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August , 1986.

Dr. Roger Eeckels
Executive Director, ICDDR,B
Mohakhali
Dhaka

Subject : Grant No. 388-0073-G-SS-60
for the Child Survival Urban Volunteers Project.

Dear Dr. Eeckels:

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, and the Federal Grant and Cooperative Agreement Act of 1977, the U.S. Agency for International Development (hereinafter referred to as "A.I.D." or "Grantor") hereby grants to the International Centre for Diarrhoeal Disease Research, Bangladesh (hereinafter referred to as "ICDDR,B" or "Grantee") the sum of U.S.\$ 4.0 million (Four Million U.S. Dollars) to provide support for the Child Survival Urban Volunteer Program, as described in the Schedule of this Grant and the Attachment 2, entitled "Program Description."

This grant is effective and obligation is made as of the date of this letter and shall apply to commitments made by the Grantee in furtherance of program objectives during the period beginning with the effective date and ending September 30, 1991.

This grant is made to the ICDDR,B, on condition that the funds will be administered in accordance with the terms and conditions as set forth in Attachment 1, entitled "the Schedule"; Attachment 2, entitled "Program Description" and Attachment 3 entitled "Standard Provisions (Mandatory and Optional)"; which have been agreed by your organization.

Please sign the two originals and the stencil copy of this letter to acknowledge your acceptance of the grant, and return one original and the stencil to USAID/Bangladesh. We will reproduce multiple copies for all concerned.

Sincerely,

John R. Westley
Director, USAID/Dhaka

- Attachments: 1. The Schedule
2. Program Description
3. Standard Provisions (Mandatory and Optional)

ACKNOWLEDGED AND ACCEPTED:

BY:
Typed name: Dr. Roger Eeckels
Title: Executive Director
International Centre for Diarrhoeal Disease Research, Bangladesh

Date: August , 1986

FISCAL DATA

APPROPRIATION: 72-1161021

BUDGET PLAN CODE: QDAA-86-27388-FG-13; AMOUNT \$2,000,000

QDAA-86-27388-CG-13; AMOUNT \$2,000,000

TOTAL OBLIGATED AMOUNT: \$4,000,000

TOTAL ESTIMATED AMOUNT: \$4,500,000

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ATTACHMENT 1: THE SCHEDULE

A. PURPOSE OF GRANT

The purpose of this Grant is to provide support for child survival interventions in the urban areas of Bangladesh, as more specifically described in Attachment 2 to this Grant, entitled "Program Description".

B. PERIOD OF GRANT

1. The effective date of this Grant is August 31, 1986. The expiration date of this Grant is September 30, 1991. The terminal date of disbursement is June 30, 1992.

2. Funds obligated hereunder are available for program expenditures for the estimated period August 31, 1986 to September 30, 1990 as shown in the Financial Plan below.

C. AMOUNT OF GRANT AND PAYMENT

1. The total estimated amount of this Grant for the period shown in B.1 above is U.S. \$4.5 million.

2. AID hereby obligates the amount of U.S.\$4,000,000 for program expenditures during the period set forth in B.2 above and as shown in the Budget below.

3. Payment shall be made to the Grantee in accordance with procedures set forth in Attachment 3 - the Standard Provisions entitled "Payment - Periodic Advance;" or "Payment - Cost Reimbursement" and in accordance with Section D.2 below.

4. Additional funds up to the total amount of the grant shown in C.1 above may be obligated by AID subject to the availability of funds, and to the requirements of the Standard Provision of the Grant, entitled "Revision of Grant Budget."

D. BUDGET

1. The following is the Budget for this Grant, including authorized local cost financing items. Revisions to this Plan shall be made in accordance with the Standard Provision of this Grant, entitled "Revision of Grant Budget."

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AMOUNT IN U.S. DOLLARS

<u>Cost Element</u>	<u>Obligated 8/86 - 9/90</u>	<u>Estimated Additional Amount 10/90 - 9/91</u>	<u>Total Estimated Amount 8/86 - 9/91</u>
1. Personnel Costs:			
a) Local staff	1,051,000	125,000	1,176,000
b) Int'l staff	750,000	81,000	831,000
c) Consultants (ST)	87,000	12,000	99,000
(Subtotal)	<u>1,888,000</u>	<u>218,000</u>	<u>2,106,000</u>
2. Travel Costs:			
a) Local	173,000	23,000	196,000
b) International	57,000	8,000	65,000
(Subtotal)	<u>230,000</u>	<u>31,000</u>	<u>261,000</u>
3. Supplies and Equipment	501,000	52,000	553,000
4. Inter-departmental Service (Training)	205,000	27,000	232,000
5. Evaluation	150,000	31,000	181,000
6. Accounting and Audit Services	125,000	28,000	153,000
7. Other Direct Costs	<u>100,000</u>	<u>13,000</u>	<u>113,000</u>
Total Operating Costs	3,199,000	400,000	3,599,000
Overhead Costs: (25%)	<u>801,000</u>	<u>100,000</u>	<u>901,000</u>
TOTAL U.S. DOLLARS	<u>4,000,000</u>	<u>500,000</u>	<u>4,500,000</u>

2. All funds of the Grant is subject to the following limitations:

a. A separate bank account will be maintained for purposes of this OPG and copies of reconciled monthly bank statements will be submitted with reimbursement vouchers. All accounting records will be maintained separately for this OPG and only expenses for such will be charged to the grant.

b. Budget Line Items 1 and 2 will not be exceeded without the written approval of USAID. Variation among other budget line items in excess of 5% will require written approval of the USAID/Dhaka project officer.

c. Advances will be limited to immediate operating needs only, but in no case will exceed requirements for 90 days.

d. Reimbursement vouchers, by budget line item, based upon actual payments made, will accompany subsequent advance requests.

e. Reimbursement vouchers will be supported by copies or extracts of the local payroll, documentary evidence and itemization of payment of international and consultants salaries, copies of travel and transportation vouchers for local and international travel and documentary support of inter-departmental (training) and all other costs for all expenses in excess of \$200.00.

f. ICDDR,B will hire an independent U.S. public accounting firm to establish and/or review the direct and overhead accounting systems maintained/developed by ICDDR,B both for this grant as well as ICDDR,B as an institution to ensure they are in conformance with generally accepted accounting procedures/principles as well as ensure all costs are accounted for properly. Monies will be made available for such within the grant. Expenses such as field office and guest house operating costs excluding lease costs, vehicle registration, M & R and POL costs, office supplies, reproduction and other miscellaneous costs are normally attributable to overhead. As ICDDR,B has elected to have these costs charged directly to the grant, the provisional overhead rate will be 25%.

g. Overhead will be charged to this grant in equitable proportion to grants of other donors.

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E. REPORTS AND EVALUATION

1. REPORTS:

ICDDR,B shall submit the following reports.

a. Progress and Planning Report (quarterly):

ICDDR,B will submit a brief report which will narrate implementation progress and any problems encountered over the last three months. The report will also include program plans/targets for the next three months. The progress and planning report will be keyed to the specific project objectives given in the Log Frame annexed to this grant. (This report should not exceed four pages.)

b. Intervention Report and Workplan (annual):

The Intervention Report will be based on and presented in the AID/W-developed format, consistent with Child Survival "three-tiered" approach. The AID/W three-tiered reporting format to be used, adapted to this project, has been designed by ICDDR,B and USAID (called the Monitoring and Evaluation Questionnaire).

The Workplan will set out program plans and targets, and include a monthly schedule, for each of the major interventions. The annual Workplan will be related to the expected budget expenditures during the year.

The Intervention Report and Workplan will be submitted to USAID by ICDDR,B by September 1st of each year.

c. Periodic Reports:

As needed, USAID may request from time to time, that ICDDR,B shall submit reports on activities which are of special interest.

d. Financial Reports:

All financial reports and voucher for payment and reporting of expenditures will be submitted quarterly (on an advance/reimbursement system) by ICDDR,B, and will conform to AID regulations. Details are provided in AID Handbook 13, Chapter 1, Section 1M, in the Standard Provisions concerning "Payment" and in Section D.2. above.

2. EVALUATION:

a. AID will arrange one comprehensive "mid-term" external evaluation 20 to 24 months following the commencement of project funding.

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b. All evaluations, including mid-term and final, to be conducted 4 to 6 months before the end of the project. Both the mid-term and final evaluations will be based upon the Logical Framework and/or amendments thereof, as given in Annex 1; the results of the annual Monitoring and Evaluation Questionnaire developed by USAID in conjunction with ICDDR,B; and the annual Workplan.

c. From time to time AID may request special, focussed evaluations of selected program activities. Special evaluations may be recommended by the Executive Director of the Urban Volunteer project.

d. Funds provided above for accounting and auditing services will be used, as determined by ICDDR/B in consultation with the USAID/Dhaka project manager and the USAID Controller to finance services of qualified firms or individuals in connection with formulation of written evaluations, judgments and conclusions concerning accounting systems, policies and procedures and other financial aspects of ICDDR/B. All funds utilized from this line item must have written AID approval.

e. The USAID/Dhaka project manager will conduct an annual, internal evaluation, using a format to be developed. ICDDR,B will assist the project manager to complete the internal evaluation by providing required data and reports about the project.

F. SPECIAL PROVISIONS

1. Local cost financing (local currency expenditure) is authorized for this Grant.

2. The Optional Standard Provisions concerning Title to Property, U.S. Government and Cooperating Country Title, and entitled "Cost Sharing," are deleted as inapplicable to this Grant.

3. KEY PERSONNEL:

a. In the performance of this Agreement, the following personnel are to be furnished by the ICDDR,B and are to be considered to be Key Personnel.

		<u>% of Time</u>
(1)	Executive Director - Dr. Bonita Stanton	100
(2)	Service Coordinator - Mrs. Tajkera Khair	100
(3)	Research Coordinator - Mrs. Khodeza Khatoon	100
(4)	Implementation Coordinator - (To be selected by the end of CY 1986)	
(5)	Expansion Coordinator - (To be selected by the end of 1986)	

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b. The personnel specified above are considered to be essential to the work being performed hereunder. Prior to making any change in the key personnel, ICDDR,B shall notify A.I.D. reasonably in advance and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the program. The listing of key personnel, with the consent of the contracting parties, may be amended from time to time during the course of the agreement to either add or delete personnel, as appropriate.

c. (1) ICDDR,B shall obtain USAID's approval to change the Executive Director, or any of the Coordinators, or continue the work hereunder during a continuous period in excess of three months without the participation of the approved key personnel.

(2) ICDDR,B shall consult with USAID if a key person plans to devote or is devoting substantially less effort to the work than anticipated in paragraph A. above.

(3) ICDDR,B shall pay the salary and benefits shown in the Budget of this Grant for the present Executive Director. Unless otherwise agreed upon, the Executive Director shall be seconded from Johns Hopkins University and ICDDR,B shall reimburse Johns Hopkins for her/his salary.

(4) Hiring of, contract renewal for, and financial clearance for hiring or extension of all program personnel (local and international) shall depend upon the financial status and needs of the Urban Volunteer Program (UVP). Selection of local and international personnel for the UVP shall be made solely on the basis of the professional and job-related qualifications of the applicants. Payment of salaries to UVP personnel out of Grant funds shall be made on a timely basis, and shall not be withheld or delayed for reasons extraneous to the UVP. All appointments to positions funded under this OPG must have the approval of the Executive Director or his designee.

(5) ICDDR,B shall notify USAID of any project positions that have been vacant more than three months.

G. OVERHEAD RATE

The following overhead rate is established for this Grant:

<u>Rate</u>	<u>Type</u>	<u>Period</u>	<u>Base</u>
25%	Provisional	6/1/86 - 5/31/90	Total Direct Operating Costs.

H. TITLE TO PROPERTY

Title to property financed under this Grant shall vest in the Grantee ICDDR,B under the Standard Provision entitled "Title to and Use of Property (Grantee Title)."

I. THE AUTHORIZED GEOGRAPHIC CODE

The authorized geographic code for procurement of goods and services under this Grant is A.I.D. Code 941, and Bangladesh for local cost financing.

J. VOLUNTARY POPULATION PLANNING

(a), (b) and (c): See Optional Standard Provision 13.

(d) Ineligibility of Foreign Nongovernmental Organizations That Perform or Actively Promote Abortion as a Method of Family Planning

(1) The recipient certifies that it does not now and will not during the term of this grant perform or actively promote abortion as a method of family planning in AID-recipient countries or provide financial support to any other foreign nongovernmental organization that conducts such activities. For purposes of this paragraph (d), a foreign nongovernmental organization is a nongovernmental organization which is not organized under the laws of any State of the United States, the District of Columbia or the Commonwealth of Puerto Rico.

(2) The recipient agrees that the authorized representatives of AID may, at any reasonable time, (i) inspect the documents and materials maintained or prepared by the recipient in the usual course of its operations that describe the family planning activities of the recipient, including reports, brochures and service statistics; (ii) observe the family planning activity conducted by the recipient; (iii) consult with family planning personnel of the recipient; and (iv) obtain a copy of the audited financial statement or report of the recipient, if there is one.

(3) In the event AID has reasonable cause to believe that the recipient may have violated its undertaking not to perform or actively promote abortion as a method of family planning, the recipient shall make available to AID such books and records and other information as AID may reasonably request in order to determine whether a violation of the undertaking has occurred.

(4) The recipient shall refund to AID the entire amount of assistance furnished under this grant in the event it is determined that the certification provided by the recipient under subparagraph (1), above, is false.

(5) Assistance to the recipient under this grant shall be terminated if the recipient violates any undertaking required by this paragraph (d), and the recipient shall refund to AID the value of any assistance furnished under this grant that is used to perform or actively promote abortion as a method of family planning.

ATTACHMENT 1: THE SCHEDULE: PART 1 OF 12 1977

(6) The recipient may not furnish assistance under this grant to a foreign nongovernmental organization (the subrecipient) unless (i) the subrecipient certifies in writing that it does not perform or actively promote abortion as a method of family planning in AID-recipient countries and does not provide financial support to any other foreign nongovernmental organization that conducts such activities and (ii) the recipient obtains the written agreement of the subrecipient containing the undertakings described in subparagraph (7), below.

(7) Prior to furnishing assistance under this grant to a subrecipient, the subrecipient must agree in writing that:

(i) The subrecipient will not, while receiving assistance under this grant, perform or actively promote abortion as a method of family planning in AID-recipient countries or provide financial support to other foreign nongovernmental organizations that conduct such activities.

(ii) The recipient and authorized representatives of AID may, at any reasonable time, (A) inspect the documents and materials maintained or prepared by the subrecipient in the usual course of its operations that describe the family planning activities of the subrecipient, including reports, brochures and service statistics; (B) observe the family planning activity conducted by the subrecipient; (C) consult with family planning personnel of the subrecipient; and (D) obtain a copy of the audited financial statement or report of the subrecipient, if there is one.

(iii) In the event the recipient or AID has reasonable cause to believe that a subrecipient may have violated its undertaking not to perform or actively promote abortion as a method of family planning, the recipient shall review the family planning program of the subrecipient to determine whether a violation of the undertaking has occurred. The subrecipient shall make available to the recipient such books and records and other information as may be reasonably requested in order to conduct the review. AID may also review the family planning program of the subrecipient under these circumstances, and AID shall have access to such books and records and information for inspection upon request.

(iv) The subrecipient shall refund to the recipient the entire amount of assistance furnished to the subrecipient under this grant in the event it is determined that the certification provided by the subrecipient under subparagraph (6), above, is false.

(v) Assistance to the subrecipient under this grant shall be terminated if the subrecipient violates any undertaking required by this paragraph (d), and the subrecipient shall refund to the recipient the value of any assistance furnished under this grant that is used to perform or actively promote abortion as a method of family planning.

(vi) The subrecipient may furnish assistance under this grant to another foreign nongovernmental organization (the sub-subrecipient) only if (A) the sub-subrecipient certifies in writing that it does not perform or actively promote abortion as a method of family planning in AID-recipient countries and does not provide financial support to any other foreign nongovernmental organization that conducts such activities and (B) the subrecipient obtains the written agreement of the sub-subrecipient that contains the same undertakings and obligations to the subrecipient as those provided by the subrecipient to the recipient as described in subparagraphs (7)(i)-(v), above.

(8) Agreements with subrecipients and sub-subrecipients required under this subparagraphs (6) and (7) shall contain the definitions set forth in subparagraph (13) of this paragraph (d).

(9) The recipient shall be liable to AID for a refund for a violation by a subrecipient relating to its certification required under subparagraph (6) or by a subrecipient or sub-subrecipient relating to its undertaking in the agreement required under subparagraphs (6) and (7) only if (i) the recipient knowingly furnishes assistance to a subrecipient which performs or actively promotes abortion as a method of family planning, or (ii) the certification provided by a subrecipient is false and the recipient failed to make reasonable efforts to verify the validity of the certification prior to furnishing assistance to the subrecipient, or (iii) the recipient knows or has reason to know, by virtue of the monitoring which the recipient is required to perform under the terms of this grant, that a subrecipient has violated any of the undertakings required under subparagraph (7) and the recipient fails to terminate assistance to the subrecipient, or fails to require the subrecipient to terminate assistance to a sub-subrecipient which violates any undertaking of the agreement required under subparagraph (7)(vi), above. If the recipient finds, in exercising its monitoring responsibility under this grant, that a subrecipient or sub-subrecipient receives frequent requests for the information described in subparagraph (13)(iii)(A)(II), below, the recipient shall verify that this information is being provided properly in accordance with subparagraph (13)(iii)(A)(II) and shall describe to AID the reasons for reaching its conclusion.

(10) In submitting a request to AID for approval of a recipient's decision to furnish assistance to a subrecipient, the recipient shall include a description of the efforts made by the recipient to verify the validity of the certification provided by the subrecipient. AID may request the recipient to make additional efforts to verify the validity of the certification. AID will inform the recipient in writing when AID is satisfied that reasonable efforts have been made. If AID concludes that these efforts are reasonable within the meaning of subparagraph (9) above, the recipient shall not be liable to AID for a refund

in the event the subrecipient's certification is false and if the recipient knew the certification to be false or misrepresented to AID the efforts made by the recipient to verify the validity of the certification.

(11) It is understood that AID also may make independent inquiries, in the community served by a subrecipient or sub-subrecipient, regarding whether it performs or actively promotes abortion as a method of family planning.

(12) A subrecipient must provide the certification required under subparagraph (6) and a sub-subrecipient must provide the certification required under subparagraph (7)(iv) each time a new agreement is executed with the subrecipient or sub-subrecipient furnishing assistance under this grant.

(13) The following definitions apply for purposes of this paragraph (d):

(i) Abortion is a method of family planning when it is for the purpose of spacing births. This includes, but is not limited to, abortions performed for the physical or mental health of the mother but does not include abortions performed if the life of the mother would be endangered if the fetus were carried to term or abortions performed following rape or incest (since abortion under these circumstances is not a family planning act).

(ii) To perform abortions means to operate a facility where abortions are performed as a method of family planning. Excluded from this definition are clinics or hospitals which do not include abortion in their family planning programs.

(iii) To actively promote abortion means for an organization to commit resources, financial or other, in a substantial or continuing effort to increase the availability or use of abortion as a method of family planning.

(A) This includes, but is not limited to, the following:

(I) Operating a family planning counseling service that includes, as part of the regular program, providing advice and information regarding the benefits and availability of abortion as a method of family planning;

(II) Providing advice that abortion is an available option in the event other methods of family planning are not used or are not successful or encouraging women to consider abortion (passively responding to a question regarding where a safe, legal abortion may be obtained is not considered active promotion if the question is specifically asked by a woman who is already pregnant, the woman clearly states that she has already decided to have a legal abortion, and the family planning counsellor reasonably believes that the ethics of the medical

profession in the country require a response regarding where it may be obtained safely);

(III) Lobbying a foreign government to legalize or make available abortion as a method of family planning or lobbying such a government to continue the legality of abortion as a method of family planning;

(IV) Conducting a public information campaign in AID-recipient countries regarding the benefits and/or availability of abortion as a method of family planning.

(B) Excluded from the definition of active promotion of abortion as a method of family planning are referrals for abortions as a result of rape, incest or if the life of the mother would be endangered if the fetus were carried to term.

(C) Action by an individual acting in the individual's own capacity shall not be attributed to an organization with which the individual is associated, provided that the organization neither endorses nor provides financial support for the action and takes reasonable steps to ensure that the individual does not improperly represent that the individual is acting on behalf of the organization.

(iv) To furnish assistance to a foreign nongovernmental organization means to provide financial support under this grant to the family planning program of the organization, and includes the transfer of funds made available under this grant or goods or services financed with such funds, but does not include the purchase of goods or services from an organization or the participation of an individual in the general training programs of the recipient, subrecipient or sub-subrecipient.

(v) To control an organization means the possession of the power to direct or cause the direction of the management and policies of an organization.

(14) In determining whether a foreign nongovernmental organization is eligible to be a recipient, subrecipient or sub-subrecipient of assistance under this grant, the action of separate nongovernmental organizations shall not be imputed to the recipient, subrecipient or sub-subrecipient, unless, in the judgment of AID, a separate nongovernmental organization is being used as a sham to avoid the restrictions of this paragraph (d). Separate nongovernmental organizations are those that have distinct legal existence in accordance with the laws of the countries in which they are organized. Foreign organizations that are separately organized shall not be considered separate, however, if one is controlled by the other. The recipient may request AID's approval to treat as separate the family planning activities of two or more organizations, which would not be considered separate under the preceding sentence, if the recipient believes, and provides a written justification to AID

therefor, and the family planning activities of the organizations are sufficiently distinct as to warrant not imputing the activity of one to the other.

(15) Assistance may be furnished under this grant by a recipient, subrecipient or sub-subrecipient to a foreign government even though the government includes abortion in its family planning program, provided that no assistance may be furnished in support of the abortion activity of the government and any funds transferred to the government shall be placed in a segregated account to ensure that such funds may not be used to support the abortion activity of the government.

(e) The grantee shall insert this provision except paragraph (d) in all subsequent subgrants and contracts involving family planning or population activities which will be supported in whole or part from funds under this grant. Paragraph (d) shall be inserted in subagreements and sub-subagreements in accordance with the terms of paragraph (d). The term subagreement means subgrants and subcooperative agreements.

ATTACHMENT 2: PROGRAM DESCRIPTION

CHILD SURVIVAL: URBAN VOLUNTEERS
PROGRAM DESCRIPTION

I. OBJECTIVES AND DESCRIPTION

A. THE GOAL OF THE PROJECT:

Through selected child survival interventions, reduce morbidity and mortality in the approximately 1 million infants and children dwelling in the slum areas of Dhaka. Guidelines to be established for an extension of the project to Chittagong and Khulna.

There are two purposes:

Purpose 1: To make the basic child survival interventions, as described below, available to 95% children of the slum areas of Dhaka city and to institute, through selected NGOs or the BDG, the Urban Volunteer Program in the slum areas of Chittagong and Khulna cities, by 1991. In Dhaka, the interventions will be provided by approximately 2,000 trained women "Urban Volunteers" who reside in the slum areas where they work at an average ratio of one volunteer to 350 families. The interventions will include the following:*

Output a. To attempt to reduce death due to dehydration to 0% there will be 1) home visitation by urban volunteers to 40,000 mothers per month to provide instructions for treatment of diarrhoeal diseases and 2) Oral Rehydration Solution (ORS) packet distribution to treat approximately 16,000 children (<15 years) per month.

Output b. In an attempt to reduce the prevalence of xerophthalmia by 50% and reduce the prevalence of corneal involvement to 0%, the volunteers will perform the following services: nutrition education to 40,000 mothers/month; establishment of 4,000 backyard vegetable gardens; and distribution to 2,000 children per quarter of Vitamin A tablets for treatment of children with existing Vitamin A deficiency and prophylactic treatment for children with chronic diarrhoea.

Output c. To attempt to reduce mortality due to polio, tetanus and measles, the urban volunteers will refer children to local EPI centers for immunization against these diseases and provide follow-up to achieve coverage of an estimated 40% of Dhaka's approximately 1 million slum dwelling children by 1991.

Output d. Distribution of an effective and affordable soap ("neem") to help control scabies, and a health education program in an attempt to reduce the rate of diarrhoea and scabies by 25% and increase the practice of targeted hygienic practices by 30%.

*See modified logframe elements (Annex 1) for details of project inputs, outputs and baseline data.

Output e. Provision of information on the methods and source(s) of family planning services, by referring to Concerned Women for Family Planning (CWFP) clinics and alerting the CWFP outreach workers of potential clients. On a pilot basis selected contraceptives (pill and condom) will be carried by some UVs in areas not serviced by CWFP.

Output f. Aid communities in establishing 10 nutrition education clinics to increase the nutritional status of approximately 1500 moderately and severely malnourished children and 3 diarrhoeal clinics to reduce morbidity and mortality due to moderately severe and severe diarrhoea in peri-urban communities.

Purpose 2: To conduct service-related research and data collection activities in selected Dhaka slum areas to document the prevalence, incidence, and factors involved in the development and prevention of diarrhoea, scabies, nutritional blindness and malnutrition. Other activities planned include: (a) further evaluate the effectiveness of a community-based volunteer network for the provision of child survival interventions; (b) to assess the procedures for expansion and replication in other urban areas, and (c) to collect service-related statistics for evaluation and reporting purposes.

B. DESCRIPTION

1. BACKGROUND

Dhaka has over four million inhabitants (1985), approximately two million of whom reside in slum areas.

The population of urban poor in Bangladesh is increasing more rapidly than either the rural or urban population in general due, in large part to the substantial migration of rural poor to the city. The population of Dhaka tripled between 1961 and 1981 from 1.3 to nearly 3 million with half of this increase resulting from migration. It is conservatively estimated that the population of Dhaka will be 7 million by 1991 - at the end of the project - and over 3.5 million will be slum dwellers.

Nearly 25% of the homes in Dhaka slums have no access to latrine facilities and over 70% of those with latrines share them with up to 40 other families. Population densities of 5,000 per square acre are reported in Dhaka, even in areas of single-storied homes. Most areas lack masonry drains, and in areas with drains a lack of proper maintenance results in frequent overflowing. In the few areas with litter boxes, collection is sporadic and infrequent. On the average over 1000 persons utilize each tap or tubewell in some areas of Dhaka.

That such living conditions will be accompanied by considerable excess morbidity and mortality is to be expected. Although detailed demographic data is not available for urban Bangladesh to substantiate the above speculation, health indicators do exist that suggest that the health of poor urban dwellers of all major urban areas of Bangladesh is at least as suboptimal as that of poor rural dwellers.

Results from study sites in Dhaka suggest that in some age groups (1 year old) the diarrhoea rate exceeds 12 episodes per 100 weeks of child observation, a rate as high or higher than the rates in rural Bangladesh or elsewhere in the developing world (1). The prevalence of another disease, nutritional blindness (xerophthalmia), appears to be at least three times in excess of the maximum acceptable limits established by WHO, above which there exists a major public health problem. A third indicator of poor health, prevalence of malnutrition, appears to also be alarmingly high: nearly 40% of a random sample of children less than 5 years old who presented for treatment of diarrhoea at the ICDDR,B clinic from October through December 1983 were severely malnourished (weight for age was less than 55 percent of the median) (2) and prevalence studies in slums in Dhaka suggest that over one third of the children are moderately or severely malnourished. In addition, studies at Matlab indicate that reduced fertility was associated with a significant decrease in neonatal and child mortality (3).

Although there are numerous small NGO projects in Dhaka including, but not limited to, the Red Cross, Radda Barnen, the Children's Nutrition Center, Mohammadpur Modern Clinic, Mirpur Sattelite Clinic, Bashabo Sattelite Clinic, National Hospital, Irish Concern, The Aga Khan Health Care Project, Badda Self Help Clinic, Concerned Women for Family Planning (CWFP) and the New Life Center that offer primary health care; in general the activities are clinic based, curative, and are associated with little or no outreach work. Further, in most of these projects the catchment area is small.

In addition, the municipal government health system consists of only 187 workers who cover all of the over 4 million inhabitants of Dhaka city - they supply Vitamin A capsules, ORS, mosquito control and EPI services. These activities are field based and in conjunction with government EPI centers which are staffed by government physicians. Recently the UVP was requested to provide training for the virtually untrained municipal workers; 60 of the workers have completed the UVP 2-week training course to date (3/86). The UVP works closely with the Municipal workers on the EPI program. Future, permanent links between the urban volunteers and the Municipal delivery system will be built into the Program.

Overall, the health service offered to Dhaka and other urban areas was, and still is, not nearly sufficient. For these reasons scientists at ICDDR,B in 1981 created a program to attempt to identify and help control diarrhoeal and other common childhood diseases. Recognizing both the importance of community involvement, the involvement of women and the ability of individuals to treat diarrhoea and other common childhood diseases at home, the ICDDR,B established the Urban Volunteer Program.*

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- 1 Stanton B, Clemens J. Socioeconomic variables and rates of diarrhoeal disease in urban Bangladesh. Transactions of the Royal Society of Tropical Medicine and Hygiene (In Press).
 - 2 Stanton B, Clemens J, Khair T, Shaheed NS. Followup of children discharged from hospital after treatment for diarrhoea in urban Bangladesh. Tropical and Geographical Medicine (In press).
 - 3 Koneig M. ICDDR,B internal publication.
- 18

2. THE SERVICE PROGRAM:

a. Overview:

The Urban Volunteer Program (UVP) is a neighborhood delivery system of women who provide basic childhood interventions, as described below. The Urban Volunteers (UV) are women who live in the slum neighborhood which they serve. UV candidates, attend a two-week training course at ICDDR,B to recognize then treat (and/or refer) common childhood diseases. The volunteers are visited weekly in their homes by one of eight pairs of paid field supervisors (all former volunteers) who discuss problems, replenish supplies and tabulate service data.

b. Selection and Training of Trainees:

Municipal commissioners recommend female candidates who are 14 to 40 years of age, intelligent, willing to serve the community and have the permission of their guardians to join the program. The initial training course which these women must attend at ICDDR,B includes 60 hours of teaching by the central staff given over a 10-day time period. Most training is conducted at the ICDDR,B Treatment Center. Some training time is spent in the ICDDR,B hospital ward observing and teaching patients or their attendants.

Those trainees who successfully complete the examination given on the last day, return to their homes as health workers. While participating in the training course the women receive a small stipend, but upon returning to their communities they serve on a volunteer basis.

A series of additional courses, lasting one week and focusing on advanced nutrition, immunization, hygiene, tubewell maintenance and obstetrics are offered to all volunteers at three month intervals. Approximately 10% of the volunteers receive a scholarship to a two-month comprehensive health course offered elsewhere in Dhaka.

* Since its inception the Urban Volunteer Program has received funding from: the Belgian Government, UNICEF, Arab Gulf Fund, UNDP and some "core" ICDDR,B funds.

c. Overall Strategy:

Upon completion of the course the volunteer returns to her community where she is initially introduced to approximately 40 neighbors by several members of the central staff. Her coverage will - on average - increase to approximately 350 families.* Her role as an educator, provider of ORS, vegetable seeds, Vitamin A capsules and soap is explained to her neighbors and they are instructed to contact her at her home for treatment of diarrhoea and general questions. The volunteer is expected to circulate in her neighborhood to provide preventative counselling and to be available to initiate treatment of patients with diarrhoea, accompany them to a hospital if necessary and perform follow-up visits.

d. Child Survival Interventions:

(1) ORS distribution

The UV provides necessary packets of ORS with mixing/feeding instructions and teaches the preparation of "lobon-gur". She provides frequent follow-up until the patient recovers.

(2) Personal hygiene activities

In order to provide affordable soap to their communities and to help with scabies control and basic hygiene in the slum areas, the volunteers distribute "Neem" soap. The medicinal soap made from an extract from the neem tree - is sold at a nominal profit to those who can afford it, or is given free to those who can not. The field supervisors collect the money from the volunteers on a weekly basis and deposit it in a soap fund maintained at the UVP central office. In 1985 approximately 2200 bars were delivered per month. Further, extension through the volunteers of the simple hygiene messages developed in the research wing was begun.

* This leads to a ratio of approximately one UV to 2,100 people, which in the normal densely packed urban slum environment appears to allow successful coverage of the target population with the selected child survival intervention strategies. This ratio, however, will be monitored during project implementation.

(3) Vitamin A distribution, Vegetable seeds distribution and Nutrition education

The volunteers are taught to recognize signs of nutritional blindness (xerophthalmia, i.e., night blindness, bitot spots, etc.) and to provide the correct dosage of Vitamin A capsules. Earlier work has shown that Vitamin A deficiency is more common in children with chronic diarrhoea, so volunteers treat children with a history of >14 days of diarrhoea in the past month prophylactically. Approximately 500 children per annum have been treated since 1984. Packets of vegetable seeds have been distributed to all 1200 volunteers and an estimated 75% have raised vegetable gardens. These efforts will be expanded to include more community residents.

(4) Immunization referral

All volunteers (1,100 in 1985) and their children were immunized against polio, tetanus and measles. The project is currently working with the local, Municipal government EPI centers to expand its immunization efforts and, currently on an informal basis, refer slum-resident mothers and children for the above immunizations to local EPI centers on specified days. Currently arrangements to involve the volunteers as motivators and organizers for local drives on a more formal basis is being attempted as a part of the Government of Bangladesh EPI masterplan for Dhaka.

A five year increase in the rate of immunization coverage in the urban slums from the present (1986) approximate 1% to 40% as a direct result of efforts of the UVP is not unrealistically low. UVP efforts will not be the only efforts so presumably overall the rates will be higher. Second, even in some medically sophisticated countries (France <20%, Italy <10%)* measles immunization coverage rates remain well below 50% and the urban poor in the U.S. have also been notoriously difficult to immunize.

* Bart, K, et al. Measles and models. Int J Epidemiol 12:263-66.

(5) Nutrition Education and Rehabilitation Center
and Diarrhoea Sub-centre

On a pilot project basis, one feeding and nutrition education center has been established in Kaliganj and 1 diarrhoeal clinic has been established in Joydebpur, 2 peri-urban slum areas of Dhaka. Staff and curriculum are provided by the UVP and buildings and supplies have been contributed by the community. In the nutrition center severely malnourished children and their mothers, referred by the UV, are provided with supplement food and education in nutrition, ORT and hygiene. Thus far 108 children and their mothers have been through the 3 to 5 week program which consists of 4 meals a day, 2 "classes" and 1 participatory cooking demonstration. Children experience a mean improvement in percent weight for height of 8 1/2% while in the center. The long term impact on nutritional status is currently being evaluated.

The diarrhoea clinic is located in a distant (2 1/2 hour rickshaw ride) municipal area. The 20 volunteers staff the clinic which has treated over 4000 patients in 15 months for moderate and severe diarrhoea and dehydration.

The project will combine future diarrhoea and nutrition centers if recipient communities will provide appropriate facilities adequate to avoid iatrogenic ("hospital-induced") diarrhoea in already malnourished children. The feeding and nutrition /diarrhoea centers will be replicated in other urban slum areas per the implementation plan.

(6) Family planning

A family planning initiative will be added. The Urban Volunteers will cooperate with NGO family planning workers assigned to their areas, to improve accessibility and awareness of services. As requested by community members, they will also provide selected FP methods. In Sutrapur, Lalbagh and Kotwali this will be achieved by referral to one of the 6 family planning clinics run by Concerned Women for Family Planning (CWFP) and by notifying the appropriate outreach CWFP worker of potential clients. In the other thanas, referrals will be made to existing clinics (CWFP and others) and, on a pilot basis, a small number of volunteers (50) will carry pills and condoms on visits to homes.

3. THE RESEARCH PROGRAM

The Urban Volunteer Program has been involved in several primary health care research projects. The impetus for these projects usually stems from volunteers themselves and the volunteers have been involved in the projects directly and/or indirectly. Projects to date have included the identification of risk factors for developing xerophthalmia, follow-up studies of children after discharge from ICDDR,B, basic description of disease patterns (diarrhoea and scabies) in Dhaka, and the development and testing of appropriate research tools.

The largest project to date is the sanitation and hygiene education intervention. Between September 15, 1984 and February 28, 1985, we obtained information about socioeconomic and demographic characteristics, behaviours related to water use and sanitation, and rates of diarrhoea in children aged <6 years in 51 communities of 38 families each in urban Dhaka. We contrasted those families with the highest rates of diarrhoea (top 25%) with those with the lowest rates. Having demonstrated the comparability of sociodemographic characteristics between these 2 groups we then contrasted actual hygienic practices of these groups of families and observed 3 behavioural practices which differed markedly. Based on these observations we developed an educational intervention intended to improve the 3 behaviours which appeared to influence the incidence of diarrhoea: lack of handwashing before preparing food; open defecation by children in the family compound; and, inattention to proper disposal of garbage and feces, increasing the opportunity for young children to place objects in their mouths. The same 51 communities were then randomized either to receive the intervention (N=25) or to receive no intervention (N=26). The intensive intervention was implemented between March 6 through May 1, 1985, and was followed by less intensive reinforcement efforts to date. During the 6 months after the intervention, the rate of diarrhoea (per 100 person-weeks) in children <6 years was 4.3 in the intervention communities and 5.8 in the control communities (26% protective efficacy; $p < .01$). A corresponding improvement of handwashing practices before preparing food was noted.

Additional work already in progress and planned includes an evaluation of the long term impact of the nutrition center on nutritional status, the epidemiology and risk factors for chronic diarrhoea, epidemiology and determinants of urban childhood mortality and utilization patterns of ORS, and urban volunteer/population coverage ratio(s).

4. MANAGEMENT AND INPUT MONITORING

The service components of the Urban Volunteer Program are monitored in the following fashion. (This monitoring format provides the basis for the Monitoring and Evaluation Questionnaire, which provides the basic data for ICDDR,B's annual report to USAID. The annual report is design to conform to AID/W's three-tiered monitoring system.)

a) Records of central Urban Volunteer Program

- (1) # of new volunteers trained.
- (2) # of volunteers undergoing review courses.
- (3) # of persons from other organizations trained.

b) Urban volunteer records

- (1) # of packets ORS delivered to # of patients of specific age and sex per month.
- (2) # Vitamin A capsules delivered to # of patients per month.
- (3) # bars of soap delivered per month.
- (4) # of children brought to EPI center to be immunized.
- * (5) # of homes visited for preventative/education discussion.

(These "records" are pre-coded data sheets completed by the volunteers and collected weekly by the field supervisors who return them for computation and analysis at ICDDR,B.)

The research and study areas have detailed records obtained by trained research personnel on sociodemographic changes**, morbidity recording, observational data and microbiological data.

II. IMPLEMENTATION PLAN

This project will be implemented under the direction of the ICDDR,B working group. The staff, which can be expanded as approved by USAID, will:

1) Recruit and train new community volunteers, and to provide refresher training to old volunteers, in order to increase coverage of the target population of Dhaka with the selected interventions to achieve a coverage of 95%.

2) Continue informal immunization referral activities and develop formal plan with EPI, BDG as soon as their schedule permits.

* To be added.

** Utilizing adaptation of SRS-MCH/FP Extension Project.

3) Orchestrate meeting of supervisors of UV Program and supervisors of CWFP in May, 1986 with introduction of volunteers following. Training and supplying of pilot volunteers to be arranged in late 1986.

4) Expand the number of nutrition feeding/diarrhoea centers in Dhaka to 10 by 1991. (Note: expansion of centers contingent upon upcoming evaluation of existing centers).

5) Continue the service-related research and data collection activities in select slum areas of Dhaka.

(ICDDR,B will submit a progress report and Implementation plan to USAID each quarter for review and approval, thus implementation progress and design will be monitored closely. (See Attachment 1, E, 1.a.)

At the end of the first year of project implementation, an assessment of the methodology of transferring the project to other urban areas will be made. At the conclusion of this evaluation a detailed implementation plan to transfer the project to the urban centers of Chittagong and Khulna will be designed which may include selected NGOs or the BDG. ICDDR,B will train all necessary administrators, trainers and supervisors of the NGO(s) or the BDG and provide guidance in the implementation of the UVP in the other urban areas.

It is estimated that project implementation in Chittagong could commence in the middle of year 2 of the project (late 1987) and, in Khulna, year 4 (1989).

AID 1020-28 (1-72)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORKLife of Project:
From FY 86 to FY 90
Total U.S. Funding \$4.50 Million
Date Prepared: 3/1/86

Project Title & Number: URBAN VOLUNTEER PROGRAM (UVP) GRANT NO. 388-0073-G-SS-60 - 00

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE CONDITIONS AS OF: 3/1/86	MEANS OF VERIFICATION
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>Through selected child survival interventions, reduce morbidity and mortality in the approximately 1 million slum areas and children dwelling in the slum areas of Dhaka. Guidelines to be established for Chittagong and Khulna.</p>	<p>Measures of Goal Achievement:</p> <p>15% reduction in mortality; 25% reduction in diarrhoea; 50% reduction in xerophthalmia; and 25% reduction in scabies.</p>	<p>1. 42 deaths in children <6 years out of approx. 2,000 children. .</p> <p>2. 70% annual cumulative incidence of scabies.</p> <p>3. 5.63 episodes diarrhoea/100 child weeks observed.</p> <p>4. 27 cases of xerophthalmia in 1,442 children.</p>	<p>Records from water and sanitation study area; and, (See Attachment 3 page 2: study area questions 1-3.)</p>
<p>Project Purpose:</p> <p>1. To make basic child survival interventions available to 95% of the children in the slum areas of Dhaka, and to institute, through selected NGOs or the BDG, the UVP in the slum areas of Chittagong and Khulna, by 1991.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>1. (a) Treatment of diarrhoeal diseases in children (25% reduction). (b) Nutrition education (40,000 mothers/month); distribution of vitamin A capsules (upto 6,000 capsules/QTR); and establishment of 4,000 backyard gardens. (50% reduction of xerophthalmia) (c) Referral of children to local EPI centers for polio, tetanus and measles (coverage upto 20%).</p>	<p>1. Basic Child Survival interventions (Executive Family Planning) are offered to approximately 50% of the slum mothers and children of Dhaka.</p>	
<p>2. To conduct service-related research and data collection activities in selected Dhaka slum areas.</p>	<p>(d) Control of scabies: neem soap distribution (25% reduction). (e) Family planning counselling and selected methods provided. (f) Establishment of 10 Nutrition Education and three Diarrhoea Treatment Clinics in Dhaka</p> <p>2. Seventy study sites to be established. Twenty two field research workers. Specific morbidity mapping for interventions. Demographic Surveillance System.</p>	<p>2. Presently 51 study sites and 18 field research workers. Morbidity mapping and surveillance system is ongoing and will be expanded to all seventy-one sites in Dhaka.</p>	
<p>* SEE ATTACHED PAGES FOR SEPARATE</p>	<p>(Sample Registration System) Tests of selected interventions or components thereof.</p> <p>OUTPUTS AND INPUTS</p>		

* SEE ATTACHED PAGES FOR SEPARATE

OUTPUTS AND INPUTS

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**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of Project: _____
 From FY _____ to FY _____
 Total U.S. Funding _____
 Date Prepared: _____

(a) OUTPUT: DIARRHOEAL TREATMENT AND PREVENTION

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE CONDITIONS AS OF: 3/1/86	MEANS OF VERIFICATION
<p>Program or Sector Goal: The broader objective to which this project contributes:</p>	<p>Measures of Goal Achievement:</p>		
<p>Project Purpose:</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p>		
<p>Outputs:</p> <p>1. Identification and treatment of diarrhoeal diseases in children by urban volunteers (and/or mothers, who have been taught by UVs) targeting those episodes of diarrhoea which are associated with dehydration (5%).</p>	<p>Magnitude of Outputs:</p> <p>1. 16,000 children under 15 years treated with ORS per month for potentially dehydration diarrhoea.</p> <p>2. # packets: <u>For Dhaka</u> 60,000 packets per month to children <15 years.</p>	<p>1. 4261 children under 15 years treated with ORS per month.</p> <p>2. Approximately 10,983 1/2-litre packets per month for children <15 years.</p>	<p>Urban volunteer records. (See Monitoring & Evaluation Questionnaire (M&EQ) page 1 & 2; general question 1-8).</p>
<p>Inputs:</p> <p>1. Periodic visitation to 40,000 mothers per month to educate re: diarrhoea, services and availability of volunteer for treatment of child's diarrhoea.</p> <p>2. # ORS packets taken by field supervisors/month.</p>	<p>Implementation Target (Type and Quantity) Increase visits by 10% per year.</p> <p>1. 135,000 per month: 60,000 for children 60,000 for adults 15,000 "waste"</p> <p>2. # UV trained: 15 new urban volunteers trained per month.</p> <p>3. Approx. 35 UV receive refresher course per month.</p>	<p>Uncertain</p> <p>1. 32,000 1/2-litre ORS packets per month delivered to the urban volunteers.</p> <p>2. 15 new urban volunteer per month trained.</p> <p>3. 35 urban volunteers for review per month.</p>	<p>Urban volunteer records. (See M&EQ, page-2; general question 9)</p> <p>Urban Volunteer central records. (See M&EQ page 1 & 2; general question 1-8)</p>

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of project: _____
From FY _____ to FY _____
Total U.S. Funding _____
Date Prepared: _____

(b) OUTPUT: DELIVERY OF VITAMIN A CAPSULES; NUTRITIONAL BLINDNESS

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE CONDITIONS AS OF 3/1/86	VERIFICATION
<p>Program or Sector Goal: The broader objective to which this project contributes:</p>	<p>Measures of Goal Achievement:</p>		
<p>Project Purpose:</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p>		
<p>Outputs:</p> <ol style="list-style-type: none"> Halve prevalence of night blindness and xerophthalmia and decrease active corneal lesions by 75% ? impact of diarrhoea and mortality. 	<p>Magnitude of Outputs:</p> <p>Prevalence of: Night blindness of .9%.</p> <p>Prevalence of conjunctival xerosis: Bitot spot .9%.</p> <p>Corneal involvement .0004%.</p>	<p>Prevalence of:</p> <ol style="list-style-type: none"> Night blindness in December 1984 27/1442 children = 1.9%. Bitot spot and conjunctival xerosis in December 1984 28/1450 children = 1.9%. Corneal involvement in March 1985 3/1361 children = .002%. Chronic diarrhoea: (To be determined from existing data) 	<p>Study population records.</p> <p>Quarterly assessment of nutritional status and signs of vitamin A deficiency in approx. 2,000 children living in study population.</p>
<p>Inputs:</p> <ol style="list-style-type: none"> Nutrition counselling by urban volunteer Vegetable gardens. Vit. A capsules for children with xerophthalmia in conjunction with Helen Keller International (HKI) and for children with >14 days diarrhoea. <p>Vegetable seeds and Vit. A capsules.</p>	<p>Implementation Target (Type and Quantity)</p> <ol style="list-style-type: none"> See "ORS output-education of volunteers" 1 garden per volunteer and 2 per community per volunteer = 3,000 vegetable gardens in 1986 with 250 increase per annum. (60,000 capsules) per quarter for treatment: We will provide 10% (6,000). <ol style="list-style-type: none"> As above. 4,000 packets for 1986 with 250 increase thereafter. Each volunteer identify and treated active cases as stated. 	<p>Training on Vitamin A</p> <ol style="list-style-type: none"> Included in basic and refresher course. Approx. 1,000 gardens in 1985. 200 capsules by UVP per quarter. <ol style="list-style-type: none"> Education Volunteer had garden herself and approx. 1/3 introduced packets to others. Volunteer identify .5 case annually 	<p>Urban Volunteer records</p> <ol style="list-style-type: none"> # patients visited. # packets of seeds given. Attachment 3 page 4; question 1 - 6. <p>Urban Volunteer records.</p> <p>See above</p>

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORKLife of Project:
From FY _____ to FY _____
Total U.S. Funding _____
Date Prepared: _____

, (c) OUTPUT: IMMUNIZATION

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	BASELINE CONDITIONS AS OF 12/86	MEANS OF VERIFICATION
Program or Sector Goal: The broader objective to which this project contributes:	Measures of Goal Achievement:		
Project Purpose:	Conditions that will indicate purpose has been achieved: End of project status.		
Outputs: Immunize 20% of Dhaka's children or 40% of those children in catchman area (slums)	Magnitude of Outputs: 100% increase in immunization rates per year in the study areas. 100% coverage of volunteers and children per year. a) All volunteers and children fully immunized. b) Each volunteer brings in 10 children <5 years per quarter and their mothers for immunization. (48,000 mid 85-89) approx. 5%	a) UNICEF - 1% children immunized. b) Kaliganj Nutrition Centre: 1 of 92 children (1%) had had measles immunization. c) Perform immunization survey in study areas. d) 75% children & 95% volunteers immunized. Same. Pending but far lower	Study area (See M&EQ page 6 of 6; study - 1). Urban volunteer records. (See M&EQ page 6 of 6; general 1, 2 & 3).
Inputs: 1) 1 orchestrated EPI day per quarter: every volunteer bring 10 children. 2) All volunteers and children immunized in 1st course.	Implementation Target (Type and Quantity) 350,000 children immunized. 225,000 mothers immunized.		Urban volunteer records. (See M&EQ page 6 of 6; general 1,2 & 3).

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