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PAKISTAN CHILD SURVIVAL PROJECT

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**by
Management Sciences for Health
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I. EXECUTIVE SUMMARY

The Project faced three major challenges during the period covered in this report: (1) evacuation of the Technical Assistance Team (TAT) due to the Gulf War crisis (mid-January to mid-April), (2) marked reduction in funding and an associated decrease in the duration of the Project as a result of the "negative" Pressler designation, and (3) changes in a number of key staff positions at the GOP, USAID and in the Project itself (resignation of the Chief of Party during evacuation in January 1991).

The cumulative effect of the evacuation and the Pressler Amendment inevitably resulted in a significant delay in implementation of project activities. The impact of Pressler was particularly significant since it forced an immediate review and prioritization of all project activities, including a total revamping of the budget. Although the entire workplan was revised, the Communication, Research and Training components received the most significant reductions in activity levels. All proposed revisions were made with an attempt to maintain the integrity of established Project objectives. While funding under this contract will be sufficient to establish the framework for Training and Health Information Systems, additional outside financial assistance will be required to accomplish essential activities.

Despite these constraints, significant achievements were made in each of the Project component areas. These included:

Project Planning and Management

- o Established Federal Steering Committee and held first meeting in May. Initiated the Provincial CS Steering Committees
- o Completed plans for the first Donor Consortium meeting
- o In response to the Pressler Amendment, developed a list of priority activities and revised the Project Workplan
- o Established and staffed the Project offices in Islamabad and the four provinces

Training

- o Continued training in the existing ten Diarrheal Training Units and advanced plans for converting them into integrated Child Survival Training Units
- o Completed assessment of ten ORT corners
- o At National Workshop of DTU Directors and CDD Program Managers, reached consensus on an integrated, child-focused curriculum for four intervention areas (nutrition, immunization, diarrhoea disease and acute respiratory infections), with training to be done on a decentralized basis. There is to be a minimum of five trainers at each integrated Child Survival Training Unit (CSTU), and one full-time Training Coordinator
- o Conducted evaluation of eight teaching hospitals (without DTUs) to assess the feasibility of initiating integrated Child Survival training at these sites.
- o Initiated an extensive review of existing Child Survival training materials

Health Information Systems

- o Completed an HIS assessment
- o Conducted a Mortality study
- o Assessed existing computer cells
- o Held First National Workshop on Health Information Systems in May 1991. Reached consensus on: (1) the need to strengthen central information management at the federal and provincial levels, (2) the need to replace existing routine reporting systems at first level care facilities (FLCF) by comprehensive integrated health information systems, and (3) the need to improve the existing disease surveillance system
- o GOP counterparts were appointed to work with the HIS Team

Communication

- o Selected Spectrum Communications of Karachi as the Project's advertising agency
- o Initiated the selection process for a market research sub-sub-contractor
- o Revised the Communication Component in response to the decreased budget to place more emphasis on less-costly activities such as interpersonal communication and community development.

Drugs and Logistics

- o Completed a drug procurement analysis in Balochistan and NWFP
- o Published "Drugs and Logistics Summary Report"
- o Conducted an assessment of EPI storage facilities at the federal level, and in Balochistan, NWFP, and Punjab

Research

- o Completed initial planning and development for the Cotrimoxazole Impact Study for children with pneumonia and Focused Ethnographic Study for ARI. Drafted the protocol for the Cotrimoxazole study
- o Assisted the Applied Diarrheal Disease Research group in planning for a Proposal-Writing Workshop in July

Despite the aforementioned challenges, the Project was successful in re-establishing its credibility and viability with the Government of Pakistan, USAID and other international agencies. Successful implementation of key activities in each component, along with the establishment of central and provincial offices, has put the PCSP in a good position to accomplish its objectives for the next six months.

LIST OF ABBREVIATIONS

ADB	Asian Development Bank
ADDR	Applied Diarrheal Disease Research
AED	Academy for Educational Development
AJK	Azad Jammu and Kashmir
ARI	Acute Respiratory Infections
BHU	Basic Health Unit
BHS	Basic Health Services
CDC	Centers for Disease Control
CDD	Control of Diarrheal Diseases
CIDA	Canadian International Development Agency
COP	Chief of Party
CS	Child Survival
CSTUs	Child Survival Training Units
DG	Director General
DTUs	Diarrheal Training Units
EPI	Expanded Programme of Immunizations
FLCF	First Level Care Facilities
GOP	Government of Pakistan
HIID	Harvard Institute for International Development
HIS	Health Information Systems
HMIS	Health Management Information Systems
HPN	Health, Population, and Nutrition
IPC	Interpersonal Communication
MIS	Management Information Systems
MOH	Ministry of Health
MSH	Management Sciences for Health
NIH	National Institute of Health
NWFP	Northwest Frontier Province
ORT	Oral Rehydration Therapy
PCSP	Pakistan Child Survival Project
PHC	Primary Health Care
PMRC	Pakistan Medical Research Council
PPA	Pakistan Pediatric Association
RHC	Rural Health Care
TAT	Technical Assistance Team
USAID	U.S. Agency for International Development
UNICEF	United Nations International Children's Educational Fund
WHO	World Health Organization

INTRODUCTION

This is a brief summary of the accomplishments and activities of the Technical Assistance Team (TAT) from January 1991 through June 1991. All activities described here were conducted in consultation with our USAID colleagues and Pakistani counterparts, whose contributions and support we gratefully acknowledge.

This report addresses only those Child Survival activities under the scope of work specified in the Contract between MSH and USAID, and does not refer to the activities managed directly by USAID which are outside the scope of the contract.

I. ACHIEVEMENTS

Technical Activities

Program Planning and Management

1. Funding Reductions

In early February, the Team was informed that the U.S. Government had made a negative Pressler determination as of 1 February, that is, from that date, it was no longer assumed that the Government of Pakistan would sign the non-nuclear certification required by the U.S. Government. This decision initiated a process of discussions that would drastically alter the future of the Pakistan Child Survival Project. Rather than looking toward our just-approved workplan for guidance over the remaining life of the Project, we were asked to begin "Priority Activity" discussions, with a goal toward an overall reduction of activities to fit within a new budget framework which consisted of the current contract obligation as the new contract total. This is a 54 percent reduction in the Base period of the project, or through September 1993. This date would also be considered the new end date of the Project, thereby eliminating any consideration of the Option period of the contract, which was scheduled to run an additional two years. This was a significant activity during the period, which can be broken down to several distinct phases:

- 1.1. During the months of February and March, the TAT was asked to review each component and assess which activities could be reduced, without altering the basic design of the project. The first presentation of this work was presented to Anne Aarnes and Lois Bradshaw, the new HPN Project Officer in Washington on 28 March. During that presentation, the TAT stressed that without the input of the GOP, the proposed changes in activities should be considered tentative, which would be confirmed after discussion with the GOP.
- 1.2. With the return of the TAT from evacuation in April (Dr. Upreti returned in mid March), discussions began with the PCSP Project Director, Dr. Mushtaq Chaudhry to involve the GOP in these discussions. We received several clear messages from the Government in terms of areas where they would like to see activities reduced. With a goal toward keeping the administrative time devoted to this activity to a minimum, in order to concentrate on implementation of activities, a plan with an associated timeline was discussed and agreed upon with USAID and the GOP on the submission of the revised "Priority Activities."

- 1.3. Mr. Peter Huff-Rousselle spent a week in Islamabad in early May participating in individual and group meetings with USAID to discuss the revised activities and assist in the re-budgeting process. His visit concluded with a comprehensive meeting at USAID with the entire USAID/TAT where the next phase was discussed and agreed on.
- 1.4. A meeting was arranged for May 19 to present the priority PCSP activities to the Government, and to seek their input regarding the activities presented.
- 1.5. The first PCSP Federal Steering Committee was held on 28 May, with the reduced funding activities as the main agenda topic. During that meeting, chaired by the D.G. (Health), the MOH reaffirmed their commitment to the PCSP and support to the priority activities presented. (See Appendices 1 and 2.)

2. New Project Director(s)

- 2.1 During this reporting period, the Project sustained a number of changes in key leadership positions. The Federal Project Director changed two times, necessitating significant orientation time for each new Director. There is every indication that the Project Director will change at least one more time in the next reporting period, which will result in another "orientation" period. Such turnover in this position is detrimental to establishing a strong support base for Child Survival within BHS.
- 2.2 Contrary to the Federal level, our relationships with provincial Project Directors, Director Generals and Program Heads/Coordinators related to Child Survival (of programs such as EPI, CDD, ARI), have been relatively stable. This has allowed us to strengthen Child Survival activities and our relationship with the Government agencies responsible for these activities.
- 2.3 Within USAID there were also significant changes in leadership. We gained a new Project Health Officer during the evacuation, again necessitating an orientation and establishment of a new relationship.
- 2.4 Finally, within the Project itself, there was a change in the Chief of Party during the evacuation which resulted in the placement of an interim Acting Chief of Party until the long-term position could be filled. In fact, the Acting Chief of Party has been in place throughout this reporting period. Once again, the change in this critical position has required the TAT to expend time/energy to acquaint the Acting Chief of Party with the Project and component-specific activities.

The Acting Chief of Party assumed responsibilities during the evacuation period and returned with the team in April. The initial several months were devoted to the re-creation of credibility for the Project, as well as the establishment of the Acting Chief of Party in her role, particularly building rapport with critical GOP and USAID colleagues. Given the political sensitivity surrounding the evacuation, as well as the history of this Project, including difficulties in initiating implementation, the change in the Chief of Party was a most sensitive issue.

- 2.5 Given these circumstances, significant efforts were required by all TAT members to re-establish the credibility and strength of the project in the eyes of our Government colleagues. Nonetheless, by the close of this reporting period, a new foundation of relationships, credibility and trust had been established with our AID and GOP

counterparts or colleagues.

3. Establishment of Federal and Provincial Child Survival Steering Committees

3.1 **Planning and Establishment of Federal Child Survival Steering Committee.** During this reporting period, plans for the first meeting of the Federal Steering Committee were consolidated, the Steering Committee appointed, and the meeting held on 28 May, during which the proposed priority activities corresponding with the reduced budget, post-Pressler, were discussed and approved. There was considerable discussion regarding a revision of the PC-1, but happily, it was determined that such revisions should not take place immediately, but would be reconsidered after the circumstances surrounding Pressler were clarified between the two Governments. There was overwhelming and full support for the continuity of the PCSP, particularly by the Provincial Director Generals attending this meeting. The Steering Committee will meet on a regular (semi-annual) basis. It serves as an important forum for leaders in Child Survival from both national and provincial levels, from a variety of departments instrumental in the planning and implementation of Child Survival activities, as well as from the departments included in the development of related policies.

3.2 **Planning and Establishment of Provincial Steering Committees.** Patterned along the same line as the Federal Steering Committee, the Project has worked with provincial leaders to establish provincial Child Survival Steering Committees, with basically the same type of membership, but from corresponding provincial positions.

Particularly at the provincial level, the steering committee plays an essential role in coordinating Child Survival interventions, activities, and policy for the variety of programs involved in these endeavors. The Secretary of Health has been proposed as the Chairperson of the steering committees, since he has authority over the autonomous bodies, the teaching institutions, and the Director General (who in turn has responsibility for the Basic Health Services Cell and its staff of implementors, in addition to programs involved in child health, such as EPI, CDD, ARI, Nutrition (which is currently under the Planning Division) and some aspects of maternal child health.

3.3 At both provincial and federal level, the coordination and integration of Child Survival activities, whether in training, communication, or health information system development, is complicated by the fact that structures remain somewhat "vertical" within intervention-specific programs and departments. Thus, the steering committees should provide an "umbrella function" for appropriate authorities to coordinate activity implementation and associated planning or policy. Policy-makers and those responsible for planning or financial decisions, such as membership from Planning and Development (Health) as well as the Finance Department, are included for the precise purpose of involving such individuals from early in the process, ultimately contributing to longer term incorporation into provincial government structure, and sustainability of child survival activities. At the time of writing this report, steering committees had been set up in Balochistan and AJK. Plans for institution in the other provinces were in process.

4. Donor Consortium Meeting

4.1 As a result of the markedly reduced funding and related scope of activities of the

Child Survival Project, it was clear that if the original objectives were to be accomplished in any of the component areas, additional funding would have to be identified. Given the current political climate, it seemed unlikely that USAID's contribution would be greatly altered. Thus, in order to maintain the longer term objectives of this Project, coordination with other donors (with similar Child Survival objectives) would be essential. This approach, discussed with USAID and GOP colleagues, was well-received.

- 4.2 Several projects in UNICEF, World Bank, and ADB have similar objectives and goals as the original PCSP, particularly in training and health information systems. Thus, it made sense to initiate a forum for cooperative planning and implementation of Child Survival-related activities and in due course, to consider cooperative funding. Such efforts should decrease overlap between project activities, and augment implementation, potentially extending the foundation laid by PCSP.
- 4.3 With this in mind, plans for a Donor Consortium were made, with the first meeting to be held in early July. Although this would be the formal vehicle for discussion of cooperative activities related to Child Survival, a number of informal discussions were also initiated with those donors known to have similar scopes of work.

5. Establishment of inter-agency Relationships

- 5.1 Concerted efforts were made to meet with other agencies involved in Child Survival activities, be they in training, health information systems, communication, or intervention-specific programs such as EPI, CDD, ARI, or Nutrition. In particular, international agencies such as UNICEF and WHO, as well as donor agencies like the World Bank, were targeted for specific discussions regarding project goals and objectives, activities (planned or accomplished to date), and funding to support these activities.
- 5.2 Efforts were made to establish ongoing communication channels at federal and provincial levels between PCSP staff and the Child Survival staff of other agencies. Specific areas of overlapping activities were identified and efforts made to promote cooperative planning and implementation, avoiding duplication as much as possible. Summaries of these meetings are available. Once the PCSP provincial offices are well-established, specific cooperative ventures in training and health information systems can be identified.
- 5.3 This type of effort has also been extended with UNICEF, CIDA, and the World Bank. Specific discussions have been held regarding continuity of PCSP activities in HIS and training.
- 5.4 Regular meetings with WHO, UNICEF, and CIDA have been established not only between Project Directors, but also with individual component TAT and appropriate colleagues in these agencies.

Training

The Training Advisor, Dr. Tara S. Upreti during this period was assisted by Mr. Rashid Khan, Field Operation Coordinator and Dr. Ayub Salariya, Training Education Specialist (who joined the Project on April 30, 1991).

1. Continuation of CDD Activities in Existing 10 DTUs

- 1.1 During this reporting period a total of 422 participants were trained through existing 10 Diarrheal Disease Training Units. Of this total, 352 were physicians and 70 were nurse/paramedic tutors. (For the preceding six months total number of persons trained was 558.)
- 1.2 During the reporting period, the total number of health facilities equipped with ORT corner furnishings and supplies was 100, compared to 149 facilities for the preceding six months. Both the number of trained manpower and health facilities assisted are fewer for this reporting period. This reduction was intentional and reflects the decision and desire to continue training on diarrhea (albeit at a gradually reduced rate), while simultaneously developing detailed plans and logistics for integrated (4 intervention) Child Survival training.
- 1.3 Data collection from 10 ORT corners affiliated with the 10 DTUs was completed and presented at the April 29 and 30 meeting of DTU Directors and CDD Programme Managers. This set of information illuminated the operational status of the ORT corners.

2. Workshops

- 2.1. One 2-day, National Workshop of DTU Directors, CDD Programme Managers, and Director Generals of Health (federal and provincial) was held in April to reach a consensus on:

1. Training strategy
2. Training material

A separate report has been submitted on this activity. General agreements reached at this meeting include:

1. A 1 integrated and child-focused training on nutrition, immunization, diarrhea and acute respiratory infections will be provided to medical officers and paramedics of first level care facilities.
 2. Teaching hospitals will conduct:
 - a) Training of district level trainers, supervisors, medical students, house staff and (in urban areas) private practitioners
 - b) Five to 10 trainers will be trained for each training unit
 - c) One full time training coordinator is needed at each training unit
 - d) A nutrition subcommittee is to be formed to develop guidelines on nutrition curriculum content.
- 2.2. A two-day staff meeting was held in March for DTU staff. They were oriented to

the PCSP activities and were asked to reduce their training activities and field visits.

3. Provincial visits

3.1 A total of 17 visits were made to various health facilities within the four provinces from January to April. The purpose of these visits was to collect data on the operational status of the 10 ORT corners affiliated with DTUs. Most of the visits in May and June also included assessment of teaching hospitals as future sites for the establishment of Child Survival Training Units (CSTUs). During these visits, discussions were initiated regarding the best way to implement Child Survival (CS) training activities.

In addition, during these provincial visits, discussions were held with members of Pakistan Pediatric Association (PPA) regarding the role that such a professional organization could play in providing continuing education to physicians. PCSP training team members will work with PPA to develop a training plan and associated material for private practitioners.

4. Teaching Hospital assessment

4.1 During the month of May three teaching hospitals in Punjab (2 in Lahore and 1 in Faisalabad) were visited. During each of these visits, the training team met with the Principal of the Medical College, the Medical Superintendent of the hospital, the Pediatric Professor, and his staff. These individuals were briefed on the Child Survival Project, its training plan and the purpose of the visit. Everyone we met seemed eager to participate in PCSP activities and all were very enthusiastic about training activities. They were informed as to the essential input required to establish a training unit; what would be provided by the Project and what the teaching hospital would be expected to provide (such as an adequate number of trainers and space). Future visits will focus on the specific needs of each institution.

5. Staffing

5.1 On April 30th, Dr. Ayub Salariya joined the project as a Training Education Specialist in the Islamabad Office. He recently retired from the Punjab Government as Additional Secretary of Health (Technical). He is also the founder of the Management Training Institute for Doctors at Lahore established in 1989. In two months he has made significant contributions to the Project.

Ninety-four applications were reviewed for four provincial training coordinator positions from which a short-list for interviews was prepared in May. Interviews were held in June, and the approval process for those selected was initiated. A second training person was identified for the Islamabad Office and will be interviewed.

6. Revising Training Plan

6.1 During this period, a significant amount of time was spent identifying essential training tasks and revising the training plan as a result of the reduced PCSP budget secondary to Pressler.

7. Training Materials Development

- 7.1 **An extensive review of existing Child Survival (especially nutrition) training materials was initiated and a trainers manual for coordinated Child Survival training begun. This will be a continuing activity over the next six months.**

Health Information Systems

The Health Information System (HIS) component activities are the responsibility of the HIS team. The HIS team during the period of this report consisted of: Dr. Theo Lippeveld, HIS Advisor; Mr. M. Zamin Gul, provisionally acting as Information Manager; and, since January 26, Mr. Shafat Sharif, Computer Specialist (who replaced Dr. Nancy Limprecht, former Primary Health Care Project Information Specialist). Dr. Limprecht left the Project on January 15 at the occasion of the Gulf War evacuation.

I. Assessment Study on Health Information Systems

I.1. Mortality Assessment Study

As part of the overall assessment of health information systems, a study was planned to examine the present status of mortality data collected in Pakistan. Two consultants, Prof. Michel Garenne, Associate Professor in Demographics from Harvard School of Public Health and Dr. Akram Parvez, former PMRC Director, undertook this study between January 1 and January 12, 1991.

The major findings of the study are summarized below.

1. Except in some urban areas, the vital events registration system has virtually stopped functioning.
2. Mortality data are collected through surveys and, to some extent, through routine reporting from inpatient departments of hospitals.
3. Existing age-specific mortality data, and particularly that related to children (neonatal mortality, infant mortality, child mortality, etc.), are inaccurate with degrees of uncertainty as high as 25%.
4. Cause-specific mortality rates in children under five are not available.

The study recommended that a more in-depth assessment of existing mortality data be made, in order to ascertain more "likely" estimates of mortality rates, and confidence intervals for these estimates.

For impact evaluation of the PCSP interventions, the authors of the report recommended the organization of a prospective study of levels and causes of mortality among preschool children.

I.2. HIS Assessment Study Report

A major activity during this period was the production of the HIS Assessment Study Report by the HIS team. Communications were particularly difficult since the three authors of the report were in different locations at the time the report was written. The final version of the report was produced in April, and distributed to different government agencies active in the health sector. As of today, approximately 150 copies of the report have been distributed.

In summary, the study points out that existing health information systems do not widely provide adequate information for decision-making, either to health managers

for system planning and management, or to health workers for facility or patient management. The reasons are multiple:

1. Overall health information system management is weak;
2. Indicators do not always respond to specific information needs at different levels in the health system;
3. Data collection in health facilities is poorly organized;
4. Information flows are fragmented. Most national programs have set up separate reporting systems, and, often, separate supervision systems;
5. Data consolidation and processing is mostly done manually. In addition to being time consuming, this process compounds the opportunity for human error;
6. Use of the information generated is greatly limited by the quality of the data collected, by the fragmented information flow, and by the virtually non-existent feedback mechanisms.

Major recommendations given in the report are:

1. Overall information system management responsibility should be given to one statistical office at the federal level, and to one office in each province;
2. Inefficient systems should be replaced with relevant and sustainable alternatives, in particular: a Health Management Information System (HMIS) for first level care facilities, and a disease surveillance system focused on priority diseases;
3. Future users of the information should be actively involved in the design of such alternative systems;
4. Data processing for both subsystems should be computerized at appropriate levels in the health system;
5. Implementation of these systems should involve extensive training of health personnel in data collection procedures, in computerized data processing and analysis, and in the use of the information for improved planning and management.

2. Development of Improved Health Information Systems

2.1. Identification of Government Counterparts

As outlined already in the first Semi-Annual Project Report, the identification of HIS counterparts in the Government for the restructuring effort in HIS was crucial to ensure future sustainability. Ideally these counterparts should be health professionals with experience in health services planning and management, rather than statistical officers.

We discussed this issue at the federal level and in each province. At the federal level, both the Chief of the Biostatistics Cell and one of the Assistant Directors of Basic Health Services were assigned as our counterparts. In each province and in AJK, as well as the Northern Areas, a health professional has been identified as the HIS counterpart. Except for AJK, all these counterparts are physicians with relevant experience in health services planning and management.

2.2. First National Workshop on Health Information Systems

The First National HIS Workshop was held in Islamabad Hotel from May 28-30. About 50 participants attended representing the Federal Ministry of Health, the Planning Division, the Federal Bureau of Statistics, the Provincial Departments of Health, and the donor community.

The main objective of the workshop was to agree upon future restructuring of health information systems in Pakistan. The basis for discussions were the findings and the recommendations put forward in the HIS assessment study report. The workshop ended in a general consensus on the following decisions:

1. Strengthen central information management at the federal and provincial levels through the appointment of health planners/epidemiologists in charge of health information system offices;
2. Replace existing routine reporting system in government managed first level care facilities by a comprehensive and integrated health management information system (HMIS/FLCF);
3. Improvement of the existing disease surveillance system, through
 - * Simplification of reporting in first level care facilities and focusing on priority diseases
 - * Standardization of inpatient disease reporting
 - * Standardization of disease outbreak reporting
 - * Morbidity/mortality surveys pending funding.

Agreement was also reached on the proposed design and implementation plan for HMIS/FLCF. Each provincial delegation appointed an HIS workgroup, representing the users of the future HMIS, from the director of health services up to the health worker in the facilities. These workgroups will design the future HMIS/FLCF in the coming months.

Further details on this Workshop can be found in the official report.

3. Strengthening Computer Capacity in the Ministry

- 3.1 Mr. Shafat Sharif, our newly appointed Computer Specialist, made an assessment of the existing computer cells at the federal level and in the provinces. The information generated through this assessment on hardware and training needs will be the basis for the development of a computer implementation and training plan.

Some on-the-job training in database management was also provided to the provincial computer staff in Peshawar and Hyderabad, where PHC Monitoring System reports are entered.

A comprehensive hardware and software order has been prepared and sent out. By the end of June, some of this material had already arrived in the Project Office.

4. Maintaining the Primary Health Care (PHC) Monitoring System

- 4.1 Reports for the PHC Monitoring System are still regularly being sent by the participating centers in Sindh and NWFP. They are entered in the provincial computers in Hyderabad and Peshawar. Soft copies of the data are then sent to the Project Office. In Punjab, no more reports have been received from the Rural Health Centers in Rawalpindi Division. Discussions with the management analyst in Rawalpindi are underway to remedy this situation.

We analyzed the Sindh and NWFP 1990 data and prepared a feedback analysis report for the Director General and for the District Health Officers.

Communication

The Communication Component is under the direction of Mr. Jim Messick.

1. Government Working Relationships

- 1.1 Developed a mutually trustful, straightforward rapport and professional relationship with the Communication Counterpart, the Federal Health Education Advisor for the Ministry of Health and a good working and communication relationship with other Government officials including the Deputy Director General, BHS/MOH, officials of NIH, the Nutrition Office of the Ministry of Planning, the national ARI Director, Provincial Directors of Health and staffs, including the Assistant Directors and Health Educators.

2. Evacuation Period

- 2.1 There was a continuity of work even during the evacuation. During the January 14-April 5 period, the Communication Advisor maintained steady contact with his GOP counterpart and Islamabad PCSP personnel and continued the search for an advertising agency and a research firm. Additional accomplishments during this period included the development of a prototype PCSP brochure, a draft outline for a slide presentation, and a "bridging" plan using reduced budget scenarios (for discussion with Pakistani colleagues when the Team returned to Islamabad).

3. Advertising Agency Selection

- 3.1 Selection and subcontracting of a professional advertising agency, Spectrum Communications of Karachi, was completed during this period. The competitive selection process followed by the PCSP served as an example for future selections and included the direct involvement of two relevant government officials, the Federal Health Education Advisor (Communication Counterpart) and the Senior Health Education Advisor for the NIH. The Public Health Physician from the Office of HPN of the USAID Mission also participated. The selection process for a research firm was also initiated.

4. Development of Revised Communication Activities

- 4.1 Despite the upheaval from evacuation and a greatly reduced budget, work progressed on the design of a new media campaign which included a TV drama based on the enter-educate model. The strategy of this component was revised to include more interpersonal communication training and community development activities.

Research

The Research Component is under the direction of Dr. Diana Silimperi, Acting Chief of Party.

1. Revision of Research Component in Light of Budgetary Reductions and Reduced Timeframe

- 1.1 Major revisions in this component were completed with the maintenance of basic objectives in terms of institution capability-building and investigation of key research questions essential to Child Survival program activities. However, given the drastic reduction in funds available to develop and implement specific research projects, the decision was made to focus on several critical research questions particularly important for the initiation of the National ARI Program and Child Survival interventions in ARI. In addition, close collaborative efforts with ADDR and potentially UNICEF would be pursued, especially in the area of protocol development and institution capability-building ventures, such as workshops. In essence, the technical assistance of PCSP (particularly the COP) would be utilized in these endeavors, with most of the capital coming from ADDR and (potentially) UNICEF/other donors.

2. Essential Research - Acute Respiratory Infections (ARI)

- 2.1 "The Impact of Cotrimoxazole Resistance on the Clinical Outcome of Therapy for Children With Pneumonia": Worked with the national ARI Coordinator to finalize the development of this protocol, in conjunction with WHO and CDC. Particularly focused on quality assurance issues and supervision, budget and staffing. (Complete documentation of meetings, fax correspondence and protocols are available upon request.) Pilot to be initiated in August and full study in November.
- 2.2 "Focused Ethnographic Study of Respiratory Infections": Worked with national ARI Coordinator, WHO and UNICEF to initiate the development of budget, staffing needs, and adaptation of existing survey. (Complete documentation available.) Pilot and full study to be initiated next reporting period - planned for September/October.

3. Collaboration with ADDR

- 3.1 Strengthened PCSP's collaboration with ADDR and assisted in the implementation of their research activities, including the Protocol Development Workshop. PCSP assisted ADDR in the selection of protocols to be developed at the Workshop (scheduled for the end of June and July), assisted in the planning of this Workshop, and attended the Workshop in Quetta at which sixteen protocols were developed for funding consideration (documentation available).

4. Strengthening PCSP's Research Relationship with UNICEF

- 4.1 The new Medical Advisor is quite interested in promoting research, particularly operations and nutrition-related research. We have thus begun to develop other possible areas of cooperation in research (beyond those noted above in ARI), such as operational research in HIS, and nutritional protocols regarding supplemental feeding, breast feeding, and micronutrients.

Drugs and Logistics

The Drugs and Logistics component are under the direction of Dr. Youssef Tawfik.

1. Workplan Modification

- 1.1 As a result of the so-called "negative" Pressler amendment and the subsequent decrease in our Project budget, the workplan for the Drugs and Logistics Component has been modified to achieve the most impact from the limited resources available.

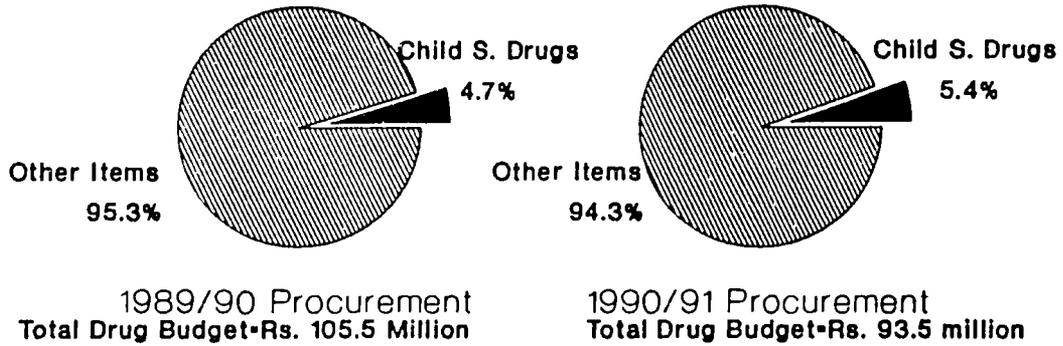
The resources for the component have been reduced from a total of 18 months of long-term technical assistance to 13 months, and from a total of 12 months of short-term technical assistance to 6 months. This reduction necessitated focusing the technical activities on improving the availability and use of Child Survival drugs in a selected province. Less emphasis will be put on providing technical assistance in the field of EPI Logistics, an area already receiving attention by NIH, WHO and UNICEF.

2. Completion of Drug Procurement Analysis in Balochistan and NWFP

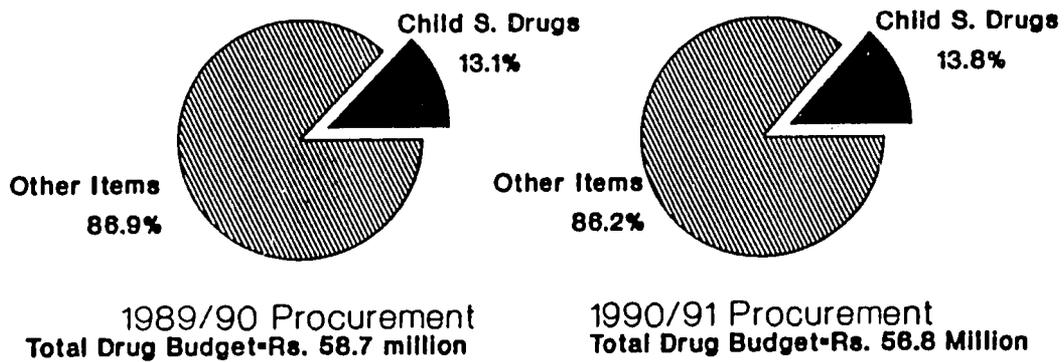
Drug procurement data for 1989/90 and 1990/91 were collected from Medical Supply Depots in both provinces. Using Lotus 123, all items purchased during that time, their quantities and their unit price were entered. Results point where most of the money allocated for drugs is spent and ways of achieving cost reduction without reducing the therapeutic value of purchased drugs. Some of the most important results are:

- 2.1. Antibiotics, Analgesics, Surgical Dressings, Vitamins and Electrolyte Solutions consume almost half the drug budget. The potential for cost reduction is great if only necessary items with proven scientific value and reasonable price are purchased.
- 2.2. Only 10 drugs out of more than 400 items purchased consume one fifth of the budget. Most of these drugs are Antibiotics and Electrolyte Solutions. Such pattern of money spending indicates that the emphasis is on items used primarily at secondary or tertiary health care levels.
- 2.3. Balochistan took a step in the right direction by reducing the amount of money spent on antidiarrheals in 1990/91. Furthermore, some of the saved funds were used to purchase ORS packets. Both Balochistan and NWFP stopped ordering "Imodium" and "Lomotil", two antimobility drugs which have been removed from national formularies in many developing countries.
- 2.4. Child Survival Drugs consume a small fraction of the total drug budget especially in Balochistan. See figure below.

Spending on Child Survival Drugs in Balochistan



Spending on Child Survival Drugs in NWFP



3. Dissemination of Results

- 3.1 Presentations were made to the Secretary Health, Director Health, Medical Supply Depot Officer in Charge, and members of the Drug Purchasing Committee in Balochistan and NWFP.

"Drugs and Logistics Summary Report" has been initiated and technical materials for the first issue have been completed and a draft has been circulated for discussion. The main purpose of the "Summary Report" is to share with planners and decision makers, briefly and as early as possible, results of the analysis of the drugs and logistics system at the provincial level.

4. Assessment of the EPI Storage at Federal and Provincial Levels

- 4.1 The purpose of the assessment is to help the PCSP decide what is the best way of using the Refurbishment Fund available under the Drugs and Logistics Component. So far, an assessment of the Epi Storage at the Federal level, Balochistan, NWFP and Punjab has been completed. A report summarizing results and conclusions will be issued after the completion of the assessment in Sindh.

Project Monitoring and Evaluation

The changes in activities induced by the consequences of the Pressler Amendment necessitated a review of the project indicators. A new set of indicators has been developed for each Project component. The targets have been set at two different levels: one level is based on the present limited availability of funds in the Project, the other assumes that additional funding sources will be identified in the training and health information system component. These changes are explained in an updated version of the Project Monitoring System document.

Randy Wilson from the MIS program at MSH worked with us from June 1 to June 7 on a further refinement in the design of computerized interrelational database for the Project Monitoring System. This permitted Mr. Shafat to start setting up the health institutions database and some related databases.

Administrative Activities

1. Personnel

1.1 Islamabad Office

During this interval, the establishment of the Islamabad Office and associated hiring was essentially completed after being delayed by the evacuation in mid-January. The change in the Chief of Party has been noted above under Program Planning and Management as well as other changes in key GOP and USAID personnel. However, in the Islamabad PCSP Office, the recruitment of two local professionals for the training component resulted in the hiring of one Training Specialist (Dr. Salariya joined April 30) and the identification of another professional (recruited in June but negotiations were not completed by the end of this report interval).

In addition, several administrative positions were also filled: one office Receptionist, two Secretaries, and an Office Aide. The recruitment and selection of the Drug and Logistics Specialist, as well as the Communication Marketing Specialist, were also performed. At the close of this reporting period, our first choice rejected the offer for the Drug and Logistics position as did selected candidates for the Communication Specialist and the second Training Specialist. Second-ranked candidates were then identified for these positions and the process initiated to hire them as soon as possible.

During this reporting interval, Sonia's promotion to Officer Manager was approved and the HIS Computer Specialist was also hired. Appropriate documentation was submitted to initiate key personnel changes for the Project Manager position as well as for the newly-selected Chief of Party.

1.2 Provinces

During this time interval, recruitment for the PCSP Provincial Office Staff: Chief Provincial Officers, Training Coordinators, and Health Information System Coordinators (for Punjab and Sindh), as well as drivers and secretarial staff was carried out. Shortlists were made for each position (from the hundreds of applications received) and interviews performed throughout June. The interview process itself was carried out so that it served as an institution capability-building exercise for the provincial government staff involved. Objective selection criteria were utilized throughout the process, including an individualized objective scoring sheet during the interviews.

Selections were made for nine of the ten available professional positions and JBL began negotiating salaries. The tenth position was deferred until one of the shortlisted candidates who could not be available at the time of the interview could return and be interviewed.

Interviews for provincial drivers and secretaries were delayed until professional provincial staff were confirmed, so that they could take part in the selection process.

1.3 Orientations

Orientations for all new Islamabad staff were performed and planning for the Provincial Offices orientation initiated.

2. Project Systems Development

2.1 Accounting and Finance

- i. Major revisions in the PCSP budget consonant with reduced activities post-Pressler were initiated. Specific revisions in the budgets for each of the Consortium members, including JBL, were also begun. Considerable effort was expended to delineate component and activity-specific costs.
- ii. The development of a standardized quarterly expenditures reporting system for MSH and its sub-contractors was completed and implemented, as was the development of financial monitoring and MSH field expense systems, especially for training activities and short-term technical assistance.

2.2 Administrative Procedural Issues

- i. A number of administrative systems were completed during this period including the development of office procedures; a standardized set of guidelines or administrative steps to follow when hiring consultants; a system for hard disk file management and computer hardware; and an initial revision of the PCSP Employees Handbook.
- ii. Much energy was also expended on revising the JBL and HIID subcontract documents, incorporating necessary changes requested by USAID, as well as those reflecting the new funding realities in PCSP.

3. Office Arrangements

3.1 Islamabad Office

During this reporting period, the physical establishment of the Islamabad Office was completed, including the necessary refurbishments, the placement of our furniture, and arrival of computers. The central computer network was developed and initiated.

3.2 Provincial Offices

Arrangements for Provincial Office space were deemed acceptable except for Sindh, where the Basic Health Services Cell itself has minimal accommodation and virtually no place for the PCSP staff. Appropriate furnishings and equipment have been ordered for all Provincial Offices.

II. PROBLEMS AND CONSTRAINTS

Technical Activities

Program Planning and Management

1. Gulf War and Related Evacuation

- 1.1 The evacuation, as a result of the Gulf War, resulted in the loss of a key person, the Chief of Party, in a prolonged delay in Islamabad and Provincial Office staff selection and hiring, as well as in an overall loss of an estimated three to six months in the implementation of each component.

2. Pressler-Induced Funding Cuts

- 2.1 The slashing of the original budget clearly called for a major revision in PCSP's scope of work and the specific activities possible within each component area. Such marked revision in activities and time (since the base period of the contract became the new end of the contract with no option period possible), necessitated total overhauls in the strategies of several components, particularly communications and research. Both training and health information systems also underwent significant alterations and were reduced to largely development and initial implementation strategies (with the hopes that other donors would be capable of extending activities in accordance with the original PCSP scope).
- 2.2 All TAT were involved in this remarkable re-planning exercise, and devoted major proportions of time and energy to the adjustments. In addition to the literal re-writing of the strategies, significant amounts of time were required to discuss these alterations with our colleagues in the GOP and USAID, to obtain a consensus on the re-directed priority activities, as well as to gain the necessary approvals. Clearly, such an endeavor is sensitive in the best of times, but in the light of the current political climate, it was a definite challenge to maintain credibility and some semblance of stability. If one considers the evacuation, loss of key staff, this drastic reduction in funding, and corresponding revised scope of work, the challenges which faced this project are obvious!

3. GOP Project Director Turnover

- 3.1 The turnover in this position resulted in lapses in continuity in the relationship established with the Basic Health Services Cell. Such turnover has also required significant amounts of time to re-orient each Project Director and to develop a relationship of credibility and trust. Turnovers limited the strength of PCSP's support base within the Basic Health Services Cell. Furthermore, given the critical decisions faced during this reporting interval, the lack of a consistent Project Director at the Basic Health Services Cell made rapid decision-making more difficult. (A long-term public health professional in this position would certainly strengthen the PCSP, and augment the support base necessary for successful implementation of PCSP component activities.)

4. Change in Chief of Party

- 4.1 The loss of the Chief of Party during the evacuation necessitated the utilization of an interim or Acting Chief of Party throughout the tenure of this reporting period. However, the recruitment of a long-term Chief of Party was actively pursued by the prime contractor. Thus, by the termination of this reporting period, several likely candidates have been considered and a candidate was selected, although formal commitment and approval have not yet been obtained.
- 4.2 The necessity to re-orient the Acting Chief of Party no doubt resulted in a loss of time and productivity in certain components, particularly Training.
- 4.3 The lack of certainty and security surrounding an "Acting" position was another impediment to the long-term stability of this project.

Training

1. Evacuation, Office Set-up and Staffing

- 1.1 Evacuation brought a sudden stop to the flow of activities, especially those involving the establishment of the central office and selection of provincial training staff. Upon return to post (mid-March), activities began at a rapid pace and significant progress has since been made in office set-up and staffing. Staff shortages initially delayed report-writing and written communications. However, Dr. Salariya joined in late April, and a second central office training specialist was identified in June. Provincial training coordinators were also selected in June. Thus, since the middle of June, these problems have been overcome.

2. Pressler Amendment and Reduced Budget

A markedly reduced budget and the associated decrease in the duration of the project (as a result of Pressler) have proven to be big constraints. Training Strategy Plans have been revised several times and definite decisions have not been possible in the following critical areas:

- 2.1 Number of districts to be selected for the establishment of training units
- 2.2 Project inputs on routine training activities such as per diem rates; resource person remuneration rates etc.

Not having a definite decision on these points has made it difficult to proceed with specific provincial discussions and plans.

3. Continuation of DTU Activities

- 3.1 Continuation of DTU training activities has been a plus as well as a constraint. It is positive that some of the training activities have continued since termination of the PHC project. However, the continuation has proven to be a constraint because much of the Training Advisor's time has been spent in supervising and monitoring DTU activities, while simultaneously planning for the initiation of comprehensive, integrated Child Survival training. Furthermore, diarrhea training activities utilize funds from the greatly reduced PCSP budget, leaving less for the implementation of

the integrated Child Survival Project training package.

Health Information Systems

1. The Gulf War Evacuation

- 1.1 The Gulf War evacuation has substantially slowed down the implementation of overall activities in the Project. Dr. Lippeveld was out of the country between January 14 and April 9. Communications with the federal and provincial health authorities were nearly impossible during that period. Fortunately, the major activity planned during that period was the writing up of the assessment study report, and did not absolutely need the in-country physical presence of the HIS Advisor. Therefore, the delay in implementation for the Health Information Systems component was rather limited, in comparison with other project components.

2. The Pressler Amendment

- 2.1 Another event that diverted time and energy of the Project staff away from the implementation of planned activities was the revision of component activities and budget as a result of Pressler. For the Health Information Systems component, it was decided to focus mainly on the development of a Health Management Information System (HMIS), and not to dedicate resources to a larger improvement of disease surveillance systems.

Although it was decided to go ahead with the development of HMIS/FLCF, neither the present funding nor the present time frame (project end date September 1993) permit the completion of this activity. In fact, only approximately 45 % of the required funds for nationwide implementation of the planned HMIS/FLCF are presently available under the Project. It was hoped that other sources of funding can be identified.

3. Strengthening central information system management

- 3.1 The first recommendation of the National HIS Workshop was to strengthen central information system management at the federal and provincial levels through the appointment of health planners/epidemiologists.

Although all participants of the workshop felt strongly about this recommendation, it will be the most difficult to implement. It will require the creation of new posts in the Ministry and in the Provincial Departments, which is a lengthy and complex process.

To create a single agency in charge of all health information management at the federal level and in each province is certainly not less complex. It involves a revision of the organization charts of the Federal MOH and of most of the Provincial Health Departments.

Communication

1. Reduced Budget and Changed Program Focus

- 1.1 The reduced budget resulting from the negative Pressler decision produced great changes within this component since many long-planned private sector approaches and activities, such as marketing and promotion for ORS and iodized salt, were eliminated. The revised component largely focused on public sector health education and training. The dynamic intervention planned for the public-private sector was lost. The title of the PCSP Advisor has been changed from Communication and Marketing to simply Communication Advisor to reflect these changes.

2. Reduced Personnel

- 2.1 Before the revision and reduced budget, the component was planned to have two Specialists, one in Islamabad and one in Karachi. The Karachi position has been eliminated, which negatively impacts on the management of communication plans and operations in that area.

Research

1. Restricted ADDR Mandate

- 1.1 In strengthening our relationship with ADDR, its limited mandate, focused on diarrhoeal diseases, is an impediment to a more productive collaboration. If, in fact, this mandate can be broadened to include other key intervention areas critical to Child Survival, the collaborative arrangement would be more effective and many of the original objectives of the Child Survival research component could be gained through combined efforts with ADDR (essentially using their funding base!).

2. Multiple Donor Research

- 2.1 The essential research projects outlined require intensive communications and collaboration between multiple organizations, necessitating a regular system of communication to avoid mis-interpretation and to coordinate activity implementation. Initially, this required a bit of time and effort, but once the system was established, it has worked well and promoted smooth operations.

Drugs and Logistics

1. Confusion Over USAID/Contractor Responsibilities

- 1.1 Some Federal and Provincial officials are expecting inputs from the Drugs and Logistics Component which are beyond the capacity of the project. For example, requests to provide a vehicle or to provide syringes (in Balochistan and Punjab a shortage in syringes is expected within 2 months if a new supply does not arrive) are frequently met. These requests reflect lack of understanding of the separate roles played by the Contractor portion and the USAID portion of the Project. Such a situation is creating frustration for the Pakistani officials when they find that the Drugs and Logistics team cannot help (except in carrying the message to Islamabad)

as well as for the Drugs and Logistics Staff team who feel they need concrete answers to such requests.

Project Monitoring and Evaluation

1. Lack of Mortality Rates to Measure Impact

- 1.1 The PHC Project Evaluation Report advised to use age and disease specific mortality rates as outcome indicators to measure impact of the PCSP. In developing countries, such data are usually not routinely available, and Pakistan is not an exception. Given the limited funding presently available, it is not realistic to perform such a prospective morbidity/mortality survey to measure impact, as was recommended by Garenne and Parvez in their report.

Administrative Activities

1. Gulf War and Related Evacuation

See section under Project Planning and Management.

2. Staffing

- 2.1 As already noted, the evacuation resulting from the Gulf War crisis eventually resulted in a standstill of all hiring decisions for both Provincial and Islamabad Offices of the Project. Just prior to the evacuation, the recruitment and selection process had been nearly completed for essential professional staff, and so virtually three months time were lost in the finalization and establishment of these positions.

3. Establishment of Offices

- 3.1 Again, with the evacuation of the critical Technical Assistance Team members, neither the establishment of the Central Office in Islamabad nor the Provincial Offices could be continued. With the able assistance of the host country staff members, and particularly the vital assistance of Jaffer Brothers, Ltd., however, essential functions in the Central Islamabad Office were continued. Nonetheless, the development and institution of office procedures were severely delayed by the evacuation of the Technical Assistance Team members. Furthermore, the establishment of the Provincial Offices was virtually stopped until the team could return, recruitment of selection staff could take place, and negotiations for office sites begun.

III. RECOMMENDED ACTIONS

Technical Activities

Program Planning and Management

- 1. Gulf War and Related Evacuation**
 - 1.1 Work to re-establish credibility. Push visible outputs and implementation of plans!
- 2. Pressler-Induced Funding Cuts**
 - 2.1 Make revisions in budgeting and scope of activities, with major alterations in communications, training, and research component strategies.
 - 2.2 Re-program budget and develop program and component budget breakdown for analysis and decision-making needed during this period.
 - 2.3 Strengthen ties with other donor agencies and create a network for cooperative planning (Donor Consortium). Discuss future joint ventures, including funding considerations to extend current PCSP activities.
- 3. GOP Project Director Turnover**
 - 3.1 Attempt to strengthen relationships with other members of the Basic Health Services Cell, particularly the Assistant D.G., since there appears to be ongoing turnover in the Deputy D.G. Project Director position. Also, strengthen PCSP relationship with the D.G. himself to insure increased stability and understanding of the Project despite turnover in the Project Director position.
 - 3.2 Establish regular monthly meetings with the D.G., as well as weekly meetings with the Project Director for updates, communication and exchange of information.
- 4. Change in the Chief of Party**
 - 4.1 Maintain regular meetings and communications with the new USAID Project Officer as well as technical professionals working with the Project. Encourage TAT members to strengthen their relationship with USAID colleagues and Government officials, so that the constraint of the Acting Chief of Party position is minimized by strengthened TAT relationships with key officials.
 - 4.2 Finalize the COP position as soon as possible. Assure for a smooth transition between the acting and long-term Chief. In the interim, the Acting Chief of Party should pursue activities with full vigor and work to assure Government and other colleagues that the Project position is secure and that transition to the long-term Chief will not result in a total revision of decisions made during the interim period.

Training

1. Pressler Amendment and Reduced Budget

- 1.1 Revise the scope and plan of Training component activities. Focus on initial implementation of decentralized training in a limited number of districts to be used as a "phase one" model, carefully evaluated, and then expanded (with the assistance of other donors and increased responsibility at the Provincial Government level).
- 1.2 Work to strengthen Provincial Government involvement at an early stage, encouraging preliminary planning for transition and assumption of responsibilities by the provinces. Include discussions of recurrent costs and staffing from an early phase, so that appropriate planning and ultimate inclusion in Provincial Government budgets and PC-Is can occur as soon as possible.
- 1.3 Establish and strengthen cooperative methods with other donor agencies, particularly at provincial levels, such as UNICEF, the World Bank (Family Health Project), and to a lesser extent WHO and CIDA, in order to assure that the foundation laid by the PCSP will be continued through other agencies with similar scopes of work and objectives. Gain additional donor support for the expansion of the integrated Child Survival training curriculum in a larger number of districts and divisions beyond the original ten established by the PCSP.
- 1.4 PCSP training activities should be focused on development (such as curriculum development), implementation (of the CSTUs), and evaluation (integrated curriculum and decentralized training). The findings from the evaluation will be utilized to make recommendations for improving and extending the system - with the help of the Provincial Governments and other donors.

2. Continuation of DTU Activities

- 2.1 Create a plan for the transition of the "vertical" diarrheal training units (DTUs) into the integrated Child Survival training units (CSTUs).
- 2.2 Phase out parallel staffing. Work with the Government to absorb the existing DTU staff into appropriate Child Survival programs and assist them in finding or deputing GOP staff to work in the new CSTUs, thereby avoiding the problem of parallel staffing in the PCSP.
- 2.3 Work with the D.G. and the National CDD Manager in the establishment and implementation of this transition plan (of DTUs to CSTUs). Cease individual PCSP-sponsored CDD training in DTUs within the next reporting period, and arrange for transfer of staffing so that CSTU activities can begin by the fall or winter of this calendar year.

Health Information Systems

1. Gulf War Evacuation

- 1.1 Ensure additional funding for nationwide implementation of the planned HMIS/FLCF. Several donors have already expressed their interest in supporting the development of improved health information systems. UNICEF is ready to include health information systems activities in its upcoming five year plan. The Family Health Project, funded through a loan from the World Bank, had already planned for management training activities. Since the budget planning for the Balochistan and Punjab sub-projects is not yet finalized, part of the future training in data collection could be financed through this project. The mechanisms for this joint financing need to be worked between the Ministry of Health, USAID and the other donors.

2. The Pressler Amendment

- 2.1 Ensure involvement of other agencies in the improvement of disease surveillance systems. The PCSP does not have the resources at present to assist the GOP in implementing the third recommendation of the National HIS Workshop: the improvement of disease surveillance systems. The HMIS/FLCF will partly address this issue through disease reporting from first level care facilities. Disease outbreak management, disease reporting from in-patient facilities, and the organization of morbidity/mortality surveys are no longer in the scope of this Project. It is hoped that WHO will provide the necessary funding and technical assistance to the Government. A resident advisor in epidemiology is planned to arrive in early 1992.

Communication

1. Reduced Budget and Changed Program Focus

- 1.1 Modify the human resources, long-term and short-term, to optimize the interest and backgrounds to the new situation. Revise activities and focus more on less expensive IPC and community development activities, rather than mass media. Develop less costly mass media activities, such as TV/radio dramas ("enter-educate" models rather than "spots").

2. Reduced Personnel

- 2.1 Expand the responsibilities of the Islamabad Specialist position to include the Karachi area position.

Research

1. Restricted ADDR Mandate

- 1.1 Support ADDR in its attempt to obtain approval for broadened mandate.

2. Multiple Donor Research

- 2.1 Establish regular update meetings with Pakistan and UNICEF colleagues, regular teleconferences with CDC and WHO colleagues. Develop "cc" fax network to assure rapid communication of vital information to all interested parties. Provide written updates at regular intervals.

Drugs and Logistics

1. Confusion Over USAID/Contractor Responsibilities

- 1.1 Better communication between USAID procurement staff, PCSP project staff and GOP provincial staff should be established, particularly regarding EPI purchases (especially syringes), and expected arrival dates.

Project Monitoring and Evaluation

1. Lack of Mortality Rates to Measure Impact

- 1.1 All proposed indicators of the Project Monitoring System are Project output indicators. Specifically for training activities, we consider the eventual improvement in the quality of care delivered in the trained health facilities as a valuable indicator for Project success. As pointed out by van Norren et al¹, the current status of knowledge on determinants of Child Survival allows the use of such indicators as "intermediate variables which directly influence the health status of children". In the absence of reliable age and disease-specific mortality rates, we therefore recommend the use of these "intermediate" indicators for future evaluations of the Project.

Administrative Activities

(See Program Planning and Management: Recommended Actions related to **Gulf War and Related Evacuation, and Staff.**)

1. Establishment of Offices

- 1.1 Proceed with selection and approvals for remaining Central Office positions and Provincial Office positions as quickly as possible and establish the full Provincial Offices within the next quarter.
- 1.2 Arrange for orientation of all new staff (especially Provincial Office staff) as soon as possible.

¹ Van Norren B., Boerma J.T., Sempebwa E.K.: Simplifying the Evaluation of Primary Health Care Programmes. 1989. Soc. Sci. Med. Vol 28. No 10, pp 1091-1097.

IV. PLANNED ACTIVITIES FOR THE NEXT SIX MONTHS

Technical Activities

Program Planning and Management

1. Provincial and Federal Steering Committees (and Sub-committees)

- 1.1 Work with the D.G. and the Basic Health Services Cell at the Federal level to assure that the second meeting of the Federal Steering Committee occurs, probably in the winter (November), to review the outcome of the Annual Workplan Review Meeting as well as Project accomplishments during the last 18 months.
- 1.2 The Federal Curriculum Subcommittee should hold at least two Curriculum Committee meetings, one to obtain consensus on the format and content (topic items) of the integrated training curriculum, and a second to review/approve the draft curriculum before its initiation (including nutrition section).
- 1.3 The Federal Nutrition Subcommittee should hold several meetings to approve the content/format of the Nutrition Curriculum (to be developed as part of the integrated CS curriculum), as well as to approve the draft developed by the expert nutrition panel, before its inclusion as part of the integrated CS curriculum.
- 1.4 Encourage ongoing communication between the teaching institutions, the BHSC implementors, and the individual intervention programs (EPI/CDD/ARI/Nutrition) at both provincial and national levels. The Curriculum Subcommittee can function as the vehicle for ongoing exchange between these groups.
- 1.5 Assist the PCSP Provincial Officers to work with the GOP Provincial Project Directors and related staff to initiate Provincial Steering Committees in all provinces. During the next reporting period, there should be at least one and perhaps two meetings in each province.
- 1.6 Encourage the establishment of appropriate provincial subcommittees, particularly for training (curriculum) and HIS, or for other topic areas such as nutrition. The Provincial Steering Committee can serve as the vehicle for coordinating Child Survival activities implemented through the BHSC and individual Child Survival Programs such as EPI/CDD/ARI/Nutrition.
- 1.7 Encourage and develop the support of the Secretaries of Health and key individuals in Planning and Development at the provincial level - orient them to the Child Survival Project and maintain an ongoing flow of information. Encourage early thinking about modifications ultimately required in the provincial PC-1 and GOP/Provincial government assumption of staffing and recurrent costs for major Child Survival activities, especially in training and HIS.

2. Donor Consortium

- 2.1 Work with the BHSC and D.G. (federal level) to hold at least quarterly Donor Consortium Meetings. The focus of the first one would be information-sharing regarding current or planned Child Survival activities supported by key donors. The second meeting should focus on the creation of subcommittees in crucial areas such as HIS and training for coordination of activities and funding.

3. Workplan

- 3.1 Prepare for the Annual Workplan Review Meeting, including the revision of the workplan document and associated background materials to be distributed prior to the meeting.
- 3.2 Perform preliminary discussions with provincial and national level colleagues prior to the Workplan Meeting. Particularly focus on Secretaries of Health and Planning and Development officials (Provincial and Federal) who have not received as much information as the Director Generals. Hopefully, the Chief of Party will be in place by the time of the Workplan Meeting, so these activities will be included as part of orientation.

Training

Since the National Training Workshop of April 29th and 30th, a list of essential training tasks have been identified and agreed upon. A tentative schedule for these activities have also been developed. Recruitment of national and provincial staff is progressing well, so it should be possible to keep on schedule by carrying out the following activities:

- 1. **Selection and Orientation of Provincial Training Staff**
- 2. **Curriculum Development**
 - 2.1 Formation of Nutrition Subcommittee and development of nutrition training curriculum (as part of integrated Child Survival Curriculum).
 - 2.2 Adaption of curricula in CDD, EPI, ARI.
- 3. **Establishment of Child Survival Training Units (CSTUs)**
 - 3.1 Initiate training of Pediatric Professors and teaching hospital master trainers in the integrated (4 intervention) CS curriculum.
 - 3.2 Transition of existing DTUs into CSTUs
 - i. Absorption of existing DTU staff into Government services
 - ii. Cessation of vertical CDD training in DTUs
 - 3.3 Select training institutes to be involved in district level training (phase 1)
- 4. **Initiation of District Level Training**
 - 4.1 Visit provinces (August through November) to develop province-specific training plans.
 - 4.2 Establish relationship/involve Secretary of Health and Planning Chief (Health) in provincial training plans.

Health Information Systems

1. Development of HMIS/FLCF

- 1.1. National HIS team meetings (July - October)
- 1.2. Consultations with national program managers on indicators for the system (July - August)
- 1.3. Provincial Workshops on indicators for the system (September - October)
- 1.4. Provincial Workshops on structure of the system (November - December)

2. Computerization of Data Processing Procedures

- 2.1. Production of Computer Implementation Plan
- 2.2. Production of Computer Training Plan
- 2.3. Installation of additional hardware and software in the provincial capitals
- 2.4. Generic training of federal computer staff
- 2.5. Training of provincial master computer trainers
- 2.6. Generic training of additional provincial staff

3. Maintaining the PHC Monitoring System

Communication

1. Selection of Research Subcontractor

- 1.1 Complete selection of PCSP research subcontractor firm and employ their services to support communication activities.

2. Communication Specialist

- 2.1 Hire, orient, and activate the Islamabad Communication Specialist to assist the Communication Advisor and MOH Counterpart.

3. Review and Revise Technical Assistance

- 3.1 Review and revise long-term and short-term technical assistance needs and related plans in view of the changes which have occurred in the Communication Component.

4. Develop IPC Module

- 4.1 Develop an interpersonal communication training module, as part of the PCSP training component.

5. Develop TV and Radio Enter-Educate Drama Series

- 5.1 Develop a TV and Radio Drama series as an innovative media vehicle for communicating Child Survival messages in an entertainment-education mode.

6. Transfer of Technology

- 6.1 Work closely with the MOH Counterpart to continue the development transfer process which began in October 1990.

Research

1. Complete Development of Essential Research Protocols

- 1.1 Complete development of Cotrimoxazole Clinical Trial and Ethnographic Focus Study - complete proposal and protocol development for each, including budgeting and staffing.
- 1.2 Complete pilots and initiate the formal studies during the next reporting period.

2. Assist ADDR in Workshops and Protocol Development

- 2.1 Assist in the ADDR Proposal Writing Workshop in July and follow through with selection of proposals to be funded through this mechanism. Provide ongoing assistance to ADDR as requested.
- 2.2 Encourage ADDR to finalize selection of a Research Coordinator who could also be of assistance to PCSP.
- 2.3 Support ADDR in obtaining approval for extension of diarrheal disease mandate (to include ARI and nutrition).

3. Work with Other Interested Donor Agencies to Promote Institution Capability Building in Research

- 3.1 Examine PMRC as an institution which might be strengthened through a series of research training workshops focusing on such topics as protocol development and data analysis.
- 3.2 Identify other donors who might support such endeavors.

4. Essential National Research

- 4.1 Follow up on the outcome of the Essential National Research Workshop held in March, 1991, and encourage the development of a subcommittee or other forum for developing research projects essential to the promotion of Child Survival interventions/programs.
- 4.2 This subcommittee could also be utilized to identify key CS research questions for possible donor funding or GOP support.

4.3 Contact Aga Khan University (which strongly supported the Essential National Research Workshop) for information and interest in collaboration.

5. Research for Decision-Makers

5.1 Develop plans for PCSP-sponsored workshop for decision-makers to present critical Child Survival research findings (initially from ADDR and PCSP-sponsored projects).

5.2 Solicit input from other interested donor agencies.

Drugs and Logistics

1. Complete EPI Storage Site Assessments

1.1 Complete assessment of EPI storage sites at the provincial level and recommend the most cost effective way of allocating the refurbishment fund.

2. Complete Procurement Analyses

2.1 Complete procurement analysis for Punjab and Sindh and arrange training of selected staff in Balochistan and NWFP on carrying out future procurement analysis using spread sheets.

3. Design Focus Study

3.1 Design a focus study to measure the availability and use of Child Survival drug items in one province.

4. Disseminate Results

4.1 Disseminate results of procurement assessment studies in Punjab and Sindh to relevant decision- makers.

Project Monitoring and Evaluation

1. Set-up of PMS related databases

1.1. Health Institutions Database

1.2. Training Databases

1.3. Initiate Health Personnel Databases

2. 3rd Consulting Assignment for Randy Wilson (Sept 91)

Administrative Activities

1. Personnel

- 1.1 Staffing: Complete the selection and approvals for all Central Office and Provincial Office staff.
- 1.2 Provide orientations for all new central and professional provincial office staff.

2. Systems Development

- 2.1 Further refine budgeting and monitoring systems.
- 2.2 Develop and implement inventory system.

3. Transitions

- 3.1 Plan for transition in two key positions - Project Manager/Deputy Chief of Party and Chief of Party. Hopefully within the next reporting interval, both of these new positions will be filled.
- 3.2 In terms of the Project Manager, develop and receive approval for revised position description (to include only Project Manager activities and not the Deputy Chief of Party activities). Recruit and select the individual, provide orientation, and assist in transition between current Project Manager and replacement.
- 3.3 Make final selection and obtain approval for the Chief of Party. As soon as selection is finalized, the Acting Chief of Party will make every effort to keep the incoming Chief of Party apprised of activities and, when appropriate, obtain his input to assure a smooth transition between Chiefs.
- 3.4 Provide full orientation and assist in the transition process, including follow-up support after the transition as necessary. Maintain good communications with Child Survival colleagues in the Government and USAID, assure them of a smooth transition and that there will be no loss in activity level as a result of these transitions.

4. Establishment of Provincial Offices

- 4.1 Complete establishment of Provincial Offices, including equipment and supplies.
- 4.2 Assist new CPOs in establishment of these offices and institution of systems.
- 4.3 Find suitable office space for the Sindh Provincial Office.

APPENDIX I

SHORT-TERM TECHNICAL ASSISTANCE

Project Planning and Management

Consultant: Peter Huff-Rousselle
Level of Effort: 8 days
Time Period: 5/5/91-5/18/91

Training

Consultant: Michel Garenne
Level of Effort: 12 days
Time Period: 12/30/90-1/12/91

Health Information Systems

Consultant: Randy Wilson
Level of Effort: 6 days
Time Period: 6/1/91-6/7/91

Communication

None

Drugs and Logistics

Consultant: Zafar Ahmed
Level of Effort: 16.5 days
Time Period: 6/1/91-6/30/91

Research

None

APPENDIX 2

KEY DOCUMENTS PRODUCED DURING THE PERIOD

Planning and Management

1. PCSP Five Year Workplan, January 13, 1991
2. PCSP Priority Activities
3. Revised Project Workplan
4. PCSP Indicators, with Targets
4. Federal Child Survival Steering Committee Composition and Agenda for First Meeting, May 28, 1991
5. PCSP Employee Handbook, December 1990
6. PCSP Guidelines for Hiring Consultants
7. PCSP Office Procedures
8. Report on Levels and Causes of Infant and Child Deaths in Pakistan, January 1991

Training

1. Diarrhea Training Unit Survey Report - Training (1/1/91-6/30/91)
2. Operational Status of Ten ORT Corners in Implementing National Diarrhea Treatment Policy During December 1990 - April 1991
3. Essential Training Tasks and Tentative Schedule, April 1991

Health Information Systems

1. HIS Assessment Study Report, April 1991
2. Mortality Assessment Study, January 1991
3. Assessment of Existing Computer Cells at the Federal Level and in the Provinces <<< date >>>
4. First National Workshop on HIS, May 28-30, 1991
5. MIS Consultancy Trip Report (Wilson, R.), June 1991

Communication

None

Drugs and Logistics

1. Drug Procurement Analysis in Balochistan and NWFP
2. Assessment of EPI Storage Facilities at the Federal Level and in Balochistan, NWFP and Punjab

Research

1. Protocols for study on "The Impact of Cotrimoxazole Resistance on the Clinical Outcome of Therapy for Children with Pneumonia" (final draft)
2. Protocol for "Focused Ethnographic Study of Respiratory Infections" (preliminary draft)