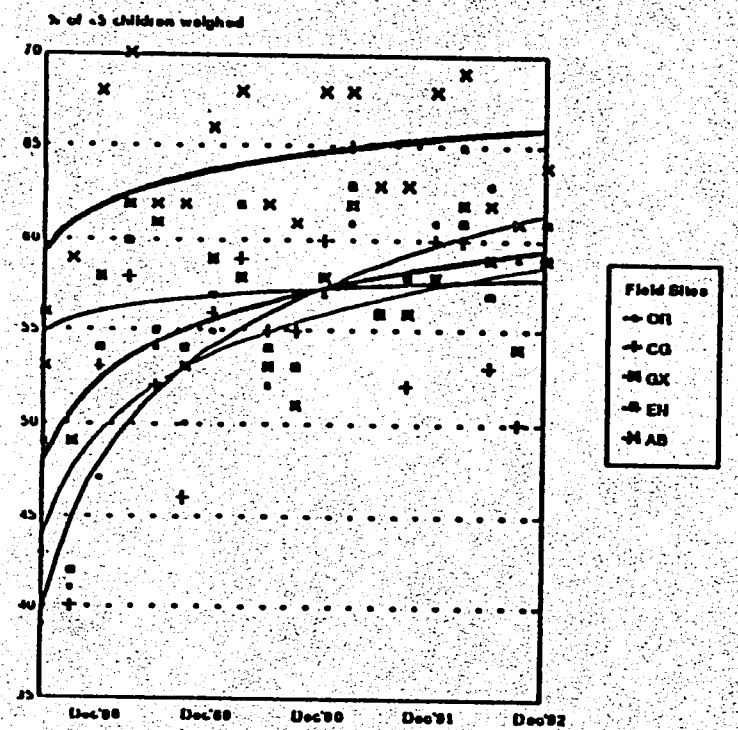
	Dec 1988		Dec 1989		Dec 1990		Dec 1991		Dec 1992	
	#	%	#	%	#	%	#	%	#	%
ORANGI										
Total	1481		1563		1511		1389		1317	
Children Weighed	1405	95	1302	83	1209	80	1195	86	1068	81
Nutritional Status										
Normal	661	47	713	55	694	57	727	61	650	61
I	628	45	493	38	417	34	408	34	360	34
II	104	7	82	6	84	7	52	4	47	4
III	12	1	14	1	14	1	8	1	11	1
Weight Change*										
Gained +			884	68	904	79	971	83	882	84
Stable 0			334	26	165	14	157	13	112	10
Loss -			58	4	74	6	38	3	51	5
CHANESAR GOTH										
Total	1813		1817		1801		1875		1810	
Children Weighed	1679	93	1489	82	1592	88	1639	87	1486	82
Nutritional Status										
Normal	883	53	841	56	952	60	976	60	880	59
I	555	33	502	34	509	32	503	31	479	32
II	199	12	125	8	102	6	136	8	105	7
III	42	3	21	1	29	2	24	1	22	1
Weight Change*										
Gained +			1054	71	1184	75	1150	71	1075	73
Stable 0			228	15	193	12	310	19	271	18
Loss -			181	12	192	12	156	10	118	8
GRAX										
Total	1328		1417		1332		1297		1274	
Children Weighed	1165	88	1143	81	1077	81	1000	77	995	78
Nutritional Status										
Normal	673	58	676	59	628	58	580	58	588	59
I	420	36	372	33	363	34	344	34	319	32
II	60	5	78	7	66	6	61	6	75	8
III	12	1	17	1	20	2	15	2	13	1
Weight Change*										
Gained +			755	66	935	88	805	83	839	86
Stable 0			211	18	41	4	83	8	39	4
Loss -			177	15	85	8	85	9	92	9

	Dec 1988		Dec 1989		Dec 1990		Dec 1991		Dec 1992	
	#	%	#	%	#	%	#	%	#	%
ESSA NAGRI										
Total	1811		2055		1993		2000		1922	
Children Weighed	1675	92	1682	82	1844	93	1749	87	1692	88
Nutritional Status										
Normal	904	54	959	57	1068	58	1009	58	1032	61
I	639	38	616	37	659	36	623	36	555	33
II	112	7	93	6	105	6	98	6	90	5
III	20	1	14	1	12	1	19	1	15	1
Weight Change*										
Gained +			1255	75	1447	79	1373	79	1418	84
Stable 0			221	13	247	13	210	12	160	9
Loss -			179	11	144	8	146	8	104	6
AZAM BASTI										
Total	1202		1419		1361		1255		1269	
Children Weighed	1068	89	1274	90	1164	86	1106	88	1049	83
Nutritional Status										
Normal	721	68	837	66	792	68	754	68	669	64
I	309	29	381	30	320	27	314	28	336	32
II	34	3	50	4	48	4	33	3	38	4
III	4	0.4	6	0.5	4	0.3	5	0.5	6	0.6
Weight Change*										
Gained +			1069	84	1040	91	948	89	950	93
Stable 0			64	5	45	4	63	6	38	4
Loss -			109	9	59	5	60	5	33	3
TOTAL										
Total	7635		8271		7998		7816		7592	
Children Weighed	6992	92	6890	83	6886	86	6689	86	6290	83
Nutritional Status										
Normal	3842	55	4026	58	4134	60	4046	60	3819	61
I	2551	36	2364	34	2268	33	2192	33	2049	33
II	509	7	428	6	405	6	380	6	355	6
III	90	1	72	1	79	1	71	1	67	1
Weight Change*										
Gained +			5017	73	5510	80	5247	80	5164	84
Stable 0			1058	15	699	10	823	12	620	10
Loss -			704	10	554	8	485	7	398	6

* Denominator is the number of children weighed at least once in the last quarter and in this quarter.

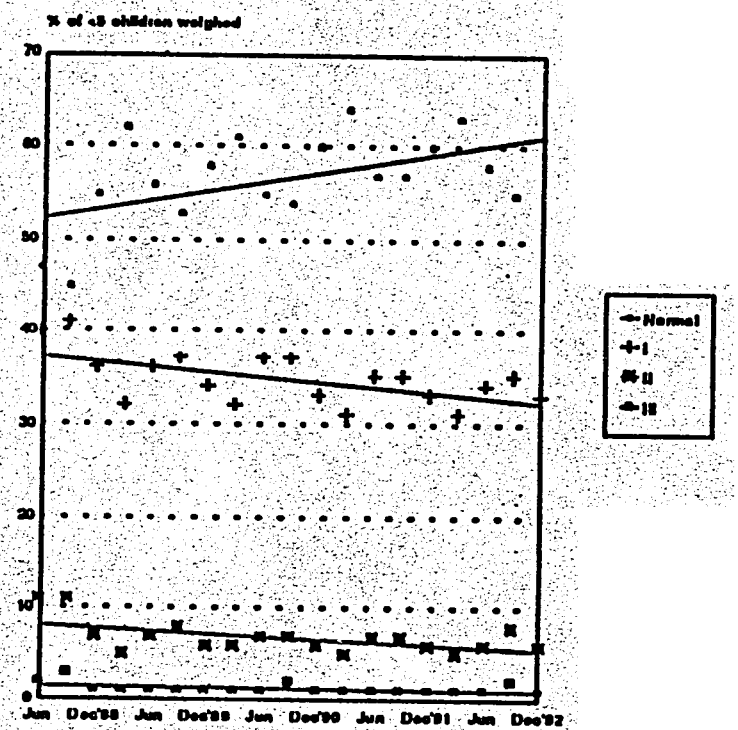
NUTRITIONAL STATUS OF < 5 CHILDREN

NORMAL CATEGORY BY WEIGHT FOR AGE
(GOMEZ CLASSIFICATION)



Children weighed in December 1992
CH=1008, CG=1469, GX=985, EN=1692, AB=1049

ALL FIELD SITES



TRADITIONAL BIRTH ATTENDENTS AND DELIVERIES

		July-Dec 1991		Jan-June 1992		July-Dec 1992	
		#	%	#	%	#	%
Orangi *	Total # of deliveries	156		125		144	
	Total Trained TBAs	0		6		6	
	No. of deliveries done by: (% of delv.)						
	- Trained TBAs	0		55	44	41	29
	- Other trained personnel	97	62	58	46	81	56
	Avg. # of TBAs Reported deliveries	0		2	33	1	17
	# of Delv. Repot.by TBAs within 48 hours after Birth	0		8	15	2	5
Chanesar Goth	Total # of deliveries	201		178		192	
	Total Trained TBAs	7		4		10	
	No. of deliveries done by: (% of delv.)						
	- Trained TBAs	46	23	65	37	70	36
	- Other trained personnel	59	29	80	45	96	50
	Avg. # of TBAs Reported deliveries	1	14	1	25	3	30
	# of Delv. Repot.by TBAs within 48 hours after Birth	5	11	2	3	10	14
Grax	Total # of deliveries	135		133		156	
	Total Trained TBAs	14		13		13	
	No. of deliveries done by: (% of delv.)						
	- Trained TBAs	80	59	61	46	69	44
	- Other trained personnel	49	36	55	41	58	37
	Avg. # of TBAs Reported deliveries	12	86	10	77	9	69
	# of Delv. Repot.by TBAs within 48 hours after Birth	66	83	47	77	42	61
Essa Nagri	Total # of deliveries	213		168		208	
	Total Trained TBAs	12		10		10	
	No. of deliveries done by: (% of delv.)						
	- Trained TBAs	97	46	97	58	116	56
	- Other trained personnel	33	15	36	21	60	29
	Avg. # of TBAs Reported deliveries	6	50	7	70	7	70
	# of Delv. Repot.by TBAs within 48 hours after Birth	63	65	66	68	66	57
Azam Basti	Total # of deliveries	142		105		125	
	Total Trained TBAs	10		10		9	
	No. of deliveries done by: (% of delv.)						
	- Trained TBAs	21	15	30	29	23	18
	- Other trained personnel	51	36	44	42	85	68
	Avg. # of TBAs Reported deliveries	6	60	5	50	5	56
	# of Delv. Repot.by TBAs within 48 hours after Birth	6	29	15	50	16	70
Total	Total # of deliveries	847		709		825	
	Total Trained TBAs	43		43		48	
	No. of deliveries done by: (% of delv.)						
	- Trained TBAs	263	33	308	43	319	39
	- Other trained personnel	289	34	273	39	380	46
	Avg. # of TBAs Reported deliveries	25	58	25	58	25	52
	# of Delv. Repot.by TBAs within 48 hours after Birth	140	50	138	45	136	43

* Orangi trained a new batch of TBAs in November 1991.

FAMILY PLANNING AND BIRTH RATE

		Baseline		Dec'89		Dec'90		Dec'91		Dec'92	
		#	%	#	%	#	%	#	%	#	%
Orangi:	Married women practicing * FP in Regd.area	**		280	22	291	23	412	35	395	34
	Pregnant women (% or married Women)			141	11	136	11	143	12	92	8
	Crude Birth Rate(past yr)	43.1		28		32		28		28	
Ch. Goth:	Married women practicing FP in Regd.area	26	7.4	198	13	233	15	321	20	439	29
	Pregnant women (% or married Women)			151	10	117	8	153	10	113	7
	Crude Birth Rate(past yr)	40.7		27		31		29		31	
Grax:	Married women practicing FP in Regd.area	20	6.2	133	18	201	19	213	20	239	22
	Pregnant women (% or married Women)			94	9	92	9	107	10	96	9
	Crude Birth Rate(past yr)	35.4		32		38		29		33	
E. Nagri:	Married women practicing FP in Regd.area	41	11.7	142	9	260	17	379	25	500	33
	Pregnant women (% or married Women)			164	10	161	11	379	25	156	10
	Crude Birth Rate(past yr)	43.8		33		35		34		33	
A. Basti:	Married women practicing FP in Regd.area	89	14.7	229	18	165	14	310	27	289	24
	Pregnant women (% or married Women)			120	10	114	9	93	8	88	7
	Crude Birth Rate(past yr)	41.1		31		33		33		28	
Total:	Married women practicing FP in Regd.area			1042	16	1140	21	1635	25	1860	29
	Pregnant women (% or married Women)			570	10	820	10	885	14	548	8
	Crude Birth Rate(past yr)	40.8		30		34		31		31	

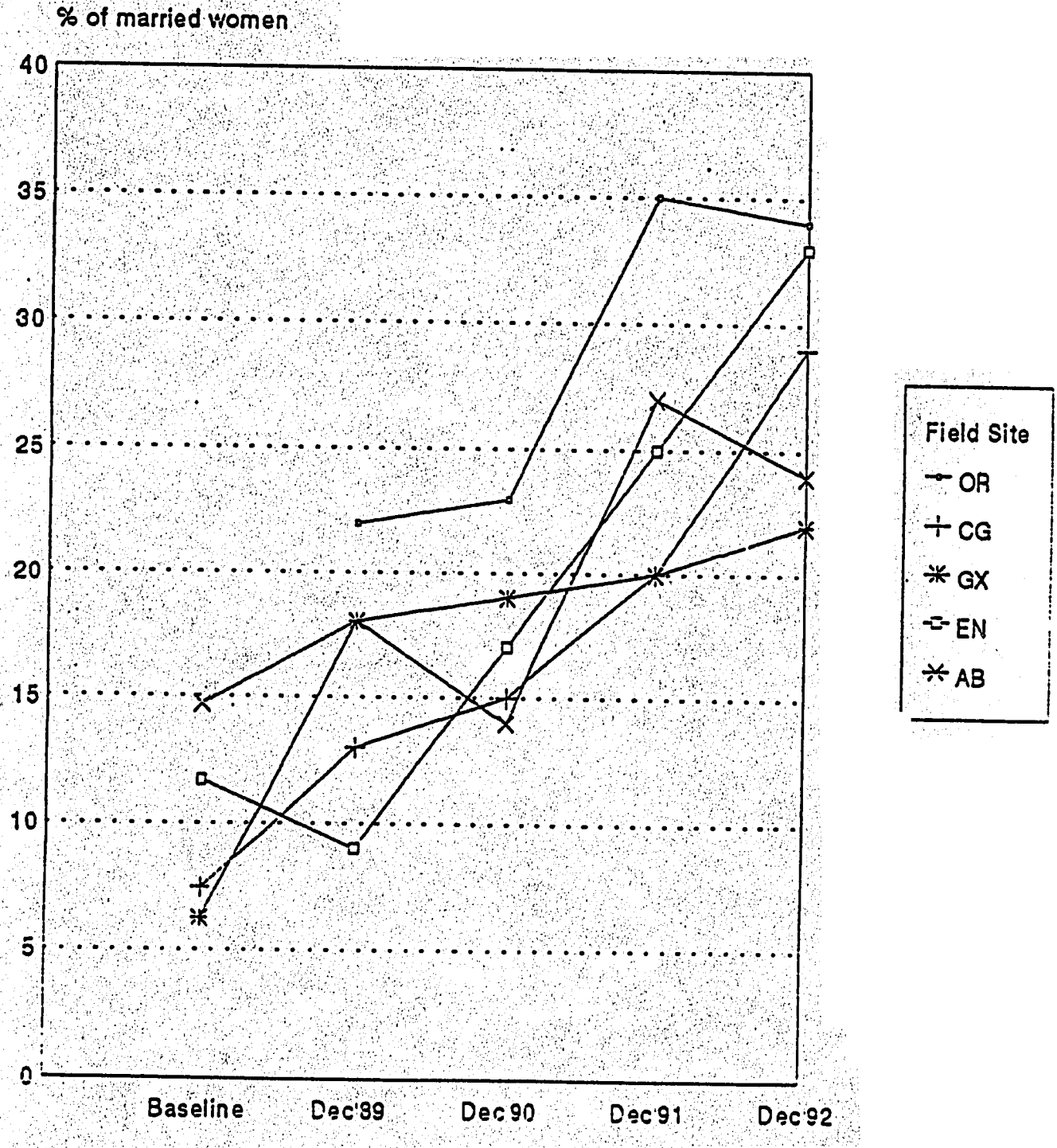
* Denominator includes pregnant women

FAMILY PLANNING PREVALENCE BY METHOD
DECEMBER 1992

		Total married women	FAMILY PLANNING METHODS USED						
			Pills	Condoms	Injection	IUD	TL	Other	Total
Orangi	#	1169	50	148	15	44	138	0	395
	%	12	13	37	4	11	35	0	34
Chanesar Goth	#	1534	23	67	56	57	197	36	438
	%	13	5	15	13	13	45	8	29
Grax	#	1036	19	54	14	9	143	0	239
	%	13	8	23	6	4	60	0	22
Essa Nagri	#	1502	17	154	35	40	250	4	500
	%	14	3	31	7	8	50	1	33
Azam Basti	#	1207	17	94	13	49	116	0	289
	%	15	6	33	4	17	40	0	24
Total	#	6508	126	517	133	199	844	42	1861
	%	13	7	28	7	11	45	2	29

CONTRACEPTIVE PREVALENCE

TRENDS

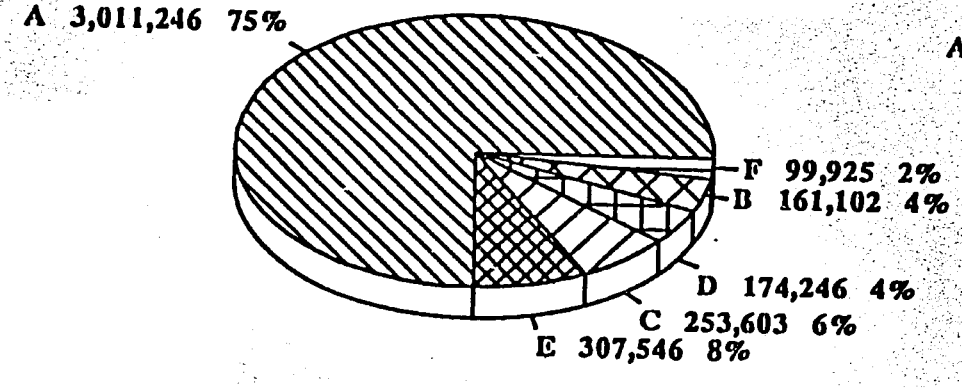


Number of married women practicing FP in Decmember 1992:
OR=395, CG=438, GX=239, EN=500 & AB=289

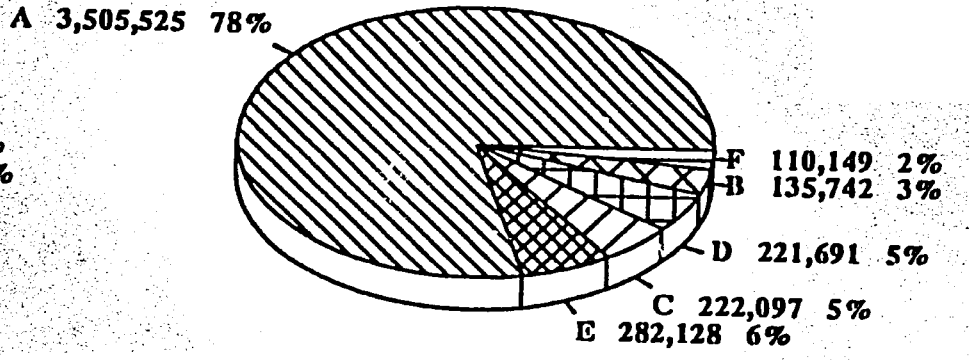
ANNUAL COSTS

CONTRIBUTION BY ALL(AKU, Community, govt., others)

1991



1992



A: Salaries, B: Drugs, C: Medical supplies
D: Other Supplies, E: Transport, Rent, Utilities
F: Depreciation on Capital

1992 TOTAL EXPENSES URBAN PHC PROGRAM
Contribution by All -- (AKU, Community, Govt.)

EXPENSES		ORANGI Rs.	%	CHANESAR GOTH Rs.	%	GRAX Rs.	%	ESSA NAGRI Rs.	%	AZAM BASTI Rs.	%	TOTAL EXPENSES Rs.	%	BABA ISLAND Rs.	%
SALARIES & BENEFITS:															
Field Staff	1	173,002	20	171,489	20	161,952	19	195,436	25	181,458	16	883,237	20		
Other PHC Team Members	2	482,719	56	508,010	58	509,836	61	394,996	51	552,951	49	2,448,512	55	287,590	53
Instructors	3	14,000	2	22,032	3	9,792	1	14,892	2	110,060	10	170,776	4		
Volunteers Time	4					1,500	0.2	1,500	0.2			3,000	0.1	138,300	25
Total Salaries		669,721	77	701,531	80	682,980	82	606,824	78	844,469	75	3,505,525	78	425,890	78
SUPPLIES AND G&A EXPENSES:															
Office Supplies	5	18,162	2	17,362	2	14,625	2	16,870	2	21,787	2	88,806	2	5,594	1
Other Supplies	6	3,559	0.4	2,377	0.3	2,252	0.3	3,490	0.5	5,350	0.5	17,028	0.4		
Other G & A	7	13,887	2	12,269	1	11,970	1	9,483	1	15,680	1	63,289	1	616	0.1
Training	8	12,615	1	3,733	0.4	12,737	2	12,264	2	11,219	1	52,568	1	182	0.03
Medical Supplies															
Drugs		26,001	3	34,311	4	16,269	2	12,059	2	47,102	4	135,742	3	16,272	3
ORS	9	6,110	1	6,599	1	6,273	1	8,743	1	8,262	0.7	35,986	1	7,800	1
Vaccines	10	21,848	3	21,000	2	14,860	2	30,630	4	33,177	3	121,515	3	14,077	3
Family planning supp		236	0.03	2,108	0.2	1,657	0.2	2,829	0.4	1,454	0.1	8,294	0.2		
Med/Surg.Supp	11	10,784	1	9,615	1	6,695	1	10,164	1	19,054	2	56,312	1	4,114	1
TRANSPORT,RENT AND UTILITIES :															
Vehicle Running Exp	12	23,247	3	12,868	1	15,661	2	10,997	1	13,767	1	76,540	2	13,003	2
Boat														15,840	3
Rent and Utilities	13	36,670	4	32,329	4	23,706	3	32,398	4	75,495	7	205,538	5	7,200	1
Total		173,119	20	154,570	18	131,705	16	149,917	19	252,347	22	861,658	19	84,698	16
TOTAL RECUR. EXPENSES:		842,940	97	856,101	98	814,685	97	756,741	98	1,096,816	99	4,367,183	99	510,588	94
DEPRECIATION ON CAPITAL :	14														
Furniture & Fixture		5,879	1	5,938	1	5,571	0.7	5,934	0.8	8,209	0.7	31,531	0.7	2,725	0.5
Equipment		3,050	0.4	3,846	0.4	3,959	0.5	4,662	0.6	13,374	1	28,891	0.6	5,355	1
Vehicles		12,880	1	7,000	1	12,880	2	7,000	0.9	7,000	1	46,760	1	7,000	1
Building				867	0.1					2,100	0.2	2,967	0.1	18,000	3
Total depreciation		21,809	3	17,651	2	22,410	3	17,596	2	30,683	2	110,149	2	33,080	6
TOTAL FIELD :		864,549	100	873,752	100	837,095	100	774,337	100	1,127,499	100	4,477,332	100	543,668	100
COST PER CAPITA :	15														
Total population		91		77		100		71		144		93		82	
Target population		308		240		332		216		417		232			
AKU CENTRAL EXPENSES	16	203,425		203,425		203,425		203,425		203,425		1,317,125		203,425	
COMMUITY MGNT. TIME	17													14,000	
TOTAL FIELD & CENTRAL :		[illegible]		[illegible]		1,040,520		[illegible]		1,330,924		[illegible]		761,093	
COST PER CAPITA :															
Total population		[illegible]		95		124		[illegible]		[illegible]		[illegible]		[illegible]	
Target population		[illegible]		299		[illegible]		[illegible]		[illegible]		[illegible]			

4:\COST'92
MAIN-EXP.WK1

[illegible]-Jul-93

PURPOSE OF INSTRUMENTS

MATERNAL AND CHILD:

1. MCH CARD :

CHILD SECTION:

- To identify and monitor high risk children.
- To monitor the growth of the child and promote nutrition from birth up to three years of age.
- To aid the health worker in assessing the need for special care and referral.
- To promote and help the mother monitor growth and development of her child.

MOTHER SECTION :

- To identify and monitor high pregnancies.
- To aid the health worker in assessing the need for special care and referral.
- To provide health education for the mother herself and help her to monitor her own pregnancy.
- To establish better communication between the Dia, the mother, the health facility and the referral hospital.

2. MATERNAL REGISTER:

- To facilitate the monitoring of pregnant women and follow up high risk women and neonate by LHV/CHN/CHD.
- To have a concise history of the antenatal women available at the center.
- To facilitate aggregation and reporting.

CLINICAL:

1. REGISTRATION TOKEN:

- To serve as a ID card for a registered family.
- To provide a link between the preventive and curative system.

- To help referral and follow_up of patients.

2. INDIVIDUAL CLINICAL TREATMENT RECORD:

   - To record information for patient management.

3. CLINICAL TREATMENT RECORD:

   - To help in summarizing information for preparation of quarterly report.

4. DRUG USE RECORD:

   - To document daily & monthly drug dispensed for inventory control.
   - To monitor prescription patterns.

5. LAB REGISTER:

   - To monitor the number of laboratory examinations performed.
   - To facilitate the aggregation for laboratory data.

6. DAILY EPI REGISTER:

   - To monitor number of people coming in for immunization services.
   - To report type and number of vaccinations given to EPI.

7. OTHER CLINICAL RECORD REGISTER (FOR ANC AND FP):

   - To monitor utilization of ANC and FP services.
   - To monitor utilization of family planning supplies.
   - To facilitate aggregation and report.

OVERALL:

1. FAMILY FOLDER (will soon be changed to family profile):

   - To register the family.
   - To get a demographic break down & identify the target population.
   - To get an overall risk status of the family.

2. MIGRATION:

- To keep track of migrations & update the catchment and target population figures.

3. CHW ACTIVITY REGISTER:

- To help CHW monitor the health status of her target population.
- To help CHW evaluate her own performance.
- To help LHVs/CHNs identify problems and support the CHW.
- To help in summarizing information for preparation of quarterly report.

4. MEETING REGISTER/TRAINING REGISTER:

MEETING

- To monitor the number of meetings held with TBAs, number of TBAs attending and the issues discussed.
- To monitor the number of lane meetings conducted, the number of people participating and the topics covered.
- To monitor the number of other meetings held.

TRAINING

- To monitor the number of training sessions held, the number of people trained and the topics covered during the training.

5. REHABILITATION WORKER'S ACTIVITY REGISTER:

- To follow-up the handicapped and monitor them in terms of number and % meeting objectives.
- To help in summarizing information for preparation of quarterly report.
- To monitor the number of sessions handicapped and the number of participants.
- To monitor the number of volunteers actively participating in the rehabilitation activities.
- To monitor the number of NGO's collaborating in the program.

6. COMMUNITY COORDINATOR'S ACTIVITY REGISTER:

- To follow-up the trained volunteers to see the number and % active.
- To monitor the involvement of the active volunteers and the community leaders.
- To monitor the collaboration of the NGOs and other organizations with the PHC activities.
- To monitor the working of the number of women's groups formed.

REPORTS

1. DEATH REPORT (verbal autopsy):

- To identify causes and risk factors leading to death.
- To generate cause specific death rate.

2. QUARTERLY REPORT:

- To report activities performed.
- To monitor progress.
- To identify problems areas & achievements.

3. PIE REPORT:

- To plan activities and resources needed.
- To monitor progress.
- To evaluate achievements.

Urban Primary Health Care Programme

سینٹر کا نام
تحصیل / قصبہ
ضلع

ماں اور بچے کا صحت کارڈ

رجسٹریشن نمبر ___ - ___ - ___

ماں کا نام
شوہر کا نام
پتہ / گاؤں
لیڈی ہیلتھ ورکر / دائی کا نام

کل پیدائش بچے

15	14	13	12	11	10	9	8	7	6	5	4	3	2	1	0

زندہ ...... ضائع ......

سب سے چھوٹے بچے کی عمر 2 سال سے کم	نہیں ☐	ہاں ☐
3 یا اس سے زیادہ بچے ضائع ہونے	نہیں ☐	ہاں ☐
بچہ مردہ پیدا ہونے ...... تعداد	نہیں ☐	ہاں ☐
ماں کی عمر	18 سے 35 سال ☐	18 سال سے کم یا 35 سال سے زیادہ ☐
قد		
وزن 40 کلوگرام سے کم	نہیں ☐	ہاں ☐
خون کا گروپ	آر ایچ پازیٹو ☐	آر ایچ نیگیٹو ☐
خطرے کی علامات	5 4 3 2 1 0	

موجودہ اور گذشتہ صحت کی معلومات

کوئی بیماری
	نہیں ☐	ہاں ☐

تفصیل

کیا ماں کوئی دوا استعمال کر رہی ہے

	نہیں ☐	ہاں ☐

تفصیل

گذشتہ تمام حمل کی معلومات

آپریشن	نہیں ☐	ہاں ☐
وضع حمل 24 گھنٹے سے زیادہ	12 گھنٹے ☐	☐
وزن	نہیں ☐	ہاں ☐

موجودہ حمل

آخری ماہواری کی تاریخ ______ زچگی کی متوقع تاریخ ______

	(13)	4 (18)	5 (22)	6 (27)	7 (31)	8 (36)	9 (40)	10 (44)
حمل کا دورانیہ								
معائنے کی تاریخ								
شکایات / تکالیف								
وزن — وزن میں فی مہینہ ایک کلوگرام سے کم یا 2.25 کلوگرام سے زیادہ اضافہ								
خون کا دباؤ (بلڈ پریشر) — 140/90 ملی میٹر سے زیادہ								
خون کی کمی — نہیں ہے / موجود ہے								
سوجن — نہیں ہے / موجود ہے								
رحم کی اونچائی — حمل کے دورانیہ سے کوئی تعلق نہیں								
بچے کا رخ و پوزیشن								
بچے کی حرکت — موجود ہے / بہت آہستہ / نہیں ہے								
اندر سے خون آنا — نہیں ہے / موجود ہے								
پانی کا اخراج — نہیں ہے / موجود ہے								
پیشاب کا معائنہ — نارمل / البومن / شوگر								

چھاتیوں کا معائنہ — نارمل / نارمل نہیں | اندرونی معائنہ

غذا کے متعلق مشورہ

گولیاں

مستقل رابطہ و تعاون — دائی / لیڈی ہیلتھ ورکر

معائنے کی اگلی تاریخ

زچگی کہاں ہوگی — ہسپتال / ہیلتھ سنٹر / گھر

زچگی اور وضع حمل

درد زہ کا دورانیہ	12 گھنٹے تک ☐	12 گھنٹے سے زیادہ ☐
پیدائش کے وقت بچے کا رخ (Presentation)	نارمل ☐	نارمل نہیں ☐
پیدائش کی تاریخ	... / ... / ...	
بچے کی پیدائش کس طرح ہوئی	نارمل ☐ / اوزاروں کی مدد سے ☐	آپریشن سے ☐
بچے کی پیدائش کس جگہ ہوئی	گھر ☐ / ہیلتھ سنٹر ☐	ہسپتال ☐
بچے کی پیدائش کس نے کروائی	تربیت یافتہ دائی ☐ / غیر تربیت یافتہ ☐	☐
آنول (Placenta) کا اخراج	نہیں ☐	ہاں ☐
زچگی کے بعد خون کا اخراج	نہیں ☐	ہاں ☐
زچگی کے بعد زہر پھیلنا	نہیں ☐	ہاں ☐
دیگر پیچیدگیاں (تفصیل)	نہیں ☐	ہاں ☐
نتیجہ	زندہ ☐	مردہ ☐

زچگی کے بعد / خاندانی منصوبہ بندی کیلئے رابطہ

معائنے کی تاریخ						
شکایات						
وزن						
خاندانی منصوبہ بندی کا طریقہ						
غذائیت						
ماں کا دودھ						
علاج						
اگلی ملاقات کی تاریخ						

MAJOR RNP ACTIVITIES

DATE	ACTIVITY	PLACE	TOPICS COVERED	PUBLICATIONS	ACHIEVEMENTS
Feb. 1989	Meeting	Kisumu, Kenya Host: AKHSK	Self assessment		RNP was initiated
	Field trip	Kisumu PHC			
June 1989	International workshop	Karachi Pakistan Host: AKU	-Self Assessment -Social Indicators -Minimal Information System	Participatory Approach to Management.	Initiated a relationship between the members.
	Field trip	Urban PHC			Lessons learned from AKU Baba model applied in Bangladesh.
Feb. 1990			Background of the RNP member programmes	RNP Newsletter: Issue I	
Jan. 1990	Local workshop	Thatta, Pakistan	-Management -Self Assessment		
Feb. 1990	International Workshop	Dhaka, Bangladesh Host: AKCHP	-Self Assessment -Social Indicators -Minimal Information Systems -Rapid Assessment Methods	Information for Action	Together Identified a broader agenda for RNP
	Field Trip	AKCHP			
Sep. 1990			Community Participation	RNP Newsletter: Issue II	
April 1991	International Workshop	Gilgit, Pakistan Host: AKHSP	-Community Participation -Growth Monitoring -Community Health Workers -Family Health -Sustainability	Moving Together	Included India -- were ready to grow.
	Field trip	Northern Areas PHC Programme			
Dec. 1991			Community Health Workers	RNP Newsletter: Issue III	
Feb. 1992	International workshop	Mombasa, Kenya Host: AKHSK	-Growth Monitoring, CHWs and Community Participation -Comparative vs Selective -Family Health -Sustainability -Ethics	Growing Together	Shifting focus from PHC system initiation to refinements and larger uses

DATE	ACTIVITY	PLACE	TOPICS COVERED	PUBLICATIONS	ACHIEVEMENTS
Aug. 1992	Training Workshop	Karachi, Pakistan Lead: AKHSK	Heath Through Schools		New incites into how to work with children and parents.
Feb. 1993	Training Workshop	Dhaka, Bangladesh Lead: AKHSK Host: AKCHP	Training of trainers of CHWs		
March 1993	International Workshop	Kathmandu, Nepal	- Health Transition - Health System Development - Women in Health and Community Development - Alternative Approaches of Financing - Ethics	Report being prepared	Reshaping of RNP to address the shift from PHC to Health systems
	Field Trip	UMN Community Development and Health Project in Kathmandu, Nepal			
April 1993	Conducted a session in AKHSP Annual Staff Meeting	Islamabad Lead: AKU Host: AKHSP	- Ethics		The AKHSP staff got an incite into ethical principles.

Cost of sending <u>one full set</u> of PHC MAP Guides by Air/ Surface Mail to:

Afghanistan: $92/85; Algeria: $109/55; Angola: $128/50; Argentina: $175/54; Australia: $85/43; Austria: $85/45; Bahrain: $68/43; Bangladesh: $49/43; Belgium: $96/43; Benin: $117/53; Bhutan: $69/47; Bolivia: $96/49; Botswana: $146/49; Brazil: $141/51; Brunei: $43/36; Bulgaria: $96/49; Burkina Faso: $131/71; Burundi: $128/56; Cambodia: $39/ NA; Cameroon: $125/55; Canada: $111/40; Central African Republic: $123/61; Central Asian Republics: $122/53; Chile: $174/53; China: $61/43; Colombia: $154/63; Congo: $135/ 52; Costa Rica: $150/48; Cuba: $151/49; Czech and Slovakia: $93/43; Denmark: $86/41; Djibouti: $117/45; Dominican Republic: $141/45; Ecuador: $163/51; Egypt: $90/48; El Salvador: $158/50; Finland: $86/50; Fiji: $104/43; France: $98/45; French Guinea: $135/48; French Polynesia: $118/ 51; Gabon: $133/55; Gambia: $123/51; Germany: $92/41; Ghana: $109/47; Great Britain: $99/50; Greece: $85/48; Greenland: $136/41; Guadaloupe: $133/48; Guatemala: $156/ 54; Guinea: $126/51; Haiti: $154/52; Honduras: $165/51; Hong Kong: $43/36; Hungary: $95/48; Iceland: $102/49; India: $62/48; Indonesia: $59/45; Iran: $90/54; Iraq: $87/ NA; Ireland: $101/44; Israel: $81/52; Italy: $81/52; Jamaica: $145/67; Japan: $66/40; Jordan: $77/50; Kenya: $80/41; Korea, North: $82/75; Korea, South: $57/43; Laos: $44/38; Malaysia: $42/33; Martinique: $134/48; Mexico: $155/48; Mongolia: $50/43; Morocco: $101/49; Nepal: $NA/49; Netherlands: $91/43; New Zealand: $100/47; Nicaragua: $163/48; Niger: $118/52; Nigeria: $107/48; Norway: $91/ 47; Oman: $77/51; Papua New Guinea: $106/47; Pakistan: $62/41; Paraguay: $161/60; Peru: $166/55; Philippines: $47/ 37; Poland: $82/41; Portugal: $104/50; Qatar: $67/48; Romania: $102/50; Saudi Arabia: $76/43; Senegal: $124/53; Singapore: $41/35; Somalia: $NA/49; South Africa: $97/45; Spain: $98/43; Sri Lanka: $49/42; Sweden: $89/50; Switzerland: $88/41; Syria: $77/49; Taiwan: $52/36; Tanzania: $107/52; Thailand: $-/24; Tunisia: $94/51; Turkey: $86/47; Uganda: $126/48; UAE: $68/45; USA: $140/52; Uruguay: $160/53; Venezuela: $145/51; Vietnam: $58/NA; Yemen: $88/58; Zaire: $142/53; Zambia: $105/61; Zimbabwe: $155/44

The cost per set is reduced when multiple sets are ordered from the Somboon Vacharotai Foundation.

<u>PHC MAP Workshop</u>
24 June 1993 - Washington D.C.

The National Council of International Health (NCIH) will host a one-day PHC MAP Workshop on June 24, 1993, at the annual NCIH Conference in (or near) Washington D.C., to give participants a full orientation to the PHC MAP modules and reference guides.

Contact NCIH Tel: (202) 833-5900; Fax: (202) 833-0075; AKF USA Tel: (202) 293-2537; Fax: (202) 785-1752; or URC Tel: (301) 654-8338; Fax: (301) 654-5976 for more information.

<u>PHC MAP Trainers Course</u>
2-20 August, 1993 - Thailand

A PHC MAP Trainers Course, will be conducted August 2-20, 1993, at the ASEAN Institute for Health Development (AIHD), Mahidol University, Salaya, Nakorn Pathom, Thailand.

This course, which is co-sponsored by UNICEF, the Aga Khan Foundation, the Somboon Vacharotai Foundation and AIHD, is mainly for participants from Southeast Asia, South Asia and Pacific nations.

AIHD is also using PHC MAP materials in its annual one-year Mahidol University Master of PHC Management degree course.

Use PHC MAP modules, guides and diskettes to enable you to achieve your health program targets and objectives more quickly and efficiently and to design and implement more sustainable health programs.

Why is the PHC MAP series important?
PHC MAP facilitates intelligent management

The PHC MAP series addresses one of the main constraints of PHC and population-based health programs: inadequate information for the managerial process. PHC MAP was planned in response to the 1987 World Health Organization's report on "Evaluation of the Strategy for Health for All by the Year 2000", which states that:

"The main constraint reported by practically all countries is inadequate information for the managerial process ... to provide systematic and analytical information for continuous assessment of the situation, determination of priorities, improvement of management and evaluation. The information generated by the traditional system is, in most countries, quite insufficient."

WHO's "Eighth Report on the World Health Situation" (1992) emphasizes that:

"Health management must be seen as both a technical and administrative enterprise which requires better information in a number of areas: technological, epidemiological, community perspectives, professional attitudes, environmental trends, financial and personnel status, and indicators of service performance, quality and efficiency."

PHC MAP tools can empower managers to strengthen health information, operate more effective and efficient population-based health programs, and achieve the sustainability of these programs <u>anywhere</u>.

PRIMARY HEALTH CARE MANAGEMENT ADVANCEMENT PROGRAM

PHC MAP

PHC Management Advancement Programme

Attachment 29.1

PHC MAP

PHC MAP: Let simple management information tools developed by health care experts and field-tested by health management teams, guide you to more effective, efficient and sustainable health programs.

For more than four years, experts from four continents have been working to develop and field test practical tools to help PHC management teams collect, analyze and use high quality data to improve health program effectiveness, efficiency and sustainability. Within weeks, you can use scarce resources most effectively. And you'll have a better chance of sustaining your program for maximum long-term benefits. Field-tested in 13 countries, PHC MAP modules and guides have won acclaim from both government and NGO health program managers.

Initiated by the Aga Khan Foundation, PHC MAP is a collaborative program of the Aga Khan Foundation, the Aga Khan University, the Aga Khan Health Services and the PHC Operations Research (PRICOR) Project, Center for Human Services/University Research Corporation. Key partners include the ASEAN Institute for Health Development, Mahidol University, and the Somboon Vacharotai Foundation in Thailand; and several PHC management teams in 13 countries. PHC MAP is co-funded by AKF, Alberta Aid, the Canadian International Development Agency, the Commission of the European Communities, the Rockefeller Foundation and the United States Agency for International Development.

What is the PHC MAP series?

PHC MAP has produced a highly practical set of materials for easy use by health program managers in any setting, which are organized around nine thematic modules. Each of the nine modules includes a user's guide, a facilitator's guide, and related computer programs (EPI Info, etc); the series is completed by three manager's guides and a computerized version of the PRICOR Thesaurus.

Module 1: ASSESSING INFORMATION NEEDS. This module helps managers to identify information needs, set priorities and determine which PHC MAP modules are likely to be of most use to them.

Module 2: ASSESSING COMMUNITY HEALTH NEEDS AND COVERAGE. This module provides PHC managers with simple tools to gather required data on community health needs for planning program strategies and resource use. The managers can use the same instruments later to assess program effects on health knowledge, behavior and coverage, as well as program impact on morbidity and mortality.

Module 3: PLANNING AND ASSESSING HEALTH WORKERACTIVITIES. A module that supervisors and other managers can use to help field workers and clinic staff plan their work better. It shows how to identify individuals in need of services, set realistic targets, assess individual performance and take corrective action, if warranted.

Module 4: SURVEILLANCE OF MORBIDITY AND MORTALITY. The module describes the basic indicators of morbidity and mortality to be included in a PHC surveillance system. It discusses how to set up a surveillance system, how to monitor the occurrence of diseases, how to identify causes of mortality and morbidity, and how to use that information to improve program planning and implementation.

Module 5: MONITORING AND EVALUATING PROGRAMS. Lists of indicators and guidelines that managers can use to monitor PHC and management activities for short periods. Managers can also use them to construct a project-specific "mini-MIS".

Module 6: ASSESSING THE QUALITY OF SERVICE. Simple, but comprehensive discussion guides and checklists of essential service resources and processes. Supervisors can use these to assess the quality of care provided and to set priorities for improving service delivery.

Module 7: ASSESSING THE QUALITY OF MANAGEMENT. Discussion guides and checklists for assessing PHC management services (planning, training, supervision, etc.).

Module 8: COST ANALYSIS. This module can help PHC managers to set up simple systems to monitor costs themselves. They can make projections about future revenues and expenses.

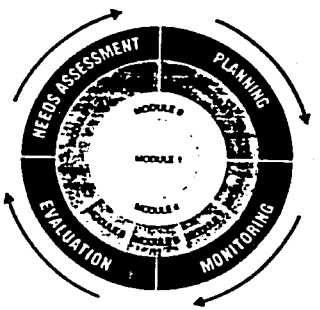
Module 9: SUSTAINABILITY ANALYSIS. Guidelines and tools that managers can use to develop and analyze alternative strategies for sustaining health improvement, service coverage, and the PHC services and resources needed to do so.

BETTER MANAGEMENT- 100 TIPS: A helpful hints book that describes effective ways to help managers improve what they do.

PROBLEM-SOLVING: A guide to help managers deal with common problems.

COMPUTERS: A guide book providing useful hints on buying and operating computers, printers, other hardware and software.

THE COMPUTERIZED PRICOR THESAURUS: A compendium of PHC indicators.



How to order the PHC MAP series?

The series is free of charge and can be ordered against the cost of shipment. PHC MAP modules and guides are in the public domain and may be copied, revised and adapted to your program needs. They can be ordered by completing the order form and sending it to the Somboon Vacharotai Foundation, together with a bank draft in the correct U.S. dollar amount to cover the mailing cost. Please see the back of the order form for the cost of mailing one set of the PHC MAP series, including 3.5" DD computer diskettes, to you. Bulk shipment by air or surface freight can also be arranged.

Please allow 1-3 weeks for delivery by air and 1-3 months for delivery by surface. The cost of courier service, which will assure delivery within a week, can be requested from the Somboon Vacharotai Foundation.

PHC MAP

ORDER FORM

Name:_____

Title:_____

Organization:_____

Mailing address:_____

_____

Telephone:_____ Fax:_____

Date:_____ Signature:_____

Method of shipment preferred (check one):

Air mail: Surface mail:

For bulk shipments, air cargo or courier services to specific locations, the Somboon Vacharotai Foundation will provide the cost upon request.

Bank draft enclosed in amount of US$:_____

Please mail the completed order form and bank draft to:

The Honorary Secretary-General
Somboon Vacharotai Foundation
101 Prapinklao-Nakornchaisri Road
Talingchan District
Bangkok 10170
Thailand

Tel: (00662) 448 60 50 / 448 69 42 / 448 64 61
Fax: (00662) 448 64 62

Attachment 29.2

1/8

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Kenya - Mombasa Primary Health Care Project
BUDGET VS ACTUALS - GRANT YEAR 2

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries/expenses	48.5	-	48.5	30.5	-	30.5	18.0	0.0	18.0
b. Travel	2.7	0.3	3.0	0.8	-	0.8	1.9	0.3	2.2
c. Sub-Project Funding	-	-	0.0	-	-	0.0	0.0	0.0	0.0
d. Other									
Training, Workshops and Seminars	16.0	-	16.0	7.8	-	7.8	8.2	0.0	8.2
Vehicles Operation	18.5	-	18.5	22.9	-	22.9	(4.4)	0.0	(4.4)
Other Administrative Costs	34.1	-	34.1	29.8	-	29.8	4.3	0.0	4.3
Sub-total Other	68.6	0.0	68.6	60.5	0.0	60.5	8.1	0.0	8.1
SUB-TOTAL -- Program Elements	119.8	0.3	120.1	91.8	0.0	91.8	28.0	0.3	28.3
II. Procurement									
a. Supplies	16.7	37.0	53.7	18.7	0.0	18.7	(2.0)	37.0	35.0
b. Services/Consultants	2.9	6.7	9.6	4.9	0.0	4.9	(2.0)	6.7	4.7
SUB-TOTAL -- Procurement	19.6	43.7	63.3	23.6	0.0	23.6	(4.0)	43.7	39.7
III. Ongoing Monitoring/Evaluation (1)									
a. Consultants/staff	-	-	0.0	-	-	0.0	0.0	0.0	0.0
b. Travel	-	-	0.0	-	-	0.0	0.0	0.0	0.0
c. Other	-	-	0.0	-	-	0.0	0.0	0.0	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COUNTRY GRAND TOTAL	139.4	44.0	183.4	115.4	0.0	115.4	24.0	44.0	68.0

Notes:
1. Costs of ongoing evaluations are included under procurement - service/consultants.

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Kenya - Mombasa Primary Health Care Project
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries/expenses	90.7	-	90.7	74.7	-	74.7	16.0	0.0	16.0
b. Travel	2.7	0.3	3.0	0.8	0.0	0.8	1.9	0.3	2.2
c. Sub-Project Funding	-	-	0.0	-	-	0.0	0.0	0.0	0.0
d. Other									
Training, Workshops and Seminars	20.2	2.9	23.1	13.5	2.9	16.4	6.7	0.0	6.7
Vehicles Operation	39.1	4.6	43.7	43.5	4.6	48.1	(4.4)	0.0	(4.4)
Other Administrative Costs	49.6	14.2	63.8	47.3	14.2	61.5	2.3	0.0	2.3
Sub-total Other	108.9	21.7	130.6	104.3	21.7	126.0	4.6	0.0	4.6
SUB-TOTAL -- Program Elements	202.3	22.0	224.3	179.8	21.7	201.5	22.5	0.3	22.8
II. Procurement									
a. Supplies	16.7	66.8	83.5	18.7	46.7	65.4	(2.0)	20.1	18.1
b. Services/Consultants	3.0	7.2	10.2	5.0	0.5	5.5	(2.0)	6.7	4.7
SUB-TOTAL -- Procurement	19.7	74.0	93.7	23.7	47.2	70.9	(4.0)	26.8	22.8
III. Ongoing Monitoring/Evaluation (1)									
a. Consultants/staff			0.0	-	-	0.0	-	-	0.0
b. Travel			0.0	-	-	0.0	-	-	0.0
c. Other			0.0	-	-	0.0	-	-	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COUNTRY GRAND TOTAL	222.0	96.0	318.0	203.5	68.9	272.4	18.5	27.1	45.6

Notes:
1. Costs of ongoing evaluations are included under procurement - service/consultants.

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Bangladesh - Aga Khan Community Health Program
BUDGET VS ACTUALS - GRANT YEAR 2

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries/expenses	50.2	12.4	62.6	50.2	12.4	62.6	0.0	0.0	0.0
b. Travel			0.0			0.0			0.0
c. Sub-Project Funding			0.0			0.0			0.0
d. Other									
Training, Workshops and Seminars	1.7	0.5	2.2	1.7	0.5	2.2	0.0	0.0	0.0
SUB-TOTAL -- Program Elements	51.9	12.9	64.8	51.9	12.9	64.8	0.0	0.0	0.0
II. Procurement									
a. Supplies			0.0			0.0			0.0
b. Services			0.0			0.0			0.0
SUB-TOTAL -- Procurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
III. Ongoing Monitoring/Evaluation									
a. Consultants/staff			0.0			0.0			0.0
b. Travel			0.0			0.0			0.0
c. Other			0.0			0.0			0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COUNTRY GRAND TOTAL	51.9	12.9	64.8	51.9	12.9	64.8	0.0	0.0	0.0

Note: Costs for year 2 as above exclude $105,000 provided from other, non U.S. Government sources.

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Bangladesh - Aga Khan Community Health Program
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries/expenses	100.4	51.6	152.0	100.4	51.6	152.0	0.0	0.0	0.0
b. Travel	0.0	0.0	0.0	0.0	0.0	0.0			0.0
c. Sub-Project Funding	0.0	0.0	0.0	0.0	0.0	0.0			0.0
d. Other									
Training, Workshops and Seminars	9.7	0.5	10.2	9.7	0.5	10.2	0.0	0.0	0.0
SUB-TOTAL -- Program Elements	110.1	52.1	162.2	110.1	52.1	162.2	0.0	0.0	0.0
II. Procurement									
a. Supplies	0.0	0.0	0.0	0.0	0.0	0.0			0.0
b. Services	0.0	0.0	0.0	0.0	0.0	0.0			0.0
SUB-TOTAL -- Procurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
III. Ongoing Monitoring/Evaluation									
a. Consultants/staff	0.0	0.0	0.0	0.0	0.0	0.0			0.0
b. Travel	0.0	0.0	0.0	0.0	0.0	0.0			0.0
c. Other	0.0	0.0	0.0	0.0	0.0	0.0			0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COUNTRY GRAND TOTAL	110.1	52.1	162.2	110.1	52.1	162.2	0.0	0.0	0.0

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Pakistan - Urban Primary Health Care Program
BUDGET VS ACTUALS - GRANT YEAR 2

(In $'000s)

	Budget			Actuals			Variance		
I. Program Elements	AID	AKF	Total	AID	AKF	Total	AID	AKF	Total
a. Salaries/expenses	-	224.1	224.1	-	231.7	231.7	0.0	(7.6)	(7.6)
b. Travel	-	5.4	5.4	-	3.5	3.5	0.0	1.9	1.9
c. Sub-Project Funding	-	-	0.0	-	-	0.0	0.0	0.0	0.0
d. Other	-	25.8	25.8	-	42.7	42.7	0.0	(16.9)	(16.9)
SUB-TOTAL -- Program Elements	0.0	255.3	255.3	0.0	277.9	277.9	0.0	(22.6)	(22.6)
II. Procurement									
a. Supplies	-	26.9	26.9	-	13.3	13.3	0.0	13.6	13.6
b. Services	-	10.5	10.5	-	3.1	3.1	0.0	7.4	7.4
SUB-TOTAL -- Procurement	0.0	37.4	37.4	0.0	16.4	16.4	0.0	21.0	21.0
III. Ongoing Monitoring/Evaluation									
a. Consultants/staff	-	20.0	20.0	-	18.5	18.5	0.0	1.5	1.5
b. Travel	-	-	0.0	-	-	0.0	0.0	0.0	0.0
c. Other	-	-	0.0	-	-	0.0	0.0	0.0	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	20.0	20.0	0.0	18.5	18.5	0.0	1.5	1.5
COUNTRY GRAND TOTAL	0.0	312.7	312.7	0.0	312.8	312.8	0.0	(0.1)	(0.1)

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Pakistan - Urban Primary Health Care Program
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries/expenses	-	456.3	456.3	-	463.9	463.9	0.0	(7.6)	(7.6)
b. Travel	-	10.4	10.4	-	8.5	8.5	0.0	1.9	1.9
c. Sub-Project Funding	-	-	0.0	-	-	0.0	0.0	0.0	0.0
d. Other	-	53.7	53.7	-	70.6	70.6	0.0	(16.9)	(16.9)
SUB-TOTAL -- Program Elements	0.0	520.4	520.4	0.0	543.0	543.0	0.0	(22.6)	(22.6)
II. Procurement									
a. Supplies	-	45.7	45.7	-	32.1	32.1	0.0	13.6	13.6
b. Services	-	20.0	20.0	-	12.6	12.6	0.0	7.4	7.4
SUB-TOTAL -- Procurement	0.0	65.7	65.7	0.0	44.7	44.7	0.0	21.0	21.0
III. Ongoing Monitoring/Evaluation									
a. Consultants/staff	-	38.0	38.0	-	36.5	36.5	0.0	1.5	1.5
b. Travel	-	-	0.0	-	-	0.0	0.0	0.0	0.0
c. Other	-	-	0.0	-	-	0.0	0.0	0.0	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	38.0	38.0	0.0	36.5	36.5	0.0	1.5	1.5
COUNTRY GRAND TOTAL	0.0	624.1	624.1	0.0	624.2	624.2	0.0	(0.1)	(0.1)

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Multi-Country - Regional Network Program
BUDGET VS ACTUALS - GRANT YEAR 2

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries/expenses	15.1	39.7	54.8	15.1	39.7	54.8	0.0	0.0	0.0
b. Travel	29.8	-	29.8	24.3	-	24.3	5.5	-	5.5
c. Sub-Project Funding	-	-	0.0	-	-	0.0	-	-	0.0
d. Other	27.0	-	27.0	24.5	-	24.5	2.5	-	2.5
SUB-TOTAL -- Program Elements	71.9	39.7	111.6	63.9	39.7	103.6	8.0	0.0	8.0
II. Procurement									
a. Supplies	28.2	6.4	34.6	20.5	4.7	25.2	7.7	1.7	9.4
b. Services	-	-	0.0	-	-	0.0	-	-	0.0
SUB-TOTAL -- Procurement	28.2	6.4	34.6	20.5	4.7	25.2	7.7	1.7	9.4
III. Ongoing Monitoring/Evaluation									
a. Consultants/staff	-	-	0.0	-	-	0.0	-	-	0.0
b. Travel	-	-	0.0	-	-	0.0	-	-	0.0
c. Other	-	-	0.0	-	-	0.0	-	-	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PROGRAM GRAND TOTAL	100.1	46.1	146.2	84.4	44.4	128.8	15.7	1.7	17.4

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Multi-Country - Regional Network Program
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

(In $'000s)

	Budget			Actuals			Variance		
I. Program Elements	AID	AKF	Total	AID	AKF	Total	AID	AKF	Total
a. Salaries/expenses	15.1	92.1	107.2	15.1	92.1	107.2	0.0	0.0	0.0
b. Travel	47.5	–	47.5	42.0	–	42.0	5.5	–	5.5
c. Sub-Project Funding	–	–	0.0	–	–	0.0	–	–	0.0
d. Other	52.0	–	52.0	49.5	–	49.5	2.5	–	2.5
SUB-TOTAL — Program Elements	114.6	92.1	206.7	106.6	92.1	198.7	8.0	0.0	8.0
II. Procurement									
a. Supplies	32.9	12.1	45.0	25.2	10.4	35.6	7.7	1.7	9.4
b. Services	–	–	0.0	–	–	0.0	–	–	0.0
SUB-TOTAL — Procurement	32.9	12.1	45.0	25.2	10.4	35.6	7.7	1.7	9.4
III. Ongoing Monitoring/Evaluation									
a. Consultants/staff	–	–	0.0	–	–	0.0	–	–	0.0
b. Travel	–	–	0.0	–	–	0.0	–	–	0.0
c. Other	–	–	0.0	–	–	0.0	–	–	0.0
SUB-TOTAL — Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PROGRAM GRAND TOTAL	147.5	104.2	251.7	131.8	102.5	234.3	15.7	1.7	17.4

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Primary Health Care Management Advancement Program (PHC MAP)
BUDGET VS ACTUALS - GRANT YEAR 2

Center for Human Services (CHS)

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries	62.4	6.8	69.2	44.8	4.9	49.7	17.6	1.9	19.5
b. Fringe Benefits	24.5	-	24.5	16.9	-	16.9	7.6	-	7.6
c. Overhead on Personnel	16.8	-	16.8	14.5	-	14.5	2.3	-	2.3
d. Travel	1.4	-	1.4	(5.6)	-	(5.6)	7.0	-	7.0
e. Other	17.1	-	17.1	24.3	-	24.3	(7.2)	-	(7.2)
f. CHS G & A	27.3	-	27.3	25.1	-	25.1	2.2	-	2.2
SUB-TOTAL -- Program Elements	149.5	6.8	156.3	120.0	4.9	124.9	29.5	1.9	31.4
II. Procurement									
a. Supplies	-	-	0.0	1.6	-	1.6	(1.6)	-	(1.6)
b. Services	-	-	0.0	-	-	0.0	-	-	0.0
c. Consultants	15.5	-	15.5	33.7	-	33.7	(18.2)	-	(18.2)
d. Overhead on Consultants	-	-	0.0	-	-	0.0	-	-	0.0
e. Subcontracts	4.5	-	4.5	4.7	-	4.7	(0.2)	-	(0.2)
SUB-TOTAL -- Procurement	20.0	0.0	20.0	40.0	0.0	40.0	(20.0)	0.0	(20.0)
III. Ongoing Monitoring/Evaluation									
a. Consultants/staff	-	-	0.0	-	-	0.0	-	-	0.0
b. Travel	-	-	0.0	-	-	0.0	-	-	0.0
c. Other	-	-	0.0	-	-	0.0	-	-	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
GRAND TOTAL - CHS	169.5	6.8	176.3	160.0	4.9	164.9	9.5	1.9	11.4

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Primary Health Care Management Advancement Program (PHC MAP)
BUDGET VS ACTUALS - GRANT YEAR 2

Dr. Jack Reynolds

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Professional Fees	-	-	0.0	-	-	0.0	-	-	0.0
b. Travel	-	-	0.0	-	-	0.0	-	-	0.0
c. Other	-	-	0.0	-	-	0.0	-	-	0.0
SUB-TOTAL — Program Elements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
II. Procurement	-	-	0.0	-	-	0.0	-	-	0.0
GRAND TOTAL - Dr. Jack Reynolds	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PROGRAM GRAND TOTAL - PHC MAP	169.5	6.8	176.3	160.0	4.9	164.9	9.5	1.9	11.4

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Primary Health Care Management Advancement Program (PHC MAP)
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

Center for Human Services (CHS)

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries	76.0	126.5	202.5	58.4	124.6	183.0	17.6	1.9	19.5
b. Fringe Benefits	39.5	31.0	70.5	31.9	31.0	62.9	7.6	0.0	7.6
c. Overhead on Personnel	26.4	19.5	45.9	24.1	19.5	43.6	2.3	0.0	2.3
d. Travel	65.4	0.0	65.4	58.4	-	58.4	7.0	0.0	7.0
e. Other	67.4	4.1	71.5	74.6	4.1	78.7	(7.2)	0.0	(7.2)
f. CHS G & A	32.3	65.5	97.8	30.1	65.5	95.6	2.2	0.0	2.2
SUB-TOTAL -- Program Elements	307.0	246.6	553.6	277.5	244.7	522.2	29.5	1.9	31.4
II. Procurement									
a. Supplies	0.0	0.0	0.0	1.6	-	1.6	(1.6)	0.0	(1.6)
b. Services	0.0	0.0	0.0	-	-	0.0	0.0	0.0	0.0
c. Consultants	27.4	0.0	27.4	45.6	-	45.6	(18.2)	0.0	(18.2)
d. Overhead on Consultants	0.0	0.0	0.0	-	-	0.0	0.0	0.0	0.0
e. Subcontracts	44.7	2.6	47.3	44.9	2.6	47.5	(0.2)	0.0	(0.2)
SUB-TOTAL -- Procurement	72.1	2.6	74.7	92.1	2.6	94.7	(20.0)	0.0	(20.0)
III. Ongoing Monitoring/Evaluation									
a. Consultants/staff	0.0	0.0	0.0	-	-	0.0	-	-	0.0
b. Travel	0.0	0.0	0.0	-	-	0.0	-	-	0.0
c. Other	0.0	0.0	0.0	-	-	0.0	-	-	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
GRAND TOTAL - CHS	379.1	249.2	628.3	369.6	247.3	616.9	9.5	1.9	11.4

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Primary Health Care Management Advancement Program (PHC MAP)
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

Dr. Jack Reynolds

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Professional Fees	0.0	42.7	42.7	-	42.7	42.7	-	0.0	0.0
b. Travel	0.0	0.0	0.0	-	-	0.0	-	-	0.0
c. Other	0.0	0.0	0.0	-	-	0.0	-	-	0.0
SUB-TOTAL -- Program Elements	0.0	42.7	42.7	0.0	42.7	42.7	0.0	0.0	0.0
II. Procurement	0.0	0.0	0.0	-	-	0.0	-	-	0.0
GRAND TOTAL - Dr. Jack Reynolds	0.0	42.7	42.7	0.0	42.7	42.7	0.0	0.0	0.0
PROGRAM GRAND TOTAL - PHC MAP	379.1	291.9	671.0	369.6	290.0	659.6	9.5	1.9	11.4

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Headquarters - AKF USA
BUDGET VS ACTUALS - GRANT YEAR 2

(In $'000s)

	Budget			Actuals			Variance		
I. Program Elements	AID	AKF	Total	AID	AKF	Total	AID	AKF	Total
a. Salaries/expenses			0.0			0.0	0.0	0.0	0.0
b. Travel			0.0			0.0	0.0	0.0	0.0
c. Other			0.0			0.0	0.0	0.0	0.0
SUB-TOTAL -- Program Elements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
II. Procurement									
a. Supplies			0.0			0.0	0.0	0.0	0.0
b. Services			0.0			0.0	0.0	0.0	0.0
SUB-TOTAL -- Procurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
III. Ongoing Monitoring/Evaluation									
a. Consultants - Ongoing Evaluation	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8
b. Final Evaluation									
Consultants			0.0			0.0	0.0	0.0	0.0
Travel			0.0			0.0	0.0	0.0	0.0
Other Direct Costs (Supplies, etc.)			0.0			0.0	0.0	0.0	0.0
Sub-Total Final Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
SUB-TOTAL -- Monitoring/Evaluation	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8
COUNTRY GRAND TOTAL	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Headquarters - AKF USA
BUDGET VS ACTUALS - GRANT YEARS 1 AND 2

(In $'000s)

I. Program Elements	Budget AID	Budget AKF	Budget Total	Actuals AID	Actuals AKF	Actuals Total	Variance AID	Variance AKF	Variance Total
a. Salaries/expenses			0.0			0.0	0.0	0.0	0.0
b. Travel			0.0			0.0	0.0	0.0	0.0
c. Other			0.0			0.0	0.0	0.0	0.0
SUB-TOTAL -- Program Elements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
II. Procurement									
a. Supplies			0.0			0.0	0.0	0.0	0.0
b. Services			0.0			0.0	0.0	0.0	0.0
SUB-TOTAL -- Procurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
III. Ongoing Monitoring/Evaluation									
a. Consultants - Ongoing Evaluation	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8
b. Final Evaluation									
Consultants			0.0			0.0	0.0	0.0	0.0
Travel			0.0			0.0	0.0	0.0	0.0
Other Direct Costs (Supplies, etc.)			0.0			0.0	0.0	0.0	0.0
Sub-Total Final Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
SUB-TOTAL -- Monitoring/Evaluation	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8
COUNTRY GRAND TOTAL	9.5	2.3	11.8	0.0	0.0	0.0	9.5	2.3	11.8

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Kenya - Mombasa Primary Health Care Project
GRANT YEARS 1 TO 3 - REVISED BUDGET

I. Program Elements	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
a. Salaries/expenses	44.2	-	44.2	30.5	-	30.5	26.1	-	26.1	100.8	0.0	100.8
b. Travel	-	-	0.0	0.8	-	0.8	0.6	-	0.6	1.4	0.0	1.4
c. Sub-Project Funding	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
d. Other												
Training, Workshops and Seminars	5.7	2.9	8.6	7.8	-	7.8	11.5	-	11.5	25.0	2.9	27.9
Vehicles Operation	20.6	4.6	25.2	22.9	-	22.9	11.7	-	11.7	55.2	4.6	59.8
Other Administrative Costs	17.5	14.2	31.7	29.8	-	29.8	15.2	-	15.2	62.5	14.2	76.7
Sub-total Other	43.8	21.7	65.5	60.5	0.0	60.5	38.4	0.0	38.4	142.7	21.7	164.4
SUB-TOTAL -- Program Elements	88.0	21.7	109.7	91.8	0.0	91.8	65.1	0.0	65.1	244.9	21.7	266.6
II. Procurement												
a. Supplies	-	46.7	46.7	18.7	0.0	18.7	13.7		13.7	32.4	46.7	79.1
b. Services/Consultants	0.1	0.5	0.6	4.9	0.0	4.9	1.3	16.0	17.3	6.3	16.5	22.8
c. Vehicles	-	-	0.0	-	-	0.0	-	20.0	20.0	0.0	20.0	20.0
SUB-TOTAL -- Procurement	0.1	47.2	47.3	23.6	0.0	23.6	15.0	36.0	51.0	38.7	83.2	121.9
III. Ongoing Monitoring/Evaluation (1)												
a. Consultants/staff			0.0	-	-	0.0	1.5	-	1.5	1.5	0.0	1.5
b. Travel			0.0	-	-	0.0	1.2	-	1.2	1.2	0.0	1.2
c. Other			0.0	-	-	0.0	1.2	-	1.2	1.2	0.0	1.2
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	3.9	0.0	3.9	3.9	0.0	3.9
COUNTRY GRAND TOTAL	88.1	68.9	157.0	115.4	0.0	115.4	84.0	36.0	120.0	287.5	104.9	392.4

Notes:
1. Budget for Grant Year 3 includes $20,000 for vehicle replacement and $16,000 for a study of the economic development opportunities in the Coast Province (both from the AKF USA share).
2. Consultant/staff costs for monitoring and evaluation of $1,711 in Grant Year 1 and 2 shown on Procurement-Services/Consultants line.

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Bangladesh - Aga Khan Community Health Program
GRANT YEARS 1 TO 3 - REVISED BUDGET

(In $'000s)

I. Program Elements	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
a. Salaries/expenses	50.2	39.2	89.4	50.2	12.4	62.6	-	-	0.0	100.4	51.6	152.0
b. Travel			0.0			0.0			0.0	0.0	0.0	0.0
c. Sub-Project Funding			0.0			0.0			0.0	0.0	0.0	0.0
d. Other												
Training, Workshops and Seminars	8.0	0.0	8.0	1.7	0.5	2.2	-	-	0.0	9.7	0.5	10.2
SUB-TOTAL -- Program Elements	58.2	39.2	97.4	51.9	12.9	64.8	0.0	0.0	0.0	110.1	52.1	162.2
II. Procurement												
a. Supplies			0.0			0.0			0.0	0.0	0.0	0.0
b. Services			0.0			0.0			0.0	0.0	0.0	0.0
SUB-TOTAL -- Procurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
III. Ongoing Monitoring/Evaluation												
a. Consultants/staff			0.0			0.0			0.0	0.0	0.0	0.0
b. Travel			0.0			0.0			0.0	0.0	0.0	0.0
c. Other			0.0			0.0			0.0	0.0	0.0	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
COUNTRY GRAND TOTAL	58.2	39.2	97.4	51.9	12.9	64.8	0.0	0.0	0.0	110.1	52.1	162.2

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Pakistan - Urban Primary Health Care Program
GRANT YEARS 1 TO 3 - REVISED BUDGET

(In $'000s)

I. Program Elements	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
a. Salaries/expenses	-	232.2	232.2	-	231.7	231.7	-	232.0	232.0	0.0	695.9	695.9
b. Travel	-	5.0	5.0	-	3.5	3.5	-	5.0	5.0	0.0	13.5	13.5
c. Sub-Project Funding	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
d. Other	-	27.9	27.9	-	42.7	42.7	-	30.0	30.0	0.0	100.6	100.6
SUB-TOTAL -- Program Elements	0.0	265.1	265.1	0.0	277.9	277.9	0.0	267.0	267.0	0.0	810.0	810.0
II. Procurement												
a. Supplies	-	18.8	18.8	-	13.3	13.3	-	13.3	13.3	0.0	45.4	45.4
b. Services	-	9.5	9.5	-	3.1	3.1	-	10.0	10.0	0.0	22.6	22.6
SUB-TOTAL -- Procurement	0.0	28.3	28.3	0.0	16.4	16.4	0.0	23.3	23.3	0.0	68.0	68.0
III. Ongoing Monitoring/Evaluation												
a. Consultants/staff	-	18.0	18.0	-	18.5	18.5	-	19.0	19.0	0.0	55.5	55.5
b. Travel	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
c. Other	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	18.0	18.0	0.0	18.5	18.5	0.0	19.0	19.0	0.0	55.5	55.5
COUNTRY GRAND TOTAL	0.0	311.4	311.4	0.0	312.8	312.8	0.0	309.3	309.3	0.0	933.5	933.5

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Multi-Country - Regional Network Program
GRANT YEARS 1 TO 3 - REVISED BUDGET

(In $'000s)

I. Program Elements	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
a. Salaries/expenses	-	52.4	52.4	15.1	39.7	54.8	60.3	-	60.3	75.4	92.1	167.5
b. Travel	17.7	-	17.7	24.3	-	24.3	33.3	-	33.3	75.3	-	75.3
c. Sub-Project Funding	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
d. Other	25.0	-	25.0	24.5	-	24.5	35.0	-	35.0	84.5	-	84.5
SUB-TOTAL -- Program Elements	42.7	52.4	95.1	63.9	39.7	103.6	128.6	0.0	128.6	235.2	92.1	327.3
II. Procurement												
a. Supplies	4.7	5.7	10.4	20.5	4.7	25.2	25.0	1.7	26.7	50.2	12.1	62.3
b. Services	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
SUB-TOTAL -- Procurement	4.7	5.7	10.4	20.5	4.7	25.2	25.0	1.7	26.7	50.2	12.1	62.3
III. Ongoing Monitoring/Evaluation												
a. Consultants/staff	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
b. Travel	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
c. Other	-	-	0.0	-	-	0.0	-	-	0.0	-	-	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PROGRAM GRAND TOTAL	47.4	58.1	105.5	84.4	44.4	128.8	153.6	1.7	155.3	285.4	104.2	389.6

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Primary Health Care Management Advancement Program (PHC MAP)
GRANT YEARS 1 TO 3 - REVISED BUDGET

Center for Human Services (CHS)

(In $'000s)

I. Program Elements	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
a. Salaries	13.6	119.7	133.3	44.8	4.9	49.7	11.8	-	11.8	70.2	124.6	194.8
b. Fringe Benefits	15.0	31.0	46.0	16.9	-	16.9	-	-	0.0	31.9	31.0	62.9
c. Overhead on Personnel	9.6	19.5	29.1	14.5	-	14.5	-	-	0.0	24.1	19.5	43.6
d. Travel	64.0	-	64.0	(5.6)	-	(5.6)	7.7	-	7.7	66.1	0.0	66.1
e. Other	50.3	4.1	54.4	24.3	-	24.3	-	-	0.0	74.6	4.1	78.7
f. CHS G & A	5.0	65.5	70.5	25.1	-	25.1	3.5	-	3.5	33.6	65.5	99.1
SUB-TOTAL -- Program Elements	157.5	239.8	397.3	120.0	4.9	124.9	23.0	0.0	23.0	300.5	244.7	545.2
II. Procurement												
a. Supplies	-	-	0.0	1.6	-	1.6	1.5	-	1.5	3.1	0.0	3.1
b. Services	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
c. Consultants	11.9	-	11.9	33.7	-	33.7	1.3	-	1.3	46.9	0.0	46.9
d. Overhead on Consultants	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
e. Subcontracts	40.2	2.6	42.8	4.7	-	4.7	-	-	0.0	44.9	2.6	47.5
SUB-TOTAL -- Procurement	52.1	2.6	54.7	40.0	0.0	40.0	2.8	0.0	2.8	94.9	2.6	97.5
III. Ongoing Monitoring/Evaluation												
a. Consultants/staff	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
b. Travel	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
c. Other	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
GRAND TOTAL - CHS	209.6	242.4	452.0	160.0	4.9	164.9	25.8	0.0	25.8	395.4	247.3	642.7

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Primary Health Care Management Advancement Program (PHC MAP)
GRANT YEARS 1 TO 3 - REVISED BUDGET

(In $'000s)

Dr. Jack Reynolds

I. Program Elements	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
a. Professional Fees	-	42.7	42.7	-	-	0.0	-	-	0.0	0.0	42.7	42.7
b. Travel	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
c. Other	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
SUB-TOTAL -- Program Elements	0.0	42.7	42.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	42.7	42.7
II. Procurement	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
GRAND TOTAL - Dr. Jack Reynolds	0.0	42.7	42.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	42.7	42.7
AKF USA - Direct Costs												
I. Program Elements												
a. Professional Fees	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
b. Travel	-	-	0.0	-	-	0.0	-	-	0.0	0.0	0.0	0.0
c. Other - Workshops	-	-	0.0	-	-	0.0	5.8	3.0	8.8	5.8	3.0	8.8
SUB-TOTAL -- Program Elements	0.0	0.0	0.0	0.0	0.0	0.0	5.8	3.0	8.8	5.8	3.0	8.8
II. Procurement - Services	-	-	0.0	-	-	0.0	78.1	21.0	99.1	78.1	21.0	99.1
GRAND TOTAL - AKF USA Direct Costs	0.0	0.0	0.0	0.0	0.0	0.0	83.9	24.0	107.9	83.9	24.0	107.9
PROGRAM GRAND TOTAL - PHC MAP	209.6	285.1	494.7	160.0	4.9	164.9	109.7	24.0	133.7	479.3	314.0	793.3

AGA KHAN FOUNDATION USA
AID MATCHING GRANT 1991-1994
ANNUAL REPORT: Headquarters - AKF USA
GRANT YEARS 1 TO 3 - REVISED BUDGET

(In $'000s)

I. Program Elements	Year 1 AID	Year 1 AKF	Year 1 Total	Year 2 AID	Year 2 AKF	Year 2 Total	Year 3 AID	Year 3 AKF	Year 3 Total	ALL YEARS AID	ALL YEARS AKF	ALL YEARS Total
a. Salaries/expenses			0.0			0.0			0.0	0.0	0.0	0.0
b. Travel			0.0			0.0			0.0	0.0	0.0	0.0
c. Other			0.0			0.0			0.0	0.0	0.0	0.0
SUB-TOTAL -- Program Elements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
II. Procurement												
a. Supplies			0.0			0.0			0.0	0.0	0.0	0.0
b. Services			0.0			0.0			0.0	0.0	0.0	0.0
SUB-TOTAL -- Procurement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
III. Ongoing Monitoring/Evaluation												
a. Consultants - On-going Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
b. Final Evaluation												
Consultants			0.0			0.0	12.5		12.5	12.5	0.0	12.5
Travel			0.0			0.0	23.2	4.3	27.5	23.2	4.3	27.5
Other Direct Costs (Supplies, etc.)			0.0			0.0	2.0		2.0	2.0	0.0	2.0
Sub-Total Final Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	37.7	4.3	42.0	37.7	4.3	42.0
SUB-TOTAL -- Monitoring/Evaluation	0.0	0.0	0.0	0.0	0.0	0.0	37.7	4.3	42.0	37.7	4.3	42.0
COUNTRY GRAND TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	37.7	4.3	42.0	37.7	4.3	42.0

COUNTRY INFORMATION FOR
A.I.D.-SUPPORTED PVO PROJECTS

Organization: Aga Khan Foundation U.S.A.
Project/Grant No.: PDC-0158-A-00-1102-00
Grant Dates: July 1, 1991 to June 30, 1994
Funding Mechanism: Matching Grant
(i.e., HG, OPG, Contract, CA, Etc.)

*COUNTRY NAME OR HEADQUARTERS: Kenya - Mombasa PHC

Project Purpose: (limit to 40 words or less)
To make available affordable primary health care services to women and children of poor underserved populations, collaborating with local residents, governments and donors to create an effective, equity-oriented health delivery system, mobilizing local resources supported by gradually diminishing external funds.

Project Implementation:
Start Date: 07/01/91 Estimated Completion Date: 06/30/94
Status: (limit to 25 words or less) Community mobilization and PHC services continued. Community participation of 71% achieved. CHW training, PHC services, and water improvement activities are ongoing and being met.

Project Funding:

Year FY 91	Year FY 92	Year FY 93	Year	Year	TOTAL 7/91-6/94
AID$ 88.1	AID$ 115.4	AID$ 84.0	AID$	AID$	287.5
PVO$ 68.9	PVO$ 0.0	PVO$ 36.0	PVO$	PVO$	104.9
OTHER	OTHER	OTHER	OTHER	OTHER	
INKIND	INKIND	INKIND	INKIND	INKIND	
LOCAL	LOCAL	LOCAL	LOCAL	LOCAL	
TOTAL 157.0	TOTAL 115.4	TOTAL 120.0	TOTAL	TOTAL	392.4

Location in Country: (Region, District, Village - Be Specific)
Mombasa (Coast Province - Kwale District)

PVO Representative in Country: (if any) or Program Manager for Headquarters:

(name) Mr. Mirza Jahani,-CEO - Aga Khan Foundation (Kenya)
(address) P.O. Box 40898, Nairobi, Kenya
(phone) 254-2-27-369

Local Counterpart/Host Country Agency: (If no PVO representative)

*Complete separate sheet for each country program and headquarters.

COUNTRY INFORMATION FOR A.I.D.-SUPPORTED PVO PROJECTS

Organization: Aga Khan Foundation U.S.A.
Project/Grant No.: PDC-0158-A-00-1102-00
Grant Dates: July 1, 1991 to June 30, 1994
Funding Mechanism: Matching Grant
(i.e., MG, OPG, Contract, CA, Etc.)

*COUNTRY NAME OR HEADQUARTERS: Bangladesh - Aga Khan Community Health Program (AKC

Project Purpose: (limit to 40 words or less)

To improve the health and nutritional status of the target population, living in slum and low-income areas of urban Dhaka, through a sustainable, well managed, PHC initiative with a strong capacity to mobilize local, human and financial resources

Project Implementation:
Start Date: 07/01/91 Estimated Completion Date: 06/30/94
Status: (limit to 25 words or less) PHC services continued and major targets met. New health education, fees for service, income generation and community activities implemented. MIS strengthened.

Project Funding:

Year FY 91	Year FY 92	Year FY 93	Year	Year	TOTAL
AID$ 58.2	AID$ 51.9	AID$	AID$	AID$	7/91-6/94
PVO$ 39.2	PVO$ 12.9	PVO$	PVO$	PVO$	110.1
OTHER	OTHER	OTHER	OTHER	OTHER	52.1
INKIND	INKIND	INKIND	INKIND	INKIND	
LOCAL	LOCAL	LOCAL	LOCAL	LOCAL	
TOTAL 97.4	TOTAL 64.8	TOTAL	TOTAL	TOTAL	162.2

Location in Country: (Region, District, Village - Be Specific)
Dhaka - (Paltan, Shantinagar, South Shajanpur, North Shajahanpur, Farkirapul &

PVO Representative in Country: (if any) or Program Manager for Headquarters: Aramba

(name) Dr. Amir Ali, CEO - Aga Khan Foundation (Bangladesh)
(address) SW(F) 3B, Road No. 2, Gulshan, P.O. Box 6025, Dhaka, BANGLADESH
(phone) 880-2-60-19-24

Local Counterpart/Host Country Agency: (If no PVO representative)

*Complete separate sheet for each country program and headquarters.

COUNTRY INFORMATION FOR A.I.D.-SUPPORTED PVO PROJECTS

Organization: Aga Khan Foundation U.S.A.
Project/Grant No.: PDC-0158-A-00-1102-00
Grant Dates: July 1, 1991 to June 30, 1994
Funding Mechanism: Matching Grant
(i.e., MG, OPG, Contract, CA, Etc.)

*COUNTRY NAME OR HEADQUARTERS: Pakistan - Urban PHC Program

Project Purpose: (limit to 40 words or less)

To expand urban PHC sites to high risk populations of low-income settlements with shifts toward lower costs and devolution onto community control and alternative resources, while initiating the development of a macro-PHC site prototype for larger-scale replication.

Project Implementation:
Start Date: 07/01/91 Estimated Completion Date: 06/30/94
Status: (limit to 25 words or less) PHC modules stable in 7 communities. Expansion of services through scaling-up and links with other health providers. MIS and comparative analysis strengthened.

Project Funding:

Year FY 91	Year FY 92	Year FY 93	Year	Year	TOTAL 7/91-6/94
AID$ 0.0	AID$ 0.0	AID$ 0.0	AID$	AID$	0.0
PVO$ 311.4	PVO$ 312.8	PVO$ 309.3	PVO$	PVO$	933.5
OTHER	OTHER	OTHER	OTHER	OTHER	
INKIND	INKIND	INKIND	INKIND	INKIND	
LOCAL	LOCAL	LOCAL	LOCAL	LOCAL	
TOTAL 311.4	TOTAL 312.8	TOTAL 309.3	TOTAL	TOTAL	933.5

Location in Country: (Region, District, Village - Be Specific)

Karachi (Orangi, Karimabad, Essa Nagri, Azam Basti, Grax, Chanesar Goth & Baba Isl

PVO Representative in Country: (if any) or Program Manager for Headquarters:

(name) Mr. Hakim Feerasta, CEO - Aga Khan Foundation (Pakistan)
(address) Jubilee Insurance House, 2nd Floor, I.I. Chundrigar Road, POB 101(
(phone) 9221-241-1141 Karachi 2, PAKIST

Local Counterpart/Host Country Agency: (If no PVO representative)

Aga Khan University, Department of Community Health Sciences, Karachi

*Complete separate sheet for each country program and headquarters.

COUNTRY INFORMATION FOR A.I.D.-SUPPORTED PVO PROJECTS

Organization: Aga Khan Foundation U.S.A.
Project/Grant No.: PDC-0158-A-00-1102-00
Grant Dates: July 1, 1991 to June 30, 1994
Funding Mechanism: Matching Grant
(i.e., MG, OPG, Contract, CA, Etc.)

*COUNTRY NAME OR HEADQUARTERS: Multi-Country: Primary Health Care Management Advancement Program (PHC MAP)

Project Purpose: (limit to 40 words or less)

To use tools developed to help PHC managers collect, process, analyze and use information in a timely, efficient, effective manner, while developing methods for analyzing the social, organizational and financial sustainability of PHC programs.

Project Implementation:
Start Date: 07/01/91 Estimated Completion Date: 06/30/94
Status: (limit to 25 words or less) 9 PHC Modules and Guides finalized, Desk Top Publishing production and printing completed. Promotion and training activities begun.

Project Funding:

Year FY 91	Year FY 92	Year FY 93	Year	Year	TOTAL 7/91-6/94
AID$ 209.6	AID$ 160.0	AID$ 109.7	AID$	AID$	479.3
PVO$ 285.1	PVO$ 4.9	PVO$ 24.0	PVO$	PVO$	314.0
OTHER	OTHER	OTHER	OTHER	OTHER	
INKIND	INKIND	INKIND	INKIND	INKIND	
LOCAL	LOCAL	LOCAL	LOCAL	LOCAL	
TOTAL 494.7	TOTAL 164.9	TOTAL 133.7	TOTAL	TOTAL	793.3

Location in Country: (Region, District, Village - Be Specific)

10-12 PHC/MCS programs in Asia and Africa will be involved.

PVO Representative in Country: (if any) or Program Manager for Headquarters:

(name) Mr. Iqbal Noor Ali, CEO - Aga Khan Foundation U.S.A.
(address) 1901 L Street, NW, Suite 700, Washington, D.C. 20036
(phone) 202-293-2537

Local Counterpart/Host Country Agency: (If no PVO representative)

*Complete separate sheet for each country program and headquarters.

COUNTRY INFORMATION FOR A.I.D.-SUPPORTED PVO PROJECTS

Organization: Aga Khan Foundation U.S.A.
Project/Grant No.: PDC-0158-A-00-1102-00
Grant Dates: July 1, 1991 to June 30, 1994
Funding Mechanism: Matching Grant
(i.e., MG, OPG, Contract, CA, Etc.)

*COUNTRY NAME OR HEADQUARTERS: Multi-Country: Regional Network Program (RNP)

Project Purpose: (limit to 40 words or less)

To continue to facilitate interaction among PHC/MCS programs in four countries within the Aga Khan Health Network while strengthening their individual capacitie to improve PHC health services, as well as increasing the effectiveness of PHC Management while working toward greater equity, effectiveness, efficiency and sustainability of these respective programs.

Project Implementation:

Start Date: 07/01/91 Estimated Completion Date: 06/30/94

Status: (limit to 25 words or less) PHC programs from Bangladesh, India, Pakistan, Kenya participating in meetings, workshops, and newsletter. Annual workshop held in Kathmandu in March 1993.

Project Funding:

Year FY 91	Year FY 92	Year FY 93	Year	Year	TOTAL 7/91-6/94
AID$ 47.4	AID$ 84.4	AID$ 153.6	AID$	AID$	285.4
PVO$ 58.1	PVO$ 44.4	PVO$ 1.7	PVO$	PVO$	104.2
OTHER	OTHER	OTHER	OTHER	OTHER	
INKIND	INKIND	INKIND	INKIND	INKIND	
LOCAL	LOCAL	LOCAL	LOCAL	LOCAL	
TOTAL 105.5	TOTAL 128.8	TOTAL 155.3	TOTAL	TOTAL	389.6

Location in Country: (Region, District, Village - Be Specific)

PVO Representative in Country: (if any) or Program Manager for Headquarters:

(name) Mr. Iqbal Noor Ali, CEO - Aga Khan Foundation U.S.A.
(address) 1901 L Street, NW, Suite 700, Washington, D.C. 20036
(phone) (202) 293-2537

Local Counterpart/Host Country Agency: (If no PVO representative)

*Complete separate sheet for each country program and headquarters.

COUNTRY INFORMATION FOR A.I.D.-SUPPORTED PVO PROJECTS

Organization: Aga Khan Foundation U.S.A.
Project/Grant No.: PDC-0158-A-00-1102-00
Grant Dates: July 1, 1991 to June 30, 1994
Funding Mechanism: Matching Grant
(i.e., MG, OPG, Contract, CA, Etc.)

*COUNTRY NAME OR HEADQUARTERS: Headquarters

Project Purpose: (limit to 40 words or less)

To provide for monitoring and evaluation of the various Matching Grant Projects.

Project Implementation:
Start Date: 07/01/91 Estimated Completion Date: 06/30/94
Status: (limit to 25 words or less) External evaluation planned and scheduled for Sept.-Oct. 1993.

Project Funding:

Year FY 91	Year FY 92	Year FY 93	Year	Year	TOTAL 7/91-6/94
AID$ 0.0	AID$ 0.0	AID$ 37.7	AID$	AID$	37.7
PVO$ 0.0	PVO$ 0.0	PVO$ 4.3	PVO$	PVO$	4.3
OTHER	OTHER	OTHER	OTHER	OTHER	
INKIND	INKIND	INKIND	INKIND	INKIND	
LOCAL	LOCAL	LOCAL	LOCAL	LOCAL	
TOTAL 0.0	TOTAL 0.0	TOTAL 42.0	TOTAL	TOTAL	42.0

Location in Country: (Region, District, Village - Be Specific)
Washington, D.C.

PVO Representative in Country: (if any) or Program Manager for Headquarters:

(name) Mr. Iqbal Noor Ali, CEO - Aga Khan Foundation U.S.A.
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Local Counterpart/Host Country Agency: (If no PVO representative)

*Complete separate sheet for each country program and headquarters.

LOGICAL FRAMEWORK

CONSOLIDATED

NARRATIVE SUMMARY	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Goals			
1. Contribute to improving the equity, effectiveness, efficiency and sustainability of PHC programs in developing countries of Asia and Africa.	PHC and health services coverage, and infant, child and maternal mortality rates in countries concerned; level of awareness of AKHN's PHC efforts among key government and NGO health professionals in countries where AKHN is working, and beyond.	National and international (WHO, UNICEF, World Bank) reports on selected health indicators; interviews with key professionals. Project annual reports and project MIS tracking key indicators.	Social and financial commitment to PHC in project countries is maintained; AKHN can develop potentially replicable prototypes for health system organization and management which others find useful; AKHN continues to work effectively with communities in ways which local groups consider useful for their own development; availability of funding.

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Purposes			
1. Expand coverage, increase effectiveness and test new organizational models for community-based PHC in three projects serving the health needs of more than 200,000 urban and rural residents by strengthening the capacities of local communities and NGOs to deal with their own health problems.	Increase in total populations covered from 168,000 to 200,000 as follows: Kenya: Baseline 44,435; End of Project 44,435 Bangladesh: Baseline 62,000; End of Project 70,000 Pakistan (incl. macro site): Baseline 57,900; End of Project 87,900 Total: Baseline 164,335; End of Project 202,335 PHC/MCS programs will be accessible and available to at least 80% and up to 90% of their respective target populations (29,500 women between 15 and 49 years, and 36,900 children under 5) leading to improved health status, as evidenced by: increase in levels of availability and use of immunization, growth monitoring, antenatal safe delivery and basic treatment services; decrease in infant and maternal mortality rates as appropriate; cause-specific death rates of immuno-preventable diseases, diarrhoea, ARI and pregnancy-related causes. Increase in levels of community participation measured by social indicators as developed by RNP and new organizational models tested by AKU in Karachi.	Project MIS, including routine reports and home and health facility-based records; community surveys; project and/or officially mortality reporting systems; periodic monitoring and evaluation exercises.	Stable political and socio-economic environment in the project areas; project activities are acceptable to and welcomed by the target population; PHC/MCS management teams are committed to PHC/MCS strategies and goals; project staff maintain strong spirit of enquiry and innovation in seeking better ways to work with communities to improve health.

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2. Strengthen management, information systems, and the social, organizational and financial sustainability in 10 to 12 PHC programs involved in RNP and PHC MAP activities.	Levels of development, relevance to program goals, and efficiency of program management and information systems; levels of management skills of PHC staff and communities; proportion of program costs being covered from community and other local resources, and from outside the project area; qualitative indicators of social, organizational and financial sustainability developed.	Project reports and evaluations; PHC MAP and RNP reports on management and sustainability related issues; analysis of trends in community involvement and financial projection.	Management and information are important constraints to more effective health programs which can be overcome with better tools, skills and training; sustainability can be defined in meaningful and operational terms for useful analysis; such analysis is meaningful in the context of a three year project period.
3. Produce, distribute and promote the use of 9 field-tested PHC management information modules and related training and resource materials.	Distribution and use of PHC MAP management tools and reference materials by PHC/MCS projects involved.	PHC MAP and RNP annual workshops; PHC service statistics, presentations at RNP and PHC MAP managers workshop; management and information modules produced by PHC MAP; midterm and final evaluations.	Continued regional stability of relationships and associated possibilities of constructive interaction among participating programs and with other NGOs and Governments.

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Outputs			
A. In Mombasa PHC, AKCHP and Urban PHC areas:			
1. Greater community participation in health, including enhanced capabilities for community planning and management which will facilitate long-term local sustainability.	Increase in number of communities with community organizations responsible for health and exercising some degree of control over local health activities; extent of community management of financial and in-kind contributions.	Project reports and evaluations; analysis of trends in community involvement and financial projections; midterm and final evaluations.	Services offered will be accessible, acceptable and used by communities; communities are willing and able to organize and exercise local responsibility for health activities, and to commit their own resources to its support.
2. Increased use of priority health services by women and children.	Target populations effectively covered by antenatal care, delivery and immunization services; while each program has its own set of priorities, indicators such as the following will be used as appropriate; pregnant women using prenatal services; deliveries conducted by trained birth attendants; children fully immunized in the first year of life. Percent of children <5 to be immunized by end of Year 3. Baseline / Year 3 MPHC 62% / 85% AKCHP 50% / 85% UPHC 68% / 85% The AKCHP and UPHC programs have targeted increases in tetanus toxoid immunizations of all women (15-49) from 51% to 60% and 53% to 75% over three years respectively.	Community contributions in existing PHC fields sites; contributions from NGOs to be determined in course of project; possible contribution from World Bank project under discussion. PHC service statistics. CHWs and LHVs monthly monitoring and evaluation records; household visitation records; census data.	Immunization clinics held regularly availability of adequate cold-storage chain for vaccine delivery to often remote, inaccessible areas; availability of adequate supply of vaccines. Acceptability by communities of relevant immunizations to help prevent disease and promote better health for population.

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3. Increased numbers of appropriately trained PHC human resources.	MPHC staff will increase to include 1 CHN, 18 HDC members, 125 CHWs, 60 TBAs, 20 shopkeepers (for pharmaceutical distribution), 10 Traditional Healers, and 96 school teachers who are involved in the child-to-child school health program. Ongoing refresher courses will be provided as appropriate. At AKCHP staffing pattern will transform slightly as project evolves to a community-led approach. The program will train/retrain 8 CHOs, 40 CHWs, 100 CHVs, 150 TBAs, 100 CMVs and 85 school teachers involved in educating children about preventive health are. The UPHC, Karachi, will continue its current staffing patterns for its existing micro-sites but expand for its macro PHC system of approximately 10 modules by 120 CHWs, 15 LHVs, 10 CHNs, 10 FTE CHDs with administrative support from a project oversight team including a Project Team/Director, CHN, CHD, CHO, administrator, education trainer, MIS coordinator and a secretary.	Project reports, midterm and final evaluations.	Continued involvement of the targeted communities in health care planning and development; acceptance by communities to allow its young women to participate and be trained to render health care services.

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4. Increase in awareness and effective use by families of home and community-based PHC technologies, such as ORT (including cereal-based forms), recognition and treatment of ARI, growth monitoring and improved infant feeding.	Number (%) of mothers/families trained to use technologies, e.g. increase number of mothers trained in home-based ORT use who can demonstrate proper preparation and use when requested; mothers awareness of available means of prevention and treatment and knowledge about treatment of childhood disease; number of mothers who can interpret growth monitoring information about their children. Targeted growth monitoring and nutrition promotion (children <3 being weighed regularly): Baseline / Year 3 MPHC 40% / 80% AKCHP 70% / 80% UPHC 75% / 85%	Service statistics, clinic and home-based records, sample surveys, project reports and evaluations.	Program is able to provide effective health education which is consistent with cultural values and traditional health beliefs; community is willing and able to put health education messages into practice; mothers will be actively involved in accessing health care for their family.
5. Mechanisms for local financing of PHC activities which are likely to ensure long-term financial sustainability.	Feasibility studies of Income Generating Activities (IGA)s; technical assistance to women's groups and others involved in IGAs; number of communities with income-generating activities, fee-for service schemes, prepaid insurance or alternative local financing mechanisms; total amount of local resource generated annually; amount of these resources available and used for health activities; level of community health contributions, both financial and in-kind; level of community involvement in management of local resources.	Ongoing progress reports; monitoring and evaluations; reports of studies completed; consultants input and reports.	Each of the program sites will have an IGA expert available over the three years; MPHC & AKCHP are successful in recruiting an IGA officer for short term basis over the three years; communities will support IGAs and generate funds that will be used for health care services; "seed" funding available for start up IGAs planned; technical assistance available as required.

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B. In addition, in Urban PHC, Karachi:			
6. Greater knowledge and awareness of local, social and environmental determinants of morbidity and mortality and testing of potential strategies for improvement of social and environmental determinants through community and institutional efforts.	Health education, nutritional surveillance activities conducted by CHWs, CHVs, CMVs, CHN as appropriate. Educational sessions provided on a regular basis to communities particularly to target high-risk group. Analysis of local disease determinants available; strategies formulated against critical determinants; potential strategies tested and evaluated by AKU/CHS; results used to improve delivery, morbidity and mortality.	Community participation and numbers of participants at educational sessions held; improved status noted on child growth cards, and collected through AKF Standardized Indicators used by Programs. Design, assess and implement studies planned; data collection and analysis of studies conducted. Final analysis of study findings, progress reports.	Availability of appropriate health education materials; participation of communities in health education sessions; availability of trained personnel in health communications and data collection.
7. A functioning prototype of a Mcro-PHC system involving collaboration with government and NGOs engaged in community-based activities, and establishment of reliable linkages for technical support and clinical referrals.	Established macro-field sites fully staffed and operational at planned levels. The PHC Macro Project will be supported by a Project Oversight Team as described in Output 3.	Dialogue/discussion with governmental agencies that are involved in this collaborative effort; progress reports.	Community participation; collaboration with Ministry of Health and other NGOs interested and committed to this projects political social and economic stability; availability of external funding and community contributions.

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C. In the 10-12 projects involved in RNP and/or PHC MAP:			
8. Increased innovation and exchange of knowledge and experience in both social and technical aspects of PHC implementation.	Annual PHC MAP and RNP managers workshops; regular publication and circulation of RNP newsletters. Collaboration between PHC managers, AKU/CHS, ASEAN Institute of Health (Thailand), AKHS, India and other individuals invited to participate.	PHC MAP and RNP reports and evaluations, RNP newsletters, project reports and evaluations; interviews with key AKHN staff and other participants.	Active participation of all PHC/MCS programs involved; availability of external funding to supplement internal resources; availability of technical backstopping; continued regional stability of relationships and associated possibilities of constructive interaction among participating programs and with other NGOs and governments.
9. Stronger planning and management capabilities, and greater availability and appropriate use of information for rational decision-making.	Improved skills in planning and management among program management teams, as evidence by: availability and quality of program plans, implementation schedules, budgets, operating guidelines and procedures, supervisory skills, monitoring and evaluation procedures, and management information systems; program MIS generates regular reports on key program indicators; MIS reports reviewed regularly by PHC management teams and action taken to address problems identified.	Progress reports; RNP newsletters, midterm and final evaluations; exchanges during annual meetings and workshops for PHC managers.	PCH/MCS program managers appreciate importance of improving management information, skills and procedures to support their service activities; appropriate technical assistance is available and can be provided.

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10. Nine field-tested tools addressing generic PHC management information needs of PHC managers, such as methods for rapid surveys, cost analysis, sustainability analysis and analysis of health worker performance, supported by related training and reference materials.	Distribution of PHC MAP field-tested tools to all participants. Use by PHC/MCS programs of PHC MAP modules and reference materials.	Project reports, midterm and final evaluations, project site visits.	As above. Availability of funding to develop and field-test material.

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Inputs

Funding from AID, AKF USA, and other donors for: program elements, including project staff salaries, mainly local travel, and other operating expenses such as training, workshops and seminars, rentals of facilities and equipment, repairs and maintenance and other administrative expenses; procurement of consultants' services for technical assistance, project development, etc., their travel costs, and capital and consumable items required by various projects; ongoing monitoring, and midterm and final evaluation costs for consultants, external evaluators, and local and international travel.

In-kind contribution from AKF USA and other network affiliates of staff and volunteer time and related costs, including travel, for overall program management technical backstoppoing, and ongoing monitoring are not charged to the Matching Grant budget and have not been quantified, but are estimated to be $1,500,000 over the three year grant period.

Budgeted Costs ($000)

	Yr 1	Yr 2	Yr 3	Total	%
Kenya:					
MPCH	157.0	115.4	120.0	392.4	15
Bangladesh:					
AKCHP	97.4	64.8	0.0	162.2	6
Pakistan:					
UPHC	311.4	312.8	309.3	933.5	34
Multicountry					
RNP	105.5	128.8	155.3	389.6	14
PHC					
MAP	494.7	164.9	133.7	793.3	29
HQ:	0.0	0.0	42.0	42.0	2
TOTAL	1166.0	786.7	60.3	2713.0	100

Sources ($000)

AID	403.3	411.7	385.0	1200.0	44
AKF, Other	762.7	375.0	375.3	1513.0	56
TOTAL	1166.0	786.7	760.3	2713.0	100

Periodic Financial reports and requests for reimbursement to AID; Annual Reports; AKF USA's annual audited financial statements; midterm and final evaluations; project site visits.

Availability of funding from AID.

Inflation rates will not exceed amounts factored into budgets.

Currency exchange rates will remain stable.