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FINAL EVALUATION
for

CHILD SURVIVAL VII PROJECT
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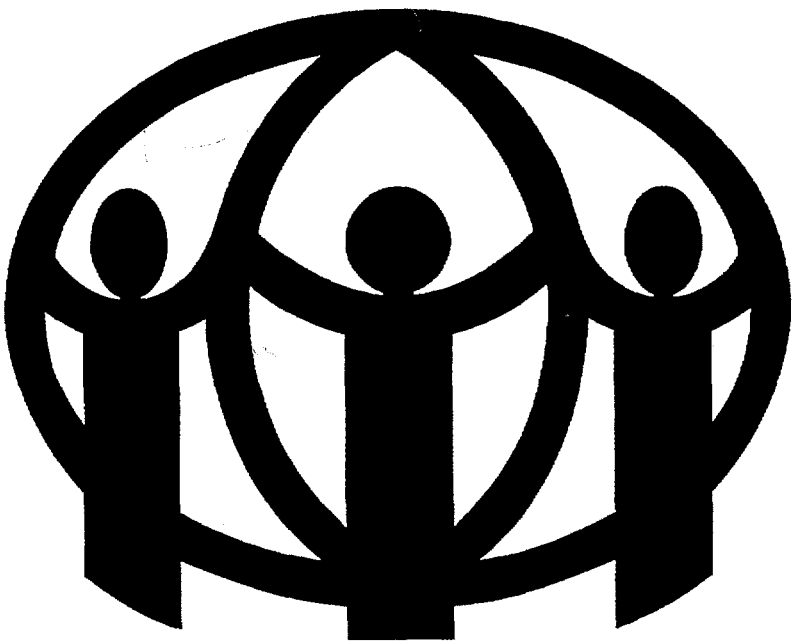
UGANDA



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CHILD SURVIVAL VII PROJECT

OTR #PDC-0500-A-00-1007-00

UGANDA

FINAL EVALUATION

1994, AUGUST 14-23

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APPENDICES

LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
CBA	Child Bearing Age
CDD	Control of Diarrhoeal Diseases
CS	Child Survival
DIP	Detailed Implementation Plan
DMO	District Medical Officer
HIS	Health Information System
HP	Health Promotor
HT	Health Trainer
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
TOT	Training of Trainers
TT	Tetanus Toxoid
UCBHCA	Uganda Community Based Health Care Association
VHC	Village Health Committees
TASO	The Aids Support Organization
MOH	Ministry of Health
"DISH"	Delivery of Improved Services for Health
FPAU	Family Planning Association of Uganda
UPMB	Uganda Protestant Medical Bureau
UNEPI	Uganda National Expanded Program for Immunization

EXECUTIVE SUMMARY

The Uganda Child Survival VII Project was a three year project to improve the health of mothers and children under five years of age in the Luwero District of south central Uganda. This project was jointly funded by USAID and ADRA/Uganda.

The goal of the project was to increase the self reliance of families and communities by protecting the mothers and child's health through improved delivery of basic health services. At the heart of ADRA's strategy is the mother as the primary care giver.

The Uganda CS VII Project included five major interventions namely:

* Immunization of children under one year of age

* Control of Diarrheal Diseases and the promotion of Oral Rehydration Therapy

* Nutrition education and growth monitoring of children under five years of age

* Family planning and child spacing

The prime purpose of the Final Evaluation was to address three crucial issues, namely effectiveness (impact), lessons learned and sustainability.

Major findings include project accomplishments as measured by set objectives, project activities that lead to sustainability of the project and lessons learned. Summary of recommendations based on lessons learned were articulated for application in future Child Survival interventions.

The CS VII project was highly effective as revealed by the quantitative and qualitative findings of the final evaluation survey conducted concurrently with the final evaluation (see Appendix A). The effectiveness of the project was validated by observations focus group discussions, and in-depth interviews held during the evaluation exercise.

The sustainability of CS VII activities included aspects of community participation, linkages with the MOH and other local organizations. Cost recovery measures implemented by the project staff, measures to increase efficiency and activities geared to increasing household income and food security. Significant progress was achieved in all the above mentioned areas.

The involvement and participation of the community members and linkages with the MOH and SDA health services featured strongly in the sustainability of future CS interventions.

A summary of recommendations and lessons learned concludes the evaluation report with a strong appeal for continued support for Child Survival activities, particularly in the

areas of family planning and integrated STDs, HIV/AIDS education, promotion and service provision.

In conclusion, the Uganda Child Survival VII Project was a great success, given the constraining environment in which activities were carried out. Continuity of intervention activities was requested by the community and is strongly recommended; only by so doing, shall the maximum efficiency and effectiveness (impact) be achieved.

BACKGROUND OF THE PROJECT

Project Description

The Uganda Child Survival VII Project was a three-year project to improve the health of mothers and children under five years of age in the Luwero District of south-central Uganda. This project was jointly funded by USAID and ADRA/Uganda. The project intervention areas were the two contiguous sub-counties of Kalagala and Zirobwe in Wabusaana County, Luwero District.

Reasons for the Choice of Project Location

This area was chosen for three reasons:

a) This area was one of the hardest hit areas of Uganda during the recent Uganda Civil War. There was much loss of life, looting and destruction of property. At the peak of the war, the area was largely abandoned. Only recently has the population begun to return to their homes in this area.

   This area lags behind other parts of Uganda in preventive health care; the population's capita earnings, is below national average and has, sub-standard housing and poor water supplies. The present government is aware of the problems in this area which is called the "Luwero Triangle" and has established a separate ministry which is responsible for its restoration.

b) ADRA's parent organization, the Seventh-day Adventist Church, has operated an educational institution-Bugema College in Kalagala sub-county since 1948. It includes a primary school, a secondary school and a four year college. The Bugema College Dispensary and Maternity Center, which is located on the campus of Bugema College is the only 24-hour medical service in the ares. These institutions which are located at Bugema would be able to provide some logistical support to the project in this location.

Interventions

This Child Survival Project included five interventions:

a) The immunization of children under one year of age
b) The control of diarrhoeal diseases and the promotion of oral rehydration therapy
c) Nutrition education and growth monitoring of children under five years of age
d) Family planning and child spacing
c) AIDS education

I. THE PURPOSE OF FINAL EVALUATION

The prime purpose of the Final Evaluation for Child Survival Project was to address three crucial issues. These are: effectiveness, sustainability and lessons learned.

In the area of effectiveness, the Final Evaluation looked at the extent to which the Child Survival activities met the basic health needs of the recipient communities as stated in the goals and objectives of the project.

Furthermore, the Final Evaluation assessed the project's competence and prospects in terms of carrying out sustainable and effective Child Survival activities.

Ultimately, the Final Evaluation shows the lessons learned. It is expected that such lessons will benefit ADRA's own current and future Child Survival projects around the world. In addition, if and when applicable, the gained knowledge will be disseminated to all other organizations who deal with Child Survival Projects.

II. GOALS AND OBJECTIVES

The goal of the project was to increase the self reliance of families and communities by protecting the mothers and child's health through improved delivery of basic health services, especially to under-fives, in one of the poorest and most disadvantaged areas of Uganda. In other terms the goal was to improve the health status of children and mothers through supporting various CS activities while seeking to develop cost recovery/income generation to help sustain all the health gains.

At the heart of ADRA's strategy is the mother as the primary care giver. As such the majority of activities were educational and promotional in nature. This involved educating and motivating mothers to improve their health practices and encouraging them to increase the utilization of the existing, but enhanced communities and/or government services.

Planned Inputs:

Training for at least 500 female health promoters, all of whom would receive, additional training as intervention promoters (100 for each project intervention), 200 village health committee members, and 30 CHW supervisors trained as TOTs. Bicycles for each CHW supervisor and each health center. Weighing scales, additional cold chain equipment, equipment to initiate family planning services.

Expected Outputs:

A heightened awareness of major health problems affecting women and children.

- An organized community based health program that links with MOH and private health services and the National Resistance Council system.
- Better health for mothers, children and the whole community.

Utilization Of Previous Documents For the Final Evaluation

The goals and objectives (including planned inputs and expected outputs) of Uganda's Child Survival VII Project were viewed in the light of previous documents, which were reviewed as part of the evaluation; these included the following:

1. Child Survival VII. Baseline Survey Report (Knowledge and Practice Survey), February 1992.

2. Uganda Consultation Report, April 1992

3. First Annual Report, 7th October 1992

4. Mid-term Evaluation Report for Child Survival, 7th October 1993

5. Uganda Essential Drugs Manual, Second Edition 1991

6. Uganda, Demographic and Health Survey 1988/1989

7. Facts for Life (Published by Ministry of Health, Health Education Division in Collaboration with UNICEF Uganda Country Office.

8. Uganda Country Program 1990-1995

9. A situational Analysis: Children and Women in Uganda, 1989

10. Uganda National Program of Action for Children: Priorities for Social Services Sector Development in the 1990's and Implementation Plan 1992/93 - 1994/95.

11. Report on contraceptive Prevalence Survey carried out in some selected Districts of Uganda: December 1992.

12. Final Evaluation Survey on knowledge, practice and coverage. Child Survival VII Project, August, 1994.

These documents helped the evaluation team understand the strengths and weaknesses of the project and provided strategic direction for the team's lessons learned/recommendations.

III. EVALUATION METHODS

A. Evaluation Concept

It is helpful to remember that the process of evaluation is never far from its social setting. In view of this, the evaluation team recognized the fact that no matter how objectively the data was gathered and analyzed, in the end, the final interpretation cannot totally be free of the social and political climate of the time and the personal biases of the evaluators. The team kept in mind that they were social beings and as such, every assessment apparently took place in a cultural context. Consequently, there are ideas that may not make sense outside their social milieu.

This evaluation took place in the context of two cultures, that of the funder's culture and that of the beneficiary's culture. The evaluation team kept in mind that it was undertaking a major responsibility in its attempt to make a cross-cultural analysis and interpretation.

B. Evaluation Guidelines

The evaluation process focused on the guidelines designed by USAID for the Final Evaluation of all USAID funded Child Survival Projects and the supplementary questions. The evaluation teams responded to the sustainability questions and issues outlined in the Child Survival Guidelines. The outline was closely followed in eliciting evaluation findings.

It goes without saying that every country is unique and Uganda is not an exception. In situations where the questions do not apply, no attempt was made to manufacture applicability.

In the preparation of this report, the evaluating team attempted to provide the reader with, as much as possible, accurate sources of its information and recommendations.

C. Evaluation Methodology:

It is obvious that a beneficial evaluation is a result of reliable data collection. The evaluation methodologies employed different instruments to ensure the information gathered was valid. These included the following:

- General observation (observation checklist)
- Focus group discussion (FGD)
- In-depth interviews
- Review of previous documents
- Structured questionnaire (interviewers using a set of standard questions).

This evaluation was of a summative nature rather than a process evaluation, as defined by theguidelines.

D. Evaluation Activities

Following these guidelines and taking the program goals and the measurable objectives and indicators for sustainability, the evaluation team performed the following:

First, the evaluation team endeavored to answer the question of the project's effectiveness.

Second, the evaluation team attempted to assess the project's competence and prospects in terms of carrying out sustainable and effective Child Survival activities.

Finally, the Final Evaluation documented lessons learned, that may help others in operating diverse Child Survival Projects, and thereafter made recommendations based on findings and lessons learned.

IV. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A1. Specific Objectives:

1. Increase complete immunization coverage among the 12-23 month age group from 55% to 80%.

2. Increase the percent of women of CBA who have had at least two TT immunizations from 40% to 70%.

3. Increase the use of ORS (either cereal based or sachets) from 43.2% to 60%.

4. Decrease the amount of diarrhoea reported to have occurred in children under-five in the past two weeks from the present 46.3% to 20% or less.

5. Increase the number of homes with kitchen gardens growing at least 5 kinds of vitamin and/or iron foods from 28.8% to 45%.

6. Increase the number of children under five who have been weighed at least once within the past 3 months from 34% to 60%.

7. Increase the couples who use modern methods of child spacing from 1.7% to 12% or more.

A2. Accomplishments of the Project related to each Objective (see table below)

OBJECTIVES	BASELINE	TARGET	ACTUAL	DIFFERENCE
COMPLETE-IMMUNIZATION	55%	80%	67%	-13%
CBA WOMEN WITH >2T.T	40%	70%	45.7%	-24.3%
USE OF ORS	43.2%	60%	61.7%	+1.7%
DIARRHEA >2/52	46.3%	20%	23.3%	-3.3%
KITCHEN GARDENS	8.8%	45%	77%	+32%
WEIGHT >3/12	34%	60%	52%	-8.0%
MODERN SPACING	1.7%	12%	13.5%	+1.5%

Immunization

Mothers produced an immunization card for 233 children (77.7%). The majority of the mothers (86.8%) in the sample knew that a child should be immunized against measles at nine months of age. Only 8.3% of the mothers in the sample did not know that TT protected either the mother or the child against tetanus. About 56.7% of the mothers in the sample declared that more than two injections were needed to protect a newborn against tetanus. The percentage of children fully immunized 67% were between (12-23 months)

Maternal Care

About 51.6% of the mothers (155/300) had a maternal health care card. Among the mothers who had a maternal health care card 56.7% received two or more TT vaccinations. Among all the mothers in the sample 45.7% received two or more TT vaccinations.

Use of ORS and Diarrhea

At least 23.0% (70) of the children in the sample had diarrhea in the last two weeks. About 36% of mothers whose children had diarrhea used ORS packages and 61.7% used cereal-based solutions and other recommended fluids including some sugar-salt solution.

Kitchen Gardens

Out of 300 in the sample, 213 of the mothers interviewed declared they had a Kitchen Garden while 87/90 who didn't have a garden want one and in most instances the food produced was used to feed the family (77%).

Growth Monitoring

Majority of the children 231 (77%) out of 300 in the sample had a growth monitoring card. 52% (231/300) of the children were weighed in the last three months.

Modern Spacing (Family Planning)

Although 51% of the mothers did not want to have another baby in the next two years, only 13.5% were using a modern contraceptive method.

A3. Comparison of Project Accomplishments with Objectives: (see table in section A2).

- Complete immunization was lower than expected. This can be attributed to several reasons including, a high drop-out rate due to illness, lack of vaccines due to break-down of the cold-chain from the MOH and the fact that MOH personnel were involved in some cases and ADRA project staff had no managerial control over them.

- The significant difference between target of 2TT for CBA women (70%) and the actual (45.7%) was due to the logistic difficulties of getting all eligible CBA women to present themselves for TT immunization. In our opinion the objective would have been more realistic if it targeted a specific group who are especially vulnerable i.e. pregnant women. This would be more realistic and cost-effective.

- It was clear that the health monitoring needs improvement, since many of the children had GM cards but less than half were weighed in the last three months.

- Kitchen gardens were highly valued as shown by the percentage with kitchen garden (77%) which is greater than the targeted percentage of 45%.

- Modern spacing (family planning) was slightly greater than targeted. There is great potential for increasing the contraceptive prevalence rate (CPR). The Uganda National Implementation Plan (NIP) has set a nation-wide target at CPR of 20% by 1995.

A4. Unintended Benefits of Project Activities

A major unintended benefit of the project activities was the high level of community awareness and knowledge of the dangers of HIV/AIDS. In the final evaluation survey, out of 300 women interviewed, 235 or 78.3% felt that people in their community were in danger of getting AIDS. Results from other HIV/AIDS questions showed that a person could look healthy and have HIV/AIDS; 269 out of 300 interviewed responded correctly.

Preliminary research findings by researchers at the Johns Hopkins University strongly suggest that foods rich in vitamin A reduce the foetal transmission of HIV virus from the mother to the unborn child. The unintended benefits of kitchen gardens with vitamin A rich vegetables consumed locally is therefore of far reaching importance in the intervention area which has a high prevalence of HIV/AIDS, indeed like any other areas.

A5. Project's Final Evaluation Survey (see Appendix A).

B. Project Expenditures

B1. Pipeline analysis of project expenditures (see Appendix B).

B2. Comparison of budget approved in DIP with actual expenditures of project.

B3. Handling of project finances.

B4. Lessons learned regarding project expenditures helpful to other PVO projects/relevant to USAID:

The major lessons learned from ADRA's CS-VII, is that there is need for closer monitoring of budgeting implications on a line item basis, alongside programmatic activities to ensure maximum outputs and project efficiency. There is a need for a closer liaison between the head office staff and project staff. Project Directors should have a sound understanding of financial management, particularly as relates to program sustainability.

C. Lessons Learned:

The main lesson learned regarding the entire project which are applicable to other PVO CS projects, and are relevant to USAID's support of these projects include:

1. Health education and promotion using a combination of training and traditional methods of communication like song, dance and drama are powerful, yet inexpensive methods of communicating health messages. This was clearly evidenced from the 3 field visits made to the intervention sites during the evaluation period.

2. Need for thorough understanding of the financial implications of achieving project objectives, especially the indirect costs, capital expenditure and maintenance costs related to major equipment like vehicles. These costs including staff related overheads should always be explicitly understood before undertaking any intervention projects. This is particularly with a view to the potential sustainability of the project after donors are no longer available.

V. PROJECT SUSTAINABILITY

A. Community Participation

A1. Lists of community leaders and members interviewed and groups they represented. (see list of contacts and persons visited, field visits, itinerary for final project evaluation and Appendix A).

In addition to the above, it is important to mention that at Zirobwe/ Lunyolya, Kalagala sub-county and Busoke sub-county, focus group discussions (FGD) were held. These included the local Resistance Council (RC), chairmen, the local chiefs, chairperson of Village Health Committees (VHC) and women leaders. It is significant to note that more than 50% of all the VHC were composed of women. This included women in leadership positions at the community level.

A2. Child Survival activities perceived by community as being effective in meeting current health needs.

In addition to the final evaluation survey results (see Appendix A), clean water availability and early diagnosis and treatment of malaria were community priority needs. All the objectives of CS-7 were well ingrained in the community as expressed in song and drama.

A3. Activities carried out by the PVO that enabled the community to meet basic health needs and increase their ability to sustain effective child survival activities were as outlined in the DIP. The success of the intervention activities was evident by the achievement of the measurable project objectives.

A4. Community participation in design, implementation and evaluation of project.

The baseline survey was done before the intervention involved the community in identifying their priority needs. A review of the annual reports and mid-term evaluation report clearly demonstrates community involvement in all the 3 stages of the life of ADRAs' CS-VII Project.

A5. All the health committees in the area, as detailed in the DIP were functional and met at least once every month in the last 6 months. Committee representation was strongly gender sensitive (see A1 for details)

A6. The most significant issues currently being addressed by health committees is the need for project support to continue especially in

the areas of HIV/AIDS and family planning. Committees (VHC) do not feel prepared to carry out these activities without ADRA's assistance.

A7. Examples of methods used by committees and precise role in providing direction to the project include willingness to set aside land for agricultural extension activities and make in kind contribution to dig wells and for health facilities for immunization and other health related activities.

A8. Resources the community contributed that will encourage continuation of project activities after donor funding ends include in kind contribution and permanent buildings like the clinics and project office from which other activities can be carried out.

A9. The success of the committees to contribute resources for continuation of effective project activities is related to their commitment and sense of project ownership. They are also acutely aware of the positive effects of the project.

B. Ability and Willingness of Counterpart Institutions to Sustain Activities

B1. Persons interviewed and their organizations and relationship to the child survival project (see list of contacts and persons visited).

B2. Linkages that exist between child survival project and the activities of key health development agencies. These include linkages with:

- Other ADRA projects in Uganda
- The District Medical office Luwero
- The local USAID Mission office
- The Family Planning Association of Uganda (FPAU)
- The Uganda Protestant Medical Bureau (UPMB)
- The Uganda SDA Union head office
- The Ministry of Health (MOH)

B3. Key held institutions the PVO expects to take next in sustaining project activities; in addition to those in B2 others include:

- The Aids Support Organization (TASO)
- The Resistance Council Committees (RC)
- The "DISH" project

B4. Child survival activities that MOH personnel and other staff in key local institutions perceive as being effective include:

- The family planning activities: The MOH and FPAU feel ADRA's CS project has great potential for leading the way. From the final evaluation survey results, ADRA's CS activities have increased the CPR from 1.7% to 13% (compare national average of 7.8%).
- Kitchen gardens and other agricultural extension activities are perceived as highly successful and are often referred to for demonstrations by other local institutions including the Ministry of Agriculture Personnel.
- Immunization activities especially that of children are regarded as being effective by MOH. ADRA has been particularly helpful in providing logistic support (vehicles for transporting vaccines from District Medical office) and by providing extra incentives to clinic staff and vaccinators to increase motivation and immunization coverage.

B5. What did local ADRA do to build a shield of local MOH personnel in key counterpart NGO's.

ADRA CS-VII conducted various training sessions in specific areas of project management for the local MOH clinic personnel and SDA run clinic staff

B6. Current ability of MOH/other local institutions to provide necessary financial, human and material resources to sustain projects once CS funding ends (see recommendation 4-10).

B7. Project activities that counterpart organization perceived as effective (see B4).

B8. How project responsibilities and control have been phased over to local institutions (see recommendation 4-10).

B9. Counterpart institutions that made financial commitment to sustain project activities at the design of the project.

The MOH through the District Medical office (DMO) provided infrastructural facilities, i.e., clinic and personnel to ensure the immunization activities and objectives of the project were achieved. ADRA/Uganda and the Uganda SDA Health and Temperance departments also made financial and human resources available to the project, which can enable some level of sustainability at the end of the project.

B10. Reasons for the failure of counterpart institutions to keep their commitment can be attributed to poor management and improper allocation of resources by the MOH and a lack of proper communication and involvement by the Health and Temperance department of the Uganda SDA Union.

B11. In country agencies which worked with ADRA on the design, implementation and analysis of the mid-term evaluation included the MOH, which was represented by Dr. David M. Serwadda (Final Evaluation Team Observer) and Makerere University, which was represented by Joseph Mayuni who provided computer and statistical backup.

C. Attempts to Increase Efficiency

C1. Strategies ADRA implemented to reduce costs, increase productivity and efficiency included the use of bicycles by field educators to reach wider areas and hence reduce costs in the dissemination of health messages. The use of MOH personnel in the clinics and other staff, also reduced personnel costs while at the same time ensured the achievement of planned immunization objectives.

ADRA's strategy of using health trainers and health promoters who were volunteers, selected by the respective communities was not only a cost saving strategy but also sustainable one.

C2. The reasons for the failure of further attempts to increase the efficiency of ADRA's CS-VII were that the senior project staff were paid by the project. This together with their benefits constituted a

fixed cost. Project vehicles which initially were a capital expenditure had un-anticipated high maintenance and running costs.

C3. Lessons learned regarding attempts to increase efficiency that might be applicable to other PVOs include those described in section C1 above.

D. Cost Recovery Attempts

D1. ADRA CS-VII made attempts to introduce cost recovery (revenue generating measures). A specific measure was a project began in conjunction with Shell oil/Uganda in the cultivation of hot red peppers (pilipili). Under this arrangement ADRA/Uganda received a commission for their involvement in community mobilization while the individuals and communities which grow the pepper received cash for crops. Shell oil (ANICARE) has overseas markets for the pepper in their petrochemical manufacturing industry. This has constituted an income generation activity for the community and ADRA CS project is recovering some money. We must, however, hasten to add that, although this project has a lot of potential, there is need for clear formulation and documentation of the specific monetary expectations, a well defined financial reporting accounting and reporting system and appropriately trained personnel to manage such cost recovery activities.

ADRA CS-VII, did not seem to have specifically trained and competent personnel to manage cost recovery attempts. On the whole this concept has not been fully understood as the limited staff is still overwhelmed with the activities leading to the achievement of specific child survival objectives.

D2. At this stage, cost recovery attempts are difficult to estimate in dollar amounts or percentage of project covered by this revenue.

D3. The introduction of this cost recovery activity is viewed more as an income generation activity by community members; as a result it has increased ADRA's reputation in the community. This activity is not directly related to service delivery and hence it is difficult to see how itaffected in service delivery.

D4. As explained in section D1, this house income generation activity can only be viewed as a success. In some communities, this provides a strong incentive to cultivate and grow the red hot pepper as an extra source of household income.

D5. The main lessons learned about cost recovery attempts from ADRA CS-VII is that there is need for critical assessment and analysis right from the stage of project conceptualization and design. The necessary financial, human and material resources required to implement the mechanisms need to be weighed against the expected revenues such venture. The services of financial experts should be sought to avoid expensive mistakes.

E. Household Income Generation

E1. Household income generating activities have been initiated by all the 32 village health committees. These activities include crop cultivation (peas, sweet potatoes, green pepper, beans, soya beans and maize), animal husbandry (cattle, poultry) and the cultivation of pilipili (hot peppers).

E2. The dollar amount of income added to a family or household annual income as a result of the income generating activity is difficult to estimate since the average income before the intervention were not available. A meaningful estimate is therefore not possible.

E3. The revenues generated at each household were not quantified. It is therefore not possible to estimate how much, if any was used in health activities.

E4. The main lesson learned in our opinion, is that there is need for well designed needs assessment to establish household income levels, patterns of income utilization, control of revenues and ability of community to undertake and manage such activities before they are introduced. There is a good potential for these activities to get finally established with child survival objectives in mind.

F. Others

F1. Sustainability promoting activities actually carried out by ADRA CS-VII over its lifetime are as described in section E1 (household income related). Other sustainability/promoting activities included:

- Home management of diarrheal diseases
- Referral to the health center of children at high risk of diarrheal disease
- Supply of vaccines (using vaccinators with bicycles)
- Vaccination out reach activities to the sub-parishes
- Community level problem solving

- Continued health promotion activity
- Follow up of high risk households
- Growth monitoring/Nutrition education activities
- Kitchen garden promotion
- Provision of local varieties of seeds
- Family planning education activities
- AIDS education activities

F2. While the aspects of sustainability outlined in previous sections, including section F1 were implemented satisfactorily, their steps were not clearly prescribed. ADRA CS-VII did not adequately address all the players role and responsibilities as related to the sustainability of project interventions. These community players include:

- Village Health Committee (VHC), sub-parish level
- RC1 (village) and RC-2 (parish)
- RC-3 and RC-3 Health Committees (sub-county)

ADRA should have provided technical training to the village health committees on income generation and financial management with sustainability objectives clearly spelt out.

F3. Qualitative data by ADRA on the level of community participation, especially the different village health committees need to be strengthened and quantified. The committees need help in analyzing their problems, deciding on appropriate solutions, prioritizing budget allocation and taking general responsibility for health spending of their funds. This qualitative data indicates a charge in the sustainability potential of project benefits.

SUMMARY / RECOMMENDATIONS

1. ADRA CS-X staff to work closely with TASO staff in training, (particularly in counselling skills), and also learn practical communicating skills to reach different target groups e.g. youth, people with AIDS, AIDS orphans and care givers like grandparents. Education is the main concern to victims and orphans.

2. ADRA to start community interventions (home care activities) along the highly successful TASO framework (contact person Margaret Kabanda TASO) network and start partnership.

3. USAID/Uganda's top priority, from countrywide assessment is the integration of STD/HIV/AIDS interventions with family planning promotion activities together

with child survival interventions and education (school fees) for AIDS orphans. ADRA CS-X to strive towards those objectives, strong linkage to Uganda's Ministry of Health and Ministry of Education priorities and USAID Mission Priorities: Should collaborate with local NGO's and international NGO's in Uganda.

4. ADRA CS-X to link up with the "DISH" project and attend coordination meetings. ADRA's activities in the Luwero District being among the 10 Districts should liaise with "DISH" personnel for training their community based distributors (CBDs) their Nurses, Medical Assistants (MA), Laboratory staff and physicians, in aspects of health education and promotion related to family planning and STD/HIV/AIDS Integration.

5. ADRA CS-X should enhance the excellent involvement of local leaders and government officials in all their intervention activities. Resistance Council (RC) Chairmen should be actively involved. Further recommend that kitchen gardens should include the rich Vitamin A vegetables like carrots. Vitamin A has been found to have the unintended benefit of reducing foetal transmission of HIV.

6. ADRA CS-X to work more closely with Family Planning Association of Uganda (FPAU), especially in the training of their CRDs and their remuneration strategies. The use of non-monetary incentives like bicycles and uniforms for their CBDs should be encouraged. CBDs should view themselves as members of community and not staff of ADRA. That way motivational activities can continue, even after ADRA's CS-X project ends (sustainability).

7. ADRA CS-X should continue their collaboration with the Uganda Protestant Medical Bureau (UPMB) in areas of training, especially training of trainers (TOT's). UPMB has expressed willingness to strengthen church related NGO's in highly subsidized training and in the development of their infrastructure, including the provision of essential clinical equipment for primary health care (PHC) activities e.g. weighing scales. UPMB is undertaking income generating activities (IGA) and has expressed willingness to share it's experience with ADRA/Uganda.(sustainability)

8. ADRA CS-X should enhance the involvement of men in family planning and HIV/AIDS awareness, promotion and active participation. CS-7 did not specifically target men. Traditionally men are key decision makers in communities and homes and therefore should be held responsible for positive health seeking behavior.

9. ADRA CS-X should strengthen its collaboration with the DMO in the following areas:

- Sharing of baseline information in immunization coverage
- Training of vaccinators
- DMO willing to provide vaccine carriers and to supplement income of vaccinators (commission based honoraria)
- Instead of using vehicles, motorcycles are recommended where practical bicycles should be used (more cost efficient and cost effective)
- "Pooling" of vehicles for vaccine transportation from depots is recommended.

10. Strongly recommend that ADRA CS-X links up with the Seventh Day Adventist Health Department which has a network of clinics throughout the country, headed by a full time physician. Benefits of this linkage and collaboration include:

- Sharing of skilled and trained manpower with attendant cost savings

- Utilization of SDA clinics and personnel already in existence in CS-X intervention areas to carry out child survival activities integrated with their other curative services. This will ensure sustainability after the project ends.

- SDA health department has experience in managing family planning activities as part of the just ended SEATS project. They should share this experience with the ADRA CS-X project.

- SDA managed coordinated clinics already implement cost recovery measures which include fee-for-service for curative services: Cross-subsidization can enhance and sustain family planning and STD/HIV/AIDS activities at end of CS-X child survival project.

- Integration of child survival activities with the 25 clinics and the re-structuring of the management systems to enable central control and co-ordination from the Ugandan Union Health and Temperance office.

11. ADRA's CS-7 did not emphasize technical skill development at senior level personnel; therefore, recommend that continuing education, especially in financial management be undertaken by senior project staff, particularly the Project Director. This is consistent with institutional capacity building.

12. Recommend closer monitoring of budgeting implications on a line item basis, alongside programmatic activities to ensure maximum outputs and project efficiency. Need for closer liaison between head office staff (financial) and project staff (programmatic).

13. Recommend that ADRA CS-X cooperate closely with MOH key personnel in areas of health education and health promotion, MCH/FP, STD/AIDS and the expanded program of immunization, in Policy Formation and National Implementation Plans (NIP). This will ensure that ADRA's CS-X priorities are consistent with Uganda's Ministry of Health's Priorities.

14. Recommend for ADRA CS-X to keep the USAID mission in Uganda informed on it's project activities, progress, constraints and lessons learned throughout the life of the project. This will ensure that ADRA's priorities are consistent with USAID's mission's priorities for Uganda.

Biography:

1. October 1988. The EPI Coverage Survey Expanded Program on Immunization. World Health Organisation

2. 1982. Henderson, R.H. & Sundaresan, T "Cluster sampling to assess immunization coverage: A review of experience with a simplified sampling method, " Bulletin of the World Health Organisation. 60 (2): pp. 253-260

3. 1989. UNICEF, UNESCO & WHO. Facts for life - A Communication Challenges. UNICEF, New York NY

4. 1990 World Population Data Sheet. Population Reference Bureau Inc.

5. 1991. USD Incorporated. "Epi Info", Version 5.lb". Stone Mountain, Georgia.

6. UNICEF, Bangladesh. Situation of Children and Priorities for Action in Bangladesh: Background for the 1990s. n.d.

7. UNICEF, Bangladesh. Selected Statistical Series, Feb. 1991.

Appendix A

Uganda Final Baseline Survey

BASELINE SURVEY

PLO CHILD SURVIVAL RAPID KNOWLEDGE, PRACTICE & COVERAGE (KPC) QUESTIONNAIRE FOR UGANDA CS VII FINAL BASE LINE & CS X BASE LINE SURVEY (8/9-10/94)

LUWERO DISTRICT

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EXECUTIVE SUMMARY

Uganda represents an unique opportunity for implementing and solidifying achievements in Child Survival and protective health behaviors. The receptivity of communities to pro-act with PVOs for health improvements, in Uganda, appears related to the HIV/AIDS phenomenon. HIV/AIDS education and the daily realization that AIDS kills has been actively broadcast through the media and other health education means since the late 1980's. At the community level, daily AIDS deaths have provided direct and often personal observations regarding the reality of AIDS and its consequence. Thus, Child Survival interventions through health promotion has an unusual advantage in present day Uganda. Every villager now knows that certain behaviors produce good and bad results in terms of health and illness. The ADRA CS VII Child Survival project experienced remarkable achievements as measured through community involvement, as measured by the baseline and final evaluation cluster sampling surveys and by direct empirical observation.

A CS X baseline survey was conducted during the second week of August 1994. ADRA headquarters provided technical expertise assisted by a technical advisor from Johns Hopkins University's CSSP. The external technical assistance was used as the mechanism for empowering ADRA/Uganda's Child Survival Core Team to train, conduct, analyze and interpret results using the WHO 30 cluster survey methodology. It is expected that this Core Team will continue to conduct quality surveys without external assistance. The Core Team also provided the USAID Mission with a formal presentation of the baseline survey findings. Similar feedback sessions are scheduled for the Uganda MOH and the local communities.

Significant baseline survey findings for several key factors are reported here. Breastfeeding was found to be 85.5% (255/300) at the time of the survey while exclusive breastfeeding was only 13.8% (8/58). The cultural implications for exclusive breastfeeding is low because other family members make such decisions and traditionally water and other substances are offered a newborn infant. The desirability for changing this behavior is low as measured against any possible perceived benefit. It is not expected that this indicator will significantly change over a three year period. The point prevalence rate for diarrhea was 23% (70/300) but 36% used ORS and 25.&% used cereal-based solutions. Significantly, 73.8% stated they continued to breastfeed and 98.5% gave fluids to their children during the diarrhea episode. When asked "do you want another child in the next three years?" 140 mothers said "No." Seventy nine mothers stated they were taking action to prevent pregnancy and 13.5% were using a modern contraceptive method. The modern contraceptive rate of 13.5% has increased from the CS VII baseline finding of 1.8%.

The fully immunized coverage rates for children 12 to 23 months was documented at 67% based on cards only. This compares favorably with the national level of 70%

coverage. Local community leaders and the Resistance Councils have undertaken expanded activities to assure that every child born in the ADRA impact villages are tracked for immunization until they are fully immunized.

Mother's knowledge levels for HIV/AIDS was found to be very high. The survey showed that 78% (235/300) believed people in their community was in danger of getting AIDS and 269 women said "anybody can get AIDS" but when asked "are you doing anything to prevent yourself from getting AIDS," 65 were not taking any measures to protect themselves. There were three major reasons given for why no AIDS prevention was taken, 17 mothers stated reason "unknown," and another 17 persons stated they didn't know "how" while 19 said they didn't take measures because the husband objected.

I. INTRODUCTION

A. Background information

The ADRA Luwero District, Uganda is the location for ADRA's expansion Child Survival X Project. The project is located in Kalagala and Zirobwe sub-counties of Luwero District. The most common causes of childhood morbidity and mortality in the CS X Impact Area includes:

- malaria
- diarrhea
- respiratory infections
- parasites
- vaccine preventable diseases

HIV/AIDS and MCH related health problems represent conditions which can be prevented but require increased resource and effort. The most common cause of maternal mortality is reported as undefined birth complications which are very likely related to all aspects of pregnancy and delivery in rural Uganda. The CS VII Child Survival Project targeted major causes of high child and maternal mortality with indication of good results. Beneficiaries include a total of 41,232 women and children at a cost of about $4.97 per year over a three year period.

B. Intervention area

The ADRA CS X project area has considerable health services and preventable disease control shortages. The Uganda MOH has provided EPI immunization activities and growth monitoring services for weighing children on a routine basis. The original CS VII baseline survey showed 55.4% of children 12-23 months of age were fully immunized as compared with a national average of 80%. Infant mortality was reported at 122/1000 live births. The project location is well supported through

the ADRA Bugema College which has been operating in Kalagala sub-county since 1948. The support arrangement provides an optimal opportunity for infrastructure development and an unusual support situation. The Bugema College Dispensary and Maternity Center provides 24 hour medical service.

There are nearly 100 communities in the intervention impact area. These rural villages are fairly homogeneous in culture, language and traditions. A sampling frame population was done with a cumulative population summarized. Following the WHO format, 30 clusters were drawn for the survey.

C. Objectives of the survey

A standardized survey was carried out following an agreement between ADRA and the PLO Child Survival Support Program (CSSP) at John Hopkins University. Subsequent arrangements were made by the project staff in collaboration with ADRA Monitoring and Evaluation Unit and a survey trainer from PLO CSSP. The ADRA/Uganda core staff would be adequately trained to conduct future Rapid K & P surveys with a minimum of external assistance.

The purpose of this survey was a Rapid Knowledge and Practice baseline in the new impact intervention area for immunization, nutrition, diarrheal disease control (CDD), maternal care/birth spacing, HIV/AIDS and malaria.

The objectives of the survey are to provide ADRA/Uganda with knowledge and practice baseline information in the impact area about the following issues:

* Mothers' knowledge (mothers of children under two) regarding: maternal care, family planning, appropriate weaning practices and nutrition, diarrheal disease control, immunizations malaria chemoprophylaxis and kitchen gardening.

* Mothers' practices related to the intervention areas mentioned above and safe motherhood.

* Target groups for health education messages.

* Immunization card coverage rate of children (12-23 months) with BCG, DPT, OPV, and measles vaccine.

* Card coverage rate with Tetanus Toxoid (TT) of mothers of children under two.

D. Schedule of activities

May and June 1994 Communication and coordination between survey trainers and ADRA/Uganda's Core Team prior to their arrival at project site. See attached training schedule (Sub-Appendix D).

Preliminary Rapid KPC Survey activities include:

- Orientation to project and preliminary training of project coordinators
- Core Team formation
- Finalize the questionnaire - 50 questions
- Translation of the questionnaire into Lunganda Logistic preparation and preparation of materials
- Training Preparation and assignments
- Training of supervisors and interviewers
- Field training exercise of interviewers and supervisors with test of the teams & questionnaire including a debriefing
- Final adjustments and reproduced questionnaire
- Data collection (two days) 300 interviews of 50 questions
- Data entry files written for Epi Info 6.0 software program
- Trained the Core Team in hand tabulation of data
- Data entry into Epi Info 6.0 software program
- Finalizing data entry 300 interview records entered
- Data analysis and debriefing completed summary Harvard Graphics done showing important findings
- ADRA project staff analysis, discussion and feedback of the data
- Finalize of survey draft report

- Feedback by ADRA CS X project to communities surveyed, MOH and USAID/Uganda

II. METHODOLOGY

A. The questionnaire

The standardized survey questionnaire was designed by CSSP Johns Hopkins with assistance of US and international experts for the various intervention areas. Frequent discussions were held with ADRA Headquarters, ADRA/Uganda and CSSP support staff to further customize and finalize the standard questionnaire according to the actual CSX project interventions and the project area. The questionnaire was administered to mothers aged 14 to 49 with a child of under 24 months of age.

The questionnaire was composed of 50 questions (see Sub-Appendix B and C for the English and Lunganda language questionnaires).

The questionnaire was first written in English and then translated into Lunganda. A translated version was presented to interviewers and supervisors during training. This was further refined for clarity of the intent of the questions.

B. Determination of sample size

The sampling methodology followed the 30 cluster sampling according the WHO/EPI model.

For the determination of the sample sizes, the following formula was used: $n= z^2 pq/d^2$

where n = the sample size, z = statistical certainty chosen p = coverage rate; level of knowledge, and q = 1-p, d = degree of precision.

The sample size was set up in the following way: the degree of precision (d) was set up at 0.1 and the p was set up at 0.5. Thus, the resulting minimum sample size was 210, which was increased to 300 for statistical improvement in the sub-strata findings.

The number of clusters was 30 with a sample size equal to 300. Thus, each cluster ten mothers with children under two years of age were interviewed.

C. Selection of sample

The following methodology was used: the sampling interval was calculated by dividing the total population by 30; and using a random number as a starting point 30 clusters were chosen.

The starting point for each cluster was determined in the following manner: the center of the village was located and a random direction was selected. The first household encountered in the randomly chosen direction was the starting point. The second and subsequent households were the ones which were nearest to the previous one.

For each cluster, 10 mothers were interviewed in both intervention area, In cases the mother was not available at he time of the interview, the interviewer rescheduled the interview. If the mother was not present at the time of the rescheduled appointment, another household was chosen (the household nearest to the last household).

D. Method of Data Analysis

The data analysis was performed in two different ways: by hand and by computer. The tabulation by hand was performed to allow field staff to understand completely all the steps of the survey process. The use of computer was performed to a more refined data analysis.

The data entry and analysis was done by computer using Epi Info 6.0. For the data analysis, frequencies and cross tabs were generated for key indicators and to establish more meaningful associations between certain characteristics and behaviors that would affect the development of health education messages.

III. THE SURVEY

A. Training

There were 15 supervisors (project officers) and 30 interviewers (community health workers and students), whose training lasted three days (including the pilot test). The training was carried out in English and Lunganda by the Project Manager, the Core Team members with assistance by representatives from ADRA Headquarters and Johns Hopkins University PLO CSSP.

The training included the purpose of the survey, sample size, sampling methodology, household starting point, understanding of the meaning of each question and how to ask each question. Role plays were used to familiarize the interviewers with the technique to be used. Each interviewer was expected to role play the entire questionnaire three times and conducted at least one household interview each during the field exercise.

The tasks of the supervisors and interviewers were also outlined. The three main tasks of the supervisors were to:

1. Select the starting point
2. Observe one interview each day
3. Check the questionnaires for accuracy and completeness and sign each when finished as their approval assurance

Finally, the interviewers and supervisors went out into a project area (that had not been selected as one of the 30 clusters) to interview mothers for the pilot test. A debriefing session was held to deal with any questions that had arisen during the afternoon and to re-emphasize important points in preparation for data gathering the following day. Staff were available for input throughout the entire training process. The debriefing session after the pilot test was conducted by the Project Manager, the Core Team staff and consultants.

B. The interviews

The supervisors observed an interview for each interviewer per day. They verified the questionnaire in order to check out its quality and accuracy.

There were concerns for sensitive questions contained in the questionnaire, namely the maternal care questions on birth spacing, prenatal care HIV/AIDS and birth delivery. For this reason, the surveyors decided only to select well trained interviewers in order to make sure that the mothers interviewed were comfortable answering the questions thus assuring the reliability of the data.

C. The Baseline Survey result

Identification

The total number of mothers interviewed is 300 with mean age of 25.19.

The mother's age ranged between 15 and 44.

High-risk deliveries, that is women delivering who are under 19 years of age or, over 35 years of age are 23/300 (7.7%) under 19 and 18/300 (6.0%) over 35.

The age range of the children is 0 - 23 months.

Mother's Education/Occupation

68% (204/300) of the mothers can actually read.

Breastfeeding/Nutrition

85% (255/300) are breastfeeding their child. Furthermore 28.1% of the mothers with children between 20 and 23 months were breastfeeding at the time of the survey.

Of the mothers who are not currently breastfeeding only 2% (1/44) never breastfed her child.

Mothers who breastfed their infant during the first hour after delivery 212/300 (71%) from 1 to 8 hours after delivery 35/300 (12%) more than 8 hours after delivery 48/300(16%).

Infant and child feeding practices.

84% (253/300) of the mothers gave their child herbal tea while 15% (45/300) did not.

Response to the question when should a mother start adding foods to breastfeeding was as follow: start adding between 4 and 6 months 214/300 (71%) ; start adding earlier than 4 months 52/300 (17%); start adding 6 months or later 28/300 (9%) and doesn't know 6/300 (2%).

All mothers responded that this additional food is milk, maize, millet, soya, vegetable, meat, fish, fruit, or other.

79% (237/300) have a growth monitoring card. 6% (17/300) claim that they have lost their card and 15% (46/300) mothers did not have their growth monitoring-family unit promotion card.

Of the 237 mothers who had a growth monitoring card, the record showed that 67.5% (160/237) had their child weighed in the last three months. However, 32.5% (77/237) of the mothers with the growth monitoring card, the card indicated that the children had not been weighed in the last three months.

Diarrhea Disease

23% (70/300) mothers with children stated that their child had diarrhea two weeks prior to the survey. 78% (230/300) did not experience diarrhea in the last two weeks immediately prior to the survey.

Of the mothers that stated their children had diarrhea 46% (32/70) claimed that they breastfed their child more than usual, 19% (13/70) breastfed same as usual, 19% (13/70) breastfed less than usual, 4% (3/70) stopped breastfeeding completely and 13% (9/70) did not breastfeed their child at all.

Of the mothers whose children had experienced diarrhea disease, 79% (55/70) provided their child with more fluid than usual other than breast milk, 16% (11/70) provided fluid same as usual, 1% (1/70) provided fluid less than usual and 4% (3/70) exclusively breastfed the child.

Of the 70 mothers whose children had diarrhea, 56% (39/70) continued to provide more than usual solid or semi-solid food, 19% (13/70) provided food the same as usual, 17% (12/70) provided food less than usual, 1% (1/70) did not provide food at all and 7% (5/70) exclusively breastfed their child.

The mothers whose children had diarrhea, 9% (6/70) did not treat their children at all, 36% (25/70) treated their child with ORS sachet, 11% (8/70) treated their child with sugar-salt solution, 14% (10/70) treated their child with ORT based cereal, 9% (6/70) treated their child with other fluids, 27% (19/70) treated their child with anti-diarrhea medicine or antibiotics, 16% (11/70) treated their child with starch-food fluids and 16% (11/70) used other methods to treat their child.

Of the 70 mothers whose children had diarrhea, 73% (51/70) sought advise or treatment, 27% (19/790) did not.

Of the 50 mothers who responded to the question whom they sought advise from, 4% (2/50) said hospital, 43% (17/50) stated clinic, 2% (1/50) said pharmacy, 46% (23/50) said village health worker, 2% (1/50) stated traditional healer and 12% (6/50) said they sought other advise.

As to the signs and symptoms which caused mothers to seek advise for the treatment of the diarrhea, 9% (26/300) said they did not know, 10% (30/300) stated vomiting, 16% (47/300) stated fever, 53% (160/300) stated dry mouths, sunken eyes and decreased urine output, 20% (61/300) stated diarrhea of prolonged duration (at least 14 days), 13% (39/300) blood in the stool, 9% (28/300) stated loss of appetite, 48% (122/300) stated weakness or tiredness and 14% (43/300) said other.

Of the 300 mothers with children that had diarrhea who knew what important action they should take, 6% (10/300) did not know, 13% (38/300) would give the child more frequent feeds, 54% (161/300) would give more foods, 25% (74/300) would give more energy giving foods and 31% (94/300) would use another method.

Immunizations

Out of the 288 mothers interviewed answered as to when should their child receive the measles vaccine, 1% (4/288) said 0 months, 5% (13/288) said 1 month, 3% (8/288) said 2 months, 2% (5/288) said 3 months, 2% (5/288) said 4 months, 1% (3/288) said 6 months, 87% (250/288) said 9 months and 12 mothers did not know.

44% (131/300) mothers believed that the main reason why a pregnant women needs to be vaccinated with tetanus toxoid vaccine would be to protect both mother/newborn against tetanus, 6% (19/300) believe that it would protect only the woman against tetanus, 42% (125/300) believe that it would protect only the newborn against tetanus, 8% (25/300) did not know.

As to the number of tetanus toxoid injections that a pregnant woman needs, 3% (9/300) said 1 injections, 35% (104/300) said 2 injections, 57% (170/300) said 3 injections, less then 1% (2/300) said 4 injections and 5% (15/300) said 5 injections.

80% (239/300) women interviewed said that they had an immunization card for their child, 14% (43/300) said they lost it and 6% (18/300) said they never had one.

The vaccination card record for children over 11 months of age, shows that 80% (82/103) have BCG, 81.5 (84/103) have DPT1, 77% (79/103) have DPT2, 70% (72/103) have DPT3, 80.5% (83/103) have OPV1, 77% (81/103) have OPV2, 72% (74/103) have OPV3 and 67% (69/103) have measles.

When asked if the mothers had a TT card, 52% (155/300) said yes, 24% (72/300) said they lost their card and 24% (73/300) said they never had it.

11% (17/155) had 1 TT vaccination, 46.5% (72/155) had 2 TT vaccinations, 42% (65/155) had 3 TT vaccinations and less then 1% (1/155) had none.

Maternal care

When mothers were asked if they were pregnant now, 11% (33/300) said yes, 87% (261/300) said no and 2% (6/300) did not know.

When asked if the mother wanted to have a child in the next two years, 48% (130/269) said yes, and 52% (139/269) said no.

When asked if the mother were currently using any method to avoid/postpone getting pregnant, 56% (79/140) said yes and 44% 61/140) said no.

The reasons why the mothers who were not using a method to avoid pregnancy were, 26% (16/61) did not know, 2% (1/61) said religious reasons, 13% (8/61) said their husbands object, 3% (2/61) stated personal beliefs, 2% (1/61) said side effects/safety, 21% (13/61) said that there were not local FP services available and 33% (20/61) stated other reasons.

When asked what method the mothers or their husbands use now to avoid/postpone pregnancy were, 6% (5/78) use tubal ligation, 10% (8/78) use injections, 24% (19/78)

use the pill, 5% (4/78) use the condom, 17% (13/78) use exclusive breastfeeding, 11.5% (9/78) use the rhythm method, 18% (14/78) use abstinence, 1% (1/78) use coitus interruptus and 6% (5/78) use other methods.

When asked when a pregnant mother should first see a health professional, 68% (204/300) said in her first trimester, 29% (87/300) said in her second trimester, 2% (5/300) said in her last trimester, less then 1% (2/300) said she doesn't need to see a health professional and less then 1% (2/300) said then did not know.

When mothers were asked when their first ante-natal health professional visit occurred, 46% (137/289) answered during their first trimester, 42% (125/298) said during their second trimester, 10% (29/300) stated during their last trimester and under 2% (4/289) stated they didn't know.

When mothers were asked how many times they visited a health professional during their pregnancy, 3% (10/289) said they never visited, less then 2% (4/298) said 1 time, 12% (37/298) said they visited 2 times and 83% (247/298) said more then 3 times.

When the question was asked as to who cut and tied the umbilical cord at the delivery, 6% (17/300) stated they cut and tied their own cord, 8% (25/300) said a family member, 6% (18/300) said a traditional birth attendant did it, 78% (235/300) said a health professional and less then 2% (5/300) said they did not remember.

When asked if the mothers received a chemoprophylaxis against malaria vaccination during pregnancy, 42% (125/300) said they did, 55% (164/300) said they did not and 4% (11/300) said they did not know.

Kitchen Garden

When the mothers were asked if they had a kitchen garden, 71% (213/300) said yes, 28% (85/300) said no and less then 1% (2/300) said they did not know.

When asked if they wanted a kitchen garden, 97% (87/90) said yes, 2% (2/90) said no and 1% (1/90) said they didn't know.

When the mothers were asked what they do with the garden vegetables, 99% (208/210) stated that the family consumed it and 1% (2/300) said they sold it at the market.

When asked if they had granary, 19% (56/300) said yes, 81% (243/300) said no and less then 1% (1/300) said they did not know.

HIV/AIDS

When the mothers were asked if they thought there were people in their village who were in danger of getting AIDS, 78% (235/300) responded yes, 3% (10/300) said no and 18% (55/300) said they did not know.

65% (194/300) of the mothers in the survey believed that a pregnant women can pass the HIV virus to her unborn child, 26% (78/300) did not believe that pregnant women could pass the HIV virus to her unborn child and 9% (28/300) said they did not know.

90% (269/300) of the mothers interviews said anybody can get AIDs, 7% (21/300) said no and 3% (10/300) stated that they did not know.

When the mothers were asked if they thought a person could contract AID by having sex without a condom, 90% (270/300) answered in the affirmative, 5% (16/300) said no and 5% (14/300) said they did not know.

79% (237/300) of the mothers in the survey stated that they are taking measures to protect themselves from getting AIDs, 18% (54/300) are not taking measure from getting AIDs and 3% (9/300) stated that they did not know.

Of the mothers who stated that they do not take measures to prevent themselves against AIDs, the reasons they gave were, 26% (17/65) they did not know, 1.5% (1/65) said for religious reasons, 30% (19/65) said they husbands object, 6% (4/65) stated their own personal beliefs, 26% (17/65) do know how to protect themselves, 1.5% (1/65) stated not means available and 9% (6/65) gave other reasons.

90% (269/299) of the mothers in the survey believed a person can get AIDs from someone who looks healthy, 7% (21/299) did not believe a person can get AID from a person that looks healthy and 3% (9/299) stated that they did not know.

85% (256/300) of the mothers interviewed believed that the AIDs virus could be in the body for a long time before they get sick, 10% 31/300) stated no, and 4% (13/300) said they do not know.

D. Discussion of the survey results

Age Distribution

The mean age of mothers in the survey was 25.8 years. The mean age of children was 9.8 months. 197 (66%) children are between 0-11 months. Mean = 9.8 months

Breastfeeding/Nutrition

85.5% of the mothers declare they breastfeed their children. 13.8% of the mothers in the age group 0-3 months exclusively breastfeed their children. In the age group 4-6 months, 71% of mothers know to give their children semisolid foods (weaning practice) between 4 and 6 months.

Growth Monitoring

231 (77%) children out of the 300 children in the sample had a growth monitoring card. 52% (231/300) of the children were weighed in the last three months.

Kitchen Gardens

213 of the mothers interviewed (231/300) declared they had a Kitchen Garden while 87/90 who didn't have a garden wanted one and in most instances the food produced was used to feed the family (98%).

Diarrheal Disease

70 (23.0%) of the children in the sample had diarrhea in the last two weeks. About 36% of mother whose children had diarrhea used ORS packages and 25.7% used cereal-based solutions and other recommended fluids including some sugar-salt solution. Respectively 73.8%, and 98.5% of the mothers whose children had diarrhea continued breastmilk and liquids. Among the children who had diarrhea and whose mother looked for advice or treatment 46% of them visited a CHW.

53.3% of the mothers in the sample knew that dry mouth, sunken eyes, and decreased urine output are important symptoms of their children's diarrhea. For the knowledge about what are the important actions when a child is recovering from diarrhea 24.7% of the mothers declare they give foods with high caloric content.

Immunization

Mothers produced immunization cards for 233 children (77.7%). 86.8% of the mothers in the sample knew that a child should be immunized against measles at nine months of age. Only 8.3% of the mothers in the sample did not know that TT protected either the mother or child against tetanus. 56.7% of the mothers in the sample declared that more then two injections were needed to protect a newborn against tetanus.

67% of the children (12-23 months) were fully immunized. The dropout rate (DPT1-DPT3/DPT1) was 14.3% and the Overall Drop Out Rate was 15.9%.

Maternal Care

51.6% of the mothers (155/300) had a maternal health card. Among the mothers who had a maternal health card 56.7% received two or more TT vaccinations. Among all the mothers in the sample 45.7% received two or more TT vaccinations. 51.7% of the mothers in the sample (excluding the pregnant women) did not want to have a child in the next two years. Among the mothers who did not want to have a child in the next three years 43.6% did not use any method to avoid/postpone the pregnancy. The contraceptive utilization rate[1] (the denominator is all the women in the sample less the pregnant ones) is 25.9%.

98% of the mothers in the sample did know when they should see a health professional when they are pregnant. Mothers were aware of the need to visit a health professional during the first trimester of pregnancy by 68% (204/300) while 29% thought the second trimester was the optimal time to see a health professional. In actual practice 46% of all the mothers visited a health professional during their first trimester of pregnancy and another 41.9% made the first visit during the second trimester.

Only 5.7% of all mothers cut and tied their own cord. Family members assisted 8.3% (25/300) births, TBAs assisted 6% and health professionals were utilized 78.3% of births (235/300).

E. Comparison with national and district data

In the immunization BCG rate for the national rate is 86% while the Khulna survey is 63.8%; DPT3 in the national is 69% in the Khulna survey it is 53.2%; Measles 65% national and 40.4% Khulna. The TT1 immunization in the Khulna district is 80% while in the Khulna survey it is 13%.

For the Family Planning activity the national contraceptive rate is 32.8% while for Khulna survey is 34.6%.

F. Implication of the baseline data for the project

These data provide useful information for the future of the child survival project.

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[1] Modern methods are the following: tubal ligation, Norplant, Injections, Pills, IUD, Diaphragm, Condom, Vasectomy.

Diarrhea Control

Since 23.5% of the children interviewed had an episode of diarrhea in the past two weeks, diarrhea management should be an important emphasis for the project. Considerable work needs to be done in dissemination of the health messages in the diarrhea control and perhaps prevention. The community health workers will be trained how to pass the messages to the mothers.

Immunizations

The project staff pointed out that they have emphasized all the health messages in the immunization program since earlier survey results showed lower than national coverage rates. The high level of mother's knowledge regarding the correct age for measles immunization shows that the ADRA staff had an impact on raising knowledge levels.

The project will need to give clear messages in all the activities of immunization. Coverage levels will need to be raised approximately 20% for BCG, DPT and OPV to reach WHO targets and measles (presently 67%) will need specific attention and "baby tracking" to assure that all children are followed until fully immunized.

The project staff recognized that the training of the community health workers (Health Promoters) will be a key point for the success of the CS X Extension project.

ADRA CS staff recognize that a close relation with the MOH structure in all interventions are important for the future of the project. HIV/AIDS and Family Planning are especially targeted for intervention efforts.

Nutrition

The length of breastfeeding seems not to be an important problem since 85.5% of the mothers interviewed were breastfeeding.

Growth Monitoring

It was clear that the growth monitoring needs improvement, since many of the children had GM cards but less than half were weighed in the last three months. Kitchen Gardens were highly utilized as food sources for their families.

Maternal Care

Although 51.7% of the mothers did not want to have another baby in the next three years, a full 56% were not using any contraceptive method. The reasons behind this

lack of control mothers have over their own fertility require further exploration in terms of qualitative assessment and a sensitive approach on the part of project staff. The concept of greater male involvement needs to be explored.

These mothers were very knowledgeable about when to seek their first prenatal care with 68% aware of that need during the first trimester and another 29% indicating the second. The mother's practices were a bit different with 46% going for their first ANC visit during the first trimester and during their pregnancies only 23% received prenatal care and 77% ate the same or less than usual. This data presents a grim picture of how at-risk mothers actually are in the target area, a formula for death. The data present a compelling reason for a strong maternal care component in the project coupled with a TBA training program.

IV. FEEDBACK SESSIONS/ARRANGEMENTS

There was one feedback session held with SCF/BFO staff and the USAID representative in the SCF/Bangladesh Field Office in Dhaka. The feedback session was attended by the Field Office Director, the CSVII Program Manager, the Senior Program Officer, the Computer Systems Analyst, the JHU CSSP survey trainer, and the SCF/Headquarters representative.

A feedback session was conducted in Narsinagar by the SCF/BFO CSVIII program manager for the field-based staff which will provide feedback to the communities surveyed.

Another feedback session was planned to the MOH by the SCF/BFO in February, 1993.

V. SURVEY COSTS

A baseline survey for the expansion area and a final evaluation survey were conducted simultaneously bringing the total cost of both surveys.

REFERENCES:

The EPI Coverage Survey Expanded Program on Immunization. World Health Organization, October 1988.

Henderson, R.H. Sundaresan, T "Cluster sampling to assess immunization coverage: A review of experience with a simplified sampling method, *Bulletin of the world Health Organization.* 1982. 60 (2) : pp. 253-260

UNICEF *Bangladesh Selected Statistical Series.* Feb. 1991.

UNICEF *Bangladesh Situation of Children and Priorities for Action in Bangladesh: Background for the 1990s.* n.d.

UNICEF, UNESCO, WHO. *Facts for life - A Communication Challenge.* UNICEF. NewYork, NY. 1989.

USD Incorporated. *Epi Info, Version 6.0.* Stone Mountain, Georgia. 1991.

World Population Data Sheet. Population Reference Bureau Inc. 1990

KEY CHILD SURVIVAL INDICATORS FOR UGANDA

Practice and coverage indicator calculations are based on the PVO Child Survival Knowledge, Practice, and Coverage (KPC) Survey Questionnaire (version dated 5/25/94)

1. **Appropriate Infant Feeding Practices: Initiation of Breastfeeding**
Percent of children (less than 24 months) who were breastfed within first 8 hours after birth.

Final Baseline Survey	(212+35) / 298 * 100 = 82.9%
1st Baseline Survey	(73+64) / 240 * 100 = 57.1%

2. **Appropriate Infant Feeding Practices: Exclusive Breastfeeding**
Percent of infants less than four months, who are being given only breast milk.

N/A

3. **Appropriate Infant Feeding Practices: Introduction of Foods**
Percent of infants between five and nine months who are being given solid or semi-solid foods.

N/A

4. **Appropriate Infant Feeding Practices: Persistence of Breastfeeding**
Percent of children between 20 and 24 months, who are still breastfeeding (and being given solid/semi-solid foods).

Final Baseline Survey	9/32 * 100 = 28.1%
1st Baseline Survey	Unable to calculate without raw data

5. **Management of Diarrheal Diseases: Continued Breastfeeding**
Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more breast-milk.

Final Baseline Survey	(32+13) / (70-9) * 100 = 73.8%
1st Baseline Survey	(12+55) / (111-12) * 100 = 67.7%

6. **Management of Diarrheal Diseases: Continued Fluids**
Percent of infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breast-milk.

Final Baseline Survey	(55+11) / (70-3) * 100 = 98.5%
1st Baseline Survey	(41+38) / (111-7) * 100 = 76%

7. **Management of Diarrheal Diseases: Continued Foods**
Percent of infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food.

Final Baseline Survey	(39+13) / (70-5) * 100 = 80%
1st Baseline Survey	(5+29) / (111-36) * 100 = 45.3%

8. **Management of Diarrheal Diseases: ORT Usage**
Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.

Final Baseline Survey	49 / 70 * 100 = 70%
1st Baseline Survey	(46+2) / 111 * 100 = 43.2%

9. **Pneumonia Control: Medical Treatment**
Percent of mothers who sought medical treatment for infant/child (less than 24 months) with cough and rapid, difficult breathing in the past two weeks.

N/A

10. **Immunization Coverage (Card): EPI Access**
Percent of children 12 to 23 months who received DPT1.

Final Baseline Survey	84 / 103 * 100 = 81.6%
1st Baseline Survey	63 / 83 * 100 = 75.9%

11. **Immunization Coverage (Card): EPI Coverage**
Percent of children 12 to 23 months who received OPV3.

Final Baseline Survey	74 / 103 * 100 = 71.8%
1st Baseline Survey	58 / 83 * 100 = 69.9%

12. **Immunization Coverage (Card): Measles Coverage**
Percent of children 12 to 23 months who received measles vaccine.

Final Baseline Survey	69 / 103 * 100 = 67.0%
1st Baseline Survey	47 / 83 * 100 = 56.6 %

13. **Immunization Coverage (Card): Drop Out Rate**

Final Baseline Survey	
(84-72) / 84 * 100 = 14.3%	drop-out rate between DPT1 and DPT3
(82-69) / 82 * 100 = 15.9%	overall drop-out rate
1st Baseline Survey	
(63-58) / 63 * 100 = 7.9 %	drop-out rate between DPT1 and DPT3
(63-47) / 63 * 100 = 25.4%	overall drop-out rate

14. **Maternal Care: Maternal Card**
Percent of mothers with a maternal card.

N/A

15. **Maternal Care: Tetanus Toxoid Coverage (Card)**
Percent of mothers who received two doses of tetanus toxoid vaccine (card).

Final Baseline Survey	(72+65) / 300 * 100 = 45.7%
1st Baseline Survey	96 / 240 * 100 = 40%

16. **Maternal Care: One or More Ante-Natal Visits (Card and Self Report)**
Percent of mothers who had at least one pre-natal visit prior to the birth of the child.

Final Baseline Survey / by self report (Q 36)	288/299 * 100 = 96.6%
1st Baseline Survey / by self report (Q 36)	233/240 * 100 = 97.1%

17. **Maternal Care: Modern Contraceptive Usage**
Percent of mothers who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method (responses to # 1 through # 48 to question # 33).

Final Baseline Survey	(5+8+19+4+13+9) / 139 * 100 = 41.7%
1st Baseline Survey	(1+3+1+1) / 65 * 100 = 9.2%

Recommended Knowledge Indicators from the Rapid Child Survival Knowledge & Practice Survey Questionnaire

The following four knowledge indicators are recommended, but are not required, to be tracked at baseline and final for each PVO Child Survival project.

1. **Mother's Literacy (baseline only)**
Percent of mothers who are literate.

Final Baseline Survey	(161+43) / 300 * 100 = 68%
1st Baseline Survey	(132+31) / 240 * 100 = 67.9%

2. **Immunization Knowledge: Timeliness of Measles**
Percent of mothers who know that measles vaccine should be given at nine months.

Final Baseline Survey	250 / 288 * 100 = 86.8%
1st Baseline Survey	139 / 240 * 100 = 57.9%

3. **Immunization Knowledge: Tetanus Toxoid Protection**
Percent of mothers who know that tetanus toxoid protects both the child and the mother.

Final Baseline Survey	131 / 300 * 100 = 43.7%
1st Baseline Survey	50 / 240 * 100 = 20.8 %

4. **Maternal Care Knowledge: Timeliness of Ante-Natal Care**
Percent of mothers who know that pregnant women should start ante-natal care before the third trimester.

Final Baseline Survey	(204+87) / 300 * 100 = 97.0%
1st Baseline Survey	(79+136) / 240 * 100 = 89.6%

Sub-Appendix A

Survey Results

SURVEY RESULTS

AGE CHILD|

MEAN AGE 9.86 YEAR

AGE OF MOTHER|

MEAN AGE 25.19 YEARS

AGE RANGE FOR MOTHERS: 15 YEARS TO 44

AGE RANGE FOR CHILDREN: 0 MONTHS TO 23 MONTHS

4. Are you breastfeeding (name of child)?

	n	%
1. yes	300	85.0

5. Have you ever breast-fed (name of child)?

	n	%
1. yes	45	97.8

6. After delivery, when did you breastfeed for the first time?

	n	%
1. During the first 1 hour	212	71.1
2. 1 to 8 hours	35	11.7
3. More than eight hours	48	16.13
4. Do not remember	3	1.0

7. Are you giving (name of child) water or teas?

	n	%
1. yes	253	84.3

8. When should a mother start adding foods to breastfeeding? n=300

	n	%
1. start adding between 4 and 6 months	214	71.3
2. start adding earlier than 4 months	52	17.3
3. start adding 6 months or late	28	9.3
4. doesn't know	6	2.0

9. What should those additional foods to breastfeeding be? n=475 (multiple answers possible)

	n	%
1. Milk	118	39.3
2. Maize, porridge, grain, rice	123	21.0
3. Vegetable soup	78	26.0
4. Meat or fish soup	55	18.3
5. Fruits or juices	14	4.7
6. Other	175	58.3

10. Does (name of child) have growth monitoring/Family Unit card?

	n	%
1. yes	237	79.0

11. Has the child been weighed in the last three months?

	n	%
1. yes	160	67.5
2. no	77	32.5

12. Children who had diarrhea during the last two weeks?

	n	%
1. yes	70	23.3

13. During (name of child)'s diarrhoea did you breast-feed?

	n	%
1. more than usual?	32	45.7
2. same as usual?	13	18.6
3. less than usual?	13	18.6
4. stopped completely?	3	4.3
5. child not breastfed?	9	12.9

14. During (name of child)'s diarrhoea, did you provide (name of child) with fluids other than breast-milk?

	n	%
1. more than usual	55	78.6
2. same as usual?	11	15.7
3. less than usual?	1	.4
4. stopped completely?		
5. exclusively breastfeeding?	3	4.3

15. During (name of child)'s diarrhoea, did you provide (name of child) with solid/semisolid foods?

	n	%
1. more than usual?	39	55.7
2. same as usual?	13	18.6
3. less than usual?	12	17.1
4. stopped completely?	1	.4
5. exclusively breastfeeding?	5	7.1

16. When (name of child) had diarrhoea, what treatments, if any, did you use? (multiple answers possible)

	n	%
a. nothing	6	8.6
b. ORS sachet	25	35.7
c. sugar-salt solution	8	11.4
d. cereal based ORT	10	14.3
e. other fluid	6	8.6
f. anti-diarrhoea medicine or antibiotics	19	27.1
g. starch food	11	15.8
h. other	9	12.9

17. When (name of child) had diarrhoea, did you seek advice or treatment for the diarrhoea?

	n	%
1. yes	51	72.9

18. From whom did you seek advice or treatment for the diarrhoea of (name of child)? (multiple answers possible)

	n	%
a. hospital	2	4.0
b. health center/clinic/post	17	34.0
c. Drug seller	1	2.0
d. Village health worker	23	46.0
e. Traditional healer	1	2.0
f. TBA		
g. other	6	12.0

19. What signs/symptoms would cause you to seek advice or treatment for (name of child)'s diarrhoea? (multiple answers possible)

	n	%
1. doesn't know	26	8.7
2. Vomiting	30	10.0
3. Fever	47	15.7
4. dry mouth, sunken eyes, decreased urine output (dehydration)	160	53.3

5. diarrhoea of prolonged duration at least 14 days)	61	20.3
6. blood in stool	39	13.0
7. loss of appetite	28	9.3
8. weakness or tiredness	122	40.7
9. other	43	14.3

20. What are the important actions you should take if (name of child) has diarrhoea? (multiple answers possible)

	n	%
1. doesn't know	3	1.0
2. initiate fluids rapidly	84	28.0
3. give the child more to drink than usual	79	26.3
4. give child smaller more frequent feeds	14	4.7
5. ORS	129	46.0
6. hospital	90	30.0
7. feed more after dehydration	14	4.7
8. withhold fluids	2	0.7
9. withhold food	1	0.3
10. other	58	19.3

21. What are important actions a mother should take when a child is recovering from diarrhoea? (multiple answers possible)

	n	%
1. doesn't know	19	6.3
2. give child smaller more frequent feeds	38	12.7
3. more foods than usual	161	53.7
4. give foods with high caloric content	74	24.7
5. other	94	31.3

22. At what age should (name of child) receive measles vaccine?

MONTHS	Freq	Percent
0	4	1.4
1	13	4.5
2	8	2.8
3	5	1.7
4	5	1.7
6	3	1.0
9	250	86.8
99(do not know)	12	4.0%

23. Can you tell the main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine?

	n	%
1. to protect both mother/newborn against TT	131	43.7
2. to protect only the woman against tetanus	19	6.3
3. to protect only the newborn against TT	125	41.7
4. doesn't know or other	25	8.3

24. How many tetanus toxoid injections does a pregnant woman need to protect the newborn infant from tetanus?

	n	%
1. one	9	3.0
2. two	104	34.7
3. more than tw	170	56.7
4. none	2	0.7
5. doesn't know	15	5.0

25. Children who have an immunization card

	n	%
1. yes	239	79.7
2. lost it	43	14.3
3. never had one	18	6.0

26. Look at the card and record the dates of all the immunizations in the space below.

The denominator are children (12-23 months)

	n	%
BCG	82	79.6
DPT1	84	81.5
DPT2	79	76.7
DPT3	72	69.9
OPV1	83	80.5
OPV2	81	76.6
OPV3	74	71.8
Measles	69	67.0
Fully immunized	69	67.0
Dropout rate DPT1-DPT3		14.3
Overall dropout rate BCG1-Measles		15.9

27. Do you have a TT/maternal health card?

	n	%
1. yes	155	51.7
2. lost it	72	24.0
3. none	73	24.3

28. Mothers who have received TT vaccinations (according to the TT/maternal health card)

	n	%
1. one	17	11.0
2. two	72	46.5
3. three or more	65	41.9
4. none	1	0.6

29. Are you pregnant now?

	n	%
1. yes	33	11.0
2. no	261	87.0
3. don't know	6	2.0

30. Do you want to have another child in the next three years?

	n	%
1. yes	130	48.3
2. no	140	51.7

31. Are you currently using any method to avoid/postpone getting pregnant?

	n	%
1. yes	79	56.4
2. no	61	43.6
	(n=140)	

32. If you are not using any method to avoid pregnancy why?

	n	%
1. don't know	16	26.2
2. religious reasons	1	.6
3. husband objects	8	13.1
4. personal beliefs	2	3.3
5. side effects/safety	1	.6
6. no local FP services	13	21.3
7. other	20	32.8

33. What is the main method you or your husband are using now to avoid/postpone pregnant?

	n	%
1. tubal ligation/vasectomy	5	6.1
2. injections	8	10.3
3. pill	19	24.4
4. IUD	0	0.0
5. barrier method/diaphragm	0	0.0
6. condom	4	5.1
7. foam/gel	0	0.0
8. exclusive breastfeeding	13	16.7
9. rhythm	9	11.5
10. abstinence	14	17.9
11. coitus interruptus	1	.3
12. other	5	6.4

Modern contraceptive prevalence: 13.5% (the denominator is the sample size minus the pregnant women 37/267) All FP methods yield a child spacing rate of 55.7% (the denominator is all the mothers who do not want a baby in the next three years 78/140).

34. How soon after a woman knows she is pregnant should she see a health professional (physician, nurse, midwife)?

	n	%
1. first trimester, 1-3 months	204	68.0
2. middle of pregnancy, 4-6 months	87	29.0
3. last trimester, 7-9 months	5	1.7
4. no need to see health worker	2	0.7
5. doesn't know	2	0.7

35. When was your first antenatal health professional visit?

	n	%
1. first trimester, 1-3 months	137	46.0
2. middle of pregnancy, 4-6 months	125	41.9
3. last trimester, 7-9 months	29	9.7
4. no need to see health worker	3	1.0
5. doesn't know	4	1.3

36. How many times after your were pregnant with (name of child) did you see a health professional?

	n	%
1. none	10	3.4
2. one time	4	1.3
3. two times	37	12.4
4. more than three times	247	82.9

37. At delivery of (name of child), who tied and cut the cord?

	n	%
1. yourself	17	5.6
2. family member	25	8.39
3. traditional birth attendant	18	6.0
4. health professional (physician, nurse, or midwife)	235	78.3
5. other	5	1.7
6. doesn't know	0	0.0

38. Have you received chemoprophylaxis (treatment) against malaria during pregnancy?

	n	%
1. yes	125	41.7
2. no	164	64.7
3. don't know	11	3.7

39. Do you have a kitchen garden?

1. yes	213	71.7
2. no	85	28.3
3. doesn't know	2	0.7

40. Do you want a kitchen garden?

1. yes	87	96.7
2. no	164	64.7
3. doesn't know	1	.1

41. What do you do with your garden vegetables?

1. family consumption	208	99.0
2. sells	2	1.0

42. Do you have a granary?

1. yes	56	18.7
2. no	243	81.0
3. doesn't know	1	0.3

43. Do you think there are people in your village who are in danger of getting AIDS?

1. yes	235	78.3
2. no	10	3.3
3. doesn't know	55	18.3

SV

44. Can a pregnant woman pass the AIDS virus to a child before it is born?

1. yes	194	64.7
2. no	78	26.0
3. doesn't know	28	9.3

45. Do you think anybody can get AIDS?

1. yes	269	89.7
2. no	21	7.0
3. doesn't know	10	3.3

46. Is it possible to get AIDS through sex without using condoms?

1. yes	270	90.0
2. no	16	5.3
3. doesn't know	14	4.7

47. Are you making measures to prevent yourself from getting AIDS?

1. yes	237	79.0
2. no	54	18.0
3. doesn't know	9	3.0

48. If not, why not?

1. doesn't know	17	26.0
2. religious reasons	1	.5
3. husband objects	19	29.2
4. personal beliefs	4	6.2
5. do not know how to	17	26.2
6. no means available	1	.5
7. other	6	9.2

49. Do you think a person can get AIDS from someone who looks healthy?

1. yes	269	90.0
2. no	21	7.0
3. doesn't know	9	3.0

50. Is it possible for the AIDS virus to be in the body for years before a person begins to feel sick?

1. yes	266	85.3
2. no	31	10.3
3. doesn't know	13	4.3

Sub-Appendix B

English Questionnaire

PVO Child Survival Rapid Knowledge, Practice & Coverage (KPC)
Questionnaire for Uganda CS VII Final Base Line &
CS X Baseline Survey (8/9-10/94)

All questions are to be addressed to the mother with a child under two (less than 24 months of age)

CLUSTER #_____ HOUSE #_____

Interview date ___ / ___ / ___

1. Age of the mother in years: _____

2. Child's birth date <dd/mm/yy>
   Age in months: _____

3. What was the highest educational level you attained?
   1. none [ ]
   2. primary does not read [ ]
   3. primary reads [ ]
   4. secondary & higher [ ]

4. Are you breastfeeding (name of child)?
   1. yes [ ] --- GO TO 6
   2. no [ ]

5. Have you ever breast-fed (name of child)?
   1. yes [ ]
   2. no [ ] --- GO TO 7

6. After the delivery, when did you breast-feed (name of child) for the first time?
   1. during the first hour after delivery [ ]
   2. from 1 to 8 hours after delivery [ ]
   3. more than 8 hours after delivery [ ]
   4. do not remember [ ]

7. Are you giving (name of child) water (or herbal teas)?
   1. yes [ ]
   2. no [ ]
   3. doesn't know [ ]

8. When should a mother start adding foods to breastfeeding?
   1. start adding between 4 and 6 months [ ]
   2. start adding earlier than 4 months [ ]
   3. start adding 6 months or later [ ]
   4. doesn't know [ ]

9. What should those additional foods to breastfeeding be?
(multiple answers possible; record all answers)
a. milk
b. Maize, millet, soya porridge
c. Vegetable soup
d. Meat or fish soup
e. Fruit or juices
f. Other (Specify

10. Does (name of child) have a growth monitoring/Family Unit promotion card?
1. yes [ ] (must see card)
2. lost card [ ] --- GO TO 12
3. no [ ] --- GO TO 12

11. Look at the growth monitoring card of the child, and record the following information. (Has the child been weighed in the last 3 months?)
1. yes [ ]
2. No [ ]

12. Has (name of child) had diarrhea during the last two weeks?
1. yes [ ]
2. no [ ] --- GO TO 19
3. doesn't know [ ] --- GO TO 19

13. WHEN (name of child) had diarrhea did you breast-feed? (read the choices to the mother)
1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. child not breastfed [ ]

14. During (name of child)'s diarrhea, did you provide (name of child) with fluids other than breast-milk (read the choices to the mother)
1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. exclusively breastfeeding [ ]

15. During (name of child)'s diarrhea, did you continue to provide (name of child) with solid/semisolid foods (read the choices to the mother)
1. more than usual? [ ]
2. same as usual? [ ]
3. less than usual? [ ]
4. stopped completely? [ ]
5. exclusively breastfeeding [ ]

16. When (name of child) had diarrhea, what treatments, if any, did you use? (multiple answers possible; record all answers)
    a. nothing
    b. ORS sachet
    c. sugar-salt solution
    d. cereal based ORT
    e. other fluids
    f. anti-diarrhea medicine or antibiotics
    g. Starch-food fluids(Matooke, cassava or potatoes
    h. other specify ----------

17. When (name of child) had diarrhea, did you seek advice or treatment for the diarrhea?
    1. yes [ ]
    2. no [ ] --- GO TO 19

18. From whom did you seek advice or treatment for the diarrhea of (name of child)? (multiple answers possible; record each answer)
    a. hospital
    b. health center/clinic/post
    c. drug shop
    d. village health worker
    e. traditional healer
    f. traditional birth attendant
    g. other (specify)----------

19. What signs/symptoms would cause you to seek advice or treatment for (name of the child)'s diarrhea? (multiple answers possible; record all answers)
    a. doesn't know
    b. vomiting
    c. fever
    d. dry mouth, sunken eyes, decreased urine output (dehydration)
    e. diarrhea of prolonged duration (at least 14 days)
    f. blood in stool
    g. loss of appetite
    h. weakness or tiredness
    i. other (specify)

20. What are important actions the mother should take if (name of child) has diarrhea? (multiple answers possible; record all answers)
    a. doesn't know
    b. initiate fluids rapidly
    c. give the child more to drink than usual

d. give the child smaller more frequent feeds
e. proper mixing and administration of ORS
f. take child to the hospital/health center
g. feed more after diarrheaepisode so that child can re-gain weight
h. withhold fluids
i. withhold foods
j. other (specify) _____

21. What important actions should the mother take when the child is recovering from diaarrhea? (multiple answer possible}
a. doesn't know
b. give the child more frequent feeds
c. give more foods
d. give more energy giving food
e. other (specify)_____

22. At what age should your child receive measles vaccine?
1. Specify age in months [ ]
2. doesn't know (unknown mark 99) [ ]

23. Can you tell me the main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine?
1. to protect both mother/newborn against tetanus [ ]
2. to protect only the woman against tetanus [ ]
3. to protect only the newborn against tetanus [ ]
4. doesn't know [ ]
5. other [ ]

24. How many tetanus toxoid injections does a pregnant woman need?
1. one [ ]
2. two [ ]
3. more than two [ ]
4. none [ ]
5. doesn't know [ ]

25. Do you have an immunization card for (name of child)?
1. yes [ ] (must see card)
2. lost it [ ] --- GO TO 27
3. never had one [ ] --- GO TO 27

26. Look at the vaccination card and record the dates of all the immunization in the space below:

		<dd / mm / yy>
BCG		___ / ___ / ___
OPV	1st	___ / ___ / ___
	2nd	___ / ___ / ___
	3rd	___ / ___ / ___
DPT	1st	___ / ___ / ___
	2nd	___ / ___ / ___
	3rd	___ / ___ / ___
MEASLES		___ / ___ / ___

27. Do you have a TT card?
    1. Yes [ ]
    2. lost it [ ] ---GO TO 29
    3. No [ ] ---GO TO 29

28. Look at the TT card and record the number of TT vaccinations in the space below:
    1. One [ ]
    2. Two [ ]
    3. Three or more [ ]
    4. None [ ]

29. Are you pregnant now?
    1. Yes [ ] ---GO TO 34
    2. No [ ]
    3. Don't know [ ]

30. Do you want to have another child in the next two years?
    1. yes [ ] --- GO TO 34
    2. no [ ]
    3. doesn't know [ ]

31. Are you currently using any method to avoid/postpone getting pregnant?
    1. yes [ ]--- GO TO 33
    2. no [ ]

32. If you are not using any method to avoid pregnancy why?
    1. Don't know [ ]--- GO TO 34
    2. Religious reasons [ ]--- GO TO 34
    3. Husband objects [ ]--- GO TO 34
    4. Personal beliefs [ ]--- GO TO 34

5. Side effects/safety [ ]--- GO TO 34
6. No local FP service available [ ]--- GO TO 34
7. Other (Specify) [ ]--- GO TO 34

33. What is the main method you or your husband are using now to avoid/postpone getting pregnant?
1. tubal ligation [ ]
2. injections [ ]
3. pill [ ]
4. IUD [ ]
5. barrier method/diaphragm [ ]
6. condom [ ]
7. foam/gel [ ]
8. exclusive breastfeeding [ ]
9. rhythm [ ]
10. abstinence [ ]
11. coitus interruptus [ ]
12. other (Specify) [ ]

34. How soon after you knew you were pregnant should you see a health professional? (physician, nurse, midwife)? (probe for months)
1. first trimester, 1-3 months [ ]
2. middle of pregnancy, 4-6 months [ ]
3. last trimester, 7-9 months [ ]
4. no need to see health worker [ ]---- GO TO 37
5. doesn't know [ ]

35. When was your first antenatal health professionl visit?
1. first trimester, 1-3 months [ ]
2. middle of pregnancy, 4-6 months [ ]
3. last trimester, 7-9 months [ ]
4. no need to see health worker [ ]
5. doesn't know [ ]

36. How many times after you were pregnant with (name of child) did you see a health professional (physician, nurse, midwife) for pregnancy care?
1. None [ ]
2. One time [ ]
3. Two times [ ]
4. More than three times [ ]

37. At the delivery of (name of child), who tied and cut the cord?
    1. yourself [ ]
    2. family member [ ]
    3. traditional birth attendant [ ]
    4. Health professional (physician, nurse or midwife) [ ]
    5. other (specify) [ ]
    6. doesn't know [ ]

38. Have you received chemoprophylaxis (treatment) against malaria during pregnancy?
    1. Yes [ ]
    2. No [ ]
    3. Don't know [ ]

39. Do you have a kitchen garden?
    1. Yes [ ] --- GO TO 41
    2. No [ ]
    3. Don't know [ ]

40. Do you want a kitchen garden?
    1. Yes [ ] --- GO TO 42
    2. No [ ] --- GO TO 42
    3. Don't know [ ] --- GO TO 42

41. What do you do with your garden vegetables?
    1. family consumption [ ]
    2. sell at market [ ]
    3. other (specify) [ ]

42. Do you have a granary?
    1. Yes [ ]
    2. No [ ]
    3. Don't know [ ]

43. Do you think there are people in your village who are in danger of getting AIDS?
    1. Yes [ ]
    2. No [ ]
    3. Don't know [ ]

44. Can a pregnant woman pass the AIDS virus to a child before it is born?
    1. Yes [ ]
    2. No [ ]
    3. Don't know [ ]

45. Do you think anybody can get AIDS?
    1. Yes [ ]
    2. No [ ]
    3. Don't know [ ]

46. Is it possible to get AIDS through sex without a condom?
    1. Yes [ ]
    2. No [ ]
    3. Don't know [ ]

47. Are you taking measures to prevent yourself from getting AIDS?
    1. Yes [ ] --- GO TO 49
    2. No [ ]
    3. Don't know [ ]

48. If not why not?
    1. Don't know [ ]
    2. Religious reasons [ ]
    3. Husband objects [ ]
    4. Personal beliefs [ ]
    5. do not know how to [ ]
    6. No means available [ ]
    7. Other (specify) [ ]

49. Do you think a person can get AIDS from someone who looks healthy?
    1. Yes [ ]
    2. No [ ]
    3. Don't know [ ]

50. Is it possible for the AIDS virus to be in the body for years before a person begins to feel sick?
    1. Yes [ ]
    2. No [ ]
    3. Don't know [ ]

Sub-Appendix C

Luganda Questionnaire

PVO CHILD SURVIVAL KNOWLEDGE AND PRACTICE QUESTIONAIRE
ADRA/UGANDA - LUGANDA

EBIBUUZO BYONNA BYAKUDDIBWAMU MAAMA W'OMWANA (OW'EMYAKA 15-49)

NG'ALINA OMWANA ATASUSSA MYAKA EBIRI (ALI WANSI W'EMYEZI 24)

CLUSTER # _____ HOUSE # _____

Olunaku olw'okubuuza ___/___/94
Olunaku olw'okubuuza okulala ____/____/94 lunaku/mwezi

Erinnya ly'oyo abuuza _____

Erinnya ly'oyo akulira ababuuza

---

1. Erinnya n'emyaka gya maama w'omwana.

   Erinnya _____ Emyaka _____

2. Erinnya ly'omwana atasussa myaka ebiri.
   Erinnya _____

   Yazaalibwa nga ___/___/___/ (lunaku/mwezi/mwaka) Alina emyezi

   Ekyalo _____

OBUYIGIRIZE

3. Wasoma kutuuka mu kibiina ki?
   1. Teyasomako ( )
   2. Primary naye tasobola kusoma ( )
   3. Primary asobola okusoma ( )
   4. Senior n'okweyongerayo ( )

OKUYONSA / ENDIISA

4. (Erinnya ly'omwana) omuyonsa?
   1. Yee ( ) _____ genda ku 6
   2. Nedda ( )

5. Erinnya ly'omwana) yayonkako?
   1. Yee ( )
   2. Nedda ( )_____ genda ku 7

6. Ng'omaze okuzaala (erinnya ly'omwana). wayitawo bbanga lyenkanawa olyoke omuyonse?
   1. Mu ssaawa emu ng'azaalibbwa ( )
   2. Ebbanga elitasukka ssaawa munaana ( )
   3. Zasukka mu ssawa omunaana ng'azaalibbwa ( )
   4. Sijukira ( )

7. Erinnya ly'omwana) omuwa amazzi oba chai?
   1. Yee ( )
   2. Nedda ( )
   3. Tamanyi ( )

8. Olowooza maama yanditandise ddi okuwa omwana ayonka emmere?
   1. Wakati w'emyezi enna n'omukaaga ( )
   2. Nga tanaweza myezi enna ( )
   3. Nga asusizza mu myezi omukaaga ( )
   4. Tamanyi ( )

9. Olowooza omwana ayonka yanditandikidde ku mmere ki? (laga by'aba agambye byonna).
   a. Amata ( )
   b. Obuugi bwa soya,kasooli,obulo. ( )
   c. Supu w'enva (doodo, jjobyo) ( )
   d. Supu w'ennyama oba eby'enyanja. ( )
   e. Ebibala oba omubisi gwabyo ( )
   f. Endala (giwandiike) ( )

ENKULA Y'OMWANA

10. (Erinnya ly'omwana) alina ekipande oba kaadi eraga bwakula?
    1. Yee ( ) (otekwa okugirabako)
    2. Yagwa ( ) ___genda ku 12
    3. Nedda ( ) ___genda ku 12

11. Kebera ku kipande ky'omwana odemu ekibuuzo kino: Omwana ono yapimwamu ku buzitobwe emyezi esatu egiyise?
    1. Yee ( )
    2. Yedda ( )

OKUDDUKANA

12. (Erinnya ly'omwana) yafunako ku kiddukano mu sabiiti ebbiri eziyise?
    1. Yee ( )
    2. Nedda ( ) _____ genda ku 19
    3. Tamanyi ( ) _____ genda ku 19

13. (Erinya ly'omwana) bweyali addukana wagenda mu maaso n'okumuyonsa? (maama musomere)
    1. Okusinga bulijjo ( )
    2. Nga bulijjo ( )
    3. Kitono (wakendezaako) ( )
    4. Oba wamujjako ( )
    5. Oba omwana tayonka ( )

14. (Erinnya ly'omwana) bweyali addukana wamuwa eby'okunywa ebirala ng'ojeeko amabeere ..... (maama musomere).
    1. Okusinga bulijjo? ( )
    2. Nga bulijjo ( )
    3. Kitono (wakandezaako) ( )
    4. Oba wabiyimiriza ( )
    5. Oba yali ku mabeere gokka ( )

15. (Erinnya ly'omwana) bweyali addukana wamuwa emmere oba obuugi (maama musomere)
    1. Okusinga bulijjo? ( )
    2. Nga bulijjo? ( )
    3. Kitono (wakendeeza) ( )
    4. Oba walekerawo? ( )
    5. Oba yali ku mabeere gokka? ( )

16. (Erinnya ly'omwana) bweyali addukana olina eddagala lyewakozesa? (laga byaba agambye byonna).
    a. Tewali ( )
    b. Pakiti ye ddagala (ORS) ( )
    c. Natabula sukali n'omunnyo ( )
    d. Supu ava mu mmere ey'empeke (kasoli,obulo,muwemba,mucere) ( )
    e. Eby'okunywa ebirala ( )
    f. Eddagala eriziyiza ekiddukano ( )
    g. Supu ava mu mmere (matooke, muwogo, lumonde) ( )
    h. Ekirala (kyogere) ( )

17. Erinnya ly'omwana) bweyafuna okuddukana webuzaako ku ngeri y'okumujanjabamu oba okumutwalako mu ddwaliro?
    1. Ye ( )
    2. Nedda ( ) genda ku 19

18. Webuuza kwani amagezi oba engeri y'okujanjaba okuddukana kwa (erinnya ly'omwana)? (laga byaba agambye byonna).
    a. Mu ddwaliro eddene ( )
    b. Ku kalwaliro (dispensary) ( )
    c. Mu dduuka ly'eddagala (drug shop) ( )
    d. Omusawo ow'ekyalo (health promoter) ( )
    e. Omusawo omunnansi ( )
    f. Azalisa omunnansi ( )
    g. Mulala (mwogere) ( )

19. Bubonero ki obwandikuwalirizza okwebuuza oba okunoonya obujanjabi bwa (erinnya ly'omwana) nga abadde akwatiddwa okuddukana? (Laga by'aba agambye byonna).
    a. Tamanyi ( )
    b. Okusesema ( )
    c. Omusujja ( )
    d. Ng'akaze emimwa, amaaso gaguddemu, nga omusulo gukendedde (okugwamu amazzi) ( )
    e. Okuddukana okususizza ennaku 14 ( )
    f. Akabonero k'omusaayi mu bbi ( )
    g. Bwaba takyayagalira ddala kulya ( )
    h. Okugonda oba okugwamu amaanyi ( )
    i. Ekirala (kyogere) ( )

20. Biki ebikulu byewandikozeewo singa (erinnya ly'omwana) akwatibwa okuddukana? (laga by'aba agabye byona).
    a. Tamanyi ( )
    b. Kutandika kumuwa nnyo byakunywa ( )
    c. Kwongera kuwa mwana byakunywa ( )
    d. Kuwa mwana byakulya ebitono buli kaseera ( )
    e. Kumutabulira bupakiti bw'eddagala (ORS) ( )
    f. Kutwala mwana mu ddwaliro ( )
    g. Kuwa mwana byakulya buli luvanyuma lwakuddukana asobole okudaddamu ( )
    h. Kukomya eby'okunywa ( )
    i. Kukomya eby'okulya ( )
    j. Ekirala (kyogere) ( )

21. Biki ebikulu maama w'omwana byeyandikozeewo nga okuddukana kugenda kukendera? (laga by'aba agambye byonna).
    a. Tamanyi ( )
    b. Kuwa mwana byakulya ebitono buli kaseera ( )
    c. Kwongera ku mmere gy'alya ( )
    d. Kuwa mwana mmere ezaamu amaanyi ( )
    e. Kirala (kyogere) ( )

OKUGEMA

22. Omwana ono (erinnya ly'omwana) yandibadde agemebwa olukusense nga yenkana wa obukulu?
    1. Nga wa myezi ( )
    2. Tamanyi ( )

23. Oyinza okumpa ensonga enkulu lwaki abakyala ab'embuto betaagisa okubagema mulalama (Tetanus)?
    1. Okuziyiza mulalama mu maama n'omwana omuwere ( )
    2. Okuziyiza mulalama mu maama yekka ( )
    3. Okuziyiza mulalama mu mwana omuwere yekka ( )
    4. Tamanyi ( )
    5. Ekirala (kiwandiike) ( )

24. Empiso ziba mmeka omukyala ow'olubuto zeyandifunye okugema mulalama.
    1. Emu ( )
    2. Bbiri ( )
    3. Zisukka mu bbiri ( )
    4. Tewali n'emu ( )
    5. Tamanyi ( )

25. Olina ekipande ekiraga okugemebwa kwa (erinnya ly'omwana)?
    1. Yee ( ) (Olina okukirabako)
    2. Nedda ( ) genda ku 27
    3. Kyabula ( ) genda ku 27

26. kebera ku kipande ky'okugema olyoke ojjuzeemu wano wansi ennaku z'omwezi zonna eziraga omwana bweyagemebwa.

		lunaku	mwezi	mwaka
BCG (akafuba / TB)		_____	_____	_____
OPV (Polio)	1st	_____	_____	_____
	2nd	_____	_____	_____
	3rd	_____	_____	_____
DPT				
(Amamiro)	1st	_____	_____	_____
(Akalakiiro)	2nd	_____	_____	_____
(Mulalama)	3rd	_____	_____	_____
Olukusense		_____	_____	_____

ENDABIRIRA Y'ABAKYALA

27. Olina ekipande ekikwata kukugemebwa kw'abakyala ab'embuto?
    1. Yee (oteekwa okukirabako) ( )
    2. Kyambulako ( ) genda ku 29
    3. Nedda ( ) genda ku 29

28. Kebera ku kipande ky'omukyala olyoke ojuzeemu wano wansi emirundi gye yakagemebwa mulalama (TT).
    1. Gumu ( )
    2. Ebiri ( )
    3. Esatu n'okusingawo ( )
    4. Tewali n'ogumu ( )

29. Olina olubuto kati?
    1. Yee ( ) genda ku 34
    2. Nedda ( )
    3. Simanyi ( )

30. Wandyagadde okuzaala omwana mu myaka ebiri egijja?
    1. Yee ( ) genda ku 34
    2. Nedda ( )
    3. Tamanyi ( )

31. Olina engeri yonna gy'okozesa obutafuna lubuto kati?
    1. Yee ( ) genda ku 33
    2. Nedda ( )

32. Lwaki tolina ngeri yona gy'okozesa okwewala okufuna olubuto?

1. Simanyi	( )	genda ku 34
2. Nsonga ya ddin	( )	genda ku 34
3. Omwami takkiriza	( )	genda ku 34
4. Sikyagala	( )	genda ku 34
5. Babintiisa / Binkola bubi	( )	genda ku 34
6. Sirina wenyinza kufunira bya family planning	( )	genda ku 34
7. Ekirala (kyogere)	( )	genda ku 34

33. Ngeri ki enkulu gwe n'omwami wo gyemwayambisa okwewala okufuna olubuto kati?

1. Bankomya (bansiba enseke)	( )
2. Mpiso	( )
3. Mpeke ez'okumira (pills)	( )
4. Kaweta (coil)	( )
5. Kakopo (diaphragm)	( )
6. Akapiira (condom)	( )
7. Mpeke ez'okussayo (Foam / gel)	( )
8. Kuwa mwana bbere lyokka	( )
9. Tubala nnaku	( )
10. Sebaka na mwami	( )
11. Omwami amalira bweru	( )
12. Engeri endala (gyogere)	( )

34. Omukyala bw'abeera amaze okumanya nti ali lubuto yanditandise ddi okulaba omusawo (Nurse oba omuzaalisa) (gezaako okufuna emyezi).

1. Mu myezi esatu egisooka (1 - 3)	( )	
2. Wakati ku myezi (4 - 6)	( )	
3. Nga olubuto lukuze ku myezi (7 - 9)	( )	
4. Tekyetagisa kulaba musawo	( )	genda ku 37
5. Tamanyi	( )	

35. Waayitawo bbanga ki ng'omaze okufuna olubuto lwa (erinnya ly'omwana) okulaba omusawo (Doctor, Nurse, Omuzaalisa)?

1. Mu myezi esatu egisooka (1 - 3)	( )
2. Wakati ku myezi (4 - 6)	( )
3. Ng'olubuto lukuze ku myezi (7 - 9)	( )
4. Tekyetagisa kulaba musawo	( )
5. Simanyi	( )

36. We waberera n'olubuto lwa (erinnya ly'omwana) walaba omusawo emirundi emeka?
    1. Tewali n'ogumu ( )
    2. Omulundi gumu ( )
    3. Emirundi ebir ( )
    4. Emirundi gyasukka mw'ebiri ( )

37. Awo mukuzaalibwa kwa (erinnya ly'omwana) ani yasiba n'asala olulira (akalira)?
    1. Gwe wennyini ( )
    2. Omu kub'awaka ( )
    3. Omuzaalisa w'ekinnansi ( )
    4. Musawo (Doctor, Nurse, Midwife) ( )
    5. Muntu mulala (Mwogere) ( )
    6. Simanyi ( )

38. Wali ofunye ku ddagala eriziyiza okufuna omusujja nga oli lubuto?
    1. Yee ( )
    2. Nedda ( )
    3. Simanyi ( )

ENNIMIRO Y'ENVA

39. Olina akalimiro k'enva?
    1. Yee ( ) genda ku 41
    2. Nedda ( )
    3. Simanyi ( )

40. Wandiyagade okubeera n'akalimiro k'enva?
    1. Yee ( ) genda ku 41
    2. Nedda ( ) genda ku 41
    3. Simanyi ( ) genda ku 41

41. Enva zojje mu nnimiro ozikola otya? (laga byaba agambye byonna)
    a. Tuzirya ( )
    b. Tuzitunda mu katale ( )
    c. Ekirala kyonna (kyogere) ( )

42. Olina ekyagi omuterekebwa emmere ey'empeke?
    1. Yee ( )
    2. Nedda ( )
    3. Simanyi ( )

SILIIMU (AIDS)

43. Olowooza mu kyalo kino mulimu abantu abali mu katyabaga k'okufuna obulwadde bwa siliimu (AIDS)?
    1. Yee ( )
    2. Nedda ( )
    3. Simanyi ( )

44. Olowooza omukyala ow'olubuto ayiinza okusiiga akawuka ka siliimu (AIDS) omwanawe nga tanaba kuzaalibwa?
    1. Yee ( )
    2. Nedda ( )
    3. Tamanyi ( )

45. Osuubira nti kyangu omuntu yenna okufuna obulwadde bwa siliimu?
    1. Yee ( )
    2. Nedda ( )
    3. Simanyi ( )

46. Olowooza kisoboka okufuna akawuka ka siliimu (AIDS) nga wetabye n'omwamiwo nga temukozesezza kapiira (condom)?
    1. Yee ( )
    2. Nedda ( )
    3. Simanyi ( )

47. Olina ky'okozewo okusobola okwewala okufuna obwalwadde bwa siliimu (AIDS)?
    1. Yee ( ) genda ku 49
    2. Nedda ( )
    3. Simanyi ( )

48. Bwoba tolina ky'okozewo, lwaki?
    1. Simanyi ( )
    2. Nsonga ya byaddini ( )
    3. Omwami takkiriza ( )
    4. Sibikkiririzaamu ( )
    5. Simanyi kya kukola ( )
    6. Tewali bikozesebwa ( )
    7. Ekirala (kyogere ( )

12

49. Osuubira omuntu yenna ayinza okufuna akawuka ka siliimu (AIDS) nga yetabye n'omulala alabika nga mulamu bulungi?
    1. Yee ( )
    2. Nedda ( )
    3. Simanyi ( )

50. Olowooza kisoboka akawuka ka siliimu (AIDS) okubeera mu mubiri gw'omuntu okumala emyaka egiwerako era omuntu oyo n'abeera nga teyewuliramu bulwadde bwonna?
    1. Yee ( )
    2. Nedda ( )
    3. Simanyi ( )

Sub-Appendix D

Training Schedule

ADRA RAPID KPC SURVEY TRAINING
BASELINE FOR CS X AND FINAL FOR CS VII
AUGUST 1 - 10, 1994

Uganda Core Team:

ADRA/Uganda Coordinator: I. Musoke Sebakigye

1. Ssenteza Kajubi Masembe
2. Nakibinge Wilson
3. Annitah Namuyiga
4. Hayuni Joseph
5. Laban Rutareberwa
6. Elisha Sebaduka

SUPERVISORS

1. MR. MUGUMYA M.
2. MR. KATEREGA S.
3. MR. KYEWALABYE S.
4. MR. SSEMWOGERERE W.
5. MS. BUKIRWA J.
6. MR. KAYONGO D.
7. MR. KIYEMBA E.
8. MR. SIMBWA R.
9. MS. NAMUYIGA A.
10. MR. RUTAREBERWA L.
11. MR. KAJUBI-MASENBE
12. MR. NAKIBINGE W.
13. MR. SEBADDUKA E.
14. MR. HAYUNI J.
15. MR. MUKUME L.

PARTICIPANTS

16. MR. NATULE CHRIS
17. MR. SEMPA GEORGE
18. MS. MASAI HILDAH
19. MR. MASETE STEVE
20. MR. SENYONGA ROGERS
21. MR. KASOZI FREDRIC
22. MR. WASSWA NICHOLAS
23. MR. SEWABUGA THOMPSON
24. MS. BIRUNGI AGNES
25. MS. ZALWANGO REBECCA
26. MS. RUGWIZA ESTHER

27. MS. KAGGAW RITHA
28. MS. NAKITENDE FLAVIA
29. MR. WAMBALYE DAVIS
30. MR. WANYAMA PAUL
31. MR. MUSISI JOSEPH
32. MR. MUSISI GEORGE WILLIAM
33. MR. OBOYA STEVEN
34. MS. NAJJITA BETTY
35. MR. LWANGA JONATHAN
36. MR. MUWANGUZI PATRIC
37. MR. MUGENI STEPHEN
38. MS. NAMUTEBI ROSE
39. MS. NAKUBULWA JOY
40. MR. SEMAKULA STEPHEN
41. MR. SEBALAMU DANIEL
42. MR. KASOONHA PETER
43. MR. BYENKYA ARMSTRONG
44. MS. WALUSA YAYERI KAWANGUZI
45. MR. KAZIBWE CHRYZESTOM

Sub-Appendix E

List of Survey Team

Survey Training - Proposed Schedule

DAY	DATE	ACTIVITY
Mon.	1/8/94	Survey Trainers meet survey coordinator ADRA coordinator & trainers meet with USAID officer - David Puckett. orientation given to ADRA staff & survey workers
Tue.	2/8/94	Core Team Training Finalize Survey preparations
Wed.	3/8/94	Core Team Training Finalize Survey preparations
Thurs.	4/8/94	Train supervisors & interviewers. Test questionnaire & field training exercise Review pilot test, make final adjustments in the questionnaire & reproduce needed copies of the questionnaire
Fri.	5/8/94	Train supervisors & interviewers, Test questionnaire & field training exercise Review pilot test, make final adjustments in the questionnaire & reproduce needed copies of the questionnaire
Sat.	6/8/94	Day off
Sun.	7/8/94	Field training exercise and critique
Mon.	8/8/94	Conduct survey
Tue.	9/8/94	Conduct survey
Wed.	10/8/94	Manual and computer tabulation
Thur.	11/8/94	Manual tabulation and computer analysis of data - graphic charts of interesting findings
Fri.	12/8/94	Analyze & interpret data (frequencies and tables) and prepare report outline
Sat.	13/8/94	Day off

Sun.	14/8/94	Prepare presentation for USAID and MOH to others as needed
Mon.	15/8/94	ADRA staff presentation of findings to MOH or others & drafting final report & receive feedback - begin forward plan of action for child survival project
Tue.	15/8/94	ADRA staff presentation to USAID officials & receive feedback - continue forward plan of action for child survival project implementation
		Evaluate survey training process and develop short report to be reviewed before next survey

Appendix B

Pipeline Analysis

PVO/COUNTRY ADRA/Uganda
Cooperative Agreement No. OTR-PDC-0500-A-00-1097-00
Date Submitted to USAID Dec. 30, 1994

1995 COUNTRY PROJECT PIPELINE ANALYSIS: PART A - HEADQUARTERS

		Actual Expenditures to Date Sep.. 1, 1991 to Oct. 30, 1994			Projected Expenditures against Remaining Obligated funds Final remaining funds			Total Agreement Budget (Columns 1 & 2) Sep.. 1, 1991 to Oct. 30, 1994		
I. DIRECT COSTS		USAID	PVO	TOTAL	USAID	PVO	TOTAL	USAID	PVO	TOTAL
A. PERSONNEL (salaries, wages, frin	1. Headquarters-wages/salaries	$25,801	$19,860	$45,662	($8,341)		($8,341)	$17,460	$6,425	$23,885
	2. Field, technical personnel-wages/salaries									
	3. Field, Other personnel wages/salaries Administrative									
	4. Fringes-Headquarters + Field	$885	$315	$1,200	$3,211	$1,192	$4,403	$4,096	$1,507	$5,603
	SUBTOTAL-PERSONNEL	$26,686	$20,175	$46,861	($5,131)	$1,192	($3,938)	$21,556	$7,932	$29,488
B. TRAVEL/PER DIEM	1. Headquarters-Domestic (USA)									
	2. Headquarters-International	$18,410	$7,663	$26,073	$590	($4,193)	($3,603)	$19,000	$3,470	$22,470
	3. Field-In country									
	4. Field-International									
	SUBTOTAL-TRAVEL/PER DIEM	$18,410	$7,663	$26,073	$590	($4,193)	($3,603)	$19,000	$3,470	$22,470
C. CONSULTANCIES	1. Evaluation Consultants-Fees	$6,691	$33	$6,724	($5,638)		($5,638)	$1,053		$1,053
	2. Other Consultants-Fees									
	3. Consultant travel/per diem									
	SUBTOTAL-CONSULTANCIES	$6,691	$33	$6,724	($5,638)		($5,638)	$1,053		$1,053
D. PROCUREMENT (provide justification/ explanation in narrative	1. Supplies									
	a. Headquarters									
	b. Field-Pharmaceuticals (ORS, Vit. A. Drugs, etc.									
	c. Field-other									
	2. Equipment									
	a. Headquarters									
	b. Field									
	3. Training									
	a. Headquarters									
	b. Field									
	SUBTOTAL-PROCUREMENT									
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative	1. Communications									
	a. Headquarters									
	b. Field									
	2. Facilities									
	a. Headquarters									
	b. Field									
	3. Other									
	a. Headquarters	$2,203	$3,782	$5,984	$1,130	$2,885	$4,016	$3,333	$6,667	$10,000
	b. Field									
	SUBTOTAL-OTHER DIRECT	$2,203	$3,782	$5,984	$1,130	$2,885	$4,016	$3,333	$6,667	$10,000
TOTAL - DIRECT COSTS		$53,990	$31,653	$85,643	($9,048)	($116)	($9,164)	$44,942	$18,069	$63,011
II. INDIRECT COSTS										
A. INDIRECT COSTS	1. Headquarters	$9,178	$5,381	$14,559	($1,538)	($2,309)	($3,848)	$7,640	$3,072	$10,712
	2. Field (if applicable)									
TOTAL - INDIRECT COSTS		$9,178	$5,381	$14,559	($1,538)	($2,309)	($3,848)	$7,640	$3,072	$10,712
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		**$63,168**	**$37,034**	**$100,203**	**($10,586)**	**($2,426)**	**($13,012)**	**$52,582**	**$21,140**	**$73,722**

CSH/PUDG/5/93

PVO/COUNTRY ADRA/Uganda

Cooperative Agreement No. OTR-PDC-0500-A-00-1097-00

Date Submitted to USAID Dec. 30, 1994

1995 COUNTRY PROJECT PIPELINE ANALYSIS: PART B - FIELD

		Actual Expenditures to Date Sep.. 1, 1991 to Oct. 30, 1994			Projected Expenditures against Remaining Obligated funds Final remaining funds			Total Agreement Budget (Columns 1 & 2) Sep.. 1, 1991 to Oct. 30, 1994		
I. DIRECT COSTS		USAID	PVO	TOTAL	USAID	PVO	TOTAL	USAID	PVO	TOTAL
A. PERSONNEL (salaries, wages, frin	1. Headquarters-wages/salaries									
	2. Field, technical personnel-wages/salaries	$20,000		$20,000	$22,109	$10,000	$32,109	$42,109	$10,000	$52,109
	3. Field, Other personnel wages/salaries Administrati	$32,608	$29,000	$61,608	$21,121	$34,754	$55,875	$53,729	$63,754	$117,483
	4. Fringes-Headquarters + Field	$21,366	$44,000	$65,366	($15,186)	($41,612)	($56,798)	$6,180	$2,388	$8,568
	SUBTOTAL-PERSONNEL	$73,974	$73,000	$146,974	$28,044	$3,142	$31,186	$102,018	$76,142	$178,160
B. TRAVEL/PER DIEM	1. Headquarters-Domestic (USA)									
	2. Headquarters-International									
	3. Field-In country				$8,914	$1,500	$10,414	$8,914	$1,500	$10,414
	4. Field-International	$17,221	$8,452	$25,673	($17,041)	($8,452)	($25,493)	$180		$180
	SUBTOTAL-TRAVEL/PER DIEM	$17,221	$8,452	$25,673	($8,127)	($6,952)	($15,079)	$9,094	$1,500	$10,594
C. CONSULTANCIES	1. Evaluation Consultants-Fees	$15,008		$15,008	($3,258)		($3,258)	$11,750		$11,750
	2. Other Consultants-Fees	$44,991		$44,991	$6,225		$6,225	$51,216		$51,216
	3. Consultant travel/per diem				$58,200		$58,200	$58,200		$58,200
	SUBTOTAL-CONSULTANCIES	$59,999		$59,999	$61,167		$61,167	$121,166		$121,166
D. PROCUREMENT (provide justification/ explanation in narrative	1. Supplies									
	a. Headquarters									
	b. Field-Pharmaceuticals (ORS, Vit. A. Drugs, etc.				$10,500		$10,500	$10,500		$10,500
	c. Field-other	$44,673	$19,684	$64,357	($3,738)	($9,684)	($13,422)	$40,935	$10,000	$50,935
	2. Equipment									
	a. Headquarters									
	b. Field	$17,701	$65,851	$83,552	$516	($8,651)	($8,135)	$18,217	$57,200	$75,417
	3. Training									
	a. Headquarters									
	b. Field				$5,500	$4,500	$10,000	$5,500	$4,500	$10,000
	SUBTOTAL-PROCUREMENT	$62,374	$85,535	$147,909	$12,778	($13,835)	($1,057)	$75,152	$71,700	$146,852
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative	1. Communications									
	a. Headquarters									
	b. Field									
	2. Facilities									
	a. Headquarters									
	b. Field				$48,071		$48,071	$48,071		$48,071
	3. Other									
	a. Headquarters									
	b. Field	$143,279	$13,902	$157,181	($63,383)	$11,098	($52,285)	$79,896	$25,000	$104,896
	SUBTOTAL-OTHER DIRECT	$143,279	$13,902	$157,181	($15,312)	$11,098	($4,214)	$127,967	$25,000	$152,967
TOTAL - DIRECT COSTS		$356,847	$180,889	$537,736	$78,550	($6,547)	$72,003	$435,397	$174,342	$609,739
II. INDIRECT COSTS										
A. INDIRECT COSTS	1. Headquarters									
	2. Field (if applicable)	$60,664	$30,751	$91,415	$13,353	($1,113)	$12,240	$74,017	$29,638	$103,656
TOTAL - INDIRECT COSTS		$60,664	$30,751	$91,415	$13,353	($1,113)	$12,240	$74,017	$29,638	$103,656
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		**$417,511**	**$211,640**	**$629,151**	**$91,903**	**($7,660)**	**$84,243**	**$509,414**	**$203,980**	**$713,395**

CSH/PUDG/5/93

PVO/COUNTRY ADRA/Uganda
Cooperative Agreement No. OTR-PDC-0500-A-00-1097-00
Date Submitted to USAID Dec. 30, 1994

1995 COUNTRY PROJECT PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD

		Actual Expenditures to Date Sep.. 1, 1991 to Oct. 30, 1994			Projected Expenditures against Remaining Obligated funds Final remaining funds			Total Agreement Budget (Columns 1 & 2) Sep.. 1, 1991 to Oct. 30, 1994		
I. DIRECT COSTS		USAID	PVO	TOTAL	USAID	PVO	TOTAL	USAID	PVO	TOTAL
A. PERSONNEL (salaries, wages, frin	1. Headquarters-wages/salaries	$25,801	$19,860	$45,662	($8,341)		($8,341)	$17,460	$6,425	$23,885
	2. Field, technical personnel-wages/salaries	$20,000		$20,000	$22,109	$10,000	$32,109	$42,109	$10,000	$52,109
	3. Field, Other personnel wages/salaries Administrati	$32,608	$29,000	$61,608	$21,121	$34,754	$55,875	$53,729	$63,754	$117,483
	4. Fringes-Headquarters + Field	$22,251	$44,315	$66,566	($11,975)	($40,420)	($52,395)	$10,276	$3,895	$14,171
	SUBTOTAL-PERSONNEL	$100,660	$93,175	$193,835	$22,913	$4,334	$27,248	$123,574	$84,074	$207,648
B. TRAVEL/PER DIEM	1. Headquarters-Domestic (USA)									
	2. Headquarters-International	$18,410	$7,663	$26,073	$590	($4,193)	($3,603)	$19,000	$3,470	$22,470
	3. Field-In country				$8,914	$1,500	$10,414	$8,914	$1,500	$10,414
	4. Field-International	$17,221	$8,452	$25,673	($17,041)	($8,452)	($25,493)	$180		$180
	SUBTOTAL-TRAVEL/PER DIEM	$35,631	$16,115	$51,746	($7,537)	($11,145)	($18,682)	$28,094	$4,970	$33,064
C. CONSULTANCIES	1. Evaluation Consultants-Fees	$21,699	$33	$21,732	($8,896)		($8,896)	$12,803		$12,803
	2. Other Consultants-Fees	$44,991		$44,991	$6,225		$6,225	$51,216		$51,216
	3. Consultant travel/per diem				$58,200		$58,200	$58,200		$58,200
	SUBTOTAL-CONSULTANCIES	$66,691	$33	$66,724	$55,528		$55,528	$122,219		$122,219
D. PROCUREMENT (provide justification/ explanation in narrative	1. Supplies									
	a. Headquarters									
	b. Field-Pharmaceuticals (ORS, Vit. A. Drugs, et				$10,500		$10,500	$10,500		$10,500
	c. Field-other	$44,673	$19,684	$64,357	($3,738)	($9,684)	($13,422)	$40,935	$10,000	$50,935
	2. Equipment									
	a. Headquarters									
	b. Field	$17,701	$65,851	$83,552	$516	($8,651)	($8,135)	$18,217	$57,200	$75,417
	3. Training									
	a. Headquarters									
	b. Field				$5,500	$4,500	$10,000	$5,500	$4,500	$10,000
	SUBTOTAL-PROCUREMENT	$62,374	$85,535	$147,909	$12,778	($13,835)	($1,057)	$75,152	$71,700	$146,852
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative	1. Communications									
	a. Headquarters									
	b. Field									
	2. Facilities									
	a. Headquarters									
	b. Field				$48,071		$48,071	$48,071		$48,071
	3. Other									
	a. Headquarters	$2,203	$3,782	$5,984	$1,130	$2,885	$4,016	$3,333	$6,667	$10,000
	b. Field	$143,279	$13,902	$157,181	($63,383)	$11,098	($52,285)	$79,896	$25,000	$104,896
	SUBTOTAL-OTHER DIRECT	$145,482	$17,684	$163,165	($14,182)	$13,983	($198)	$131,300	$31,667	$162,967
TOTAL - DIRECT COSTS		$410,837	$212,542	$623,380	$69,502	($6,663)	$62,839	$480,339	$192,411	$672,750
II. INDIRECT COSTS										
A. INDIRECT COSTS	1. Headquarters	$9,178	$5,381	$14,559	($1,538)	($2,309)	($3,848)	$7,640	$3,072	$10,712
	2. Field (if applicable)	$60,664	$30,751		$13,353	($1,113)		$74,017	$29,638	
TOTAL - INDIRECT COSTS		$69,842	$36,132	$14,559	$11,815	($3,422)	($3,848)	$81,658	$32,710	$10,712
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		**$480,679**	**$248,675**	**$637,939**	**$81,317**	**($10,086)**	**$58,991**	**$561,997**	**$225,120**	**$683,461**

TOTAL CS-7 Cooperative Agreement

Combined Budget

Indonesia--Nicaragua--Uganda

OTR-PDC-050-A-00-1097-00

	Expenses to date Actual		Remaining Difference		Cooperative Agreement Budget	
	USAID	ADRA	USAID	ADRA	USAID	ADRA
Salaries	509,475	155,131	-5,846	-241	503,629	154,890
Fringe	100,052	44,945	13,772	92	113,824	45,037
Consultants	67,663	4,739	29,053	8,296	96,716	13,035
Equipment	18,720	84,740	8,983	3,611	27,703	88,351
Supplies/Services	136,438	93,627	-5,961	8,405	130,477	102,032
Evaluation	48,672	99	-18,753	-99	29,919	
Travel	254,901	31,442	9,932	-9,844	264,833	21,598
ODC	351,307	77,934	-22,682	-634	328,625	77,300
Indirect Costs	252,829	83,752	1,445	1,629	254,274	85,381
Totals	**$1,740,057**	**$576,408**	**$9,943**	**$11,216**	**$1,750,000**	**$587,624**

Pipeline Notes:

1 The pipelines have been made before final accounting/auditing has taken place. They should be considered as drafts only.

2 There is a single HQ budget for the grant, i.e. for all three countries. The USAID forms HQ (Part A) show a third of that budget.

Appendix C

Itinerary for Final Evaluation

ITINERARY FOR FINAL PROJECT EVALUATION

DAY	DATE	ACTIVITY
Sunday	14 August	Arrival and Planning Schedule of activities
Monday	15 August	Brief Evaluation Team and project staff on scope of work for CS-7 final evaluation
		Conducted interviews with MOH representative, CS-7 Project Director and other project staff
Tuesday	16 August	Continue interviews with project staff, including Technical Assistant (Advisors) for the different intervention areas, Immunization, Control of Diarrhoeal Disease and Oral Rehydration Therapy, Nutrition Education and Growth Monitoring, Family Planning and Child Spacing and HIV/AIDS Education
		Visit to USAID/Uganda
Wednesday	17 August	Visit to the Aids Support Organization (TASO)
		Visit to the "DISH" project office
		Field visit to Zirobwe/Lunyolya sub-parish
Thursday	18 August	Visit to Family Planning Association of Uganda (FPAU)
		Visit to the Uganda Protestant Medical Bureau (UPMB)
		Field visit to Kalagala sub-county
Friday	19 August	Visit to the District Medical Officer (DMO)
		Visit to SDA Uganda Union Head office
		Field visit to Busoke (kalagala sub-county)
Saturday	20 August	Day off

Sunday	21 August	Visit to ADRA Uganda Head office
		Partial debriefing to ADRA/Uganda, Director and head office staff on CS-7 evaluation.
		Interviews with Director ADRA/Uganda, Treasurer and CS-7 Project Accountant.
		Start Report writing
Monday	22 August	Visit to Ministry of Health (MOH) headquarters, Entebbe.
		Prepare debrief report
Tuesday	23 August	Debriefing - ADRA project staff
		Question and answer session
Wednesday	24 August	Travel back to Nairobi/Kenya by road.

Appendix D

Chronology of Project

CHRONOLOGY OF THE PROJECT

1990 June	-	Idea of a Uganda Child Survival Project discussed with ADRA/International and ADRA/Uganda.
1990 June to 1991 August	-	Project planning takes place
1991 August	-	New ADRA/Uganda Director arrives in country Project approved by USAID Proposed Period - 1991 October 1 to 1994 September 30
1991 August to 1992 March 1	-	Project put on hold by ADRA's Eastern Africa regional office in Harare, Zimbabwe
1992 February	-	Proposed Project director arrives in country
1992 March 1	-	Project authorized to begin by ADRA's Harare office
1992 March	-	Baseline survey organized by Lyndi Wolfe - ADRA/International and Dr. Franco - Johns Hopkins University.
1992 April	-	Staff Workshop with staff from ADRA/International. DIP prepared
1992 June	-	DIP submitted to ADRA/International
1992 June	-	First Training Session for Health Trainers of Kalagala sub-county held by the Uganda Community Based Health Care Association
1992 August	-	Second Training Session for Health Trainers of Kalagala sub-county also held by UCBHCA.
1992 November	-	Sharon Tobing from ADRA/International came and taught the staff how to run their own training session for Health Trainers-at the same time as the third Training Session for Kalagala Health Trainers.

1993 January	-	Sharon Tobing and Lester Wright from ADRA/International hold final Training Session for the Health Trainers of Kalagala sub-county
1993 April	-	First and second Training session of Health Trainers for Zirobwe sub-county
1993 June	-	Third and Fourth Training session of Health Trainers for Zirobwe sub-county
1993 July	-	Mid-term Evaluation
1994 August	-	Final Survey and Final Evaluation

Appendix E

List of Contacts and Persons Visited in Uganda

LIST OF CONTACTS AND PERSONS VISITED

Visit to USAID/Uganda

Persons Contacted:

Mr. David Puckett - Technical Advisor for Child Survival
USAID/Uganda

Visit to the Aids Support Organization (TASO)

Persons Contacted:

Ms. Marble Magezi - Public Relation Officer/TASO

Visit to "DISH" Project

Persons Contacted:

Mr. Jean Karambizi - Team Leader
Ms. Stembile Mutatu - Clinical Services Advisor

Visit to Family Planning Association of Uganda (FPAU)

Persons Contacted:

Ms. Joy Nima - Executive Director/FPAU
Mr. Tom Kakuba - Research & Evaluation Manager (FPAU)

Visit to Uganda Protestant Medical Bureau (UPMB)

Persons Contacted:

Ms. Grace Nakazimbwi- Primary Health Care Co-ordinator (PHC)/UPMB

Visit to the District Medical Office (DMO) Luwero

Persons Contacted:

Mr. Fredric M. Senkima - District Health Education Officer (DHEO)

Visit to Uganda SDA Union Head Office

Persons Contacted:

Dr. S.I. Biraro - Director Health & Temperance/Uganda Union

Visit to ADRA Uganda Head Office

Persons Contacted:
Mr. Barry Chapman - Country Director ADRA/Uganda
Mr. Edward Damrilla - Treasurer ADRA/Uganda

Visit to Ministry of Health (MOH) Uganda, Entebbe

Persons Contacted:

Dr. Christopher Kigongo - Medical Officer for Education & Health Promotion
Dr. Sam Okirwa - Epidemiologist/UNEPI
Mr. John Barenzi - Programme Manager/UNEPI
Dr. J.H.M Baziraki - Program Manager MCH/FP STD/AIDS Integration

Visit to Child Survival Project Staff Interviewed Included

Persons Contacted:

Mr. Israel Musoke Sebakigye - Project Director
Ms. Anitah Namnyiga - Technical Assistant (EPI & COD)
Mr. Sebadduka Elisha Bireke - Technical Assistant (Nutrition & Growth Monitoring)
Ms. Damarie Kibiriye - Technical Assistant (Family Planning)
Mr. Laban Rutareberwa - Technical Assistant (Agriculture)
Mr. Charles Musoke - Supervisor (Kalagala sub-county)
Mr. Andrew Semamso - Supervisor (Zirobwe Sub-county)

Appendix F

Letter from Local Chief - Luwero (Copy)

Luwero District Administration

KALAGALA SUB-COUNTY IS OFFICE.....DEPARTMENT

Telephone

P.O. Box 610.
BAMUNANIKA.

Our Ref:.....DE/94.....

Your Ref:.....

THE REPUBLIC OF UGANDA

.....10/8/.....19.91.

The Director,
Child survival project,
Kalagala Sub-county.

Sir,

Re; CONGULATULATORY MASSEGE.

I wish to thank you for the good services you are rendering to our community. This is to let you know that since I was transfered from Kikyusa sub-county I have found that children under 2 years are not dieng so much in this sub-county. That means that child survival has done so much in teaching the community about immunisation, nutrition and control of Diarehea Diseses.

Since I came here only three children have died and the cause of death has been malaria but not one of the six immunisable diseses. So I rearly appreciate with your work.

Yours in Service.
LUWERO DISTRICT ADMINISTRATION
DATE
MOSES MUGANGA.
SUB-COUNTY CHIEF, KALAGALA.

MM/rk.

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