

PD-ABP-880
95824 JC

DETAILED IMPLEMENTATION PLAN

Child Survival XI

(Project #FAO-0500-A-00-5025-00)

**Hais, Khokha and Jabal Ras Districts
Hodeidah Governorate
Republic of Yemen
1995-1999**

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- ① Include Vit A
- ② Home Case management of
CDD
 - Case Management
 - Upgrade Community Practices

Phase in

Go Slow

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Acronyms

ADRA	Adventist Development and Relief Agency
AE	Agricultural Extensionist
ALRI	Acute Lower Respiratory Infection
BCG	Tuberculosis Vaccine
CDC	Community Development Coordinator
CDD	Control of Diarrheal Diseases
CHP	Community Health Promoter
CS	Child Survival
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus
EOP	End of Project
EPI	Expanded Program of Immunizations
GM	Growth Monitoring
Health Worker	All inclusive (PHCWs and CHPs)
HIS	Health Information System
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
JHU/CSSP	Johns Hopkins University/Child Survival Support Program
KPC	Knowledge, Practice, Coverage
LBW	Low-birth Weight
LDC	Local Development Committee
MOH	Ministry of Health
MPH	Masters in Public Health
NGO	Non-governmental Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PHCW	Primary Health Care Worker
PVO	Private Voluntary Organization
QA	Quality Assurance
SCM	Standard Case Management
TDA	Tihama Development Authority
TT	Tetanus Toxoid
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children's Fund
U5MR	Under 5 Mortality Rate
WCBA	Women of Child Bearing Age

Section A - Field Project Summary

DIP Table A: Field Project Summary

PVO/Country: ADRA/Yemen
 Cooperative Agreement No. FAO-0500-A-00-5025-00

Project Duration (mm/dd/yy)
 Start Date: October 1, 1995
 Estimated Completion Date: September 30, 1999

1. Percent of Total USAID Contribution by Intervention

Percentages must add to 100%.

INTERVENTION	Percent of Total Project Effort (%)	Percent of Total USAID Funds in US \$
Immunization	40%	\$346,146
Diarrhea Case Management	30%	\$259,609
Nutrition/GM	30%	\$259,609
Micronutrients		\$0
Pneumonia Case Management		\$0
Maternal Care		\$0
Family Planning		\$0
Malaria Prevention & Management		\$0
HIV/AIDS Prevention		\$0
Other (specify)		\$0
Other (specify)		\$0
TOTAL	100%	\$865,364

2. Size of the Potential Beneficiary Population

Note: Potential beneficiaries are the individuals eligible to receive services under Child Survival funding to whom you will provide services. Females (ages 15 - 49) should only be included as direct beneficiaries of services (for example, TT immunizations or family planning services), and not for educational interventions (for example, education on proper use of ORT).

Current Population Within Each Age Group	Number of Potential Beneficiaries
Infants, 0 - 11 months	3,476
Children, 12 - 23 months	3,189
Children, 24 - 59 months	6,833
Children, 60 - 71 months (If Vitamin A component)	0
Females, 15 - 49 years	19,897
Total Potential Beneficiaries Per Year	33,395

Section B - Project Goals and Objectives

DIP Table B: Project Goals and Objectives

Project Goals: To improve the health of mothers and children in the Hais, Khokha and Jabal Ras Districts of the Hodeidah Governorate, in the Republic of Yemen.

(*) = The measurement method for the indicators/objectives listed in the table below is the rapid KPC survey.

(1) Project Objectives by	(2) Measurement Indicators/Method for Objectives (*)	(3) Major Planned Inputs	(4) Outputs	(5) Measurement Method for Outputs
1. Literacy/Small Credit (Adjunct funding)				
Develop self-sustaining functional literacy program for women followed by small credit for income generation of families in project area villages	Percent literacy among women Number of families involved in small income generation projects	1. Empower local development committees to manage literacy and small credit program. 2. Link literacy with income generation then both with CHP activity for sustainability.	1. LDCs manage literacy and small credit programs. 2. Literacy and income generation programs are linked with CHP activities for sustainability.	(Program Report)

(1) Project Objectives by	(2) Measurement Indicators/Method for Objectives (*)	(3) Major Planned Inputs	(4) Outputs	(5) Measurement Method for Outputs
II. Baseline Assessment and Formative Research				
Conduct KPC 30-Cluster Survey	(Mandated indicators plus other selected indicators noted below)	<ol style="list-style-type: none"> 1. Collect appropriate maps and demographic data. 2. Train survey staff. 3. Conduct survey. 4. Analysis of data. 5. Writing of report 6. Feedback to local community and MOH. 	KPC 30-Cluster Survey conducted.	(Survey Report)
Conduct formative research	(Primarily through focus group interviews and/or simple survey)	<ol style="list-style-type: none"> 1. Prepare/conduct focus interviews of mothers re: Diarrhea case management, knowledge and beliefs about vaccinations, nutrition practices, i.e. breast feeding, weaning foods, introduction to solid foods. 2. Conduct service quality assessments of health facilities in diarrheal management and cold chain maintenance, monitoring and vaccine delivery, vaccination techniques, education of mothers about nutrition practices. 3. Assess through random sampling KP of ORS retailers regarding education of clients in need for and appropriate use of ORS. 	<ol style="list-style-type: none"> 1. Focus group and interviews conducted. 2. Quality assessment of health facility SCM conducted. 3. Quality assurance of ORS retailer SCM conducted. 	[Formative Research/QA Coordinator Report]

(1) Project Objectives by	(2) Measurement Indicators/Method for Objectives (*)	(3) Major Planned Inputs	(4) Outputs	(5) Measurement Method for Outputs
III. Community System Strengthening				
<p>Increase community capacity to manage and resolve community problems by establishing 30 LDCs.</p>	<p>Number/percent of LDCs that met at least monthly during the last quarter. [MINUTES]</p> <p>Number/percent of LDCs that reviewed disease surveillance reports during meetings in the last quarter. [MINUTES]</p> <p>Number/percent of LDCs that participate in problem solving. [MINUTES]</p> <p>Number/percent of LDCs developing strategies to assume management responsibility of CHPs. [MINUTES]</p>	<ol style="list-style-type: none"> 1. Motivation of local communities in establishing LDCs. 2. Orientation and training of LDCs in the interventions. 3. Follow-up supervision. 4. Vital events recording. 	<ol style="list-style-type: none"> 1. At least 30 LDCs established 2. 30 LDCs trained, reviewing monthly health reports and constructively addressing local health and social issues. 3. Quarterly supervisory visits. 4. Vital events registry institutionalized. 	<ol style="list-style-type: none"> 1. [LDC Minutes] 2. [LDC Minutes] 3. [Quarterly Project Reports] 4. [Vital Events Registry] and [LDC Minutes]

(1) Project Objectives by	(2) Measurement Indicators/Method for Objectives (*)	(3) Major Planned Inputs	(4) Outputs	(5) Measurement Method for Outputs
IV. Immunization				
<p>1. Increase percent of children (<24 months) completing immunizations from the current 9.6% to 50%.</p> <p>a. Increase percent of children 12-23 months who received OPV3 from current estimate of 17.0% to 50%.</p> <p>b. Increase percent of children 12-23 months who received measles vaccine from current estimate of 11.1% to 50%.</p> <p>c. Decrease percent change between DPT1 and DPT3 doses for children 12-23 months from current estimate of 20.0% to 10%.</p>	<p>EPI Coverage: Percent of children 12-23 months who received OPV3. [SURVEY]</p> <p>Measles Coverage: Percent of children 12-23 months who received measles vaccine. [SURVEY]</p> <p>Drop-out Rate: Percent change between DPT1 and DPT3 doses for children 12-23 months. [SURVEY]</p>	<p>1. Design IEC methods/materials. 2. PHC Supervisor training. 3. PHC Worker training. 4. LDC orientation. 5. CHP training. 6. CHPs promote key EPI messages to mothers. 7. Ensure cold chain equipment. 8. Cold chain system monitoring. 9. Ensure transportation and supply of vaccine, etc. 10. Ensure use of GM as immunization cards. 11. Follow-up on drop outs. 12. Annual promotion day in schools. 13. Increase number of EPI sites. 14. Follow-up and surveillance of polio and neonatal tetanus cases.</p>	<p>1. IEC materials prepared. 2. 3 PHC Supervisors trained. 3. 22 PHCWs trained. 4. 30 LDCs oriented. 5. 200 CHPs trained. 6. Key messages on EPI given to mothers. 7. Cold chain equipment obtained and/or purchased. 8. Cold chain is monitoring is recorded and submitted to LDC monthly and district supervisor. 9. Vaccines, etc. supplied. 10. Supply and use of GM cards kept with mothers institutionalized. 11. 400 drop-outs reinstated/year. 12. School aged persons knowledgeable on key EPI messages. 13. EPI sites established. 14. Surveillance activities institutionalized.</p>	<p>1. [Materials] 2. [Training Post Test] 3. [Training Post Test] 4. [LDC List] 5. [PHCW/Trainer Reports] 6. [CHP Report] 7. [Facility Inventory] 8. [Monitoring Charts] and [Supervisor Report] 9. [Vaccination Report] and [Survey] 10. [Vaccination Report] 11. [Vaccination Report] and [CHP Report] 12. [Project Quarterly Report] and [Survey] 13. [LDC List] 14. [Supervisor Report] and [LDC Minutes]</p>
<p>2. Increase percent of WCBA receiving two doses of TT from current estimate of 4.7% to 25%.</p>	<p>TT Coverage: Percent of mothers who received two doses of TT vaccine before the birth of youngest child (<24 months) of age. [SURVEY]</p>	<p>1-8. Same as above 9. Ensure use of maternal health cards to record TT vaccinations. 10. Follow-up on drop outs. 11. Increase number of EPI sites.</p>	<p>1-8. Same as above. 9. Supply and use of maternal health cards kept with mothers institutionalized. 10. 400 drop outs reinstated/yr. 11. EPI sites established.</p>	<p>1-8. Same as above. 9. [Vaccination Report] and [Survey] 10. [Vaccination Report] and [CHP Report] 11. [LDC List]</p>

(1) Project Objectives by	(2) Measurement Indicators/Method for Objectives (*)	(3) Major Planned Inputs	(4) Outputs	(5) Measurement Method for Outputs
V. Nutrition/GM				
1. 100 families grow gardens to utilize as sources of nutrition.	Number of families growing 2 fruits/vegetables rich in vitamin A. [SURVEY]	1. Hire one garden promoter. 2. Procure seeds/seedlings for gardens. 3. Motivate 100 families to grow family gardens as community demonstrations to utilize as sources of nutrition. 4. Work through LDCs to promote vegetable gardening to all families.	1. Promoter hired. 2. Seeds/seedlings procured for gardens. 3. 100 model gardens planted. 4. Village gardens promoted by LDCs.	1. [Quarterly Report] 2. [Garden Promoter Report] 3. [Garden Promoter Report] 4. [LDC Minutes]
2. Appropriate feeding practices: a. Increase the percent of infants/children (<24 months) who were breast-fed within the first eight hours after birth from current estimate of 62.3% to 75%. b. Increase the percent of infants (<4 months) who are being given only breast milk from current estimate of 37.0% to 50%. c. Increase the percent of children between 20-24 months) who are still breast feeding and being given solid or semi-solid foods from current estimate of 62.5% to 75%. d. Increase the percent of infants between 5-9 months who are being given solid or semi-solid foods from current estimate of 69.5% to 80%	Initiation of BF: Percent of infants/children (<24 months) who were breast-fed within the first eight hours after birth. [SURVEY] Exclusive BF: Percent of infants (>4 months) who are being given only breast milk. [SURVEY] Persistence of BF: Percent of children between 20-24 months who are still breast feeding and being given solid or semi-solid foods. [SURVEY] Introduction of Foods: Percent of infants between 5-9 months who are being given solid or semi-solid foods. [SURVEY]	1. Design IEC methods/materials. 2. PHC Supervisor training. 3. PHC Worker training. 4. LDC orientation. 5. CHP training. 6. CHPs promote key nutrition messages to mothers. 7. Annual promotion day in schools.	1. IEC materials prepared. 2. 3 PHC Supervisors trained. 3. 22 PHCWs trained. 4. 30 LDCs oriented. 5. 200 CHPs trained. 6. Key messages on nutrition given to mothers. 7. School age persons knowledgeable on key nutrition messages.	1. [Materials] 2. [Training Post Test] 3. [Training Post Test] 4. [LDC List] 5. [PHCW/Trainer Reports] 6. [CHP Report] 7. [Project Quarterly Reports] and [Survey]

(1) Project Objectives by	(2) Measurement Indicators/Method for Objectives (*)	(3) Major Planned Inputs	(4) Outputs	(5) Measurement Method for Outputs
3. Increase the percent of infants/children (<24 months) who have a growth monitoring card and have been weighed in the 3 preceding months from the current .003% to 25%.	Percent of infants/children (<24 months) in who have a growth monitoring card and have been weighed in the 3 preceding months. [SURVEY]	<ol style="list-style-type: none"> 1. Design IEC methods/materials. 2. PHC Supervisor training. 3. PHC Worker training. 4. LDC orientation. 5. CHP training. 6. Ensure GM equipment. 7. CHPs promote key nutrition messages to mothers. 8. PHCWs and CHPs conduct weighing sessions at monthly vaccination sites and during home visits. 9. Ensure use of GM cards to record weight-for-age measurements. 10. Follow-up on growth faltering children. 11. Annual nutrition promotion day in schools 12. Increase number of GM sites. 	<ol style="list-style-type: none"> 1. IEC materials prepared. 2. 3 PHC Supervisors trained. 3. 22 PHCWs trained. 4. 30 LDCs oriented. 5. 200 CHPs trained. 6. GM equipment purchased. 7. Key messages on nutrition given to mothers. 8. Weighing sessions conducted at monthly vaccination sites and during home visits. Mothers institutionalized in program. 9. Supply and use of GM cards kept . 10. 400 follow-up visits for growth faltering children made per year. 11. School age persons knowledgeable in relationship between growth and nutrition. 12. GM sites established. 	<ol style="list-style-type: none"> 1. [Materials] 2. [Training Post Test] 3. [Training Post Test] 4. [LDC List] 5. [PHCW/Trainer Reports] 6. [Facility/Site Inventory] 7. [CHP Report] 8. [PHCW Report], [CHP Report], and [Survey] 9. [PHCW Report] and [Survey] 10. [PHCW Report] and [CHP Report] 11. [Project Quarterly Report] and [Survey] 12. [LDC List]
4. Improving the status (those in the moderate/sever category) of children < 2 years old that attend GM sessions by at least 10% as recorded and monitored on the GM card.	% of children < 24 months whose nutrition status improved (monthly HC GM registry/reports).	1. Continued promotion of GM and follow-up of growth defaulters by PHCWs home visits and referral.	<ol style="list-style-type: none"> 1. Key messages on nutrition given to mothers. 2. 400 follow-up visits for growth faltering children made per year. 3. Growth referred for further care to HC's/feeding centers. 	<ol style="list-style-type: none"> 1. [PHCW report],[CHP report] 2. [PHCW report] 3. [HC/CHP monthly report]

(1) Project Objectives by	(2) Measurement Indicators/Method for Objectives (*)	(3) Major Planned Inputs	(4) Outputs	(5) Measurement Method for Outputs
VI. Control of Diarrheal Disease				
<p>1. Appropriate response: Increase the percent of infants/children (<24 months) with diarrhea in the past two weeks who were:</p> <p>a. ... given the same amount or more breast milk from the current estimate of 73.8% to 84%.</p> <p>b. ... given the same amount or more fluids from the current estimate of 60.7% to 75%.</p> <p>c. ... given the same amount or more food from the current estimate of 29.0% to 45%.</p> <p>d. ... treated with ORT from current estimate of 28.3% to 45%</p> <p>e. Increase the percent of mothers of infants/children (<24 months) of age who know two or more correct symptoms indicating the need to seek trained health care from current estimate of 67.7% to 80.0%.</p>	<p>a. Percent of infants/children (<24 months) with diarrhea in the past two weeks who were given the same amount or more breast milk. [SURVEY]</p> <p>Percent of infants/children (<24 months) with diarrhea in the past two weeks who were given the same amount or more fluids. [SURVEY]</p> <p>Percent of infants/children (<24 months) with diarrhea in the past two weeks who were given the same amount or more food. [SURVEY]</p> <p>Percent of infants/children (<24 months) with diarrhea in the past two weeks who were treated with ORT. [SURVEY]</p> <p>Percent of mothers of infants/children (<24 months) who know two or more correct symptoms indicating the need to seek trained health care. [SURVEY]</p>	<p>1. Design IEC methods/materials. 2. PHC Supervisor trained. 3. PHC Worker training. 4. LDC orientation. 5. CHP training. 6. CHPs promote key prevention and CDD messages to mothers. 7. Ensure ORS supply to key distribution sites (same as vaccination sites). 8. Annual promotion day in schools. 9. Follow-up on diarrhea cases by home visits to vulnerable children.</p>	<p>1. IEC materials prepared. 2. 3 PHC Supervisors trained. 3. 22 PHCWs trained. 4. 30 LDCs oriented. 5. 200 CHPs trained. 6. Key messages on prevention and CDD given to mothers. 7. ORS supplied and distributed. 8. School age persons knowledgeable on key prevention and CDD messages. 9. 400 follow-up visits made per year.</p>	<p>1. [Materials] 2. [Training Post Test] 3. [Training Post Test] 4. [LDC List] 5. [PHCW/Trainer Reports] 6. [CHP Report] 7. [PHCW Report] 8. [Project Quarterly Reports] and [Survey] 9. [PHCW Report] and [CHP Report]</p>

(1) Project Objectives by	(2) Measurement Indicators/Method for Objectives (*)	(3) Major Planned Inputs	(4) Outputs	(5) Measurement Method for Outputs
2. Increase standard case management (SCM) of diarrheal episodes being practiced to 80% of health service facilities.	Percent of service personnel following SCM (Physicians, PHCWs). [FACILITY SURVEY]	1. Conduct facility survey. 2. PHC Supervisor training. 3. PHC Worker training. 4. Establish quality monitoring criteria and procedures. 5. Follow-up quality assurance (QA).	1. Facility survey conducted. 2. 3 PHC Supervisors trained. 3. 22 PHC Workers trained, 4. Protocols appropriate to each level established. 5. Supervisory and self-monitoring for QA accomplished.	1. [Survey] 2. [Training Post Tests] 3. [Training Post Tests] 4. [Protocols] 5. [Formative Research / QA Coordinator Report]
3. 40% of retail outlets selling ORS will consistently educate clients in need of and proper use of ORS.	Percent of retail outlets selling ORS and consistently educated clients in need of and proper use of ORS. [FACILITY SURVEY]	1. Conduct facility survey. 2. Design IEC strategy for ORS retailers and area distributors. 3. Train retailers. 4. Follow-up visits for monitoring and supervision.	1. Facility survey conducted. 2. IEC strategy/materials prepared. 3. Retailers trained and given supply of advertising/educational materials. 4. Spot checks of retailers quarterly.	1. [Survey] 2. [Materials] 3. [Supervisor Report] 4. [Formative Research / QA COORDINATOR Report]

ABBREVIATIONS

BF	Breast Feeding
CDD	Control of Diarrheal Diseases
CHP	Community Health Promoter
CS	Child Survival
EPI	Expanded Program of Immunizations
GM	Growth Monitoring
IEC	Information, Education, Communication
KP	Knowledge and Practice
KPC	Knowledge, Practice and Coverage
LDC	Local Development Committee
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PHCW	Primary Health Care Worker
TT	Tetanus Toxoid
WCBA	Women of Child Bearing Age

Section C - Project Location

C.1 Location Map (See Appendix A.)

C.2 Location Description The three targeted districts are located in the western region of the Republic of Yemen. The Khokha District borders the Red Sea on its western side. The Hais District lies between Khokha and Jabal Ras on flatter land, while Jabal Ras is a mountainous area. These three districts give the project a wide range of terrain.

In general, the economy in Yemen is passing through a difficult phase that is likely to last for a number of years. The economic hardship requires some hard economic adjustments from the government which includes price increases, import controls, government spending cuts or freezes and exchange rate adjustments. All these factors impact the deteriorating economic situation in ADRA's project area, and contribute to a further squeeze in the purchasing power of families at the grass roots level and cause deterioration in the quality and quantity of basic social and medical services. (*The Situation of Children and Women in the Republic of Yemen*, UNICEF, 1992).

The religion of Yemen is traditional Islam. Religion rules in the every day lives of the Yemeni people who take a very conservative stance. The Islamic faith is based on a believer's total submission to *Allah* (God). A Muslim, 'submitter' to God and believer in Islam, observes faithfully the five pillars of Islam: the creed, performance of prayer, giving of alms, observance of fasting and performance of pilgrimage to Mecca. There are two main divisions of Islam, Sunni'i and Shi'i. A large majority of people in the project area are of the Sunni sect called the Shafa'i (*Yemen*, 1991).

A Yemeni woman's life is short, hard, tiring and vulnerable. Yemeni women have one of the world's lowest average life expectancy at 46 years. In some governorates, it drops as low as 38 years. "From the day of her birth, a Yemeni woman faces a series of consecutive hurdles that would almost certainly confine her to a lifetime of childbearing while engaged in hard manual labor at home and in the fields" (*The Situation of Children and Women in the Republic of Yemen*, UNICEF, 1992). There is a vicious cycle of life, consisting of hard work, poor nutrition, lack of education and illiteracy, early marriage and frequent disease, that is passed on from one generation to the next.

The project area has one language group, of the Yemeni Arab origin. Through the years there have been intermarriages with the Somalis, Sudanese, Eritrean and Ethiopians, which

have influenced the ethnicity of the Yemenis in the project area.

The literacy rate is low, averaging just 33% for the nation (*The Situation of Children and Women in the Republic of Yemen*, UNICEF, 1992.) In the project area, female literacy is 5.6% (Baseline Survey), which compares poorly with the national female literacy rate which stands at 26% (*State of the Worlds Children*, 1996).

Potential constraint to implementing the CS project includes mountainous terrain which makes accessibility challenging and an unstable and poor economic situation that has made local health services woefully inadequate. Yemen exhibits significant need in many areas and presents a particularly difficult operating environment. All of the local, social, logistical and bureaucratic constraints provide a significant challenge in devising an appropriate development strategy. In Yemeni society, women and girl children are denied primary health care because of cultural taboos in regard to male health care providers. This problem is exacerbated by women's historical subordinate role in society. The poor literacy rate, especially among women, poses a major constraint for the transfer of information and training. The educational environment of mixed gender of students, male teachers, and latrine facilities are traditional cultural barriers that prevent women and girl children from obtaining an adequate education.

Infant mortality rate in Yemen is 78/1000 live births and U5MR remains at 112/1000 live births (*State of the Worlds Children*, 1996). In comparison to data of the *State of the Worlds Children*, 1995, (IMR is 91/1000 and U5MR is 137/1000) these statistics seem to reflect significant improvement. However, according to *The First National Five-Year Plan for Health Development in Republic of Yemen*, there are still major problems facing the Health Information System Program, due to irregularity of data collection, irregular recording, and unavailability of accurate comprehensive and unified data. In the project area, no health statistics are available from offices contacted. The most common causes of infant and child mortality include diarrhea, ALRI, LBW (prematurity, birth complications), malaria and immunizable diseases, as reported by local health center staff.

A 1989 UNICEF survey reported a maternal mortality rate of 387 per 100,000 live births for the southern governorates. However, rural estimates tend to be higher, even 800-1,000 per 100,000 live births. Accurate and comprehensive national and project area data is lacking. Leading causes of maternal mortality include hepatitis, postpartum hemorrhage, eclampsia and reproductive maternal related complications

(The Situation of Children and Women in the Republic of Yemen 1992, UNICEF).

The health infrastructure of the project area falls under the jurisdiction of the Hodeidah Governorate Health Office. Currently there are two health centers and thirteen PHCUs. The physicians of the health centers and some PHCWs operate private clinics in the afternoons. The health centers have two physicians each. Currently, there are 3 PHCW supervisors, 16 male and 6 female PHCWs (*murshadeen* and *murshadaat* respectively) and two midwives. Two of the PHCWs are away studying, and two are inactive due to internal conflicts. All but one of the female PHCWs is in Hais. The Hais Health Center has one lab technician and one pharmacy technician. There is very little done in the area of health interventions by the existing health infrastructure, although occasional health education programs are provided for the Hais community. Basic primary health care services are provided at these health centers. Equipment and drugs are extremely limited or lacking altogether.

References

1. *The State of the World's Children*, UNICEF, 1996.
2. *The Situation of Children and Women in the Republic of Yemen*, UNICEF, 1992.

Section D - Project Design

D.1 Summary of Overall Project Design

The project will operate in two phases. The first phase will start in March 1996 and end in December 1997. This phase will focus on strengthening the existing MOH service delivery system for the project's three primary interventions, by providing some equipment (cold chain, motorcycles, scales, etc.), by providing refresher training to health workers, and by community mobilization in the communities served through the existing services.

The second phase will begin in January 1998 and finish in September 1999. It will focus on establishing services in the project's three interventions to communities not presently reached by existing services. The focus will be on community mobilization, and on overcoming logistical barriers to service provision.

The overall project design is specifically aimed at empowering existing community entities (local councils) and creating new community level entities (local development committees, LDC) where necessary. These entities will make it possible to: 1) increase accessibility; 2) increase awareness; and 3) provide a means for quality control. LDCs will receive training in conducting efficient meetings and functions.

Supervision and follow-up of LDC CS activities will be the responsibilities of the Community Development Coordinator (CDC). LDC activities are to include such things as taking responsibility for local vaccination sites, transportation of vaccinators, promoting and supervising the role of the Community Health Promoters (CHPs), maintaining a vital events registry, reporting and reviewing the HIS for relevant information, replacement of CHPs, and family gardens in the community. These activities will require a gradual increasing involvement of the local development committees, local area councils, and the local communities in general. The strengthening of the MOH through participatory self-monitoring of the cold chain system and of SCM in health facilities, are also aimed at creating locally sustainable initiatives. The enlistment of the private health sector in education regarding proper management of diarrheal episodes in conjunction with the sale of ORS packets will also require local involvement.

This first round of funding for this project focuses on a limited number of interventions to build agency and community experience capacity, increase the understanding of knowledge, attitudes and practices of the project area, and to strengthen the local infrastructure. Should a second round of funding be granted, ADRA will include additional interventions such as maternal care, malaria control and ALRI.

The groups targeted for project activities and defined high risk populations for each intervention are listed below:

Intervention	Population at Risk
EPI: childhood diseases	Children 0-11 months of age
EPI: TT	WCBA 15 - 49 yrs of age
CDD	Children 0-23 months of age
Nutrition	Children 0-23 months of age

There are several levels at which eligible women, children and newborns will enter and participate in these programs. At the community level, for all interventions, health workers, (PHCWs/CHPs) and CHPs will encourage mothers to attend growth monitoring and immunization sessions at sites in their village, local PHCU and/or the health center. They will also promote attendance at health education sessions at the community level. At the health center level, patients will be enrolled for pediatric and maternal immunizations, nutrition counseling and diarrheal case management.

The project will promote the three Child Survival interventions of EPI, Nutrition and CDD.

EPI - 40% There are several EPI intervention strategies. One is to improve the accessibility of immunizations, by

strengthening the MOH cold chain and transport system, by making the Hais Health Center an immunization storage center for the three districts. Secondly, training and retraining of PHCWs to be vaccinators and cold chain monitors, will also strengthen the existing MOH infrastructure. Thirdly, mothers will receive key EPI messages to increase an awareness for the need of immunizations, through trained health workers and CHPs. Fourthly, local development committees and district councils will be established to assist in community-wide promotion of EPI campaign days, through posters and education of village leaders and other community members. Rationale for the strategies of this intervention is due to an irregular supply of immunizations to the communities of the three districts, mostly due to an inadequate cold chain system and an erratic supply from Zabid, the current regional depot for vaccines. There have been occasional stock shortages in recent months, particularly of needles and syringes, since they have switched to non-reusable syringes. Many of the PHCUs are inactive, and PHCWs need to be motivated to return to their posts--immunization responsibilities will help to provide the stimulus. Plans to resupply and/or repair cold chain equipment for the PHCUs will enable PHCWs to carry out responsibilities effectively.

Nutrition - 30% The nutrition intervention will educate mothers through health workers and CHPs during home social contacts and at monthly vaccination/weighing days. Particular emphasis will be placed on appropriate breast feeding and introduction-of-food practices. Secondly, there will be growth monitoring activities. Children will be weighed on monthly vaccination days. Bimonthly weighing of children discovered to be faltering in growth, will be encouraged and will be followed up more intensively with home visits. Rationale for this intervention is, that there is no current nutrition education program in the target area, and casual observation noted no education of mothers in nutrition by health personnel. Only select and seriously ill infants are weighed when they come to the Hais Health Center. Finally, a Garden Promoter will be responsible for encouraging families to grow vegetables in family gardens. In the rural areas especially, access to and availability of fresh fruits and vegetables is very limited. Seeds/seedlings will be procured from other support sources. ADRA will also explore the feasibility of developing additional water supplies. The Garden Promoter will also hold demonstration sessions on how to incorporate nutritious home-grown foods in the family diet.

CDD - 30% The CDD strategy focuses primarily on education: 1) refresher training for health center staff on SCM; 2) training of ORS retailers to transmit health messages through their counseling at the time of ORS packet

sales; and 3) the education of mothers and families through trained health workers and CHPs. This project will also provide a means for ensuring the supply of ORS packets to health centers and units. There are several reasons to support the selection of these strategies. Due to the state and use of the PHCUs (inactive or marginally active), there is little or no education regarding appropriate home management, including seeking medical care for diarrheal episodes. Casual observation of health personnel practices, indicates deficiencies in standard case management of diarrheal episodes in health facilities. The supply of ORS packets by the MOH to the Hais Health Center is inadequate for use by the PHCUs.

D.2 Collaboration and Formal Agreements

There are no existing NGOs with which to collaborate in the project area. There has been collaboration with the Hodeidah Urban PHC project and more is planned. Their experience with a cost recovery program, community health committees and HIS system will be valuable to this project. There will be active collaboration with UNICEF/WHO in sharing of pertinent information for obtaining educational materials for training. The MOH has agreed to provide cold chain equipment, charts and registry forms, and training personnel/materials for all interventions and ORS packets. (See Appendix B for letter of agreement and other supportive documents.) The cold chain equipment the MOH will provide include: 2 gas refrigerators, 10 Swedish cold boxes, 21 plastic basins, 20 steel plates, 20 steel bowls, 320 ice packs (16/health unit), 20 vaccination supply bags, 30 vaccine carriers (2/health unit, 10 health units already have). Local area councils are community bodies that will be involved at the community level in assisting with the analysis and solving of problems that arise in their particular area. They will be increasingly responsible for CS and development activities that take place. The project is currently discussing with the Tihama Development Authority possibilities for coordination of the nutrition intervention activities with those of their female agricultural extension. As part of the focus on health education among community members, collaboration with the local Ministry of Education will provide opportunities to work with the local school system.

There will be no financial exchange anticipated with these collaborations. There will be no other NGOs subcontracted to work with this project. Knowledge transfers will include the sharing of information gathered by evaluations and supervision and monitoring activities with the communities, health centers, national health offices and other NGOs working in Yemen and the assistance of the MOH in training health staff.

Administration of the KPC Baseline Survey required the involvement of community members and was successfully

completed with their assistance. Several murshadaat, midwives, teachers and agricultural extensionists were recruited as supervisors and interviewers. The Hais Health Center Director provided the training facility. Community members assisted in translation, locating randomly selected villages throughout the three districts, and in the development of relationships with the leaders of the surrounding communities.

The MOH central and regional representatives attended the DIP Workshop. Community leaders from Hais, Jabal Ras, Khokha and Zabid (the health center from which the Hais Health Center receives immunizations) also participated in this workshop. In addition, two midwives, a PHCW supervisor and agricultural extensionist contributed information during the workshop. The DIP Workshop process was participatory with the various attendees contributing to the planning as their expertise allowed.

D.3 Technical Assistance

During the initial stages of CS project planning, Paul W. Dysinger, MD, MPH provided recommendations and advice as an external consultant. His former experience of working on development projects in various countries provided a backdrop for the suggestions and insight he was able to share.

Technical assistance was obtained from Henry D. Kalter, MD, MPH from JHU/CSSP in developing the HIS. He was able to provide valuable information on this subject, although suggested use of certain HIS forms were thought to be too technical for the project area at this time. Additional assistance for the design, training and functioning of a HIS will be sought from the Hodeidah Urban PHC Program (run jointly by Dutch Aid and ICD, a British NGO). This NGO is based outside ADRA's project area.

Barbara S. Kinzie, RN, MPH, participated as a consultant in the DIP Workshop. Her experience of working in Yemen in various roles relating to community health was highly valued during the planning process. Jerald Whitehouse, DrHSc, MPH, also provided additional consultive input for the DIP.

Establishment of the cold chain equipment and system has required the technical assistance of Abdul Karim Altuwaiti, MOH EPI Technical Officer. His expertise in the management of the EPI has been very helpful in understanding MOH protocols and guidelines, details of cold chain equipment and systems, and in the training of health staff and course content.

Additional assistance in formative research will be obtained from an external consultant for the Nutrition and CDD interventions during the first year of implementation. The initiation of cost recovery strategies will also require technical

assistance from UNICEF or the Hodeidah Urban PHC Program. Further technical assistance in the areas of sustainability, assessing quality of care and project management is planned from the PVO CSSP office at JHU (in March 1998).

Section D.4a Detailed Plans by Intervention - Immunization

4a.1 Incidence and Outbreaks Currently, the MOH is not carrying out well-supervised surveillance strategies of vaccine preventable diseases for the nation and none in the project area. Discussions with the director and physician of the Health Hais Center indicate that in the past two years, there were outbreaks of whooping cough and measles in the project area.

4a.2 Baseline Coverage Estimates The estimated coverage rate for children 12-23 months of age in the project area for DPT1 is 18.5%. For OPV1 the coverage rate is 17.0%. Baseline data estimates a measles coverage at 11.1%. The current drop-out rate for DPT immunizations is 20.0%. The estimate of children completely immunized is 9.6%. Considering the total number of mothers interviewed during the baseline survey who had maternal health cards, the estimated percent of births that are fully protected by tetanus toxoid immunizations is 4.7%. The most recent data available for the national coverage levels state DPT1 at 47%, OPV3 at 47% and measles at 45%. TT coverage at the national level is 8% (*State of the World's Children, 1996*). The rate of children fully immunized is 39% for the rural area and 41% for the nation (*The Situation of Children and Women in the Republic of Yemen, 1993*).

4a.3 MOH Policies MOH immunization policies noted in the New 5-Year Plan conform to WHO/UNICEF guidelines. However, efficient supervision and reporting for the purposes of surveillance of polio and tetanus cases is in the planning stages. The MOH immunization schedules for infants and WCBA also conform to WHO/UNICEF guidelines as follows:

Infants	
Age	Vaccine
Birth	BCG, OPV0
6 weeks	DPT1, OPV1
10 weeks	DPT1, OPV2
14 weeks	DPT3, OPV3
9 months	Measles

WCBA

Dose	Schedule
TT ₁	1st contact with services or as early as possible in pregnancy
TT ₂	4 weeks after 1st dose or subsequent pregnancy
TT ₃	6 months after 2nd dose or subsequent pregnancy
TT ₄	1 year after 3rd dose or subsequent pregnancy
TT ₅	1 year after 4th dose or subsequent pregnancy

4a.4 Knowledge and Practice 16.3% of the mothers surveyed, stated that a child should receive its measles vaccine at nine months of age. 12.6% stated that the main reason why pregnant women need to be vaccinated with the tetanus toxoid vaccine is to protect both the mother and the newborn. 11.2% of the mothers stated that a pregnant mother needs more than two tetanus toxoid injections to protect the newborn infant from tetanus. 6.8% (20/295) of the mothers surveyed had maternal health cards and 4.7% (14/295) had at least two TT vaccinations recorded on their maternal health card.

4a.5 Immunization Objectives

Objective	Base-line	EOP
Increase the percent of children from 12-23 months completing immunizations from current *	9.6%	50%
Increase the percent of WCBA receiving two doses of TT from current	4.7%	25%

*For EPI mandated indicators and their measurements, see Table B.

4a.6 Approach

There are numerous barriers to achieving full immunization coverage in the project area. Poor accessibility, lack of community awareness as to the importance of immunizations, and their schedule and incorrect traditional beliefs associated with immunizations, are some of the existing barriers originating from the community. The lack of supervision at regional and local levels during transportation and distribution of vaccines, affects the overall quality of existing MOH immunization services. Furthermore, coverage has been weakened due to inadequate cold chain equipment, irregularity of electric supply and shortage of gas, and poorly trained vaccinators with a lack of supervision.

The project's planned immunization component for children less than two years old and WCBA includes 1) increasing accessibility by reopening health units as vaccination sites, establishing new vaccination sites, expanding to remote undeserved areas and 2) placing a strong emphasis on increasing community awareness through health education and 3) strengthening the existing MOH EPI structures by scheduling refresher training on immunizations for supervisors and PHCWs. (Health messages to be used are included in Appendix C.)

The MOH roles in the EPI program will include training supervisors and PHCWs, the provision of vaccines and other EPI supplies (see section D.2 for the list of cold chain equipment supplied by UNICEF via MOH), supervision and monitoring of EPI personnel at the health center and district levels, and the training and assisting in the mobilization of community groups. ADRA will play a facilitators role in community mobilization and in funding and scheduling training sessions for supervisors, health workers, community and religious leaders. ADRA will also facilitate, assist with the purchase of refrigerators (five solar refrigerators) and motorcycles to enhance the cold chain system and logistics thereof, and also in the development of educational materials. The communities' roles will be to assist in the planning of vaccination campaigns, scheduling, arranging the site and promotional activities.

The immunization activities will be implemented in phases. The first stage will commence in mid March 1996 with the purpose of strengthening the existing MOH EPI services. This includes the training of the health centers' and units' staff, ensuring adequate cold chain equipment, immunization supplies, community mobilization and organization of immunization sessions at health centers, health units and select villages located close to these facilities. The second stage, which will begin in January, 1998, will involve the establishment of new vaccination sites in villages unreached by the first phase. This will involve community mobilization and overcoming logistical problems in reaching the remote areas.

Vaccines will be supplied to the Hais Health Center on a monthly basis by the Governorate Health Office in Hodeidah and delivered by their EPI Technical Officer. The Hais Health Center supervisor will be responsible for immediate delivery to the other two main district distribution centers. District supervisors responsible for immediate delivery to the other two main district distribution centers. District supervisors will in turn deliver the vaccines to the various health units in their jurisdiction. Each PHCW will then carry out vaccine services from their fixed health unit and also as a mobile service to villages within their catchment areas. One of the LDCs

responsibilities would be to support the PHCWs with transportation (See below.)

EPI activities will initially be done mostly by male vaccinators. There is a shortage of female health workers. UNFPA's PHCW training courses will increase the health sector manpower by focusing on the enrollment of women willing to be trained as *murshadaat* and TBAs. The *murshadaat* will be able to assist in the administration of vaccines. District supervisors will be in charge of transporting the vaccines to the PHCUs under their jurisdiction catchment areas of the PHCUs covering areas with a 10 km radius. Households within 2 km of the PHC unit are expected to come to the unit for their immunizations and other health services. The next 4 kms surrounding the PHCU, the PHCW is expected to cover by foot or other means of transportation. The next 4 kms is also covered by PHCW but those communities are requested to help the PHCW with transportation costs. LDCs will be largely responsible for collecting the funds to assist the PHCW. About 4 of the PHCWs already have motorbikes or other means of travel. We think that 4 more motorbikes are sufficient. Bicycles would not be appropriate for the area/terrain -- too hot, rocky, sandy and hilly. Cold chain equipment is sufficient to cover the catchment areas.

Immunization services will be given the whole year from both fixed and mobile sites. The first stage will be from fixed health centers and units with one day campaigns to initiate these activities. During the second and third stages of the EPI intervention, mobile vaccination sites will be established to move into the more remote sites.

There are 20 existing health units and 3 health centers for the 3 districts. Nine health units have permanent buildings. The other 11 are only temporary buildings (homes or mud huts of PHCWs.) There are 4 existing refrigerators. ADRA will purchase 5 more solar refrigerators. The MOH will supply 2 gas refrigerators. This will give a total of 11 refrigerators for the 3 districts. Other health units (10) will have the cold boxed to use for storage of vaccines.

to cover only 2 months
The project anticipates reaching the "high risk" population of children less than 24 months, through the work of health centers, health units, mobile vaccination teams, and through local vaccination campaigns. The training of community leaders, religious leaders and especially *jeddah* (untrained TBAs) will enable the appropriate health messages to be disseminated to mothers with children in this age group.

All PHCWs will be trained to enhance immunization skills. The standard MOH curriculum will be used to train these vaccinators. The curriculum includes five days of training in the basic aspects of immunizations.

A careful assessment will be done for each health unit planning to carry out an immunization campaign to determine the estimated number of vaccines to order. This order will be relayed to the Governorate Health Office located in the city of Hodeidah from which they will be retrieved. The supply of vaccines will be ensured through continuous monitoring and supervision of regional distribution to health centers and units in collaboration with the regional EPI Officer.

4a.7 Individual Documentation

The project will use the immunization space on the back of the growth monitoring cards to record the date and type(s) of immunization(s) given. (See Appendix D.) This will minimize the number of cards a mother needs to keep track of. The MOH normally uses a standardized immunization card. In the case where a child's card is lost, vaccination information can be obtained from the registry located at the health facility that provided the immunizations. ADRA does not expect any expenditures for immunization cards, forms and registries which will be provided by the MOH. Women's TT vaccinations will be recorded on separate TT vaccination cards also provided by the MOH. These cards will be kept by the mothers, again, with information recorded in registries at the respective health facility. The importance of card retention by mothers will be promoted and encouraged by vaccinators at the time of vaccination and also by health education messages shared by various community members inclusive of the *jeddah*.

4a.8 Drop-outs - Children

There are numerous reasons why there are large numbers of drop-outs. Lack of vaccines, inconsistent immunization services, logistics problems, lack of trust in the PHCW, incompetence in vaccination procedures and related complications from the first vaccination, lack of monetary resources for transportation to a vaccination site, and a lack of awareness about completing the vaccination schedule all contribute to the high percentage of drop-outs.

Ensuring a regular supply of vaccines to the health centers with a frequent check on the quality and regularity of services, the training of PHCWs, intensive monitoring and supervision of those PHCWs, increasing outreach sites to remote areas through mobile vaccinators, the health education of mothers and the organization of communities for mass campaigns are activities that will help to reduce the problem of drop-outs.

Supervisors will monitor the work of PHCWs by observing the vaccination registry to ensure that defaulters are identified and visited. The PHCW will record the date of the next immunization on the registry. If on the next visit the child is

not present for the scheduled immunization, a CHP of the community will assist the vaccinator in seeking the child out.

4a.9 Drop-outs - Women

Antenatal care is not practiced in the rural areas partially because there are no female PHCWs. The first antenatal visit usually occurs late in the pregnancy and does not allow for completion of the full TT schedule. The majority of the vaccinators are males, and cultural traditions sometimes prevent women from receiving immunizations from men.

The project intends to increase the supply and accessibility of TT immunizations by making them available during the local campaigns for child immunizations. In addition, health education through female health workers and the work of CHPs will help to increase the demand for TT immunizations before and during pregnancy. The training of *murshadaat* (female PHCW) will increase the acceptability of receiving vaccinations and decrease gender biases. Methods for covering drop-outs and missed opportunities will be dealt with the same as that for other immunizations as discussed in the last section of 4a.8.

4a.10 Population

Beneficiary Population for Immunizations

0-11 Months	WCBA 15-49	Total
3,476	19,897	43,090

The estimated number of newborns for the nation each year is 623,000 (*State of the World's Children*, 1995). Assuming that approximately 3,500 children are born per year, five visits per newborn will be required to reach full coverage of children by 12 months of age. The project will target all WCBA including those who are pregnant for TT immunizations.

4a.11 Cold Chain Support Erratic availability of transportation from governorate storage areas to peripheral health centers, poor maintenance of cold chain equipment, inadequate surveillance and monitoring of temperatures, excessively high temperatures which demand more cooling capacity and fuel than normal, unavailability of an electrical power supply in any of the three districts and the combined difficulty of gas cylinder replenishment, poorly trained staff in maintenance of cold chain equipment and finally, the lack of cold chain equipment constitute the daunting challenges of inadequate cold chain system. This information was obtained from field trip observations and MOH and EPI personnel of the central, governorate, district health center and peripheral levels.

The project intends to train PHCWs in principles of cold chain management and in maintenance and monitoring of equipment. This includes additional training of district supervisors in specific supervisory duties and techniques. All PHCW activities will be supervised by these district supervisors. PHCWs will be responsible for reporting damaged or malfunctioning cold chain equipment to their health unit supervisor immediately. The supervisors will then contact the Governorate Health Office for the EPI Technical Officer to make the necessary visit to the health unit or provide appropriate advice and instruction on repair. Project protocol for monitoring vaccine temperatures are according to MOH guidelines. The PHCW will be responsible for using a temperature monitoring chart and a check list. (See Appendix E.)

Two gas refrigerators, 10 Swedish cold boxes, 21 plastic basins, 20 steel plates, 20 steel bowls, 320 ice [packs (16/health unit), 20 vaccination supply bags, 30 vaccine carriers (2/health unit, 10 health units already have supplies), will be provided by the MOH. The MOH will provide all of the carrying cases and cold boxes as necessary to facilitate reaching out to the more remote villages.

Although the accuracy of these rates could be a matter of argument, the regional MOH EPI operational officer reported that the vaccine efficacies at the district level are 95% for polio, 85% for BCG, 95% for DPT and 90% for measles.

4a.12 Surveillance The MOH has an objective to eradicate polio and neonatal tetanus by the year 2000 (*The First National Five-Year Plan*). It has a plan for training and monitoring EPI disease surveillance activities of these two diseases, but it is not yet operational. The following signs and symptoms for case identification of polio are listed in the EPI training manual: 1) apathy; 2) low-grade fever; 3) congestion of mucous membranes of nose, throat and upper respiratory tract; 4) headache, sometimes diarrhea; 5) stiffness of neck muscles; 6) pain of muscles in limbs; and 7) paralysis of main muscles of legs, thigh and sometimes muscles of shoulders. Neonatal tetanus signs and symptoms are as follows: 1) the newborn looks normal after birth, then a few days after birth or circumcision, contractions of voluntary muscles of jaw (lock jaw) and respiratory muscles occur frequently; 2) after the first week of contractions, muscle spasms occur more frequently and through the slightest stimuli, i.e., noise, touch, light, etc.; and 3) death of the child is the end result.

Once the MOH plan is initiated, surveillance will be carried out in health facilities and in the community. Special training for monitoring EPI diseases will be necessary for supervisors and PCHWs. This includes case identification and history, reporting and follow-up. Primarily, responsibilities for responding to disease outbreaks rests with the MOH and

ADRA will assist in mobilizing special vaccination campaigns for containment. This project is involved in these activities as a pilot site and because surveillance provides important and relevant information to LDCs and district councils in monitoring the health of their jurisdictions.

Reference Materials

1. *EPI Coverage Data, 1994*. UNICEF and Deutscher Entwicklungsdienst. 1995. National EPI Office, Ministry of Public Health: Sana'a, Yemen.
2. *EPI Essentials: A Guide for Program Officers*. REACH. Second Edition, 1989. John Snow, Inc.: Virginia, USA.
3. *Evaluate Vaccination Coverage: Training for Mid-Level Managers*. EPI: World Health Organization. 1991.
4. *Expanded Programme on Immunization, Plan of Action, 1992*. Ministry of Public Health: Sana'a, Yemen. 1992.
5. *The First National Five-Year Plan for Health Development in Republic of Yemen*. Ministry of Public Health: Sana'a, Yemen. 1996.
6. *Immunization Guidelines for Health Workers*. UNICEF and REACH. 1993. National EPI Office, Ministry of Public Health: Sana'a, Yemen.

Section D.4b Detailed Plans by Intervention - Nutritional Improvement

4b.1 Nutritional Improvement for Infants and Children

4b.1a Baseline The prevalence of moderate and severe malnutrition among under 5s is 30% for the nation. 4% are severely malnourished. Wasting among under 5s is 13% and stunting is 44% (*State of the World's Children, 1996*).

Moderate and severe measurements are below minus two standard deviations from median weight-for-age of the reference population; severe measurements are below minus three standard deviations from median weight-for-age of reference population. Wasting is below minus two standard deviations from median weight-for-height of reference population. Stunting is below minus two standard deviations from median height-for-age of reference population.

In accordance with the MOH protocol, the project will do weight-for-age anthropometric measurements of children less than three years of age with a particular focus on children < 24 months old. This is in variance with the standard WHO card that assesses the health of children under five years of age. The decision to maintain MOH standards supports the project's purpose in targeting the population at highest risk. These measurements will be recorded on a growth monitoring card and in registries of the health facility providing GM services.

The major causes of nutritional problems in the project area that contribute most to infant/child illness and death are numerous. Interviews with local female informants and health workers state that the knowledge of mothers is inadequate and inaccurate because there is insufficient emphasis on the importance of nutrition in the general educational system. They also state that there is a lack of hygiene and a lack of food varieties, a high prevalence of infectious diseases, women have too many children, rural areas have no access to fresh fruit and vegetables, poor economic status is prevalent and there are negative effects of marketing activities towards unhealthy foods low in nutritional value. All of these issues combine in their complexities to contribute to the low nutritional status of children.

Malnutrition is more prevalent during winter months (December through February) due to seasonal economic fluctuations in the larger towns. Conversations with community members reveal that mountainous areas have seasonal limitations to growing fresh produce, particularly during the winter months. The problem of moderate to severe malnutrition is greater in the Tihama area around Al Mokha (27%) than in the mountainous areas (12%) according to a PHC survey conducted in 1989 by Radda Barnen, UNICEF and Taiz PHC (*Taiz Governorate Primary Health Care Survey, 1989*). "Malnutrition seems to increase after the age of one after infants stop being breast-fed and instead are bottle-fed or introduced to family foods" (*The Situation of Children and Women in the Republic of Yemen, 1992*).

4b.1b Current Knowledge and Practice Baseline survey estimates that 48.4% of mothers initiate breast feeding within the first hour after delivery and 62.3% state that they had begun within the first eight hours after delivery. Of the children, 0-3 months of age, 37% were being exclusively breast-fed. Of the children 5-9 months of age, 69.5% were being given complimentary foods. 62.5% of children 20-24 months of age are continuing to breast feed.

Complimentary feeding practices include a meal three times a day and sometimes an occasional biscuit snack between meals. Meals are eaten from a communal dish on the floor with adults often eating faster than children, and therefore deprive children of the opportunity to eat sufficiently for satisfaction. Utensils are not used during meals. Traditional food beliefs often result in children being given relatively more "light" foods, at the expense of sufficient quantities of legumes, fish, eggs, fruits and meat. "Light" foods consist of things like breads, rice, tea and biscuits. Weaning practices vary throughout the country. Breast milk is withheld from children when there is stress or conflict within the family or the mother is pregnant. Heavy workloads in the sun and hot climates are thought to cause the breast milk to be "hot" and

thus to cause illness in the child. "In general, weaning is abrupt, rather than gradual, and solid foods are usually introduced too late into the child's diet" (*Situation of Children and Women in Republic of Yemen*, 1992). Among children aged 18-23 months, only 0.9% were given solid or semisolid food (*Demographic and Maternal and Child Health Survey 1991/1992*). Furthermore, food is often withheld during a child's illness. Baseline Survey data indicates that of the children who had diarrhea in the two weeks prior to the survey 26.2% of the mothers gave less breast milk or stopped completely, 39.3% gave fewer fluids other than breast milk or

stopped completely and 70.9% gave fewer solid/semisolid foods or stopped completely.

Another indirect factor that impacts the life of the unborn and newborn is the practice of qat chewing. Qat is a small green leaf with juices that contain, among many other compounds, amphetamines that cause insomnia, loss of appetite, constipation and other gastrointestinal problems. A loss of appetite will deplete the mother's resources both during pregnancy (resulting in LBW babies) and during breast feeding. This causes the infant to be robbed of adequate nutrients on two accounts.

4b.1c Nutrition Objectives

Objective	Baseline %	EOP %
Appropriate Feeding Practices		
Initiation of Breast Feeding: Increase the percent of infants/children less than 24 months of age who were breast-fed within the first eight hours after birth.	62.3	75
Exclusive Breast Feeding: Increase the percent of infants less than four months of age who are being given only breast milk.	37.0	50
Introduction of Foods: Increase the percent of infants between 5-9 months who are being given solid or semi-solid foods.	69.5	80
Persistence of Breast Feeding: Increase the percent of children between 20-24 months of age who are still breast feeding and being given solid or semi-solid foods.	62.5	75
100 families growing gardens to utilize as sources of nutrition.	0	100

*Should be 1 hour
" be 4-6 mos*

Note: The Gomez classification will be used to determine degree of malnutrition (mild, moderate and sever). A master chart, showing weight levels at 10 percent intervals for use in collecting information from mothers attending the health centers will be introduced. This is simplified using reference (100 percent), -2 SD (approximately 80 percent as mild malnutrition), -3 SD (approximately 70 percent as moderate malnutrition), and -4 SD (approximately 60 percent as sever malnutrition.)

4b.1d Approach The local health center in Hais has one scale used to weigh select children who come to the health center for illness and are presented as having lost weight significantly. Mothers are given health education instructions on nutrition and breast feeding. The local agricultural center also has activities related to growth monitoring. These are carried out by their female agricultural extensionists in four selected villages twice weekly. Growth monitoring is done once per month in these villages. They also make home visits to provide families with nutritional advice. However, due to a lack of growth monitoring cards

and registries, data concerning child weights are no longer recorded in the target districts.

The Health Center health workers will be trained in nutrition and in the communication of nutritional education to mothers who visit the center. Discussions are underway with the Tihama Development Authority (a local government agency based in the project area) to make it possible to coordinate growth monitoring activities, community training regarding nutritional health messages and the promotion of family gardens, since these are activities they are currently implementing, although in select villages. This project will enable these workers to expand into more than four villages per year.

CHPs will be trained to educate mothers through LDCs and informal home visits and social contacts. They will encourage mothers to attend monthly weighing sessions (focusing especially on underweight children), promote family gardens and provide nutrition demonstration sessions. Local school teachers have nutrition in their curriculum but it is not being taught. CHPs and health workers will work with

the local school teachers and encourage them to either include this in their lesson plans or allow them to take the responsibility of instructing the students on simple yet important basics of nutrition.

Nutritional health messages will include emphasis on early initiation of breast feeding, the persistence of breast feeding, exclusiveness of breast feeding, timely initiation of quality weaning foods, frequent feeding of sufficient quantities of food for children, continued breast/feeding during illness and catch up feeding (See Appendix C for specific health messages). In addition to these standard key messages from *Facts for Life* based on the KPC survey and other studies, efforts will be made to promote health messages related to maternal nutrition during pregnancy and lactation, weaning food recipes using local foods and the effects of qat chewing during pregnancy (resulting in LBW babies).

Project activities for the nutrition intervention will be phased in during the second project year. It will begin with the training of trainers (supervisors) in growth monitoring combined with a refresher on nutritional messages. Following this will be the training of health workers and then their involvement in the activities mentioned above. Inclusive in this second phase, is the training of CHPs, LDCs and other prominent community members such as school teachers and religious leaders.

Some of the constraints related to improving children's nutritional status include lack of awareness of nutritional need and principles, lack of accessibility to a variety of fresh fruits and vegetables, and a traditional lack of attention to weaning needs. Health education will increase awareness of local resources for foods with high nutritional quality and to overcome traditional beliefs that prevent children from obtaining sufficient weaning foods. There will be focused efforts to motivate 100 families to grow family gardens as demonstrations to others. Work will be done through local LDCs, agricultural extensionists and *jeddah* to promote home gardening to all families.

Formative research will be undertaken to gain an understanding of KAP in regard to nutrition. This will aid in the development of location specific nutrition messages, taking into account fruits, vegetables, grains and other foods available to communities and those that can be grown in family gardens. Local artists will be hired to assist in the development of posters and flip charts accompanied by appropriate health messages to be used in community training sessions. ADRA will provide health workers with the essential materials, training to the supervisors, health workers, LDCs and CHPs. Focus groups and interviews will be an important component of monitoring and quality assurance. This will be done mainly through observation and interviews

conducted by health workers with community members and families with gardens. Growth monitoring activities will be monitored by health center supervisors through reports from registries by the PHCWs.

Ladies from families who have gardens will be asked to contribute produce they have grown for nutrition demonstrations during health education sessions. A special nutrition campaign will be conducted to include a community "potluck" with different families again contributing produce for a prearranged menu.

4b.1e Low Birth Weight Babies The detection of LBW babies is not a focus of this project but there are plans to include this aspect during the second round of funding. ADRA is encouraging the training of *murshadaat* / *murshadeen* and TBAs by the UNFPA during this round of funding. This will prepare health workers to deal with the problem of LBW babies for the next round of funding. ADRA will work with the UNFPA to develop guidelines to be used by the health workers.

4b.2 Growth Monitoring

4b.2a Baseline Of all the mothers surveyed during the baseline survey, only one mother had a growth monitoring card for her child. The one growth monitoring card that was found indicated that the child had been weighed in the past four months prior to the survey. In theory, children are to be weighed on average about every month in health centers when they come for immunizations and in the four villages where female agricultural extensionists work. The project will be reaching all children under 24 months of age through health workers and CHPs.

4b.2b Knowledge and Practices It would appear, according to baseline data, that growth monitoring activities are not being practiced. Informal discussions suggest that agricultural extensionists should be involved in growth monitoring. Presently these activities are done inconsistently and in a few select villages.

Some women want to know if their child is developing properly. If their child is not weighed, they get upset. Other women are afraid to weigh their children because of superstitious beliefs that their child will become ill due to the "evil eye." The first child of a family is often brought in for growth monitoring and immunizations, but children are not given as much/subsequent attention and parents loose interest. Those women who have had health education can understand the importance and relationship between growth monitoring, feeding practices and illness, but health workers state that less

than 1% would understand this relationship without health education.

4b.2c Growth Monitoring Objectives

Objective	Baseline %	EOP %
Increase the percent of children under 24 months of age in the project area who have a growth monitoring card and have been weighed in the 3 preceding months.	.003	25
Improving the nutritional status (those in the moderate/sever category) of children <2 years old that attended GM sessions by at least 10% as recorded and monitored on the GM card.	*	*

* = Health Center GM Records

4b.2d MOH Protocol and Practices The MOH is not carrying out growth monitoring in the project area. In MOH protocols, according to the *First National Five-Year Plan*, growth monitoring recording should take place monthly and bi-monthly for children faltering in growth for children up to the age of three years. There are two types of scales utilized in health centers and units, both of the beam balance style: those for under 24 months of age and those for preschoolers and older. In the ideal situation, when a health worker or agricultural extensionist is doing growth monitoring activities, for a child who is faltering in growth, efforts are made to determine the cause (diarrhea, not eating, illness, etc.) and the child is referred to the nearest health center for treatment. If the problem is a lack of nutritional knowledge, advice is given. If, at the next weighing session there is no improvement, the child is referred to a doctor or a health center. MOH protocol refers urban mothers of underweight infants to MCH centers where World Food Program provides food supplementation. There are no MCH centers in the project area.

4b.2e Individual Documentation The project will use a standard MOH growth monitoring card. A copy of the MOH growth card is found under Appendix D. The MOH will provide these cards but ADRA will design and implement the use of a health record maintenance. In previous years, MOH protocol called for the cards to be kept by mothers. Beginning in 1996, the MOH has decided to keep the cards in the health facilities for two reasons: 1) too many mothers loose the cards; and 2) to assist health facilities in keeping records for reporting purposes. This project will continue to encourage mothers to keep the cards in a safe

place, emphasizing the importance of keeping track of a child's development through health education done by CHPs. Health facilities will keep track of measurements in a health card registry that can separate cards of infants who need to be monitored on a bi-monthly basis. For educational materials refer to Section G and the budget line item for training materials. The card does not have a space to record vitamin A capsules.

4b.2f Approach Growth monitoring and promotion will first be encouraged through the work of health workers and CHPs, initially during monthly immunization campaigns. Children will be weighed monthly and those who are growth faltering will be weighed bi-monthly. The road to health chart will be used utilizing the weight-for-age classification to determine growth faltering. The mothers of those children who continue to falter in growth, will be given nutritional counseling with emphasis on breast feeding, introduction of semi-solid foods and persistence of breast feeding. To determine the progress of the child, the CHP will make follow-up visits at the home level. If the problem continues, the child will be referred to the nearest health center where appropriate diagnosis and treatment for intestinal parasites would occur. *or counselling re: EOP*

Growth monitoring activities will be phased in during the middle of the second project year. The project will begin in the core-communities having health units and phased in to the peripheral communities as the project progresses.

The project has plans to establish and strengthen MOH growth monitoring services and this includes the purchase of about 80 scales. Supervisors, health workers and agricultural extensionists will be responsible for weighing children during immunization sessions and interpreting their growth cards. Their nutritional training will allow them to further train CHPs (who in turn help to train mothers) who can help in providing nutrition counseling and can comprehend the road to health card. The scales will be distributed to select villages to act as GM centers and who have CHPs capable of carrying out GM activities.

ADRA will support the MOH to provide the training for supervisors and PHCWs. ADRA will work with the MOH to develop appropriate training curriculum for growth monitoring and nutrition education at the various levels of supervisors and PHCWs, community leaders and CHPs.

Some of the existing constraints to weighing young children monthly with effective counseling and follow-up are as follows: lack of motivation by PHC providers and supervision to carry out quality care, lack of counseling and follow-up, lack of understanding of mothers about the

relationship between growth monitoring, nutrition, and illness, and the unavailability of growth monitoring activities.

ADRA plans to meet these constraints with effective supervision and monitoring activities to ensure quality GM activities, care, counseling and follow-up. This will be done through the use of quality assurance check lists, making monthly reports to the LDC and periodic meetings with the health staff. CHPs will also be encouraged to educate mothers and promote attendance at GM sessions. Health messages to be used are included in Appendix C. Another nutritional improvement activity includes that of home gardens but is not directly related to growth monitoring activities. The project considers all children under three years of age to be high risk. They will be reached through the normal activities of health workers, agricultural extensionists and CHPs.

4b.2g Follow-up on Children The project will keep track of the number of children who did not gain weight in the last two months by careful recording and analysis of health records and growth monitoring cards of the project's HIS system. In the ideal situation, when a health worker or female agricultural extensionist identifies a child who is faltering in growth, efforts are made to determine the cause (diarrhea, not eating, illness, etc.). The mother is given nutritional counseling with emphasis on breast feeding, introduction of semi-solid foods and persistence of breast feeding. To determine the progress of the child, the health worker or CHP will make follow-up visits at the home level. If at the next weighing session there is no improvement, the child is referred to a doctor or a health center where appropriate diagnosis and treatment would occur. Focus groups and ethnographic studies will be done to determine cultural beliefs and practices relating to nutrition, breast feeding and illness. The information obtained will be used to develop relevant educational materials. Existing MOH and UNICEF nutritional educational materials will also be utilized. Referral of children who fail to gain weight despite improved feeding practices is discussed in the previous paragraph.

4b.2h Population

Beneficiary Population for Growth Monitoring

0-11 Months	12-23 Months	24-35 Months	Total
3,476	3,189	N/A (~ 3,000?)	~ 9,665

There would be about 100 visits/month required of each trained PHCW and trained CHP to reach full coverage for all eligible children in a year. The beneficiary population will be

encouraged to enroll in nutritional activities through community mobilization, CHPs, and health workers and enrolled by a weight-for-age classification.

4b.3 Nutrition Improvement for Pregnant and Lactating Women This project does not have any objectives directed towards the nutritional improvement for pregnant and lactating women.

4b.4 Supplementary Foods This project does not have any objectives or activities directed towards supplying families with supplementary foods.

4b.5 Health Messages The project will provide educational messages on the nutrition of infants and children. In addition mothers will receive appropriate nutrition messages related to their own nutritional status but this will not be a focus of this project. Nutritional health messages are found in Appendix C.

An ethnographic study focusing on identifying nutritional practices and beliefs that are culturally based will be conducted with the assistance of an external consultant. Informal discussions with CHPs, lectures during women's gatherings, and participatory dialogues with the help of flip charts, drama and colorful posters will be educational methods used to emphasize nutritional messages. The project will train PHCWs and CHPs to educate mothers. The project will counsel mothers during pregnancy about early breast feeding and methods for exclusively breast feeding.

Reference Materials

1. *Demographic and Maternal and Child Health Survey 1991/1992*. Demographic and Health Surveys, Macro International Inc. March 1994.
2. *The First National Five-Year Plan for Health Development in Republic of Yemen*. Ministry of Public Health: Sana'a, Yemen. 1996.
3. *Growth Monitoring and Promotion: the Behavioral Issues*. Ann Brownlee, Ph.D. 1990. The Office of Health, U.S. Agency for International Development.
4. *The Situation of Children and Women in the Republic of Yemen 1992*, UNICEF.

Section D4.c Control of Vitamin A and Other Micronutrient Deficiencies This project does not have any objectives directed towards the control of Vitamin A and other micronutrient deficiencies.

Section D.4d Detailed Plans by Intervention - Diarrhea Case Management

4d.1 Baseline A child is exposed to an average of 9 episodes of diarrhea per year (*The First National 5-Year Plan for Health Development in Republic of Yemen, 1995*). Local data is not available, but it is assumed to be higher. Diarrheal disease is the highest during the summer months of June through August. "Diarrheal diseases are responsible for 57% of total morbidity of the gastro-intestinal system. It is the underlying cause for 25% of total mortalities among under 5 children. Dehydration occurs in 37% of diarrheal cases, half of them are severe. It is estimated that 69% of the diarrheal cases are not treated by ORS. Among the causative agents are: giardia, amoeba, salmonella, shigella and enteroviruses" (ibid., 1995). According to Dr. Mohammed Talib, Director of Hais Health Center, 25% of diarrhea cases are dysenteric and 5-6% of those are resistant to antibiotics. Baseline estimates

indicated that 59.0% of infants less than 24 months of age in the project area had diarrhea in the past two weeks.

4d.2 Knowledge and Practice Normally, mothers do not seek treatment for diarrhea until the child shows signs of severe dehydration. 28.3% of mothers treat with at least one of the categories of ORT including ORS packets, sugar-salt solution, cereal based ORT and other locally prepared fluids. 73.8% were breast-fed the same or amount than usual during the child's diarrhea. 60.7% were being given fluids (other than breast milk) the same amount or more than usual. 29.0% of the children were given more the same or more food as usual (other than breast milk) during the diarrhea episode. 46.2% gave their child anti-diarrheal or antibiotics as treatment for their child's diarrhea.

4d.3 Case Management of Diarrheal Diseases Objectives

Objective	Baseline %	EOP %
Increase the number of women responding appropriately to diarrheal episodes in their children 0-23 months. Appropriate practices		
Continued Breast Feeding: Increase the percent of infants/children less than 24 months of age with diarrhea in the past two weeks who were given the same amount or more breast milk.	73.8	84
Continued Fluids: Increase the percent of infants/children less than 24 months of age with diarrhea in the past two weeks who were given the same amount or more fluids.	60.7	75
Continued Foods: Increase the percent of infants/children less than 24 months of age with diarrhea in the past two weeks who were given the same amount or more food.	29.0	45
ORT Use: Increase the percent of infants/children less than 24 months of age with diarrhea in the past two weeks who were treated with ORT.	28.3	45
Increase the percent of mothers of infants/children less than 24 months of age who know two or more correct symptoms indicating the need to seek trained health care.	67.5	80
Increase standard case management (SCM) of diarrheal episodes being practiced to 80% of health service facilities.	*	80
40% of retail outlets selling ORS will consistently educate clients in the need for and proper use of ORS.	*	40

* Facility surveys will be conducted to determine the baseline percentages

4d.4 MOH Protocols and Practices The MOH protocols conform to WHO standard CDD treatment charts. Protocols are outlined for several case categories: management of acute diarrhea in children and infants and for the management of the patient with some dehydration, severe dehydration, persistent and/or dysentery. Attention is also

given to nutritional management of acute diarrhea, drugs in management and prevention of diarrhea. The MOH recommends and makes available the ORS packets for government health facilities and sales by private retailers. However, the supply is not adequate for use in the PHCUs. Due to the state of most health centers, including the fact that

the PHCUs are inactive or marginally active, there is little or no education regarding appropriate home management, including seeding medical care for diarrheal episodes. Casual observation of health personnel also indicates deficiencies in SCM of diarrheal episodes in health facilities. The MOH recommends the use of ORS packets. Further discussions with the MOH will research the possibilities of promoting the use of cereal-based ORT, especially since national productions have been reduced and the supply may be inadequate. Discussions with mothers indicate the use of *shabisa*, a porridge-like mixture of several grains. Health workers sometimes suggest this as a treatment of diarrhea. The recipe is as follows:

- ½ spoon lentil flour
- 2 spoons of wheat or sorghum flour
- 1 spoon of oil
- 1 glass of water
- 2 spoons of milk powder
- a little bit of sugar

This recipe appears to have the nutritious elements but does not seem to contain an adequate amount of fluids (water). Health education messages will promote this to be used as a food in addition to ORS treatment. Formative research in the form of focus groups will aid the project in developing and promoting a locally appropriate cereal-based ORT.

4d.5 Approach CDD intervention activities began with refresher training for supervisors. PHCWs and other health center staff on SCM and the participatory self-monitoring program. Initial training in SCM also includes the use and retailing of ORS, and negotiations will be made with the community committees, empowering them to provide health education messages regarding the treatment of diarrhea and the use of ORS at the time of sale. The project will pilot test the use of advertising and educational materials to be provided for the retailers to encourage appropriate messages through these sources. PHCWs will continue to train LDCs and CHPs in the communities of their catchment areas. In turn, CHPs will continue to promote and educate community members in ORT. They will target mothers and caretakers specifically through women's normal social networks, in their homes and during monthly vaccination/weighting days for infants and children. LDC mobilization will assist health workers and CHPs in the promotion of ORT health messages and in the maintenance of an ORS packet supply. Collaboration with local schools and teachers will facilitate child-to-child and child-to-parent health education by encouraging the use of health education curriculum in regards to diarrhea, its treatment and prevention. The MOH protocol for home management of diarrheal diseases follows the standard WHO guidelines. This involves explaining to the mother the rules for treating diarrhea at home and teaching her how to use the ORS solution to prevent dehydration.

CDD activities of this project will be phased in by strengthening existing health centers and units through training and sustaining the supply of ORS packets. The involvement of communities supporting those health units will constitute the next phase. This will be accomplished by PHCWs training LDCs and CHPs to provide mothers with messages for home management of diarrheal episodes and the prevention of diarrhea. The last phase will include reaching out to the peripheral communities through these same channels and given the same messages.

Prior to implementation of the CDD intervention, simple surveys organized by the formative research coordinator will determine baseline data regarding SCM of diarrheal episodes in health service facilities and the knowledge and counseling practices of ORS retailers with their clients on the treatment of diarrhea. Data obtained from these surveys will be used by the health and training coordinators to develop appropriate health education training for these two target groups and administered accordingly.

CHPs and mothers will be taught the signs and symptoms for seeking trained health care. These signs and symptoms include the following: 1) passes many stools; 2) is very thirsty; 3) has sunken eyes; 4) has a fever; 5) does not eat or drink normally; 6) seems not to be getting better. CHPs are already respected community members, and the women seek their advice during formal and informal gatherings. The CHPs will be trained to refer the mothers with children with the above signs or symptoms to PHCWs. Careful assessments will be made by the PHCW, and for the most severe cases, refer the patient to the health center for treatment by a physician.

The current system for assessing and treating diarrhea cases are according to MOH protocol set by WHO (see Appendix F for specifics). Assessment begins with an inquiry by the health care provider. The condition of the patient is then assessed by sight and touch. The temperature is taken if necessary and if possible the weight of the patient. A decision must then be made to determine the treatment plan (A, B, C according to WHO protocol) depending on the results of the above assessment. Treatment plan A involves education of the mother on treating the patient in the home (inclusive of ORS preparation since this is national policy). Treatment plan B involves treating the patient with ORS at the health unit and reassessment after 4 to 6 hours. Treatment plan C is followed for severe dehydration and calls for the administration of IV fluids by the PHCW or urgent referral to the nearest health center or unit that can provide this treatment. Case management of dysentery at the health center referral level is not at an acceptable level. This is due to poor scheduling of services, insufficient supplies of medications and lack of trained personnel in SCM. Project plans to improve case

management practices include providing refresher training for supervisors and PHCWs and ensuring the distribution of ORS packets to the community level through the work of health workers, CHPs and retail outlets. Supervisors will thus be empowered to carry out responsibilities of supervision and observe the practices of PHCWs in their environment. A secure supply of ORS packets will enable health care providers to follow the guidelines set for them.

4d.6 ORS

UNICEF has assisted the government in producing ORS packets within the country. They are distributed through public and private channels. The public distribution system has provision by the MOH to the governorate CD office and each health center obtains supplies from that source. Packets through the MOH services (hospitals, health centers and units) are free while those from the private sector are cost 10-15 rials/packet (approx. 10-15 cents). The project will monitor mothers' skills in ORS preparation and use through reported practice and return demonstrations to health workers and CHPs in the mothers' homes and health centers.

4d.7 Home Available Fluids

The project will promote the use of home available fluids, with emphasis on cereal-based solutions. Mint tea (nana) and rice water are available fluids that are appropriate to promote for the prevention of dehydration. The recipe for making the rice-water is as follows:

Step 1 - take one fistful of dry rice grains (20-25 grams); wash and soak in water until soft.

Step 2 - grind the soaked rice with a mortar and pestle (or grinder) until it becomes a paste.

Step 3 - add three and a half glasses of water (about 600 ml) to the paste and place it in a cooking pot.

Step 4 - stir well and boil the mixture to a boil until the first bubble appears. Take the pot off the fire and allow to cool.

Step 5 - add one "three finger" pinch of salt to the mixture and stir well

Storage: Keep the solution in a cool, clean place and use it within 6-8 hours.

4d.8 Health Education

Specific health messages to be given mothers about how to administer ORS or different fluids to a child with diarrhea are included in Appendix C. An overall look at key message will include nutritional management with continued breast feeding and feeding during episodes, extra food for two weeks following episodes, increase of fluids during episodes and treatment with ORT. Messages also include proper care seeking if diarrhea persists more than two weeks, if there is blood in the stool, or if signs of dehydration are present. Prevention will be promoted through breast feeding,

immunization, use of latrines, clean drinking water and the washing of hands with soap before touching food. Medicines will not be encouraged except on medical advice. Further education materials will come from *Facts for Life* and WHO protocol section for treatment of diarrheal at home. Methods and materials will be developed from results of formative research to discover existing beliefs and practices in more detail. This development of educational materials will also be done in collaboration with the literacy program and the MOH.

Educational methods to be used in training will include illustrated group discussions, demonstrations and return demonstrations and drama. Composing charts and short verses as a means of increasing health message retention is a method that will be explored, since they are a culturally appropriate method for memorization. Sessions will be organized at health centers and units on prearranged days well-promoted by the LDCs and CHPs. They will be conducted during morning clinic sessions by health workers for mothers attending the facility with their children. Sessions done in homes are organized at the discussion of CHPs.

The quality of health education will be nominated by supervisory observation of training that PHCWs do with the assistance of check lists. Spot checks of mothers' knowledge on ORS preparations will be done by supervisors to determine the retention and effectiveness of PHCWs training. Return demonstrations will be one method used by supervisors. Mid-term and final evaluations will also reveal the impact of CDD interventions in the project area.

4d.9 Prevention

The project will educate caretakers about specific ways to prevent diarrhea. The messages to be promoted are noted in Appendix C. Prevention will also be promoted through appropriate breast feeding practices, completion of the immunization schedule (particularly measles), use and maintenance of latrines, clean drinking water and the washing of hands with soap before touching food. These activities will provide an additional opportunity for community involvement and contribute to the prevention of diarrheal disease. This project does not address construction of water supplies or sanitation facilities.

4d.10 Population

Beneficiary Population for CDD:

0-11 Months	12-23 Months	24-35 Months	Total
3,476	3,189	N/A (~ 3,000?)	~ 9,665

CHPs will need to make approximately 50 mother contacts/yr in order to reach the desired level of coverage of ORT knowledge and use. CHPs will be made on an informal basis during women's meetings and gatherings, weddings, and other contacts.

Reference Materials

1. *Communication for Child Survival*. Rasmuson, M., Seidel, R., Smith, W. And Booth, E. 1988. Academy for Educational Development, USAID: USA.
2. *Demographic and Maternal and Child Health Survey 1991/1992*. Demographic and Health Surveys, Macro International Inc. March 1994.
3. *Facts for Life*. UNICEF. 1993. P&LA: United Kingdom.
4. *The First National Five-Year Plan for Health Development in Republic of Yemen*. Ministry of Public Health: Sana'a, Yemen. 1996.
5. *MCH Guidelines for Health Education*. Kaastra, Hieke. 1990. Dhamar Rural Health Project, SNV-Netherlands Development Organization: Republic of Yemen.
6. *The Situation of Children and Women in the Republic of Yemen 1992*, UNICEF.

Section D4.e Pneumonia Case Management

This project does not have any objectives directed towards the pneumonia case management.

Section D4.f Malaria Control This project does not have any objectives directed towards the malaria control.

Section D4.g Maternal and Newborn Care This project does not have any objectives directed towards maternal and newborn care.

Section D4.h Family Planning This project does not have any objectives directed towards family planning.

Section D4.i HIV/AIDS Prevention This project does not have any objectives directed towards the prevention of HIV/AIDS.

D.5 Schedule of Field Project Activities

DIP Table C: Field Schedule of Activities

(Check box to specify Quarter and Year)

PVO: ADRA COUNTRY: Yemen	Year 1				Year 2				Year 3				Year 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in Position																
a. Project Manager	x															
b. Asst. Project Manager	x															
c. Health/Training Coordinator		x														
d. Community Dev. Coordinator		x														
e. HIS/QA Coordinator		x														
f. Formative Research Coord.			x													
g. Community Health Promoters			x													
h. Other Support		x	x													
2. Baseline Survey																
a. Design/Preparation	x															
b. Data Collection and Analysis	x															
c. Feedback to Community	x															
3. DIP Preparation	x	x														
4. Health Information System																
a. Consultants to Design HIS	x															
b. Develop and Test HIS			x		x		x									
c. Feedback to Community				x	x	x	x	x	x	x	x	x	x	x	x	x
5. Training																
a. Design		x														
b. Training of Trainers			x		x		x									
c. Training Sessions			x	x	x	x	x	x	x	x	x	x	x	x	x	x
d. Eval. - Knowledge of Skills			x	x	x	x	x	x	x	x	x	x	x	x	x	x
6. Procurement																
a. Supplies																
- Pharmaceuticals						x										
- Other	x	x								x						
b. Equipment	x	x	x													

Section E Human Resources

E.1 Organizational Chart (See Appendix G for ADRA/Yemen organizational chart.)

E.2 Training and Supervision Summary

DIP Table D: Training and Supervision Summary

Trainee	Course Title	No. of Hours		Supervisor	Contacts	
		Per Month			Per Mo.	
Job Title		Initial	In service			Interventions
PHC Supervisor	EPI TOT and Supervision	30	12	Governorate EPI Coordinator	1	EPI
PHC Worker	EPI Refresher	30	12	District PHC Supervisor	1	EPI
Local Development Committee	EPI Orientation	4	0	District PHC Supervisor and Local PHCW	1	EPI
Community Health Promoter	EPI Introduction	12	6	Local PHCW	1	EPI
Primary School Teachers	EPI Introduction Lesson Plans	12	0	District PHC Supervisor	1	EPI
PHC Supervisor	CDD and Nutrition TOT and Supervision	30	12	Governorate PHC Coordinator	1	CDD and Nutrition
PHC Worker	CDD and Nutrition Refresher	30	12	District PHC Supervisor	1	CDD and Nutrition
ORS Retailers	CDD and Nutrition Introduction	12	0	District PHC Supervisor	1	CDD and Nutrition
Local Development Committee	CDD and Nutrition Orientation	4	0	District PHC Supervisor and local PHCW	1	CDD and Nutrition
Community Health Promoter	CDD and Nutrition Introduction	12	6	Local PHCW	1	CDD and Nutrition
Primary School Teachers	CDD and Nutrition Introduction and Lesson Plan	12	0	District PHCW Supervisor	1	CDD and Nutrition
PHC Supervisor	Growth Monitoring TOT and Supervision	30	12	Governorate PHC Coordinator	1	GM
PHC Worker and Agricultural Extensionist	GM Refresher	30	12	District PHC Supervisor	1	GM
Local Development Committee	GM Orientation	4	0	District PHC Supervisor and local PHCW	1	GM
Community Health Promoter	GM Introduction	12	6	Local PHCW	1	GM
Primary School Teacher	GM Introduction and Lesson Plan	12	0	District PHC Supervisor	1	GM
Agricultural Extensionist	Kitchen Gardens TOT and Supervision	30	12	Zonal AE Supervisor	1	Nutrition
PHC Worker	Gardens Introduction	12	3	District PHC Supervisor	1	Nutrition
Local Development Committee	Gardens Introduction	4	0	District PHC Supervisor and Local PHCW	1	Nutrition
Community Health Promoter	Gardens Introduction and Practice	30	6	Local PHCW and AE	1	Nutrition
Primary School Teachers	Garden Introduction and Lesson Plan	12	6	District AE	1	Nutrition
TOTAL		364	117		21	

E.3 Training and Supervision Plan Health education and training is a major component of this project (see Table D for training and supervision summary). The overall design of the project training program includes several levels. First of all, the 3 PHC supervisors, 16 male and 6 female PHCWs and 2 midwives who already exist in the local health centers and units will be given refresher training. More specifically, supervisors will be updated on their knowledge and supervisory and training roles in each of the interventions. The supervisors will then be responsible for the refresher training of the PHCWs and midwives of health centers and units with the assistance of MOH training personnel, also for each of the interventions.

In turn, PHCWs will train *jeddah* and other interested women to be CHPs. These women are interested in improving their knowledge of basic health messages to be shared with their neighbors and community. LDCs will be initially trained to conduct efficient meetings, discussions and functions. They will also receive follow-up training in short one-day sessions on the basic CS activities of each intervention as they are introduced. LDCs have the responsibility of identifying and recruiting local *jeddah* and other interested women.

For those health workers already working within the framework of the health care system, practice sessions in the field does not apply to their training. MOH training plans always include a pre- and post-test evaluation of PHCWs. On the job evaluations will be done on a monthly basis and carried out by the district supervisor. There is a 1:8 ratio of supervisors to PHCWs for the entire project area.

This project plans to facilitate the identification and recruitment of approximately 12-15 women interested in obtaining *murshadaat* (female PHCW) training and the same number for TBA (traditional birth attendant) training. This training will be done at the Hais Health Center but is not the direct responsibility of ADRA. These training programs are already being planned and conducted by the UNFPA across the nation, but until this point, no students have been enrolled from the Hodeidah Governorate. The development of the LDC will make it possible to mobilize women from the villages of the three districts. ADRA considers the efforts and activities of recruitment necessary in order to increase the number of health assistants in the rural areas.

The MOH is currently either revising or developing their health education curriculum. Contents of the unrevised immunization guidelines for health workers is found in Appendix H (includes EPI and nutrition evaluation tools). There are no set educational materials for nutrition and the control of diarrheal diseases except those included in the PHC Manual for training PHCWs.

E.4 Community Health Workers The total number of community health workers including CHPs to be involved in project activities is approximately 230. Of those, 3 are supervisors, 22 are PHCWs, 2 are midwives and roughly 200 are *jeddahs* or other consulted women of the village. In addition, there will be approximately 100 sheiks and religious leaders who will take a supportive role in project activities. Approximately 30 of these workers are already active or previously trained prior to project implementation. The 200 *jeddah* are active in the sense that they are currently sought for assistance in deliveries, but are not considered TBAs since they have received no formal training. These *jeddah* will be recruited as CHPs and trained by the project in their respective villages. A list of expectations for CHPs will be formulated. In order to encourage participation, accountability and ownership, the CHP will be involved in the creation of this job description document. The supervision of CHPs will be done jointly by the local PHCW and LDC. The 100 sheiks and religious leaders will also be mobilized by the local development committees. The supervisors, PHCWs and midwives that work in the health centers are on the payroll of the MOH. All other PHCWs normally receive their salary from the District Council. The ratio of community workers to number of families is about 1:45. The performance of PHCWs will be evaluated through monthly supervision (inclusive of on-the-job quality assurance checks, annual self-evaluations with dialogue and feedback with supervisors) and monitoring of monthly reports that they submit. Inservice training sessions will provide health workers with the opportunity to improve their performance.

Currently there is no way of determining the attrition rate of enrolled CHPs since this is a new concept. CHPs will need to volunteer themselves, define their own roles and plan their own work. This is done to encourage a sense of ownership of work and responsibility to themselves and their community verses a responsibility to ADRA or the MOH.

Involvement with this project will provide incentives that prevent attrition. These include training opportunities, increased status and recognition by community, career development opportunities, increased self-actualization and the benefits of community participation. There will also be regular meetings to reinforce motivation and enthusiasm. Those who do move away or resign from their position will be replaced through the actions and decisions of the LDCs. Reasons for promoter replacement may be marriage, pregnancy, child care and relocation. LDCs will be encouraged to recruit two women where one is needed to minimize the rate of replacement.

E.5 Community Committees and Groups

The project has specifically hired a Community Development Coordinator whose functions among others will be playing a liaison's role between the project and community groups.

This person will be in contact with these groups on a weekly and monthly basis. There will be approximately 30 LDCs.

The LDC will consist mostly of respected leaders of the community and the respective PHCW of that village. They will be responsible for making decisions related to the CS interventions and other health concerns of the village and overseeing the functions of the CHPs, although the PHCW will work as a liaison between CHPs and the LDC.

Overseeing the functions of CHPs can be summed up with the following activities: supervision, reporting, recognition, refresher training and replacement. The LDC will receive quarterly health situation reports from the PHCW gleaned from the activities of the CHPs. Analysis of the reports by the LDC will enhance problem solving and decision making abilities relevant to needs they present. The LDC will also be responsible for organizing specific health education campaigns for the community.

E.6 Role of Country Nationals Except for the positions of project director and assistant project director, all key CS positions are held by nationals. During the life of the project, key CS staff will be encouraged to enhance their management skills and to take increased responsibility in managerial roles. In addition, the project will create opportunities for training key project staff in the areas related to their work. Opportunities to increase typing, word processing and other computer skills will be possible for the Secretary/Office Manager. The HIS Coordinator, Health and Training Coordinator and Community Development Coordinator may enhance abilities and knowledge by attendance at workshops, seminars or other courses. Field visits to other existing NGOs and health centers in the area will enable project staff to observe and learn from the experience of those responsible for well-functioning projects.

E.7 Role of Headquarters Staff The PVO or regional office support person, is Jim Neergaard, Director ADRA/Middle East Region located in Cyprus. Betty McGraw, Senior Administrator at ADRA/International will provide managerial backstopping. Gail Ormsby, Director of Health, and Dr. Mekebeb Negerie, Associate Director of Health, will provide technical backstopping for this project from ADRA/International in Silver Spring, Maryland. There will be four 7 day trips during the course of the project from the ADRA/Regional Office for administrative purposes. In addition, there will be two 7 day trips each, by the Senior Administrator and Director/Associate Director of Health from ADRA/I for managerial and technical support respectively.

Section F Project Monitoring Health Information System

F.1 HIS Plan Project progress will be monitored according to project activities and services provided to beneficiaries by service, activity and contact-based reporting. Services will be tracked by supervisors and PHCWs, activities by supervisors, PHCWs and LDCs and contact-based reporting by health workers and CHPs. The data collection system will be the responsibility of the HIS Coordinator. The project will focus on developing and utilizing a simple HIS that will be of practical use at the local community level. It will also coordinate with the Hais Health Center, using it as the center for collecting and reporting data from the three districts to be sent to the Governorate Health Office. This will provide basic data on a few parameters at the community level. Registries for the EPI intervention are available through the MOH and additional methods for collecting data on CDD and the nutrition interventions will be developed by this project in collaboration with the MOH. Training sessions will include sections on the timely, appropriate and accurate means of recording.

F.2 Data Variables From the grassroots level, CHPs will also be asked to report their activities through the local PHCW during the monthly meetings of the LDC (See Appendix I for HIS data variable table and other EPI recording forms). The PHCW will consolidate the data to report to the supervisor. The information will be tabulated by CHPs on a weekly basis. Because of the large percentage of illiterate women, special pictorial forms will need to be created. CHPs will be asked to report on the following: 1) number and type of health messages shared; 2) number of home visits and activities with mothers; 3) number of mothers and children referred and/or followed-up on for immunizations; 4) number of mothers and children referred and/or followed up on for growth monitoring; and 5) number of children treated and/or referred for SCM of diarrhea.

As stated the LDC will review these reports on a monthly basis. LDCs will also keep a basic vital events registry of births and deaths and meeting minutes reporting surveillance activities, discussion on reviews of the monthly health reports and garden promotion activities. Most of the health problems encountered will be discussed and solutions proposed through this committee.

Data to be collected by the PHCW include the following: 1) number of CHP training sessions; 2) EPI supplies; 3) number of children immunized and needing follow-up; 4) number of growth monitoring sessions; 5) GM supplies; 6) number of children whose growth was monitored and needing follow-up; 7) number of children with diarrhea and needing follow-up;

8) number of ORS packets distributed; and 9) number of children referred by the CHP and those referred to the health center for further attention. A monthly summary of activities from the PHCU will be sent to a health center to be analyzed. The PHCU and the LDC will receive monthly feedback on the reports. A summary of the district health activities will be prepared by the health center and submitted to the regional Hodeidah Governorate Health Office on a quarterly basis. The HIS Coordinator will be responsible for assuring that ADRA receives the health reports on a regular basis from each level.

There is a plan to do qualitative research through focus groups for the interventions of CDD and nutrition. An external consultant will be asked to train PHCWs to conduct focus group discussions in the villages. Information from these focus groups will be used to increase the general understanding of beliefs and perceptions of the beneficiaries of the target area to develop appropriate health education messages and materials and organize effective health campaigns. Some of the areas to be researched include the following: 1) beliefs of mothers concerning the cause, signs, symptoms and treatment of diarrhea; 2) understanding of existing and revised health messages; 3) perceptions of health workers; 4) beliefs supporting breast feeding practices, introduction-of-foods; 5) understanding of nutritious foods and the relationships between growth, health and nutrition; and 6) perceptions of family gardens, if this is a new concept to enrich family nutrition and the feasibility of such an activity.

F.3 Data Analysis and Use Data will be manually analyzed at the health center and unit levels. The information obtained will be used to make health related decisions relevant to the respective communities. This information will be disseminated to the Governorate Health Office, project staff and further attention. Children who are not completing their immunization schedule will be identified through home visits and encouraged to attend the next immunization session. Mothers of children with diarrhea will also be identified as needing education in ORT or immediate referral through PHCWs through the HIS Coordinator, to the

community through the CHPs and LDCs and a quarterly report will be submitted to the PVO home office by the project director. The data collected on growth monitoring will be used to identify children whose weight is faltering for appropriate follow-up and nutrition counseling. If the problem persists, the child can be referred to the health center for this HIS. These actions will help to improve the coverage and quality of intervention activities.

F.4 Other HIS Issues All information obtained at each level of the health services will be kept confidential. CHPs and health workers will be trained on the importance of maintaining confidentiality of information collected. Furthermore, the interventions of this project do not call for extreme caution.

Materials needed for the HIS include health center and unit based record keeping forms and cards for each intervention, GM and EPI cards, pictorial forms for CHP reporting and summary data collection forms. Computers will be used only for the preparation of reports to the PVO home office. This will prevent dependency on technology and the presence of the PVO for sustainability purposes.

The project has already received technical assistance for the development of a HIS from Henry Kalter, MD of JHU in August of 1995. His expertise in this area was valuable to project planning in general, although in some ways too technical for our project area. The HIS for the EPI intervention will be fully operational by June 1996. The second phase of the project and CDD intervention will be in place by January 1997. By June 1997, the HIS for nutrition should also be fully operational.

Section G - Budget The following five pages are the detailed working budgets for the program. The first two pages are the HQ costs and the filed costs which are paid and managed at HQ for currency and point of payment reasons. The second pair of budgets are the actual costs that are spent and managed in the field.

**ADRA YEMEN
CHILD SURVIVAL XI
Headquarters Budget**

	First Year		Second Year		Third Year		Fourth Year		All Years	
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA
A. Personnel										
1 Direct Backstopping										
a Health Advisor	3,250	1,083	2,321	1,148	2,460	1,217	2,608	1,290	10,639	4,738
b Senior Administrator	4,875	1,624	3,482	1,722	3,691	1,825	3,912	1,935	15,960	7,106
Subtotal Direct Backstopping	8,125	2,707	5,803	2,870	6,151	3,042	6,520	3,225	26,599	11,844
2 Technical support										
a Evaluation			2,100	300			2,150	337	4,250	637
b Accounting	1,075	358	800	267	848	283	899	300	3,622	1,207
c Support staff	1,075	358	800	267	848	283	899	300	3,622	1,207
Subtotal Technical Support	2,150	717	3,700	833	1,696	565	3,948	936	11,494	3,052
Subtotal Personnel	10,275	3,424	9,503	3,703	7,847	3,608	10,468	4,161	38,093	14,895
B. Other HQ costs										
1 Communication										
a Telephone	330	117	371	124	393	131	417	139	1,510	512
b Fax	400	133	424	141	449	150	476	159	1,750	583
c Mail/express	1,100	367	1,166	389	236	412	236	437	2,738	1,604
Subtotal Communication	1,830	617	1,961	654	1,078	693	1,129	735	5,998	2,699
2 Report Preparation	450	150	477	159	506	169	536	179	1,969	656
Subtotal other HQ costs	2,280	767	2,438	813	1,584	862	1,665	914	7,967	3,355
Total HQ.	12,555	4,191	11,941	4,516	9,431	4,469	12,133	5,074	46,060	18,251
Total HQ Field Costs	18,330	1,800	33,430	1,908	23,596	2,022	37,855	2,144	113,211	7,874
Total Field Costs	120,459	100,140	163,820	44,257	143,126	22,798	140,521	24,166	567,926	191,361
19.0 % Indirect Costs	28,755	20,165	39,746	9,630	33,469	5,565	36,197	5,963	138,167	41,322
8.0 % Unrecovered IdC		12,107		16,735		14,092		15,241		58,176
TOTAL PROGRAM	180,099	138,403	248,937	77,047	209,621	48,947	226,707	52,588	865,364	316,984

*Staff
new HQ?*

**ADRA YEMEN
CHILD SURVIVAL XI
Headquarters Field Budget**

	First Year		Second Year		Third Year		Fourth Year		All Years	
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA
A. HQ Field Costs										
1 Consultants										
a. Health	1,550	300	1,643	318	1,742	337	1,846	357	6,781	1,312
b. Senior Administrator	3,100	600	3,286	636	3,483	674	3,692	715	13,561	2,625
c. Evaluation			8,500				9,500		18,000	
d. A-133 Auditor	2,000		2,120		2,247		2,382		8,749	
Subtotal Consultants	6,650	900	15,549	954	7,472	1,011	17,420	1,072	47,091	3,937
2 International Travel/Per Diem										
a. Health	3,000		3,180		3,371		3,573		13,124	
b. Senior Administrator	4,500		6,360		6,742		7,146		24,748	
c. Evaluation			5,500				6,500		12,000	
d. QA/Sustainability					3,000				3,000	
e. DIP wkshp	1,500								1,500	
f. Auditing	2,680	900	2,841	954	3,011	1,011	3,216	1,072	11,748	3,937
Subtotal Travel/Per Diems	11,680	900	17,881	954	16,124	1,011	20,435	1,072	66,120	3,937
Subtotal Consultants + Travel	18,330	1,800	33,430	1,908	23,596	2,022	37,855	2,144	113,211	7,874
Total HQ Field Costs	18,330	1,800	33,430	1,908	23,596	2,022	37,855	2,144	113,211	7,874

**ADRA YEMEN
CHILD SURVIVAL XI
Field Budget**

ITEM	YEAR 1		YEAR 2		YEAR 3		YEAR 4		ALL YEARS		NARRATIVE
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	
A. Salary											
1 Administrative											
a Regional Director		3,750		3,975		4,214		4,466		16,405	1 pm/yr @ 3750/mo w/6% annual inflation
b Country Director		4,840		5,130		5,438		5,765		21,173	4 pm/yr @ 1210/mo w/6% annual inflation
c CS Project Director	7,200		7,200		7,632		8,090		30,122		12 pm/y @\$600/mo w 6% annual inflation
d Asst Project Dir /Intern	4,800		4,800						9,600		Two year startup @\$400/month
e Interns					3,800		3,800		7,600		Interns Field Prcticum--Stipend & Air Fare Subsidy
Subtotal Administrative	12,000	8,590	12,000	9,105	11,432	9,652	11,890	10,231	47,322	37,578	
2 Technical											
a Accountant	2,700		2,862		3,034		3,216		11,811		6pm/y @\$450/m w 6% inflation
b Accounting Clerk	2,100		2,226		2,360		2,501		9,187		6pm/y @\$350/m w 6% inflation
c Health/training Coordin	3,000		6,360		6,742		7,146		23,248		1/yr 6 pm 2-4 /yr 12 pm @\$500/m w 6% inflation
d HIS/QA Coordinator	1,800		3,816		4,045		4,288		13,949		1/yr 6 pm 2-4 /yr 12 pm @\$300/ m w 6% inflation
e Community Coordinato	2,800		5,088		5,393		5,717		18,998		1/yr 7 pm 2-4 /yr 12 pm @\$400/ m w 6% inflation
f Formative Cord.	2,400		2,544		2,697				7,641		1-3 yr 6 pm @ \$400/m w 6% inflation
g Garden Promoter			2,544		2,697		2,858		8,099		2-4 yr 6 pm @ \$400/m w 6% inflation
h Health Workers	1,500		3,180		3,371		3,573		11,624		HW's & AgExt 1/yr 6 pm 2-4 yr 12 pm @ \$250 w 6% inf
Subtotal Technical	16,300		28,620		30,337		29,299		104,556		
3 Support											
a Cashier/Office Mnger	2,400		5,088		5,393		5,717		18,598		1/yr 6 pm 2-4 /yr 12 pm @\$400/m w 6% inflation
b Custodial	160		254		269		285		969		1/yr 8 pm 2-4 /yr 12 pm @\$20/m w 6% inflation
c Security	160		254		269		285		969		1/yr 8 pm 2-4 /yr 12 pm @\$20/m w 6% inflation
d Driver	1,500		3,180		3,371		3,573		11,624		1/yr 6 pm 2-4 /yr 12 pm @\$250/m w 6% inflation
Subtotal Support	4,220		8,776		9,303		9,861		32,159		
Subtotal Salaries	32,520	8,590	49,396	9,105	51,072	9,652	51,050	10,231	184,037	37,578	
B Fringe Benefits											
a Expat allowance	18,200	10,200	44,600	10,812	30,300	11,461	40,300	12,148	133,400	44,621	Shipping, Homebase, allowances,
b Expat housing	2,640		5,597		5,933		6,289		20,459		Housing rent.
Subtotal Fringe	20,840	10,200	50,197	10,812	36,233	11,461	46,589	12,148	153,859	44,621	
Total Personnel	53,360	18,790	99,593	19,917	87,305	21,112	97,638	22,379	337,896	82,199	

*allowed
2 USAID*

ITEM	YEAR 1		YEAR 2		YEAR 3		YEAR 4		ALL YEARS		NARRATIVE
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	
C. TRAVEL											
1 Domestic											
Hotel, perdiem, taxi	1,500		2,000		2,000		2,000		7,500		
a Training	1,000		2,000		2,000		2,000		7,000		Travel & perdiem for TOT and Trainers
Subtotal Domestic	2,500		4,000		4,000		4,000		14,500		
2 International											
1 PHC conferences	2,092		1,600		2,400				6,092		Regional CS Conference
Subtotal International	2,092		1,600		2,400				6,092		
Subtotal Travel	4,592		5,600		6,400		4,000		20,592		
D Equipment											
a Vehicle		22,000								22,000	1 Toyota land cruiser
b Motorcycles		8,000								8,000	4 motorbikes @ \$2000
c Computers		5,000								5,000	2 Computers+ software
d UPS	680								680		Uninterruptible power supply
e Printers	1,500								1,500		1 dot matrix/1 ink jet
f Fax machine		700								700	Fax machine
g Typewriter	750								750		Office typewriter
h Cold Chain equip.		10,000								10,000	5 Solar Refrigerators @ 2,000
i Generator		12,000								12,000	Generator for staff housing
j Air conditioners		6,150								6,150	3 21,000 BTU @ \$750, 6 18,000 BTU @ \$650
k Copier	3,000								3,000		Photocopier
l Office furniture	3,500	1,000							3,500	1,000	Desks, chairs, files
Subtotal equipment	9,430	64,850							9,430	64,850	
E Supplies											
a Office Supplies	1,450		1,537		1,629		1,727		6,343		Routine Office Supplies, paper, etc.
b IEC supplies	1,850		1,600		1,000		1,000		5,450		Information, Education, Communication supp.
c Project Identification	2,000		2,120		2,247				6,367		Notebooks, signs, tags etc. for VHWs
d Scales			2,000		2,000				4,000		40 2nd yr, 40 3rd. yr at \$50
Subtotal Supplies	5,300		7,257		6,876		2,727		22,160		

ITEM	YEAR 1		YEAR 2		YEAR 3		YEAR 4		ALL YEARS		NARRATIVE
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	
F Contractual											
1 Consultancies											
a MOPH Training	750		750						1,500		50 days/year @\$30
DIP orientation	850								850		5 days/year @ \$170
b TOT	750		750						1,500		50 days/year @\$30
c IEC/Formative research	2,250								2,250		20 days/year @\$30
d Cost Recovery	1,000								1,000		4 days/year @250
Subtotal Contractual	5,600		1,500						7,100		
G Other Direct Costs											
1 Training											
a HW/CHW Training	8,500		13,500		10,000		5,550		37,550		Training of supervisors, health and volunteer workers
b Professional Training	2,500		2,500		2,500				7,500		Staff training and upgrading
Subtotal Training	11,000		16,000		12,500		5,550		45,050		
2 Communications	2,400		2,544		2,697		2,858		10,499		Telephone, fax, express mail
3 Facilities											
a Office Rental		1,500		1,590		1,685		1,787		6,562	Central office space
b Equipment Insurance	500		530		562		596		2,187		Insurance against loss of equipment
c Utilities	2,867		4,558		4,831		5,121		17,378		Electricity, water and phone-line charges
Subtotal Facilities	3,367	1,500	5,088	1,590	5,393	1,685	5,717	1,787	19,565	6,562	
4 Other											
a Printing	4,000		4,000		4,000				12,000		Mnuals, IEC Mat, HIS Frms, Grwth Chrts (25,000 @ .05)
b Development of IEC m	1,500		1,500						3,000		Artwork, Design, Pretesting Ect.
c Surveys	4,960		2,000				3,000		9,960		
d DIP orientation	1,200								1,200		
e Formative Research	1,800		1,800						3,600		Field research activities/reporting
f Literacy training		5,000		5,000						10,000	Basic literacy training
g SED Project		10,000		17,750						27,750	Small credit programming
h Vehicle Fuel/Oil	3,600		4,876		5,169		5,479		19,123		For Vehicle and motorcycles
i Vehicle Maintenance	2,000		5,200		5,512		5,843		18,555		For Vehicle and motorcycles
j Vehicle Mileage	5,000		4,000		4,240		4,494		17,734		Rental of SED/Lit & Admin Vehicles
k Vehicle Insurance	1,350		2,862		3,034		3,216		10,461		For Vehicle and motorcycles
Subtotal Other	25,410	15,000	26,238	22,750	21,954		22,031		95,633	37,750	
Subtotal Other Direct Costs	42,177	16,500	49,870	24,340	42,545	1,685	36,156	1,787	170,748	44,312	
TOTAL FIELD COSTS	120,459	100,140	163,820	44,257	143,126	22,798	140,521	24,166	567,926	191,361	

Section H - Sustainability Strategy

H.1 Sustainability Goals, Objectives and Activities

DIP Table E: Sustainability Goals, Objectives, and Activities

Sustainability Goals	Objectives	Activities Required	
Programmatic MOH will maintain health promotion activities of CS project.	PHCWs will maintain functioning health units and outreach immunization/GM sites	Training of PHCWs Ensure supply of needed inputs (e.g. immunizations, cold chain, ORS, basic drugs) Cost recovery scheme	
	Regular supervision and quality assurance of PHCWs is institutionalized at health center level by the district supervisors.	Supervision and QA training Monthly visits to PHCUs Monthly meetings with PHCWs	
	Referral system is institutionalized.	Training Monthly supervision visits	
	Continuing education is institutionalized for PHCWs and CHPs by district supervisors.	Monthly meetings for PHCWs Monthly visits to CHPs	
	Local health authorities continue to coordinate with other local institutions.	Meetings with TDA, MOE, etc.	
	Institutional Local institutions maintain health promotion activities of CS project.	LDCs continue to function.	Training Regular meetings
		LDCs will continue to liaison with PHCWs and CHPs of their catchment area to monitor and supervise their activities.	Monthly visits and reports
		HIS is providing accurate data to local and governorate health management and regular feedback to PHCWs and LDCs.	Training of HIS Coordinator Training of LDCs Training of CHPs Monthly supervision reports
		CHPs continue to promote good health behavior.	Training Monthly meetings with PHCWs and LDCs
	Teachers continue to give health lessons.	Training Yearly planning meeting with local health authorities	
Financial Costs of CS and health promotion activities are either met locally or through some other institutionalized means.	Cost recovery system for local health services.	Design system Training for management	
	Participation of LDCs in development of health services through time, cash or kind.	Mobilization meetings with LDCs	
	Revolving drug and garden funds continue to function without losing capital.	Design of funds Management training Monitoring by LDCs	

H.2 Sustainability Plan The project plans to promote sustainability at three levels: programmatic, institutional and financial. The project is designed to produce programmatic sustainability in that it does not rely on a separate service delivery system, but rather uses the existing MOH structure and works to enhance its capacity to provide service to its constituents. Consequently, MOH preventive and curative services may continue throughout the project period and beyond.

The project also fosters institutional sustainability by its inclusion of established, local organizations during all project phases. Local development committees at the district level were at one time a well established body of decision makers that worked at the grass-roots level. The government, seeing that this was a successful means of development co-opted their efforts and created a Ministry, which eventually caused disillusionment and abandonment. ADRA seeks to reestablish these types of community-based committees to aid in the health and development of villages and support the work of CHPs. The Hais and Khokha Health Centers, through which project activities will work, are permanent indigenous medical institutions which will continue to function beyond the project period. Local schools are a third established institution that ADRA will empower to carry on sustainable health promotion activities.

The third level of financial sustainability will be done gradually through activities initiated by the project. One of these activities is the introduction of fees for services at the health units as a cost recovery program and the sale of prescription drugs to operate a drug revolving fund.

H.3 Community Involvement The plan for sustainable community involvement through the work of LDCs is described in sections D.1, E.5 and H.2. Furthermore, a major strategy of this project is to enroll the assistance of volunteer community health promoters. Identification of women willing to be trained as *murshadaat* or TBAs is an activity that will increase the manpower for the district and enable them to continue to positively influence health practices beyond the time period of ADRA's involvement.

These strategies will foster community "ownership" of the preventive health activities of child survival, rather than of the project itself. At the community level, project staff will work with CHPs and LDCs nurturing not only their approval of the activities, but also their leadership in implementation. Training and utilizing these community members will establish permanent "interest" groups committed to promoting preventive health practices and encouraging their use on the part of mothers. Only this level of direct

ownership can lead directly to community support for health activities.

Discussions with community leaders reveal four issues of top priority (not necessarily in that order): 1) the improvement of mothers' knowledge in health care of her family; 2) improvement of nutritional status; 3) development of the health center facilities and 4) better EPI services and coverage.

Current health center and unit staff exhibit an attitude of eagerness and willingness to cooperate with ADRA in its philosophy, principles and activities and there is evidence that community members desire child survival services. Sheikhs, religious leaders and other community leaders have also welcomed ADRA to work in their respective communities. In some villages, where immunizations have not been administered, the people are willing to pay for the services (this is officially prohibited by the MOH). During the time of the baseline survey, the communities expressed an interest in knowing the results.

Identification of households with under-twos will be the responsibility of the CHPs. They will cover households that are in the area surrounding their home. It will be initially done during each introduction of the various interventions (phases) and then updated as the intervention progress. This means that surveillance activities will focus on households that have under-twos at any given point of time.

H.4 Phase-over Plan The Hais Health Center will assume many of the responsibilities for the administration of preventive health care services at the end of the project period, although they will already be heavily involved during the course of the project. Discussions about the continuation of certain positions and activities will be initiated near the middle of the project period. Staff from the health centers and units are included in the training activities of the project to strengthen their program management skills so they can better sustain activities.

H.5 Cost Recovery The project will explore the introduction of a small registration fee for services at the health unit level and/or the possibility of other fees for service or drugs to test the feasibility of a revolving drug fund. This will first be done as a pilot study at the health center level. The Hais Health Center has recently initiated a fee for service and uses the funds for a few staff positions and maintenance of the health center. If this continues to show success, its function could be promoted and duplicated at the health unit level. Discussions and negotiations with the LDCs will be used to evaluate the feasibility and acceptability of cost recovery strategies. The Senior Health Manager of the

district in cooperation with the District Council will assume overall responsibility for implementing the project cost recovery strategies. Technical assistance from UNICEF or the Hodeidah Urban PHC Program (run jointly by Dutch Aid and ICD, a British NGO) will be obtained to help design cost recovery activities.

Section I - Literacy/SED

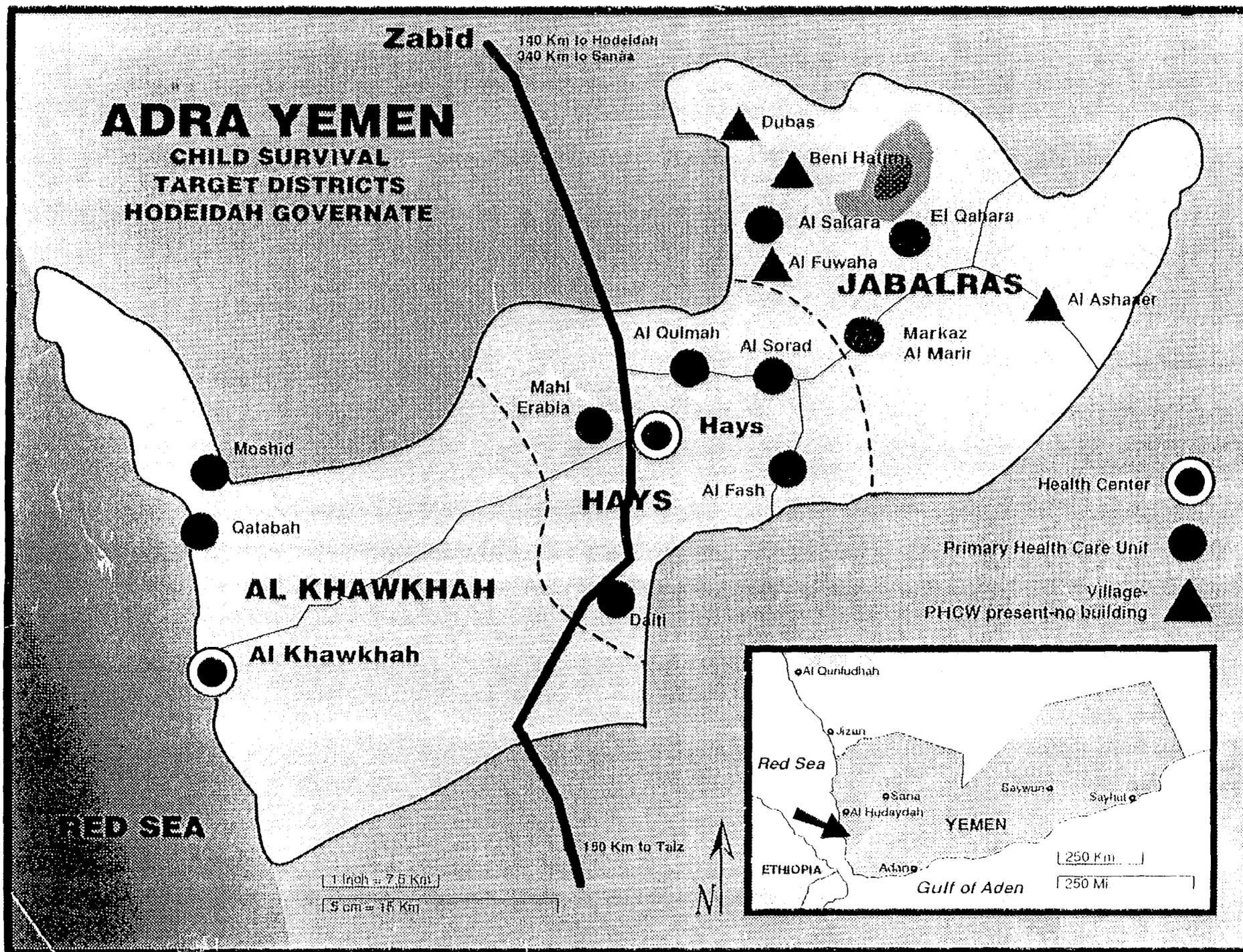
Matching funds will be utilized to develop a functional literacy program and a small enterprise development program. Functional literacy for women will use small village based classes to teach approximately three month literacy courses. The literacy program will be followed by the organization and training of local development committees for managing small loans to families for income generation projects. Linkages between literacy, small credit and CS CHP activities will be created so that access to loans will be contingent on literacy course enrolment and favored access to loans upon

participation in CS activities. All loan applicants must agree to practice as much as possible certain health principles (general hygiene, immunizations, home management of diarrhea, mother/child nutrition) to be eligible for a loan. CHPs will have favored access to loans (for example, access to larger loans or no loan service fee.) ADRA's literacy program began in November 1994. The expanded literacy and small credit program for this CS XI project will begin in April 1996, the third quarter of the first project year. Partial credit of funds from the donor agency, ADRA/Canada, have been recieved and are being utilized for program initiation.

The Literacy/SED program director will initiate activities with a short stay in Yemen to assess the current situation of women in the project area that relates to this type of a program. This will be followed by a six week training course with the Women in Development Program (WID) of ADRA/Bangladesh, which has been successfully operating for a number of years.

Appendix A

Map of Project Location



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Appendix B

ADRA/Yemen Country Agreement

Strategy of Cooperation Agreement between MOPH and the Ministry of Local Administration

Letters of Support

**Agreement
between
The Government of the Republic of Yemen
and
Adventist Development and Relief Agency (ADRA)**

Whereas, Adventist Development and Relief Agency (hereafter referred to as ADRA"), a non-government (NGO), non-profit private organization, provides a way for concerned people in Australia, Europe, and North America, to extend assistance through their voluntary contributions to people in other countries.

And whereas, THE GOVERNMENT of the Republic of Yemen represented by the Ministry of Planning and Development (referred to as THE GOVERNMENT) desires that ADRA work in the REPUBLIC OF YEMEN, in cooperation with THE GOVERNMENT and the people of Yemen.

And whereas, THE GOVERNMENT and ADRA intend, to the extent that their respective resources, interests and abilities permit, to enter into one or more project Activity, call for the joint efforts of ADRA and THE GOVERNMENT:

Now, therefore, THE GOVERNMENT and ADRA agree as follows:

Article (1)

a) As used in this document, term "Project Activity" shall mean any and all activities carried out in whole or in part by ADRA for the benefit of the people of Yemen; "Project materials" shall mean any and all commodities, food, medical supplies, equipment vehicles, material and other property used, owned or in the possession of ADRA in connection with project activities, or for distribution to the people of Yemen.

b) ADRA may furnish assistance to the people of Yemen through project activities in development, relief, rehabilitation, reconstruction or other fields of high priority to the Government. This activity will be subject to the terms of a Project Activity Agreement between ADRA and THE GOVERNMENT.

c) Project Activity Agreement concluded with one of more Ministries or Agencies of THE GOVERNMENT and considered to be supplementary to this Agreement. Each Project Activity Agreement shall define the financial, administrative, technical and other responsibilities of the various parties.

Article (2)

In response to its desire to assist THE GOVERNMENT and promote development for the people of Yemen, ADRA will:

- a) **Open a branch office in Sana'a with the objective of implementing community-based integrated development projects, promoting self-sufficiency, so that people can build a better life for themselves and their children.**
- b) **Evaluate community needs, and in consultation with THE GOVERNMENT, design projects and prepare proposals to address these needs.**
- c) **Solicit contributions from ADRA donors around the world to support Project activities.**
- d) **Use such contributions to furnish materials, management and technical services, and such other assistance as called for in the Project Activity for the benefit of people of Yemen.**

Article (3)

In recognition of the benefits of ADRA's activities to the welfare and development of the Republic of Yemen, in accordance with the enforced Laws and Regulations, THE GOVERNMENT will:

- a) **Exempt ADRA from payment of all taxes, duties, fees or restrictions imposed for the importation or exportation of all administrative or project materials, vehicles or equipment.**
- b) **Levy no taxes or fees (including income, property, sales and excise taxes) on ADRA, its property or operations, or on the salaries, allowances, or other remuneration for personal services paid by ADRA to its personnel of non-Yemeni nationality.**
- c) **Ensure that no project materials furnished for approved projects shall be requisitioned or diverted for uses other than those agreed upon by THE GOVERNMENT and ADRA.**
- d) **Enable ADRA to exchange foreign for Yemen currency, and Yemen currency for foreign currency, at rates of exchange no less favourable than those accorded to other organizations and governments according to the followed systems and regulations thereof.**
- e) **Admit into Yemen such number of non-Yemeni personnel as the two parties may deem necessary to fulfill its obligations under this Agreement, and other Project Activities pursuant to the enforced Laws and Regulations.**
- f) **To facilitate the arrival, stay and departure of ADRA's guests and consultants coming to Yemen, by the issuing of necessary permissions and visas.**
- g) **Grant to all ADRA's non-Yemeni personnel and their families the same exemptions from restrictions and fees concerning registration, entry visas, work permits, residence permits, exit permits and similar matters, as well as providing the same**

privileges of importing and exporting personal effects as are accorded diplomatic representatives of foreign governments.

Article (4)

Any dispute that may arise between ADRA or between one of its organizations or Agency and THE GOVERNMENT with respect to implementation or the interpretation of this Agreement shall be settled through negotiation between the two parties. In case of failure the courts of the Republic of Yemen shall be the jurisdiction authority adjudicating such dispute.

Article (5)

This Agreement will come into effect from the date of signature. It will last for a period of three years, and is automatically renewed for similar periods. Either party may terminate this Agreement upon ninety (90) days prior written notice to the other party. In addition, in the event of war, hostilities or other grave public emergency, ADRA, also may terminate performance of its obligations under this Agreement and any or all Project Agreements without prior notice, to the extent and at such times as ADRA may deem necessary to ensure the safety of ADRA's personnel and property.

Article (6)

Done at Sana'a, Republic of Yemen, on this day 16 February 1994 / 6 Ramadan 1414, in two original copies, one each of Arabic and English both texts being equally authoritative and the same interpretation.


Signature for THE GOVERNMENT

16.2.1994

Name: Mr. Abdul Wali Al-Aqil
Title: Deputy Minister for Economic
and Technical Cooperation




Signature for ADRA

16 - Feb - 1994

Name: Mr. James Neergaard
Title: Director, ADRA
Middle East Region

Enhancing and Enforcing Cooperation and
Coordination between Ministry of Public Health and
Ministry of Local Administration with the aim of
Improving the Current Health Status of the Community

(ADRA Translation of Document from Yemen, October 1994)

Introduction:

More than a decade has passed since our country adopted Health for All strategy through PHC approach, which was founded by the Alma Ata Conference in 1978. Since then, the country has witnessed a number of achievements. The biggest achievement has been the construction of an extended network of health units and health centers in urban and rural areas of the country, providing PHC services to deprived and remote areas. It should be emphasized that PHC proved to be the optimal approach towards solving the current health problems with minimum costs upon the community and the state, in spite of the constraints faced.

Community participation in the form of cooperative movement has played an essential role in establishing and enforcing the PHC network. It has contributed extensively in building a number of health units, as well as financially supporting the training of PHC workers for these health units. However, participation remained limited for some time, suggesting a new approach in cooperation and coordination should be considered if promotion of community involvement is sought. Participation should be more profound and comprehensive, actively involving all public social and charity organizations in planning, implementation of health programs and evaluation. This would help to ensure sustainability of PHC activities leading to the progressive health services, quantitatively and qualitatively.

Where the responsibility of the managerial devices of the two ministries is concerned, cooperation and coordination between the two aims at preparing appropriate grounds for establishing an advanced level of a cooperative and coordinative relationship between them. This will ultimately assist in improving the health services delivered and can be achieved through the following:

- MOPH, with its different branches, is responsible for designing the health policies and the technical supervision of health program implementation, as well as the various activities of the health institutions.
- Ministry of the local administration, represented by the cooperative movement, should participate actively in financial and administrative aspects of the health institutions first, and the second levels (from health units to rural hospitals) in selected areas, which are expected to expand gradually in the future.

- Field of cooperation covers all health institutions, urban and rural, regardless of which of the two ministries own these institutions.

For cooperation to be highly effective, it should be based on the following:

- Effective community participation in the field of health services should take place in all stages of planning, implementation and evaluation.
- Close coordination of related sectors should be available in the selected areas within the health sector.
- Adoption of the district health system, which is considered an optimal approach in promoting PHC services and gains strong support of the organizations involved in the health sector.

It is expected that such coordination will achieve the following:

- Improve health services delivery level, ensuring sustainability of performance at the required level.
- Assist in attracting health personnel to work in the rural areas through provision of appropriate climate and all forms of support, financially and morally.
- Encourage training of health personnel, particularly females, in urban and rural areas through facilitating the training and the qualification of these health personnel that the two ministries support strongly for the success of the process.
- Improve the building status of current health institutions through renovations and maintenance. Supply health personnel as required and provide lacking equipment. Establish an appropriate mechanism that ensures continuous supply of essential drugs to these institutions to enable them to carry out their preventive and curative responsibilities appropriately.

Coordination will be carried out at the different levels from top to bottom.

First: At the central level

Form a working group or a committee with representatives from both sides to carry out the following responsibilities:

1. Set a general framework of coordination and cooperation aspects between both ministries.
2. Establish appropriate mechanisms that interpret such cooperation and coordination to achieve the designed objectives as expected from a cooperation and coordination relationship between the two ministries.
3. Give directions to the executive departments at the lower levels to implement the designed policy.
4. Take care of, evaluate and develop the experiment.

Second: At the governate level

A committee represented by both sides is formed, composed of a General Director of Health Office and a General Director for Councils Affairs of the governate and other related individuals. This committee will be supervised by the Governor or his deputy to carry out the following responsibilities:

1. Implement the agreed upon cooperation and coordination at the central level.
2. Select one or two districts for the implementation of cooperation and coordination experience. If successful, the experience can be gradually expanded to the remaining districts in the governate.
3. Periodic reporting to explain the activities undertaken and achievements fulfilled to enable the central working committee to follow-up and supervise.

Third: At the district level

1. At this level, the actual cooperation and coordination between the two ministries starts. It is considered a comprehensive activity, aiming at promoting the health services to a better level. It seeks to expand these services to cover the whole population of the district, if possible.
2. It is important to emphasize that the department represented by the local councils is considered an actual partner in planning, implementation, supervision and evaluation of the health services and not a negative participant, merely responsible for supplying additional facilities to the health services.

3. A health council is formed in the selected district and is headed by the district general director with the membership of the chairman of the local council, a responsible person of the health services in the district, and representatives from other related fields. This health council is responsible for carrying out the following:
 - A. Designing an implementation plan to apply this cooperation after conducting the following:
 - Gather data concerning all existing health institutions, operating and non-operating.
 - Determine the needs of the districts in terms of personnel, furniture, equipment and medical facilities.
 - Determine the financial resources for the health council in the administrative units from the following areas:
 - a. A percentage of the central income of the local council should be determined, not to be less than 10%, or exceed 20%.
 - b. Whatever funding allocated by the MOPH for the health institutions as a support for the district.
 - c. All donations and aids provided for the health council. Organize ways and means for its expenditures.
 - d. Whatever local health duties determined as commitment for the provision of various health services.
 - B. Determine local duties for the provision of various health services.
 - C. Design duty payment regulation for carrying out medical examinations, tests, x-rays, surgical operations, medical reports, etc.

D. The health council financial resources should be allocated for the development of the health services in the district. These resources should not be spent unless the chairman of the local council and the responsible person of the health services in the district give their concurrence. It should be noted that these resources should be spent on the following fields only:

- To pay 50% of the monthly stipend for all trainees, whether the training will be conducted in the district or in the capital of the governorate, and to provide accommodation if the training is in the district.
- To select candidates for training.
- To determine disciplines and criteria required to pay the monthly stipends or rewards to health workers in the health units and health centers or rural hospitals, and to determine the amount of stipends to be paid.
- To pay monthly rewards to the physicians, medical assistants, technicians, midwives and other health workers in the health centers and rural hospitals based on their qualifications, years of experience, area conditions, performance level as clarified in the criteria, and discipline document set by the health council.
- To purchase medical facilities, laboratory materials and x-ray films wherever required.
- To provide the appropriate building for the health unit.
- To provide accommodation with the required furniture and pay for water and electricity bills for those workers coming from outside the district.
- To pay for the expenses of electricity and water, provide fuel, materials for cleaning, gas, stationery and registers, and spare parts for the non-medical equipment for all health units. This is to include renovations and periodic maintenance.
- To provide transportation for health workers from the health institutions to the nearby areas (about five or more kilometers away) to carry out vaccinations or when there is an epidemic in the area.

- In coordination with the health council, the local council should collect donations from the charity associations and wealthy and capable people whenever necessary to face the capital expenses, such as:

- * Renovate or participate in renovating the health institutions which the health council is unable to finance from its own financial resources.
- * Purchase some of the medical equipment and required furniture to operate and develop the health institutions.
- * Build new health institutions or expand and upgrade existing ones.
- * Utilize revenues from what is gained as a result of the investment projects in the provision of medicines.

E. The health council should design an appropriate mechanism addressing the lack of provision of medicines.

F. That which is not included in the commitments of the health council regarding operating and providing the health institutions with their requirements.

G. The health council should send monthly reports explaining achievements and constraints to the governate committee, which is responsible for direct supervision and offering all the support needed by the health council.

Fourth:

This document is considered a bilateral agreement within the framework of cooperation and coordination between the two ministries. It is also considered an experience that can be evaluated, modified and developed in the future.

Minister of Public Health

Dr. Nageeb Saced Ghanem

Minister of Local Administration

Mohamad Hassan Dammaj

((بسم الله الرحمن الرحيم))

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التاريخ 11/11/1996

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الجمهورية العربية اليمنية

وزارة الصحة العامة

مكتب الشؤون الصحية

بمحافظة صنعاء

+++++

المحترم السيد / استشار الصحة لمنظمة أمانة اللاهيات

تحية طيبة ..

السيد /

..... / حول نشاطات المشروع الواحد في محافظة العديدة
بمعرفة أن يسهل لكم بالمسألة التي المقترح الذي ورد في السودة المقدمة
من قبلكم بتاريخ 11/11/1996م الخاصة بتكليف مدخل النشاطات الصحية
في كل من منطقة (حيس) الضواحي (جبل رأس) محافظة العديدة :

1- تنفيذ المشروع في تولى الامتلاكه وتجميع الرأى بالانخراط

والمساهمة في تحسين الوضع الصحي : توسيع رتبة اعطاء اللقاحات
السيطرة على أمراض الاسهالات
تحسين التغذية :

2- التعاون مع القيادات المحلية على تأسيس جمعية ومدرسة لخدمة تطعيم جديد
مقره في الضواحي
مقره في جبل رأس
مقره في حيس

3- تأسيس نظام تسجيل المعلومات الصحية والوليات والمواليد
على المستوى المحلي بالتنسيق مع برنامج الترمذ الوبائي الوطني

بحيث تكون حيس المركز القسبي وتقدم التقارير الى العديدة

4- محو الأمية في حيس مقر قرية (حيس في حيس وحيس في الضواحي
وحيس في جبل رأس .

5- تدريب حيس مقر مدرسة للاسهام الفعال في المشروع

هذا وتاملوا لائق الشكر أملاً ان يكون تعاونا وثقافياً هذا - بر فصح مستوى
الخدمة الصحية وسيدعم المكتب بما يضمن من الخدمة الصحية

مدير عام الشؤون الصحية
صنعاء

مدير الصحة العامة

Under Secretary for
Development Sector,
Ministry of Public Health,
Sana'a, Yemen.

Date: Nov. 11th, 1994

Dear Sir,

ADRA has submitted a proposal to work in the field of health in Hodeidah Governorate in the following districts:

1. Hais
2. Al-Khokha
3. Jabal Ras

The activities of ADRA will mainly focus on developing community involvement in the following fields:

1. EPI
2. Diarrhea Control
3. Nutrition
4. Support and development of Health Information System in coordination with NEDS.

The organization has expressed readiness in supporting and developing the district health system throughout its activities, since it realises that the MOPH emphasises strongly on the development of the district health system based on Primary Health Care. In general, the district health system includes a number of interventions which aim at controlling the existing health problems in the area such as: MCH health problems and communicable diseases; community involvement and intersectoral participation.

For your kind information discussion over this issue has fully taken place between ADRA representatives and the Health Office of Hodeidah. As a result, the Health Office provided, in writing, an agreement to ADRA Proposal with respect to the various activities which will take place in the three above mentioned districts.

Attached are the following copies:

1. ADRA Yemen Proposed Project Activities in Hodeidah.
2. The letter of Agreement of Hodeidah Health Office.

Thus we wish if other related sections in the MOPH be contacted to take the necessary actions regarding the work of the organization in the Republic of Yemen.

Thanking You,

Under Secretary,
for health services sector.
Dr. Ahmed Makki

Director of Public Health
Dr. Abdul Haseem Haanem

The Health Advisor
ADRA,

Date: Nov. 11th, 1974

Dear Sir,

" Project Activities in Hodeidah Governorate"

We are pleased to inform you that we have accepted your project proposal dated Nov. 11th, 1974 regarding health activities to be implemented in the areas of Hais, Al-Khokha and Jabal Ras in Hodeida Governorate which covers the following essential activities for the health of the mother and the child:

1. Encourage the community in providing required facilities and in encouraging women to join and contribute effectively in improving health status, expand vaccination coverage, control diarrhea, and improve nutrition.
2. With the assistance of the local leaders, initiate twenty five new vaccination units- ten in Khokha, ten in Jabal Ras and five in Hais.
3. Establish Recording Health Information System at the local level, in coordination with NEDS, whereby Hais will be the coordinating center which will be responsible for sending reports to Hodeidah Health Office.
4. Illiteracy activities in fifteen villages (five in Hais, five in Khokha and five in Jabal Ras) including the preparation of fifteen teachers to carry out these activities effectively in the community.

We hope our cooperation will ultimately lead to improving health status level of the areas concerned which in turn will be providing support to the Health Office in such aspects of community involvement in health development.

Thanking you.

The General Director
of the Health Office

Dr. Abdul Hafez Kasseem

Director of Public Health

Dr. Muaid. Suhail

In the Name of God

The Honorable General Director of the Health Department in Al-Hodeidah

Greetings,

We are honored to have met with the international relief and development delegation which expressed its desire to help improve the health of the children and their mothers in our society and to lower the mortality rates and diseases among mothers and children in the district village of Al-Oulmah.

We request your cooperation to do what you can according to the system you follow. Thank You.

Written on 8 November, 1994; 1 Jamad Al-Thani, 1415 Hg.

Sincerely,

Al-Sheikh Abdo Muhammed Ali Haig
North Quarter, Hays District
Yemen Arab Republic

In the Name of God

The Honorable General Director of the Health Department in Al-Hodeidah

Greetings,

We are happy and honored to have met, in the countryside school of Gabal Ras, with the international relief and development delegation which expressed, on its first visit to Gabal Ras school, its desire to help improve the health of the children and their mothers in our society, and to lower the illiteracy rates and deseases among mothers and children in the area.

We request your cooperation to do what you can according to the system you follow.

With our best regards,

The Head Sheikh of Gabal Ras,
Sheikh Muhammad Alaa Al-Deen
Muhammad Al-Ameen Al-Nour
Member of Parliament

8 November, 1994

Appendix C

Health Messages

Health Education Messages for Immunizations

It is important to have your child vaccinated as soon as possible and all immunizations should be completed in the first year of the child's life.

It is safe to immunize a sick child.

Vaccination against measles should be given when the child is 9 months old.

It is very important that the child gets all the vaccinations. One or two is not sufficient; the child can still get the diseases.

The Koran states that the parents have to be merciful to their children. They are held responsible for the protection of their children by immunizing them against all six of the dangerous diseases that could harm them. If children have had the vaccinations, they will not get the diseases and will stay healthy.

Every woman between the ages of 15 and 44 should be fully immunized against tetanus.

References

Facts for Life. UNICEF. 1993. P&LA: United Kingdom.

MCH Guidelines for Health Education. Kaastra, Hieke. 1990. Dhamar Rural Health Project, SNV-Netherlands Development Organization: Republic of Yemen.

Health Education Messages For Nutrition

Breast Feeding

Breast milk alone is the best possible food and drink for a baby. No other food or drink is needed for about the first six months of life.

Babies should start to breast feed as soon as possible after birth. Colostrum is like a vaccination for the infant.

Virtually every mother can breast feed her baby.

Breast feeding causes more milk to be produced. A baby needs to suck frequently at the breast so that enough breast milk is produced to meet the baby's needs.

Breast feeding helps to protect babies and young children against dangerous diseases. Bottle-feeding can lead to serious illness and death.

The father should assist the breast feeding mother and ensure her the atmosphere she needs to breast feed.

The Koran states that the mother should breast feed her child for the first two years. Islam considers breast feeding to be a major duty of the mother and should not be hindered by any additional work.

Introduction of Foods

A variety of additional foods is necessary when a child is about six months old, but breast feeding should continue well into the second year of a child's life and for longer if possible.

It is better to let the child slowly get used to drinking from a cup and to other foods and gradually stop breast feeding, than to stop at once.

General Nutrition

If you don't eat enough of certain foods, you can get weak or ill, or your breast milk may decrease.

Vegetables contain a lot of vitamins.

Children from birth to the age of three years should be weighed every month. If there is no weight gain for two months, something is wrong.

A child under three years of age needs food five or six times a day.

A child under three years of age needs a small amount of extra fat or oil added to the family's ordinary food.

All children need foods rich in vitamin A: breast milk, green leafy vegetables and orange-colored fruits and vegetables.

A child that is ill and does not get any food will become weaker and weaker. A sick child needs nutritious food.

After an illness, a child needs one extra meal every day for at least a week.

References

Facts for Life. UNICEF. 1993. P&LA: United Kingdom.

MCH Guidelines for Health Education. Kaastra, Hieke. 1990. Dhamar Rural Health Project, SNV-Netherlands Development Organization: Republic of Yemen.

Health Education Messages for Control of Diarrhea

Symptoms

Symptoms of serious diarrhea include:

- the skin gets 'dry' and looks like the skin of old people
- the child does not urinate anymore, or only a few times a day
- the child gets 'sunken eyes'
- the child sleeps a lot, only a few reactions; no crying
- the child gets a sunken fontanel

Treatment

Diarrhea can kill children by draining too much liquid from the body. So it is essential to give a child with diarrhea plenty of liquids to drink.

If the stools of a small baby become like water, you have to take action immediately, because this can be very dangerous.

A child with diarrhea needs food; never withhold food.

When a breastfed child has diarrhea, it is important to continue breast feeding.

A child who is recovering from diarrhea needs an extra meal every day for at least two weeks.

Trained help is needed if diarrhea is more serious than usual, if it persists for more than two weeks, or if there is blood in the stool.

Medicines other than ORS should not be used for diarrhea, except on medical advice.

ORS - A Special Drink

A special drink for diarrhea can be made by using a packet of oral rehydration salts (ORS). This drink is used by doctors and health workers to treat dehydrated children. But it can also be used in the home to prevent dehydration.

- Dissolve the contents of the packet in the amount of water indicated on the packet. If you use too little water, the drink could make the diarrhea worse. If you use too much water, the drink will be less effective.
- Stir well, and give to the child to drink in a cup or feed with a spoon.

Prevention

Diarrhea can be prevented by breast feeding, by immunizing all children against measles, by using latrines, by keeping food and water clean, and by washing hands before touching food.

Water and food can contain germs which are dangerous; heat kills germs.

Keep food and drinking water covered when being stored.

Bottle Feeding is dangerous unless all of the water, bottle and nipple are boiled before each use.

Colostrum is like a vaccination for the infant.

Do not defecate near a water source.

References

Communication for Child Survival. Rasmuson, M., Seidel, R., Smith, W. And Booth, E. 1988. Academy for Educational Development, USAID: USA.

Facts for Life. UNICEF. 1993. P&LA: United Kingdom.

MCH Guidelines for Health Education. Kaastra, Hieke. 1990. Dhamar Rural Health Project, SNV-Netherlands Development Organization: Republic of Yemen.

Appendix D

EPI Card

Maternal Health Card

Growth Monitoring Card



بطاقة تطعيم النساء (ضد الكزاز)



أدخلى فترة بين جرعة وأخرى			
سنة	سنة	سنة	٦ أشهر
أو خلال الحمل المتعاقب			

تعليمات هامة:

١ يجب أن تعودى لأخذ الجرعة التالية المحددة في بطاقةك ولا تشغلي إحصان البطاقة.

٢ لا تلتقي لأعراض الحمى والألم واحمرار موضع الحقنة، فكل تلك الأعراض طبيعية ومماحبة لعملية التطعيم ولا ضرر منها، ودليل على تفاعل الجسم مع اللقاح.

٣ لا تنسى أن تحصي طفلك القادم بحمصته ضد أسلحة الطفولة الستة: مرضى الدرن، الحصبة، شلل الأطفال، السعال الديكي، الكزاز والخناق وذلك بتطعيمه بلقاح الدرن فور ولادته وانتهاء بلقاح الحصبة عند بلوغه الشهر التاسع من عمره.



الرقم المسلسل: بطاقة تطعيم النساء ضد الكزاز

الإسم الكامل: _____ العنوان الكامل / المحافظة: _____ المديرية: _____
السن: _____ العزلة: _____
الحالة الاجتماعية: _____ القرية / المدينة: _____

البيان	الجرعات الأساسية		الجرعات التثمينية		
	الجرعة الأولى	الجرعة الثانية	الجرعة الثالثة	الجرعة الرابعة	الجرعة الخامسة
التاريخ					
المركز					
تاريخ العودة التالية					
زمن فترة بين جرعة وأخرى: ٤ أسابيع ٦ أشهر سنة سنة					

أو خلال الحمل المتعاقب

الرقم المسلسل: 117844 من 17000

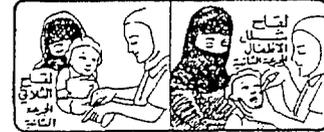
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إرشادات هامة

- ١- الطعيم الكامل يحمي طفلك من ستة أمراض فتاكه : الحصبة، السعال الديكي، الخناق، الكزاز، الشلل والدفتريا.
- ٢- اعلم أن الأطفال الرضع لهم الأكثر عرضة لمخاطر تلك الأمراض الستة.
- ٣- الطعيم مرة واحدة غير كاف، فطعيم السعال والشلل بين كل جرعة وأخرى.
- ٤- أعراض الحمى وتورم موضع الطعيم مألوف إلا أعراض التفاعل الجسم مع اللقاح، فلا تتخوف منه، فاستخدم الكمادات الباردة موضع الورم.
- ٥- هذه الطاقة مهمة جداً، حافظ عليها في مكان أمين وعند أي زيارة للطفل إلى المرفق الصحي يجب إحصارها معك.
- وكن عند دهنه المبردة، حيث يحصل على الجرعة التنشيطية وتحفظ في ملف المبردة.

التلقيح يحمي طفلك

مع زيارات للمرفق الصحي خلال السنة الأولى من عمر طفلك وفي الأعمار المحددة، تتقده من خطر الأمراض الستة الفتالة



الجرع الابتدائية



التاريخ: _____

التاريخ: ١ _____

٢ _____

٣ _____

٤ _____



التاريخ: ١ _____

٢ _____

٣ _____



التاريخ: _____



الجرع التنشيطية

السل - التاريخ: _____

الثاني - التاريخ: ١ _____

٢ _____



الجمهورية العربية اليمنية
وزارة الصحة
برنامج التخصيم الموسع
بطاقة التلقيح

اسم الطفل: _____

اسم ولي أمر الطفل: _____

تاريخ الولادة: _____

العنوان: _____

عزيزتي الأم ..
لا تنس في نفس
الوقت أن تأخذي
لقاحك ضد مرض
(الكزاز)



ملاحظ

التحصين يحمي طفلك

تاريخ التحصين	التحصين	الزيارة
		عند الولادة الزيارة الاولى
		الزيارة الثانية
		الزيارة الثالثة
		الزيارة الرابعة
		الزيارة الخامسة

التحصين يقي طفلك من الأمراض الستة الخبيثة

عزيزتي الأم ..
لتفاح الكزاز
لتفاح منبه
لحمايتك وحماية
طفلك ، فاحرصي
على أخذه



بطاقة نمو الطفل

رقم ()



من بداية الشهر
الرابع
من عمر طفلك



من بداية
الشهر
السابع
من عمر
طفلك

أطعمة بناء الجسم



الجمهورية اليمنية
وزارة الصحة العامة
الإدارة العامة للصحة العامة

اسم المركز الصحي:

الاسم:

التاريخ:



« والوالدات يرضعن اولادهن حولين كاملين »
صدق الله العظيم

- 1- ارضعي طفلك بعد الولادة مباشرة من الثدي .
- 2- من اول الشهر الرابع اضيفي الي جانب رضاعتك لطفلك مواد غذائية مثل المحلية هريسه خضار هريسه بطاط / هريسه قمح / هريسه موز / هريسه تفاح .
- 3- من اول الشهر السابع / هريسه فول / هريسه عدس / صفار البيض المغلي هريسه لحم / هريسه دجاج / هريسه سمك

Appendix E

Cold Chain Monitoring Chart

مشروع التحصين الموسع

درجة	١	٢	٣	٤	٥	٦	٧	٨	٩	١٠	١١	١٢	١٣	١٤	١٥	١٦	١٧	١٨	١٩	٢٠	٢١	٢٢	٢٣	٢٤	٢٥	٢٦	٢٧	٢٨	٢٩	٣٠	٣١	درجة	
	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢	ص ٢		
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-١٤																																	
-١٦																																	
-١٨																																	
-٢٠																																	
التراب نظمه																																	

سجل

درجة الحرارة

المركز: رقم التلاجة

التاريخ: ١٩٩٦م

المفارقة الشهرية

- مكثف البرودة خالي الباب خالي الجسم
 من الثلج معلق جيداً من الصلدى الداخلي مليئاً
 قوارير مياه مانع التسرب انابيب التبريد منظّم
 التلاجة في التلاجة بالباب جيد الحافطة نظيفة الحرارة شغال

مشروع التحصين الموسع

درجة	٣١	٣٠	٢٩	٢٨	٢٧	٢٦	٢٥	٢٤	٢٣	٢٢	٢١	٢٠	١٩	١٨	١٧	١٦	١٥	١٤	١٣	١٢	١١	١٠	٩	٨	٧	٦	٥	٤	٣	٢	١	درجة			
	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص	ص		
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-٢٠																																			
التراب نظمه																																			

مسجل

درجة الحرارة
رقم التلاجة
المركز:
التاريخ
١٩٨٨ م

الفارقة الشهرية

- مكثف البرودة خيالي
- الباب
- من الثلج
- منقوع جيبدا
- فوارير ماء
- فوارير ماء
- مانع التسرب
- بالباب جيبدا
- خيالي
- من الصلدى
- انابيب التبريد
- الخافية نظيفة
- الجسم
- الداخلي سليتم
- منظف
- الحرارة شغال

Appendix F

MOH Protocol for CDD

How to Assess your patient												
For dehydration				For other problems								
	A	B	C									
1. ASK ABOUT: DIARRHOEA VOMITING THIRST URINE	Less than 4 liquid stools per day None or a small amount Normal Normal	4 to 10 liquid stools per day - Some Greater than normal A small amount, dark	More than 10 liquid stools per day Very frequent Unable to drink No urine for 6 hours	Longer than 14 days duration Blood in the stool								
2. LOOK AT: CONDITION TEARS EYES MOUTH and TONGUE BREATHING	Well alert Present Normal Wet Normal	Unwell, sleepy or irritable Absent Sunken Dry Faster than normal	Very sleepy, unconscious, floppy or having fits Absent Very dry and sunken Very dry Very fast and deep	Severe undernutrition								
3. FEEL: SKIN PULSE FONTANELLE (In infants)	A pinch goes back quickly Normal Normal	A pinch goes back slowly Faster than normal Sunken	A pinch goes back very slowly Very fast, weak, or you cannot feel it Very sunken									
4. TAKE TEMPERATURE				Fever 38.5°C (or 101°F) or greater								
5. WEIGHT IF POSSIBLE	Loss of less than 25 grams for each kilogram of weight	Loss of 25-100 grams for each kilogram of weight	Loss of more than 100 grams for each kilogram of weight									
6. DECIDE	The patient has no signs of dehydration USE PLAN A	If the patient has two or more of these signs, he has some dehydration USE PLAN B	If the patient has 2 or more of these danger signs, he has severe dehydration USE PLAN C	<table border="1"> <thead> <tr> <th>IF YOUR PATIENT HAS</th> <th>THEN:</th> </tr> </thead> <tbody> <tr> <td>Blood in the stool and diarrhoea for less than 14 days</td> <td>Treat with an appropriate oral antibiotic for shigella dysentery. If this child is also - dehydrated - severely undernourished or - less than 1 year age reassess the child's progress in 24-48 h. For the severely undernourished child, also refer for treatment of severe undernutrition.</td> </tr> <tr> <td>Diarrhoea for longer than 14 days with or without blood Severe under-nutrition</td> <td>Continue feeding and refer for treatment</td> </tr> <tr> <td>Fever 38.5° C (or 101°F) or greater</td> <td>Show the mother how to cool the child with a wet cloth and fanning. Look for and treat other causes (for example, pneumonia, malaria).</td> </tr> </tbody> </table>	IF YOUR PATIENT HAS	THEN:	Blood in the stool and diarrhoea for less than 14 days	Treat with an appropriate oral antibiotic for shigella dysentery. If this child is also - dehydrated - severely undernourished or - less than 1 year age reassess the child's progress in 24-48 h. For the severely undernourished child, also refer for treatment of severe undernutrition.	Diarrhoea for longer than 14 days with or without blood Severe under-nutrition	Continue feeding and refer for treatment	Fever 38.5° C (or 101°F) or greater	Show the mother how to cool the child with a wet cloth and fanning. Look for and treat other causes (for example, pneumonia, malaria).
IF YOUR PATIENT HAS	THEN:											
Blood in the stool and diarrhoea for less than 14 days	Treat with an appropriate oral antibiotic for shigella dysentery. If this child is also - dehydrated - severely undernourished or - less than 1 year age reassess the child's progress in 24-48 h. For the severely undernourished child, also refer for treatment of severe undernutrition.											
Diarrhoea for longer than 14 days with or without blood Severe under-nutrition	Continue feeding and refer for treatment											
Fever 38.5° C (or 101°F) or greater	Show the mother how to cool the child with a wet cloth and fanning. Look for and treat other causes (for example, pneumonia, malaria).											

Source: Treatment of diarrhoea, WHO/CDD 1987

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Treatment plan A to treat diarrhoea

Explain the three rules for treating diarrhoea at home :

1. GIVE YOUR CHILD MORE FLUIDS THAN USUAL TO PREVENT DEHYDRATION. SUITABLE FLUIDS INCLUDE:

- The recommended home fluid of food-based fluids, such as gruel, soup or rice water.
- Breast milk or mild feeds prepared with twice the usual amount of water.

2. GIVE YOUR CHILD FOOD:

- Give freshly prepared foods. Recommended foods are mixes of cereal and beans, or cereal and meat or fish. Add a few drops of oil to the food, if possible.
- Give fresh fruit juices or bananas to provide potassium.
- Offer food every 3 or 4 hours (6 times a day) or more often for very young children.
- Encourage the child to eat as much as he or she wants.
- Cook and mash or grind food well so it will be easier to digest.
- After the diarrhoea stops, give one extra meal each day for a week, or until the child has regained normal weight.

3. TAKE YOUR CHILD TO THE HEALTH WORKER IF THE CHILD HAS ANY OF THE FOLLOWING:

- passes many stools
 - is very thirsty
 - has sunken eyes
 - has a fever
 - does not eat or drink normally
 - seems not to be getting better.
- } These 3 signs suggest your child is dehydrated.

Teach the mother how to use ORS Solution at home, if:

- The mother cannot come back if the diarrhoea gets worse.
- It is national policy to give ORS to all children who see a health worker for diarrhoea treatment,
or
- Her child has been on Plan B, to prevent dehydration from coming back.

Show her how to mix and give ORS.

Show her how much to give:

- 50-100 ml (1/4 to 1/2 large cup) of ORS solution after each stool for a child under 2 years old.
- 100-200 ml (1/2 to 1 large cup) for older children.
- Adults should drink as much as they want.

TELL HER IF THE CHILD VOMITS, wait 10 minutes. Then continue giving the solution but more slowly - a spoonful every 2-3 minutes.

GIVE HER ENOUGH PACKETS FOR 2 DAYS.

Note: When a child is getting ORS, he or she should also be given breast milk or dilute milk feeds and should be offered food. Food-based fluids or a salt and sugar solution should *NOT* be given in addition to ORS.

Explain how she can prevent diarrhoea by:

- Giving only breast milk for the first 4-6 months and continuing to breast-feed for at least the first year.
- Introducing clean, nutritious weaning foods at 4-6 months.
- Giving her child freshly prepared and well-cooked food and clean drinking-water.
- Having all family members wash their hands with soap after defecating, and before eating or preparing food.
- Having all family members use a latrine.
- Quickly disposing of the stool of a young child by putting it into a latrine or by burying it.

Annex 2c

Treatment plan B to treat dehydration

1. AMOUNT OF ORS SOLUTION TO GIVE IN FIRST 4 TO 6 HOURS

Patient's age	2 4 6 8 10 12 18 2 3 4 6 8 15 adult ←———— months —————→ ←———— years —————→										
Patient's weight in kilograms	3 5 7 9 11 13 15 20 30 40 50 										
Give this much solution for 4-6 hours	in ml	200-400	400-600	600-800	800-1000	1000-2000	2000-4000				
	in local unit of measure										

- Use the patient's age only when you do not know the weight.

NOTE: ENCOURAGE THE MOTHER TO CONTINUE BREAST-FEEDING.

If the patient wants more ORS, give more.

If the eyelids become puffy, stop ORS and give other fluids. If diarrhoea continues, use ORS again when the puffiness is gone.

If the child vomits, wait 10 minutes and then continue giving ORS, but more slowly.

2. IF THE MOTHER CAN REMAIN AT THE HEALTH CENTRE

- Show her how much solution to give her child.
- Show her how to give it - a spoonful every 1 to 2 minutes.
- Check from time to time to see if she has problems.

3. AFTER 4 TO 6 HOURS, REASSESS THE CHILD USING THE ASSESSMENT CHART. THEN CHOOSE THE SUITABLE TREATMENT PLAN.

Note : If a child will continue on Plan B, tell the mother to offer small amounts of food.

If the child is under 12 months, tell the mother to :

- continue breast-feeding or
- if she does not breast-feed, give 100-200 ml of clean water before continuing ORS.

4. IF THE MOTHER MUST LEAVE ANY TIME BEFORE COMPLETING TREATMENT PLAN B

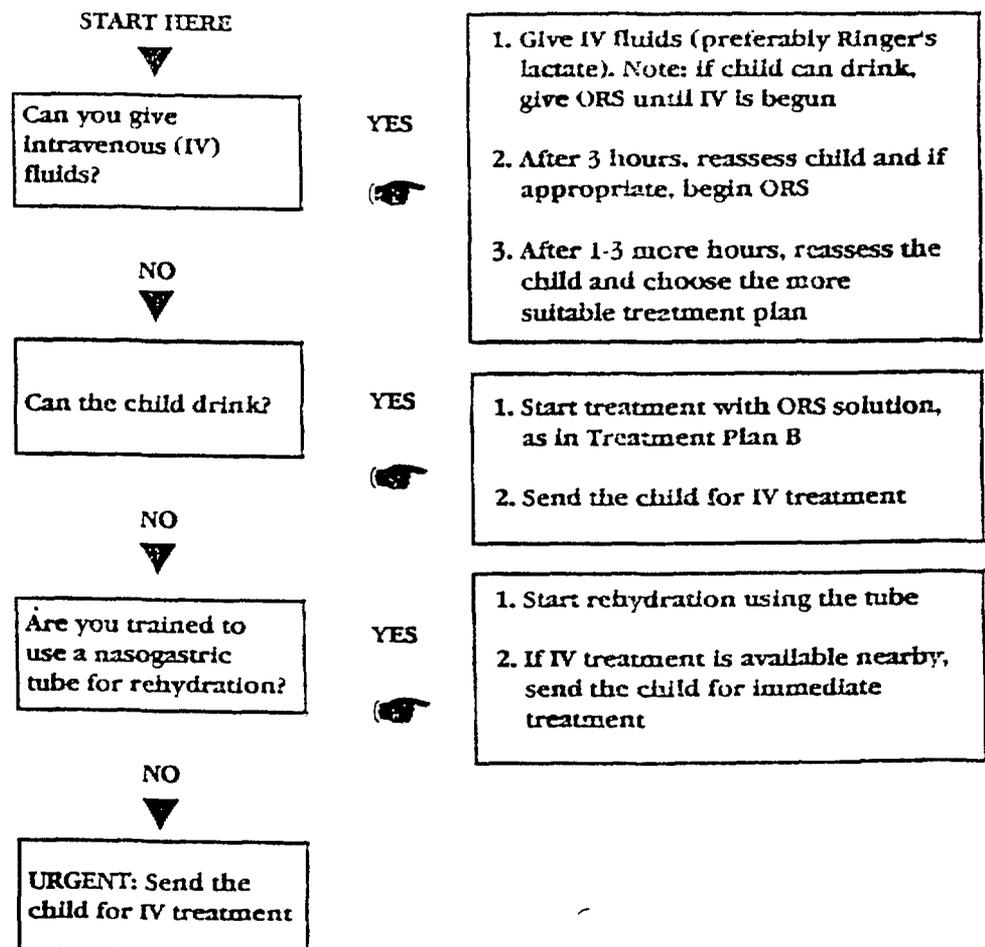
- Give her enough ORS packets for 2 days and show her how to prepare the fluid.
- Show her how much ORS to give to finish the 4-6 hour treatment at home.
- Tell her to give the child as much ORS and other fluids as he or she wants after the 4-6 hour treatment is finished.
- Tell her to offer the child small amounts of food every 3-4 hours.
- Tell her to bring the child back to the health worker if the child has any of the following :

- passes many stools
- is very thirsty
- has sunken eyes
- has a fever
- does not eat or drink normally
- seems not to be getting better.

} These 3 signs suggest the child is dehydrated.

Treatment plan C to treat severe dehydration quickly

Follow the arrows. If the answer to the questions is "yes", go across. If it is "no", go down.



NOTE: If the child is above 2 years of age and cholera is known to be currently occurring in your area, suspect cholera and give an appropriate oral antibiotic once the child is alert.

Appendix G

Organizational Chart

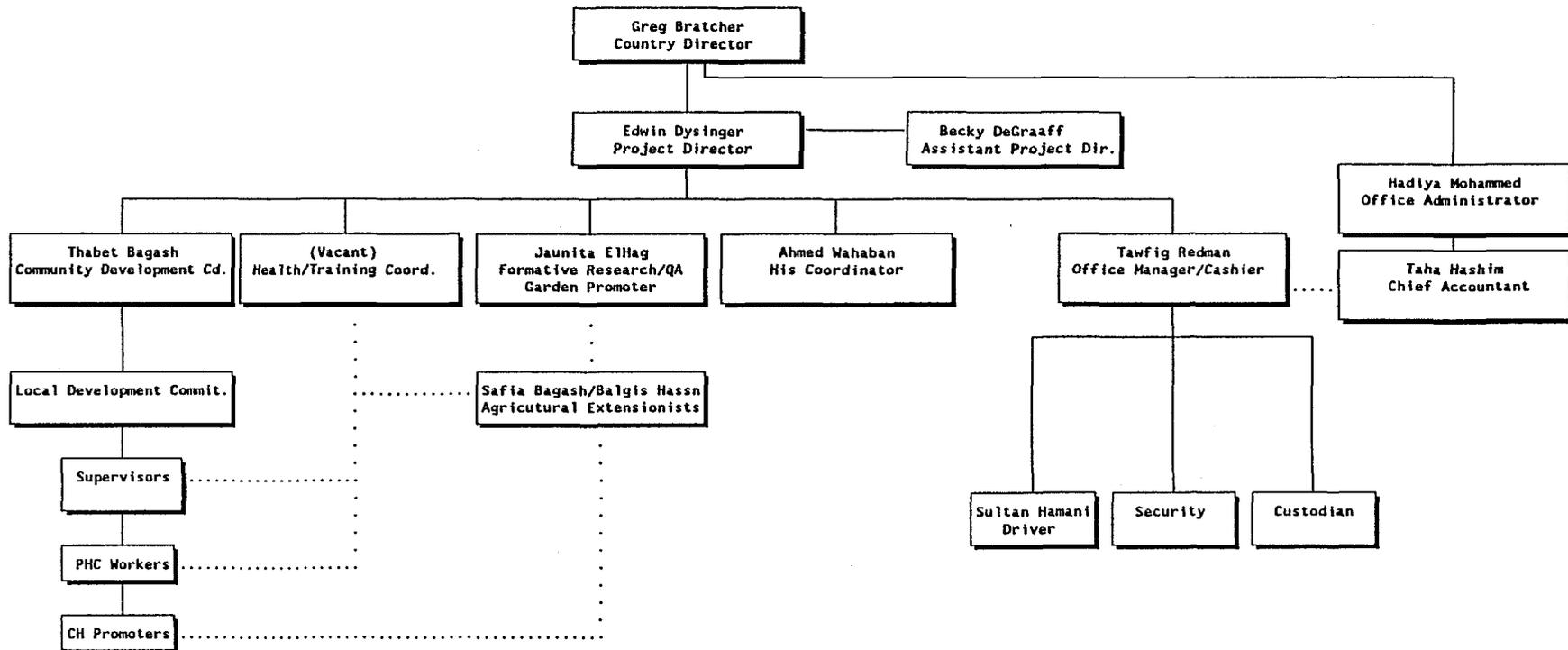
Staffing Table

Headquarters Curriculum Vitae

Country Curriculum Vitae

Job Descriptions

**ADRA YEMEN ORGANIZATIONAL CHART
CHILD SURVIVAL XI**



Staffing Table

POSITION	NAME	EXPAT/ NAT'L	FT/PT TIME	SALARY/ VOL'TR	2ND AGENCY
Country Director	Greg Bratcher	Expat	FT	S	
Field Project Director	Edwin Dysinger	Expat	FT	S	
Assistant Project Director	Becky de Graaff	Expat	FT	S	
Chief Accountant (country office-based)	Taha Hashim	Nat'l	FT	S	
Office Administrator (country office-based)	Hadiya Mohammed	Nat'l	FT	S	
Health/Training Coordinator					
Community Develop't Coordinator	Thabet Bagash	Nat'l	FT	S	
Formative Research/QA Coordinator Garden Promoter	Jamila El Hag	Nat'l	FT	S	
HIS Coordinator	Ahmed Wahaban	Nat'l	PT	S	
Office Manager	Tawfiq Radman	Nat'l	FT	S	
Driver	Sultan Hamani	Nat'l	FT	S	
Security		Nat'l	PT	S	
Custodian		Nat'l	PT	S	
Local Development Committees		Nat'ls		Vol'tr	
Agricultural Extensionists	Safia Bagash Balqis Hassan	Nat'l Nat'l			X
Supervisors		Nat'l			X
PHC Workers		Nat'l			X
Community Health Promoters		Nat'l		Vol'tr	

Headquarters Curriculum Vitae

Byron Lewis Scheuneman
12501 Old Columbia Pike
Silver Spring, MD 20904
301-680-6778

Education

1979 - 1982	University of Beverly Hills - California
1974	Glendale College - California
1970- 1972	Davenport College - Michigan
1968 - 1970	Southern College of SDA - Tennessee

Degrees

1982	Master of Business Administration - Accounting & International Finance Bachelor of Business Administration - Accounting
------	--

Work Experience

1993 - Present	Current Position: Vice President for Grants Administration Adventist Development and Relief Agency-International, Silver Spring MD
1990 - 1993	Director, Asset Management & Development Services Asia Pacific Division of SDA (APD), Singapore
1986-1990	Treasurer, South China Island Union Mission of SDA Hong Kong
1984-1986	Director, Student Financial Services, and Assistant Business Manager Pacific Union College, Angwin, CA
1980-1984	Assistant Treasurer, Asia Pacific Division Singapore
1973-1980	Adventist Media Center in the positions of: Assistant Treasurer - Voice of Prophecy Radio Broadcast; Treasurer - Voice of Prophecy Radio Broadcast; Controller - Adventist Media Center, Thousand Oaks, CA
1972-1973	Accountant at Loma Linda Foods, Eastern Division, and the Ohio Adventist Book Center, Mt. Vernon, OH

Gail M Ormsby
12501 Old Columbia Pike
Silver Spring, MD 20904 USA
301-680-6383

Education

1985	Bachelor of Education Avondale College, NSW, Australia
1977	Diploma of Secondary Education (Applied Arts) Avondale College, NSW, Australia
1982	Master of Public Health (Nutrition) Loma Linda University School of Public Health, Loma Linda, CA, USA

Work Experience

Dec 1995 - Present	Director of Health, ADRA International Silver Spring, MD
1993 - Nov 1995	Senior Manager, ADRA International Silver Spring, MD
1990 - Oct 1993	Director, Human Resource Development, ADRA International Silver Spring, MD
1987 - 1990	Director, Nutritional Education Service, Sanitarium Health Food Company, Sydney, NSW, Australia
1985 - 1987	Associate Director, Adventist Health Department, South Pacific Division Sydney, NSW, Australia
1983 - 1985	Director of Health & Temperance Department, North New South Wales Conference of SDA, Hamilton, NSW, Australia
Feb - Jul 1983	Nutrition Consultant, Nutrition Project with Government St Lucia, Inter American Division, FL, USA
Oct - Jan 1982	Assistant to Program Planning & Evaluation, Seventh-day Adventist World Service (predecessor to ADRA), Takoma Park, MD, USA
1981 - 1982	Field Practicum, Bandung Adventist University, Indonesia
1975 - 1980	Teacher, Avondale SDA High School, Cooranbong, NSW, Australia Teacher, Mt Gravatt SDA High School, Brisbane, QLD, Australia Teacher, Strathfield SDA High School, Sydney, NSW, Australia Teacher, Mt Gravatt SDA High School, Brisbane, QLD, Australia

Professional Membership

American Dietetic Association

Mekebeb Negerie
12501 Old Columbia Pike
Silver Spring, MD 20904 USA
301-680-5138

Education

1990 - 1994	DrPH Loma Linda University, School of Public Health, Loma Linda, CA
1985	Graduate Study for six months University of the Philippines, Philippines
1983 - 1985	MPH Philippine Union College, Philippines
1980 - 1983	BSc, Agriculture University of Eastern Africa, Kenya

Work Experience

Aug 1995 - Present	Associate Director of Health, ADRA International Silver Spring, MD
1991 - 1994	Refletron Lab Technician and Counselor, Center for Health Promotion Loma Linda University, Loma Linda, CA (part-time)
1990 - 1994	Circulation Desk Technician, Loma Linda University Library Loma Linda, CA (part-time)
1987 - 1989	Project Director for ADRA/Southern Sudan
1987	Mother and Child Health Project Consultant, Egypt (part-time)
1986	Mother and Child Health Coordinator, ADRA/Sudan
1985	Conducted Smoking Cessation Program for Military Personnel Philippine Union College
1983	Farm Shop Supervisor, Kenya
1980 - 1982	Painting, Construction, Gardening, Kenya
1979 - 1980	Music Instructor and Choir Director, Ethiopia

Consultancies (Primary Health Care and Child Survival)

1987 - 1995	Egypt, Sudan, Uganda, Eritrea, Honduras, Kenya
-------------	--

Languages

English, Amharic, Oromo, Arabic, Swahili

Betty A McGraw
12501 Old Columbia Pike
Silver Spring, MD 20904
301-680-6743

Education

1995 - Present Studying towards Masters of Business Administration
George Mason University, Fairfax, VA

1982 - 1986 BS in Accounting
Columbia Union College, Takoma Park, MD

Certification

1988 Certified Public Accountant

Work Experience

1996 - Present Senior Grants Administrator, ADRA/International
Silver Spring, MD

1994 - 1995 Director of Finance, ADRA/International
Silver Spring, MD

1988 - 1994 Staff Auditor, General Conference Auditing Service
Columbia, MD

1986 - 1988 Assistant Staff Auditor, General Conference Auditing Service
Berrien Springs, MI

Country Curriculum Vitae

Gregory Dewayne Bratcher
ADRA/Yemen, PO Box 15348
Sana'a, REPUBLIC OF YEMEN

Education

1975-1979 BS in Business Administration
University of Texas, Austin, Texas

Work Experience

1994 - Present Country Director, ADRA/Yemen
Sana'a, Republic of Yemen

1992 - 1994
Teachers Regional Director, Commonwealth of Independent States for International
Service, Moscow, Commonwealth of Independent States (Russia)

1991 - 1992 English Teacher, Second Automotive Works Institute
Shiyen, Hubei Province, China

1989 - 1991 Director of Development, Adventist Frontiers
Berrien Springs, MI

1986 - 1988 Director, Community Services
Richlands, VA

1984 - 1986 Title Abstractor, Self-employed
Rockville, MD

1981 - 1984 Manager/Contractor, Petroleum Landman for Mitchell Energy Corporation
Texas

Related Training

Nov 1995 ADRA Maternal Child Health Workshop
ADRA/International, Naro Moru, Kenya

Mar 1995 ADRA/International Orientation Workshop
ADRA/International, Silver Spring, MD

Nationality American

Languages English - Fluent
Russian - Familiar with
Arabic - Familiar with

Edwin Paul Dysinger
ADRA/Yemen, Child Survival Project
Hais, REPUBLIC OF YEMEN

Education

1983 - 1985	MSPH, International Health and Health Promotion and Education Loma Linda University, School of Public Health, Loma Linda, CA
1978 - 1982	BA in Sociology University of New York, New York, NY

Work Experience

1995 - Present	Child Survival Project Director, ADRA/Yemen Sana'a, Republic of Yemen
1990 - 1994	Child Survival Project Director, Kibidula Farm Institute Mafinga, Tanzania
1987 - 1990	Child Survival Project Director, ADRA/Sudan Khartoum, Sudan
1986 - 1988	MCH Coordinator, ADRA/Sudan Khartoum, Sudan
1985 - 1988	MCII Project Technical Advisor, ADRA/Sudan Khartoum, Sudan
1980 - 1981	Secondary School Teacher, Pakistan Adventist Seminary and College Pakistan

Related Training

Nov 1995	ADRA Maternal Child Health Workshop ADRA/International, Naro Moru, Kenya
Mar 1995	ADRA Leadership Workshop ADRA/International, Silver Spring, MD
1987	ADRA Child Survival Workshop ADRA/International, Jamkhed, India

Nationality American

Languages English - Fluent
Arabic - Conversational

Rebecca Louise de Graaff
ADRA/Yemen, Child Survival Project
Hais, REPUBLIC OF YEMEN

Education

1992 - 1994	MPH, International Health and Health Promotion and Education Loma Linda University, School of Public Health, Loma Linda, CA
1988 - 1991	BA in Biology, Andrews University Berrien Springs, MI
1987 - 1988	Newbold College, Bracknell, ENGLAND

Work Experience

1995 - Present	Child Survival Assistant Project Director, ADRA/Yemen Sana'a, Republic of Yemen
Jul 1995 - Oct 1995	Intern/Technical Assistant, ADRA/International Silver Spring, MD
Jul 1994 - Jul 1995	Director, Students for International Medical Service, Loma Linda University Loma Linda, CA
Jan 1993 - Mar 1994	Office Assistant, Office of Extended Programs, Loma Linda University Loma Linda, CA
Sep 1991 - Aug 1992	Research Assistant, Cancer Surveillance Project, Alaska Native Medical Center Anchorage, AK

Related Training

Nov 1995	ADRA Maternal Child Health Workshop ADRA/International, Naro Moru, Kenya
Mar 1994 - Jun 1994	Field Practicum (MPH degree requirement) Impact Teams International, Erbil, Iraqi Kurdistan

Nationality American

Languages English - Fluent
Dutch - Conversational
Spanish - Minimal

Ahmed Mohammed Talib Ali Ghuri
ADRA/Yemen
Al Qulma, REPUBLIC OF YEMEN

Education

1992 - 1995	Secondary Level Certificate Specialization: Health Worker for Public Health Health Training Center, Hodeidah, Yemen
1986 - 1989	Secondary School Certificate (Scientific Section) Al-Wahda Secondary School, Hais, Yemen
1980 - 1981	Health Worker Certificate Health Training Center, Zabid, Yemen

Work Experience

Oct 1995 - Present	Public Health Supervisor, Hais Health Center Hais, Yemen
1981 - 1992	Health Worker, Al Qulma Health Unit Yemen

Related Training

1985	Immunization Workshop, one week Zabid Health Center, Zabid, Yemen Certificate of Participation
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Nationality Yemeni

Languages Arabic

Mohammed Talib Abdul Iimnah
ADRA/Yemen
Hais, REPUBLIC OF YEMEN

Education

1987 - 1993	Medical Baccalaureate Degree (MBCHB), Mosul University, Medical College Mosul, Iraq
1983 - 1986	Secondary School Certificate (Scientific Section), Al-Wahda Secondary School Hais, Yemen

Work Experience

Jan 1995 - Present	Director, Hais Health Center Hais, Yemen
Oct 1993 - Jan 1995	General Practitioner, Al Olofi Hospital Hodeidah, Yemen

Related Training

Apr 1991	Public Health Training, 2 weeks Mosul University, Medical College, Mosul, Iraq
Jan 1990	Immunity Course lecture by visiting British physician Mosul University, Medical College, Mosul, Iraq

Memberships

Jan 1995 - Present	Local Hais Government Committee Member
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Nationality

Yemeni

Languages

Arabic - fluent (mother tongue)
English - conversational

Jamila El Hag Abdel Mahmoud
ADRA/Yemen, P O Box 7134
Sana'a, REPUBLIC OF YEMEN

Education

1983 - 1989 BS in Agriculture, University of Khartoum, Faculty of Agriculture
Khartoum, Sudan

1978 - 1982 Secondary School Certificate, Rufa'a Secondary School
Sudan

Work Experience

Oct 1992 - Oct 1994 Loan Officer, Small Enterprise Development, ADRA/Sudan
Khartoum, Sudan

Sep 1991 - Apr 1992 Sponsorship Clerk, Save the Children/US
Khartoum, Sudan

Jan 1991 - Aug 1991 Monitor in Relief Program, Save the Children/US
Khartoum, Sudan

Jul 1990 - Jan 1991 Agriculture Extension Agent, Save the Children/US
Khartoum, Sudan

Sep 1989 - Jan 1990 Women in Development, Sudan Family Planning Association
Khartoum, Sudan

Jan 1989 - Aug 1989 Volunteer, Income Generating Projects, Plan Sudan
Khartoum, Sudan

Related Training

Mar 1993 - Feb 1994 MS-DOS, Word Perfect 5.1, Lotus 123, Dbase III+, MS-Windows 3.1 Beriscom
Company Limited of California, Khartoum, Sudan Branch

Dec 1992 Computer Programming in DbaseIII and GW Basic
Elex Computers Co. Ltd., Khartoum, Sudan

Mar 1990 English Typewriting
Rufa'a Institute for Technical Studies Sudan, Khartoum, Sudan

Nationality Sudanese

Languages Arabic - fluent (mother tongue)
English - fluent

Thabet Bagash Naser Okeish
ADRA/Yemen
Hais, REPUBLIC OF YEMEN

Education

- | | |
|-------------|--|
| 1990 - 1994 | BA in Education, Sana'a University, Faculty of Education
Specialization: Teacher of English at the Secondary Level
Hodeidah, Yemen |
| 1986 - 1989 | Secondary School Certificate (Scientific Section), Al-Wahda Secondary School
Hais, Yemen |

Work Experience

- | | |
|----------------|--|
| 1994 - Present | Teacher, Al Quds Girl's Secondary School |
|----------------|--|

Related Training

- | | |
|----------------|---|
| Oct 1993 | Prevention of Desertification Workshop, one week
Agricultural Center, Zabid, Yemen |
| Sep 1993 | Family Planning Workshop, two weeks
Veterinary School of Sana'a, Sana'a, Yemen |
| Jun - Oct 1982 | Health Worker Training Course
Zabid Health Center, Zabid, Yemen
Training done for experience and as a volunteer only--no certificate obtained |

Nationality

Yemeni

Languages

Arabic - fluent (mother tongue)
English - fluent

Tawfiq Abdullah Mohammed Radman
ADRA/Yemen, Hael Street
Sana'a, REPUBLIC OF YEMEN

Education

- 1995 - Present Studying towards bachelor's degree in Psychology, Sana'a University
Sana'a, Republic of Yemen
- 1987 - 1989 Secondary Certificate, Secondary School of Kuwait
Kuwait

Work Experience

- Sep 1995 - Oct 1995 Financial Administrator, Dhamar Primary Health Care Project, Intervision
Dhamar, Republic of Yemen
- Oct 1992 - Aug 1993 Financial Administrator, Dhamar Primary Health Care Project, Consultants for
Development Programmes, Dhamar, Republic of Yemen
- Aug 1986 - Oct 1992 Medicine Sales and Public Relations, Al Mazny Pharmacy
Sana'a, Republic of Yemen

Related Training

- Aug 1995 - Oct 1995 Operating System DOS
Dhamar Computer House, Dhamar, Republic of Yemen
- Jul 1995 Windows 3.1
University of Jordan, Oman, Jordan
- Jul 1995 Computer Workshop for Accountants
University of Jordan, Oman, Jordan
- Oct 1988 - Dec 1988 Advanced Level of English
The National Institute of Public Administration, Sana'a, Republic of Yemen
- Jul 1987 - Sep 1987 English Language Training
Agricultural Development Support Program, Sana'a, Republic of Yemen

Nationality

Yemeni

Languages

Arabic - fluent (mother tongue)
English - fluent

Job Description
Child Survival XI - ADRA/Yemen

Position	Country Director	
Qualifications	BA in Business Administration or Accounting	
Experience	Minimum 5 years in Business of Business of Public Administration. Prior Project or Business Management in the Developing World. Some background in working in the Middle East.	
Skills	English fluency Administrative Organizational and Planning Analytical Reporting Financial management	Leadership -team oriented Morale Building Committed to working at least ½ time in the community/field Computer literate Delegation
Supervisor	ADRA/Yemen Country Board of Directors	
Supervises	Project Director, Chief Accountant and office Administrator	
Job Summary	Administers all aspects of the country project.	

Duties and Responsibilities

1. Leads out in the development of and continued assessment of the ADRA country strategic plans.
2. Coordinates the work of the country staff.
3. Facilitates the retirement of all project proposals.
4. Monitors and reports on progress of all projects to donors and ADRA regional and international offices.
5. Facilitates evaluation of country programs and projects.
6. Facilitates technical assistance to all country projects.
7. Facilitates staff development.
8. Represents the country agency to the ADRA entities, government, donor agencies and the public.
9. Ensures maintenance of employee files.
10. Assures donor controls.
11. Assure internal controls.
12. Serves as Secretary of ADRA country board.
13. Chairs staff meetings.
14. Collaborates with the treasurer in budget preparation.
15. Signatory to any in-country agreement, proposal or project account.
16. Project site visitation to ensure high standards of performance and effectiveness.

Training

The country director will have opportunity to participate in various training and continuing education programs, and is expected to participate in these.

Job Description
Child Survival XI - ADRA/Yemen

Position	Project Director	
Qualifications	Masters in Public Health	
Experience	Minimum 3 years managing a health project in a developing country. Some background in working in the Middle East.	
Skills	English fluency Administrative Organizational and Planning Analytical Reporting Financial Management	Leadership - team oriented Morale building Committed to working at least ½ time in the community field Computer literate Delegation
Supervisor	Country Director Also recognizes the special relationship required to ADRA/International, USAID, the MOH, and other government and non-government agencies.	
Supervises	All child survival project employees	
Job Summary	Administers all aspects of the child survival project.	

Duties and Responsibilities

1. Responsible for overall planning and direction of the CS project.
2. Responsible for tracking project achievements in relation to stated goals, objectives and budget.
3. Will provide leadership, management and coordination of all CS entities.
4. Responsible for reporting on a regular basis to ADRA/Yemen country director, ADRA/International, Ministry of Health, USAID and any others as required.
5. Will oversee hiring of all project personnel and maintains final authority in all project related personnel decisions.
6. Is a member of and reports to the ADRA/Yemen Board and will attend all meetings related to CS.
7. Responsible for proper usage, care and maintenance of all project related equipment and facilities.

Training

The project director will have opportunity to participate in various training and continuing education programs, and is expected to participate in these.

JOB DESCRIPTION
Child Survival XI - ADRA/Yemen

POSITION: HEALTH and TRAINING COORDINATOR

QUALIFICATIONS: BA degree in Education, Community Development or Health, MPH desirable

Experience: 2 years or more in teaching and organizing training programs of a primary health care related field
2 years or more in staff supervision
2 years or more experience in community development work

Skills:

. English/Arabic fluency	. Leadership - team oriented
. Administrative	. Morale building
. Organizational and Planning	. Committed to working at least
. Analytical	1/2 time in the
. Reporting	community/field
. Financial management	. Computer literate
. Teaching/Training	. Delegation

SUPERVISOR: Project Director

SUPERVISES: Trainees

JOB SUMMARY: Planning, organizing and coordinating PHC and CHP training activities.

DUTIES and RESPONSIBILITIES:

1. Coordination of all training activities undertaken by the project; includes training of supervisors and community health promoters, training for local health staff, LDCs and area councils.
2. Assists the project director in all administrative duties and in maintaining relationships with local government and community leadership.
3. Coordinates with Community Development Coordinator on PHC promotional activities such as training programs and health campaigns.
4. Coordination with other project staff regarding training needs.
5. Supervision of the field supervisors. This includes regular visits in the field to assess first-hand the work of the field supervisors and the PHC workers and CHPs under them.
6. Regular reporting of activities of field supervisors and CHPs.
7. Will hold regular meetings with field supervisors.
8. Coordinating with the Ministry of Health on appropriate health messages.
9. Reporting and documenting on training sessions.
10. Identify, secure and distribute training and educational materials.

TRAINING:

The Training/Health Coordinator will be given the opportunity to participate in various training and upgrading programs and is expected to participate in these.

JOB DESCRIPTION
Child Survival XI - ADRA/Yemen

POSITION: COMMUNITY DEVELOPMENT COORDINATOR

QUALIFICATIONS: BA degree in Education, Community Development or Communications

Experience: At least 2 years in community development work
2 years or more in staff supervision

Skills:

<ul style="list-style-type: none">. English/Arabic fluency. Organizational and Planning. Analytical. Reporting. Communication. Public Relations/Diplomatic	<ul style="list-style-type: none">. Committed to working at least 1/2 time in the community/field. Cultural flexibility. Delegation. Computer Literate
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SUPERVISOR: Project Director

SUPERVISES: Local Development Committees

JOB SUMMARY: Planning, organizing and coordinating community meetings and PHC promotional activities.

DUTIES and RESPONSIBILITIES:

1. Coordination of community development activities undertaken by the project; includes networking with local leaders, community committees and area councils and scheduling regular meetings with those entities.
2. Assists the project director in maintaining relationships with local government and community leadership.
3. Management of logistics for community meetings and PHC promotional activities such as training sessions and EPI and growth monitoring campaigns.
4. Arrange appropriate accommodations of supervisors during promotional activities and training of LDCs.
5. Coordination with other project staff regarding specific project needs.
6. Records and reports minutes and activities of LDCs.
7. Assist LDCs in initiating, organizing and the meeting of requirements.
8. Coordinate with Training/Health Coordinator and other project staff on liaison with public health sector and LDCs.
9. Translation when needed; orally and specific documents.

TRAINING:

The Community Development Coordinator will be given the opportunity to participate in various training and upgrading programs and is expected to participate in these.

JOB DESCRIPTION
Child Survival XI - ADRA/Yemen

POSITION: HEALTH INFORMATION SYSTEMS COORDINATOR

QUALIFICATIONS: Degree in Business, Statistics, Epidemiology or Health

Experience: Minimum of 2 years working with the information system in a public or private company is essential.

Completed statistical analysis or epidemiological research
Designing and implementation of evaluations

Skills:

. English/Arabic fluency	. Computer literate
. Organizational and Planning	. Computer graphics
. Analytical	. Reporting

SUPERVISOR: Project Director

SUPERVISES: Not applicable

JOB SUMMARY: Developing, testing, follow-up and tabulation of HIS system, including vital events and key disease surveillance reporting.

DUTIES and RESPONSIBILITIES:

1. Coordination of health information strategy activities undertaken by the project; includes networking with local leaders, LDCs, area councils and district health centers to develop a sustainable, "community-friendly" system.
2. Coordinates with the Ministry of Health NEDS system.
3. Develops and tests information gathering tools.
4. Analyzes results and gives regular reports to project staff and presentations to District and Ministry of Health offices on statistics relating to child survival interventions.
5. Organize and conduct training of HIS for project staff and all other staff members involved in the HIS process.
6. Assists in the preparation of monthly, quarterly and annual reports for the CS project.
7. Coordinates activities relating to mid-term and final evaluations; includes organizing the training, implementation, tabulation and analysis of the 30-cluster survey.
8. Incorporates appropriate changes to project interventions according to research results.
9. Coordinates with other project staff regarding specific project needs.

TRAINING:

The Health Information Strategies Coordinator will be given the opportunity to participate on various training and upgrading programs and is expected to participate in these.

JOB DESCRIPTION
Child Survival XI - ADRA/Yemen

POSITION: **FORMATIVE RESEARCH/QUALITY ASSURANCE COORDINATOR**

QUALIFICATIONS: BA degree in Community Development or Communications

Experience: Formative research, IEC material development and quality assurance required
At least 2 years in community development work

Skills:

. English/Arabic fluency	. Committed to working at least
. Organizational and Planning	1/2 time in the
. Analytical	community/field
. Reporting	. Cultural flexibility
. Communication	. Group dynamics
. Public Relations/Diplomatic	. Interviewing

SUPERVISOR: Project Director

SUPERVISES: Not applicable

JOB SUMMARY: Implementing formative research and applying results to intervention design, including devising of pilot testing, periodical spot interviews to test continued effectiveness.

DUTIES and RESPONSIBILITIES:

1. Coordination of formative research activities undertaken by the project; includes networking with local leaders, LDCs and area councils and scheduling meetings as needed by the project.
2. Management of logistics for community meetings.
3. Sets agenda issues for focus group discussions, coordinates efforts with a secretary and facilitates the meeting.
4. Reports minutes and activities of FGDs and other means of information gathering such as formal and informal interviews.
5. Coordination with other project staff regarding specific project needs, especially the training/health coordinator in planning and implementing formative research and quality assurance activities.
6. Works with health staff to develop and institute a participatory service quality monitoring system.
7. Incorporates appropriate changes to project interventions according to research results.
8. Researches, designs and develops appropriate health education materials for use in PHC promotional activities and training.

TRAINING:

The Formative Research/Quality Assurance Coordinator will be given the opportunity to participate in various training and upgrading programs and is expected to participate in these.

JOB DESCRIPTION
Child Survival XI - ADRA/Yemen

POSITION: GARDEN PROMOTER

QUALIFICATIONS: Agricultural Extension Worker

Experience: 2 years or more in an agricultural community development position
Nutrition counseling
At least 2 years in community development work

Skills:

. English/Arabic fluency	. Gardening
. Organizational and Planning	. Nutrition
. Reporting	. Time management
. Financial management	. Self-motivated
. Cultural flexibility	

SUPERVISOR: Project Director

COORDINATES WITH: Agricultural Extensionists

JOB SUMMARY: Encourage and train families to participate in vegetable gardening in coordination with the Agricultural Extensionists activities.

DUTIES and RESPONSIBILITIES:

1. General understanding of project functions, goals and objectives, especially those pertaining to the nutrition intervention.
2. Persuade and encourage high risk nutritional families to participate in vegetable gardening.
3. In consultation with project staff, local and traditional leaders, CHPs and volunteers to organize training sessions to teach families/groups the skills of growing of vegetables.
4. Work in close cooperation with other organizations/departments who are involved in rural development projects in order to strengthen and support each other in local gardening activities.
5. Make regular visits to families/groups in order to gain first hand knowledge on problems families face so that appropriate technical advice can be given. Follow-ups must be made to both individuals and groups.
6. Maintenance of garden supplies and equipment.
7. Records and reports vegetable garden participant activities, problems and progress and also activities pertaining to the sample garden.

TRAINING:

The Garden Promoter will be given the opportunity to participate in various training and upgrading programs and is expected to participate in these.

JOB DESCRIPTION
Child Survival XI - ADRA/Yemen

POSITION: OFFICE MANAGER/CASHIER

QUALIFICATIONS: Diploma in Secretarial/Office Administration

Experience: 2 years or more in a secretarial/office administrative position

Skills:

. English/Arabic fluency	. Typing skills (50wpm minimum)
. Organizational and Planning	. English/Arabic keyboard
. Reporting	. Friendly and personable character
. Financial Management	. Conscientious and detailed
. Time management	
. Computer Literate	

SUPERVISOR: Project Director

SUPERVISES: Guard/custodian, Driver

JOB SUMMARY: General office management in the CS project office.

DUTIES and RESPONSIBILITIES:

1. Scheduling of appointments and includes knowing staff movement.
2. Typing and distribution of office correspondence.
3. Receptionist for telephone and visitor inquiries.
4. Management of central filing system and security of records.
5. Recording, typing and distribution of minutes of meetings.
6. Maintenance of office supplies and equipment.
7. Supervision of custodial personnel.
8. General typing and translations.
9. Responsible for Postal Services.
10. Maintenance of petty cash box, and disbursement of petty cash.
11. Maintenance of log books for telephone/fax, vehicles, and photo copiers.
12. Maintain attendance records.
13. Makes arrangements for the accommodation of visitors and travel arrangements of project staff.
14. Staff entertainment.
15. General understanding of project functions, goals and objectives.

TRAINING:

The Secretary/Cashier will be given the opportunity to participate in various training and upgrading programs and is expected to participate in these.

JOB DESCRIPTION
Child Survival XI - ADRA/Yemen

POSITION: DRIVER/MECHANIC

QUALIFICATIONS: Current Yemeni Driver's License

Experience: 3-5 years driving experience; familiar with operations of 4-wheel drive vehicles; mechanical work experience

Skills:

<ul style="list-style-type: none">. Arabic fluency, English conversational. Map reading. Driving in difficult situations:<ul style="list-style-type: none">- off-road- 4-WD- steep- narrow	<ul style="list-style-type: none">. Basic vehicle repair/maintenance. Mild-mannered. Courteous. Committed to working at least 1/2 time in the community/field
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SUPERVISOR: Office Manager

SUPERVISES: Not applicable

JOB SUMMARY: Involves driving personnel to appointments, running errands, daily maintenance of vehicles and vehicle log book.

DUTIES and RESPONSIBILITIES:

1. Keeping vehicles clean inside and outside.
2. Daily check fluid levels and tire air pressure.
3. Requesting items needed to maintain vehicles (ie., fuel, oil, coolant) in writing as needed.
4. Reporting any incidents (ie., towing, thefts, tickets, damage to vehicles).
5. Ensure that when vehicle is taken for repairs, work is completed satisfactorily as requested per work order and report to Project Director if any discrepancies exist.
6. Run errands as directed.
7. Transport personnel to appointments as directed.
8. Daily maintenance of vehicle log book.
9. Ensure regular maintenance of vehicle (ie., oil changes, tire rotations).

TRAINING:

JOB DESCRIPTION
Child Survival XI - ADRA/Yemen

POSITION: GUARD/CUSTODIAN

QUALIFICATIONS:

Experience: Experience in general cleaning and security procedures.

Skills: . Arabic fluency; English conversational . Conscientious and organized
. Mild-mannered . Courteous

SUPERVISOR: Office Manager

SUPERVISES: Not applicable

JOB SUMMARY: Involves keeping the ADRA office grounds clean and neat and overnight security measures.

DUTIES and RESPONSIBILITIES:

1. Keeping all areas of the ADRA office clean inside and outside and involves trash disposal, sweeping, dusting and mopping daily.
2. Maintenance of cleaning supplies and involves requesting items needed in writing to the Secretary/Cashier.
3. Reporting any incidents (ie., damage to office equipment and/or grounds, graffiti, thefts, burglaries, or any other type of intrusion).
4. Ensures office security overnight by making regular rounds and securing locks.
5. Informs afterhour visitors of the scheduled office hours.

TRAINING:

Appendix H

Immunization Curriculum Outline

EPI Training Pre/Post Test

Nutrition Training Evaluation Tool

Immunization Curriculum Outline

Section I - EPI

1. EPI Objectives
2. EPI Policies and Strategies
 - a. Target populations
 - b. Coverage by immunization
 - c. Immunization schedule
 - d. Indications and contradictions for immunization
 - e. Lost opportunities
 - f. Catchment area of a health facility
 - g. Community participation

Section II - Childhood Communicable, Immunizable Diseases

1. Tuberculosis
2. Poliomyelitis
3. Measles
4. Diphtheria
5. Pertussis
6. Tetanus

Section III - Vaccines

1. Immunity
2. Vaccines
 - a. BCG vaccine
 - b. DPT vaccine
 - c. Tetanus toxoid
 - d. Measles vaccine
 - e. Oral polio vaccine
3. Method of Immunization

Section IV - Immunization Sessions

1. Immunization Session Procedure
2. Recording and Reporting Work

Section V - Health Education

1. Education of Individuals
2. Group Education
3. Other Community Channels for Health Education
4. Health Education Means and Materials

Section VI - Cold Chain System

1. Cold Chain Management at the Level of Health Facilities
2. Monitoring the Cold Chain and Vaccines Daily
3. At the End of the Immunization Session
4. Monitoring the Cold Chain and Vaccines Weekly
5. Do not use Vaccines in the Following Conditions
6. Managing Store Supplies

Section VII - Reporting System

1. Reporting

2. The Daily Reporting Form
3. The Monthly Report
4. Keeping Copies of the above Report
5. Evaluation

Section VIII - Communicable Disease Surveillance

1. The Significance of Surveillance
2. Role of Health Workers
3. Specific Procedures for Tetanus and Polio Cases

Reference

Immunization Guidelines for Health Workers. UNICEF and REACH. 1993. National EPI Office, Ministry of Public Health: Sana'a, Yemen.

تتلف لقاحات الثلاثي عند درجة حرارة:

أربعة	ثمانية	تحت الصفر
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

يعطى لقاح بي سي جي :

تحت الجلد	في الجلد	في العضل
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

يعطى اللقاح الثلاثي:

في العضل	تحت الجلد	في الوريد
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

يعطى لقاح شلل الأطفال:

حقن بالعضل	حقن في الجلد	فطر بالفم
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

يعطى لقاح بي سي جي بعد الولادة مباشرة
نعم

لا

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

يعطى لقاح شلل الأطفال :

ثلاث مرات	أربع مرات	مرة واحدة
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

يتم التخلص من مخلفات جلسات التطعيم:

بالدفن	بالحرق	بالإغناء في الخلاء
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

اجب على الاسئلة التاليه خلال ١/٢ ساعة :-

(١) ماهي العناصر الغذائية ؟ ماهي فائدة كل منها ؟ هات مثال لمصادرها ؟ فواكه

(٢) يتكون الجهاز الهضمي من أ - الفم - ب - المعدة - ج - الأمعاء - د - القولون - هـ - و

(٣) وملحقته هي :- الكبد - و - البنكرياس - و - المرارة - و - الغدة الكظرية ماهي وظيفة كل جزء من اجزاء الجهاز الهضمي ؟

(٤) ماهي فائدة أن تأخذ قياس الوزن والطول للطفل ؟

(٥) هل يمكنك قياس طول الرضيع حاليا : وحدك (بالمساعدة) (لا اعرف)

(٦) ايهما لغذاء اضافي " زيادة " ؟ رقم حسب الاهمية داخل المربع .

المراه الحامل () المراه المرضع () الاطفال () الشيوخ ()

(٧) اذكر ٣ فوائد للرضاعه لطبيعه للطفل ؟ الرضع والامه والاب

(٨) اذكر ٣ فوائد للرضاعه الطبيعه للام الامه والاب والرضع

(٩) متى يبدأ فطام الاطفال ؟ ١٢ شهر ١٨ شهر ٢٤ شهر

(١٠) املا الفراغ بالكلمه المناسبه : نقص فيتامين د نقص البروتين نقص الطاقة نقص اليود

نقص فيتامين أ يسبب : قصر الدم نقص تناول الحديد نقص تناول اليود نقص تناول الفيتامينات

(١١) اذكر باختصار الامراض التي تنتقل بالغذاء الاسهال

(١٢) متى يكون الغذاء غير صالح للاكل الادمي ؟ الاسهال القيء الحمى الطفح

(١٣) ماهي محاور تلوث الغذاء ؟ الماء الهواء التربة الحيوانات

Appendix I

HIS Data Variable Table

Children's Daily EPI Register

Children's Daily EPI Summary

TT Daily EPI Summary

Monthly P Report

NEDS Form

Monitoring of the Health Information System

REPORT	DATA VARIABLE	REPORT FREQUENCY	SUBMIT TO	SUBMIT TO
CHP	Health Promotion: EPI, TT, Nutrition, GM and/or CDD	Collected W; submitted M	PHCW	
	Follow-up: EPI, TT, GM, and/or CDD	Collected W; submitted M	PHCW	
	GM sessions held	Collected W; submitted M	PHCW	
	Vital events: birth and deaths	as it occurs; submitted M		
PHCW	CHP training sessions: EPI, TT, Nutrition, GM, CDD	Collected W; submitted M	LDC	Supervisor
	EPI supplies Number of children immunized Number of children needing follow-up	Collected D; submitted M	LDC	Supervisor
	GM supplies Number of children attending GM sessions Number of children needing follow-up	Collected D; submitted M	LDC	Supervisor
	CDD supplies Number of children with diarrhea Number of children needing follow-up Number of ORS packets distributed	Collected D; submitted M	LDC	Supervisor
	Number and type of referrals: EPI, GM, CDD	Collected D; submitted M	LDC	Supervisor
	Facility Inventory: Cold chain equipment, GM equipment	Q	Supervisor	
	Cold chain monitoring	Collected D; submitted M	Supervisor	
	Surveillance: polio and neonatal tetanus	as it occurs	LDC	Supervisor
	Minutes: surveillance, reviews of health report, CS activities	M	Supervisor (thru PHCW)	Community Development Coordinator
CHP supervision	M	LDC	PHCW	
Vital events: birth and deaths	M	Supervisor (thru PHCW)		

Monitoring of the Health Information System (con't)

REPORT	DATA VARIABLE	REPORT FREQUENCY	SUBMIT TO	SUBMIT TO
Supervisor	ORS retailer training sessions	M	Health/Training Coordinator	Community Development Coordinator
	LDC list: CS intervention orientations and expansions	M	Health/Training Coordinator	Community Development Coordinator
	Intervention monitoring (from PHCW reports)	M	HIS Coordinator	
	Cold chain monitoring	M	Project Director	
	Surveillance: polio and neonatal tetanus	M	HIS Coordinator	GHO
Formative Research/QA Coordinator	Focus group/interview notes: CDD, Nutrition	as it occurs	Health/Training Coordinator	
	QA of health facilities' SCM	as it occurs	HIS Coordinator	Health/Training Coordinator
	QA of ORS retailers' SCM	as it occurs	HIS Coordinator	Health/Training Coordinator

Abbreviations

D	Daily
M	Monthly
Q	Quarterly
W	Weekly

الإحصاء اليومي لتطعيم الأطفال اليوم / / ١٩٩م

نموذج (ب / ٢)

المحافظة:

المديرية:

المرفق الصحي:

لقاح الحصبة	لقاح الثلاثي / الجرعة				لقاح شلل الأطفال / الجرعة				لقاح البي.سي.جي	الفئة العمرية
	المجموع	الثالثة	الثانية	الاولى	المجموع	الثالثة	الثانية	الاولى		
										ما دون سنة واحدة من العمر
										من سنة (١٢ شهراً) الى ثلاث سنوات (٣٦ شهراً)
										المجموع

المستهلك اليومي من اللقاحات والمحاقن / الأبر

الننفة	أمبولات اللقاح					محاقن / أبر
	البي.سي.جي	شلل الأطفال	الثلاثي	الحصبة	عضلي	
الصف						جلدي (بي.سي.جي)
العدد						

إسم المطعم:

توقيعه:

بسم الله الرحمن الرحيم

نموذج (ب / ٣) الإحصاء اليومي لتطعيم النساء في سن الإنجاب (١٥-٤٤) سنة ليوم / / ١٩٩م

المحافظة:

المديرية:

المرفق الصحي:

لقاح تيتانوس توكسويد (الكزاز) - الجرعة:						البيان	الفئة
المجموع	الخامسة	الرابعة	الثالثة	الثانية	الاولى	الإشارات	الحوامل
						العدد	
						الإشارات	غير الحوامل
						العدد	
							المجموع

المستخدم اليومي من:

الصنف	لقاح التيتانوس	عاقن / أبر
عدد الزجاجات		

إسم المطعم:

التوقيع:

Women's & Children

Monthly Report
Monthly Summary

بسم الله الرحمن الرحيم

ملخص شهري لتطعيمات الأطفال والنساء خلال شهر _____ م ١٩٩

المحافظة: _____						المديرية: _____										المرفق الصحي: _____	
Women's						Children's											
تطعيمات النساء من سن (١٥ - ٤٤) سنة						تطعيمات الاطفال											
لقاح التيتانوس توكسيد - جرعة:						لقاح	لقاح الثلاثي - جرعة:			لقاح شلل الاطفال - جرعة:				لقاح		الفئة	
						الحصبة	المجموع	ثالثة	ثانية	اول	المجموع	ثالثة	ثانية	اول	تمهيدية	بي . سي . جي	ما دون سنة
المجموع	خامسة	رابعة	ثالثة	ثانية	اول	الفئة											واحدة
						حوامل											من سنة الى سنتين
						غير حوامل											المجموع
						المجموع											

المستهلك من اللقاحات والمحاقن / الابر

عدد المحاقن / الابر		أمبولات اللقاح				الوصف	
جلدي	عضلي	تيتانوس توكسيد	الحصبة	ثلاثي	شلل الاطفال	بي . سي . جي	العدد

إسم المُطعم: _____ توقيع: _____ إسم مدير المرفق: _____ توقيع: _____

التاريخ: _____ التاريخ: _____

Weekly

Date :

التقرير الأسبوعي

Out patient Form

التاريخ : العيادات الخارجية والمراكز والوحدات الصحية

Governorate: Directorate Location Hospital Name

المحافظة المديرية المنطقة اسم المؤسسة الصحية

ICD Codes	Disease	Under 1 Year		1 - 4 Years		5 - 14 Years		15 - 44 Years		45 Plus Years		Grand Total	
		M	F	M	F	M	F	M	F	M	F	M	F
001	Cholera الكوليرا												
008	Diarrhea الاسهال المعوي												
018	Tuberculosis السل												
032	Diphtheria الدفتيريا												
033	Pertussis السعال الديكي												
037	Tetanus التيتانوس (الكزاز)												
045	Poliomyelitis شلل الاطفال												
0479	Meningitis التهاب السحايا												
055	Measles الحصبة												
071	Rabies داء الكلب												
084	Malaria الملاريا												
129	Parasitic Diseases الطفيليات المعوية												
480	ARI التهاب التنفس الحاد												
7713	Neonatal Tetanus التيتانوس الولادي												
	Others امراض اخرى												

Document A

Response to Proposal Review Comments

Response to Proposal Review Comments ADRA/Yemen

1. General Concerns

Local Area Council Support: Section H.2 - Sustainability plan explains why specific letters of support from organized groups are not available. Included in the letters of support are three letters, two are from the head *sheikhs* of the districts of Hais and Jabal Ras addressed to the Director of Health of the Hodeidah Governorate and one from the Health Center director of Khokha (see Appendix B). These letters express their willingness to cooperate with ADRA activities as they correspond to the existing system.

Justification for Introduction of Child Survival Activities

It is true that the literacy and SED project components are just now being implemented and will be functioning fully by the fall of 1996. Hiring of a program manager has taken longer than expected. CS activities are commencing with the establishment of a strong foundation of a community-based EPI program. Approximately six months are dedicated to building these capacities by: 1) organizing local development committees in villages that invite us to work with them; 2) training supervisors and health workers to carry out duties effectively; and 3) establishing a functioning cold chain system. These activities will establish a trusting relationship with the communities.

The relationship between the literacy and small loan activities and the child survival components are described in Section I - Literacy/SED.

Community Health Promoters - Volunteers

The number of CHPs to be trained has been decreased from the 500 mentioned in the proposal to 200. Section E.3 - training and supervision plan describes the project's approach to training and involvement of female volunteers. Activities are beginning with organization of LDCs, EPI capacity building, training of health center personnel in SCM of diarrheal episodes and nutritional counseling.

Formation and Authorization of LDCs

Section H.2 Sustainability plan explains that village-based LDCs will be formed through the cooperation of the district level councils. The approval and support of the district level council and the health center will give the LDCs authorization to administer jurisdiction in their areas.

2. Immunizations

TT2 Coverage Objective

The project has a 25% TT2 coverage objective. See Section D.4a5 - Immunization Objectives and Table B - Project Goals and Objectives.

Cold Chain Equipment

Section D.4a.11 - Cold Chain Support describes the details about cold chain equipment that is needed for the three districts of the project area.

LDC Support

Section 4a.6 explains the role of the LDCs in supporting the PHCWs and CHPs in immunization activities. Also, see Section 4a.6 for details on cold chain equipment.

3. Case Management of Diarrheal Diseases

Section D.4d.8 - Health Education, and D.4d.9 - Prevention name the health education messages that promote hand washing, use of sanitary latrines and safe water supply as preventive measures against diarrheal disease.

4. Nutrition

Malnutrition

Section 4b.1a - Baseline defines "malnutrition" by specifying the anthropometric indexes stated in the *State of the World's Children*, UNICEF, 1996. Other sources are not available. The most recent national studies of nutrition were conducted in the former Yemen Arab Republic (YEAR) in 1979 and in the People's Democratic Republic of Yemen (PRY) in 1982.

Nutrition Objective

The nutrition objective of "reducing the prevalence of malnutrition rate among children < 24 months of age from 30% to 20%" was dropped. Proceeding with this objective would have meant conducting an anthropometric survey to establish baseline information. Another objective for which baseline data is already available was developed to substitute the one being dropped. It reads, "to increase the number of children < 24 months who have GM cards and were weighed in the past three consecutive months from 0.003% to 25.0% in the project area. The PVO CSSP at JHU was consulted to assure that by canceling a proposed objective at this stage, ADRA will not create another problem and also to assure that the newly developed objective is justifiable in terms of relevance and scope of activities given that the nutrition intervention constitutes 30% of the project's efforts. In order to measure a change in nutritional status, the objective to "improve the nutritional status of children > 24 months of age that attend GM sessions by at least 10% as recorded and monitored on the GM card" is also included.

MUAC

As recommended by the reviewers of the Yemen CS XI proposal, it is unnecessary to introduce mid-upper arm circumference (MUAC) as a separate screening tool to detect underweight children. As indicated, MUAC is not effective in identifying growth faltering children and is not interchangeable with either weight-for-height or weight-for-age anthropometric measurements. This project will rely only on growth monitoring using RTH cards (master charts at the health center) to identify malnourished children and monitor their growth. See section 4b.1c for details.

Growth Monitoring Supplies

Sections D4b.1a - Baseline, and D4b.2e - Individual Documentation clarify what GM supplies are needed and from where the project will obtain them.

CHP Monitoring

Section D4b.2f - Approach addresses the need for careful training and follow-up of CHPs and the need for monitoring of their activities.

Family Gardens and Nutrition Demonstrations

Family gardens will be promoted in this mostly non-urban population. Refer to Section D4b.1d (approach) for details on the nutrition demonstration sessions.

5. Human Resources

Appendix G contains the job description (inclusive of required qualifications) for the health and training coordinator. The person hired for this position has had prior experience in the design of health education curriculum content. He will be assisted by the project director and formative research coordinator in the preparation of materials to be used during training sessions.

6. Health Information System and Education

Identification of Households with Under-tuos

Identification of households with under-tuos will be the responsibility of the CHPs. They will cover households that are in the area surrounding that home. It will be manually done during each introduction of the various intervention phases and then updated as the intervention progresses. This means that surveillance activities will focus on households that have under-tuos at any given point of time.

Final Evaluation

The end-of project survey has been budgeted under line items "Consultant" and "International travel" of the headquarters budget and "baseline surveys" of the field budget (see Section G). It is also mentioned in Table C Schedule of Field Project Activities.

Document B

Baseline Survey Report

Separate Document

Document C

Combined CS XI Budget

ADRA INTERNATIONAL CHILD SURVIVAL XI

Multi-Country Budget Summary

	First Year		Second Year		Third Year		Fourth Year		All Years	
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA
A. Salaries										
1 Direct Backstopping										
a Grant Manager	9,876	3,291	7,475	3,461	7,838	3,641	8,221	3,830	33,409	14,223
b Health Advisor	11,375	1,916	7,217	2,006	7,573	2,101	7,948	2,200	34,112	8,224
c Financial Compliance	7,126	812	2,436	861	2,582	913	2,737	967	14,881	3,553
Subtotal direct backstopping	28,376	6,020	17,128	6,329	17,993	6,654	18,905	6,998	82,402	26,000
2 Technical support										
a Evaluation	1,550	517	2,850	840	2,699	564	3,976	926	11,075	2,846
b Accounting	2,725	908	2,224	842	2,333	884	2,447	928	9,729	3,562
c Support staff	2,675	892	2,220	826	2,333	868	2,452	914	9,679	3,499
Subtotal technical support	6,950	2,317	7,294	2,507	7,364	2,316	8,875	2,768	30,483	9,908
Subtotal Personnel	35,326	8,336	24,421	8,835	25,357	8,970	27,780	9,766	112,885	35,908
B. Other direct HQ costs										
1 Communication										
a Telephone	1,180	250	1,260	261	1,323	273	1,390	285	5,153	1,070
b Fax	920	223	967	234	1,017	245	1,069	257	3,973	960
c Mail/express	2,041	414	2,159	437	622	462	623	488	5,445	1,801
Subtotal Communication	4,141	887	4,386	932	2,961	980	3,082	1,030	14,570	3,830
2 Report Preparation	1,200	267	1,262	279	1,326	292	1,395	306	5,183	1,144
Subtotal other HQ costs	5,341	1,154	5,648	1,212	4,288	1,272	4,477	1,336	19,753	4,974
Total HQ.	40,667	9,490	30,069	10,047	29,645	10,243	32,257	11,102	132,638	40,883
HQ field costs										
F. Contractual										
1 Health	6,025	1,058	5,166	1,106	5,427	1,156	5,701	1,208	22,319	4,528
2 Management	6,025	1,033	5,166	1,079	5,427	1,128	5,701	1,178	22,319	4,419
3 Financial	4,425	306	3,518	324	3,729	343	3,953	364	15,625	1,336
4 Training										
5 Evaluation			18,500		5,250		26,108		49,858	
6 HIS	2,500		4,150		2,809				9,459	
7 A-133 Auditor	4,400	1,000	4,664	1,030	4,944	1,061	5,240	1,093	19,248	4,184
Subtotal Consultants	23,375	3,397	41,164	3,539	27,585	3,687	46,703	3,843	138,827	14,467

	First Year		Second Year		Third Year		Fourth Year		All Years	
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA
B International travel/per diem										
1 Health	6,600	333	6,754	343	7,128	354	7,524	364	28,007	1,395
2 Management	8,800	333	6,754	343	7,128	354	7,524	364	30,207	1,395
3 Financial	5,600		5,724		6,067		6,431		23,823	
4 Evaluation			11,792		2,300		15,939		30,031	
5 HIS	2,400		3,544		2,697				8,641	
6 DIP wkshp	6,600	400							6,600	400
7 Baseline	4,800	800		824	1,000	849	1,700	874	7,500	3,347
8 Auditing	5,280	2,767	5,597	2,903	5,933	3,046	6,313	3,197	23,122	11,912
Subtotal travel/perdeims	40,080	4,633	40,165	4,413	32,253	4,602	45,432	4,800	157,930	18,448
Subtotal Consultants + Travel	63,455	8,031	81,329	7,952	59,838	8,289	92,135	8,642	296,757	32,915
C. Equipment										
1 Computers		14,600								14,600
2 Printer	900	1,300							900	1,300
3 Copier	1,300								1,300	
4 UPS	480								480	
5 Fax Machine	1,200								1,200	
6 Radio systems	2,500								2,500	
7 Typewriter	600					200			600	200
Subtotal Procurement	6,980	15,900				200			6,980	16,100
G. Other costs										
a. Baseline surveys	5,000	2,400					600		5,600	2,400
b. DIP orientation	450								450	
Subtotal other costs	5,450	2,400					600		6,050	2,400
Total HQ Field costs	75,885	26,331	81,329	7,952	59,838	8,489	92,735	8,642	309,787	51,415
Country Programs								8,642		
Honduras Country Costs	111,597	35,020	110,428	39,088	113,491	37,957	110,520	28,027	446,036	140,092
Yemen Country Costs	120,459	100,140	163,820	44,257	143,126	22,798	140,521	24,166	567,926	191,361
Zambia Country Costs	143,404	87,360	142,725	49,676	130,989	49,736	118,129	50,450	535,247	237,222
Total Field Costs	375,460	222,520	416,973	133,021	387,606	110,491	369,171	102,643	1,549,209	568,675
TOTAL DIRECT COSTS	492,012	258,341	528,370	151,021	477,089	129,223	494,163	122,388	1,991,634	660,972
21.00 % Indirect Costs	104,299	54,078	110,630	31,773	100,068	27,633	103,335	26,171	418,332	139,655
6.00 % Unrecovered IdC		28,544		32,030		28,746		30,089		119,409
TOTAL PROGRAM	596,311	340,964	639,000	214,824	577,157	185,602	597,498	178,647	2,409,966	920,036
								Match		27.63%

Document D

Project Timeline

Oct. 1995 to Sept. 1996	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Project Management				
Personnel	Staff Hiring and Orientation		Staff Working	
Procurement	Procurement of Equipment and Supplies			
Formative Research			Design	Field Work/Analysis
Surveys/DIP/Evaluations	Baseline Survey-Design, Data	DIP Preparation		
Reporting(Month, Quarter, Annual)	Q	Q	Q	A
Capacity Building				
Training of Trainers		Design	EPI Training of Trainers	
Training Sessions		Supervisor Training TOT	EPI Training Sessions, Evaluation - Knowledge of Skills	
Health Information Services	Consultants to Design		EPI Develop and Test	Feedback to Community
Community System Strengthening				
LDC			LDC's Organized & Functioning PHASE I	
Vaccination			Vaccination/Weighing Sites Organized	
MOH			Cold Chain Established	
Interventions/Services				
EPI		Develop IEC EPI	Service Delivery Initiated	Key EPI Messages to Mothers
CDD			Develop IEC CDD	
Nutrition				Develop IEC Nutrition

Oct. 1996 to Sept. 1997	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Project Management				
Personnel	Staff working			
Procurement		Pharmaceuticals		
Formative Research	Design	Field Work, Data Collection, Analysis		
Surveys/DIP/Evaluations				
Reporting(Month, Quarter, Annual)	Q	Q	Q	A
Capacity Building				
Training of Trainers	CDD Training of Trainers		Nutrition - Training of Trainers	
Training Sessions	CDD Training Sessions, Evaluation - Knowledge of Skills			
Health Information Services	CDD Develop and Test	Feedback to Community	Nutrition Develop & Test	Feedback to Community
Community System Strengthening				
LDC	LDC's Functioning PHASE I			
Vaccination		Vaccination/Weighing sites Organized		Monthly Vaccination Days
MOH	HW's trng in SCM of Diarrhea			
Interventions/Services				
EPI	Weekly Vaccinations at HC	Train 3 Vaccinators	Provide Motorcycles	
CDD	Service Delivery Initiated	Train Volunteers		
Nutrition	Hire Garden Promoter	25 Model Gardens	Service Delivery Initiated	

Oct. 1997 to Sept. 1998	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Project Management				
Personnel	Staff working			
Procurement			Supplies	
Formative Research	Field Work/Analysis/Feedback			
Surveys/DIP/Evaluations	Mid Term Evaluation			
Reporting(Month, Quarter, Annual)	Q	Q	Q	A
Capacity Building				
Training of Trainers				
Training Sessions	Training Sessions, Evaluation - Knowledge of Skills			
Health Information Services	Feedback to Community			
Community System Strengthening				
LDC	LDC's Functioning/ Organized Phase II			
Vaccination	ORS supplies to vac sites	Add weighing to Vac Days		
MOH	Ref Trning SCM & Diarrhea	QA Participator Monitory System		
Interventions/Services				
EPI	Functioning			
CDD	Key CDD Messages to Mothrs	Functioning		
Nutrition		Train Vol Nutrition & Weighing	Key Nutr Messages to Mthrs	

Oct. 1998 to Sept. 1999	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Project Management				
Personnel	Staff working			
Procurement				
Formative Research	Field Work/Analysis/Feedback			Formative Res Integrated
Surveys/DIP/Evaluations				Final Evaluation
Reporting(Month, Quarter, Annual)	Q	Q	Q	A
Capacity Building				
Training of Trainers				
Training Sessions	Training Sessions, Evaluation - Knowledge of Skills			
Health Information Services	Feedback to Community			
Community System Strengthening				
LDC				Locally Sustainable Systems
Vaccination			Up grading of sites to PHCU	
MOH				Institutionalised In Health Fac
Interventions/Services				
EPI	Functioning			Vol Prog Inst in Community
CDD	Functioning			Vol Prog Inst in Community
Nutrition	Functioning			Vol Prog Inst in Community