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**PROJECT CONCERN INTERNATIONAL**

**"Improving Access to Maternal-Child Health Services"**

**Child Survival VI**

**First Annual Report**

**United States Agency for International Development  
Cooperative Agreement No. OTR-0500-A-00-0107-00**

**Contact persons:**

**Dr. Harumi Karel  
Barbie Rasmussen**

**Project Concern International  
3550 Afton Road, San Diego, California, USA  
Telephone: 619/279-9690 Fax: 619/694-0294**

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**I. Changes in Project Design**

**A. Statement of Country Project Objectives.**

Since the DIP was written, two objectives for the nutrition component have been added in order to focus efforts on improving the nutrition of pregnant women, and children at risk of the effects of poor weaning practices.

1. Increase to 80% the proportion of families (mothers and fathers) who know proper weaning practices (defined by DOH health policy).

2. Increase to 80% the proportion of families (mothers and fathers) who know the proper nutritional needs of pregnant women.

**B. Location and Size of Priority Population**

The size of the priority population has changed. The most recent population figures for 1991 are:

Kaiapit	0-11 mos.	1,497
	12-59 mos.	5,473
Women	15-44 yrs.	10,245
Lae Coast	0-11 mos.	522
	12-59 mos.	1,908
Women	15-44 yrs.	3,751

In the DIP review, comments were made about the differences in certain population figures. At the time of the DIP, two census reports were being used and this could have led to some of the confusion. The most recent figures appear above, but as of yet we can not accurately report on infants from 12-48 months of age as the DOH does not track this group at present.

**C. Health Problems Which The Project Addresses.**

No changes.

**D. Child Survival Interventions.**

**D.1. Family Planning:** At present, we are investigating ways to strengthen the family planning outreach for women in the project areas, with a special focus on gaining the support of men for family planning, since men are the primary decision-makers in the villages.

In response to the DIP, less than 1% of the women in the project area use modern contraceptive methods provided by the health department or Family Planning Association Distributors (women who have been trained in some villages to distribute pills and condoms for a small fee). It may be feasible for VBAs to distribute condoms, as little training would be involved, but it is likely that there would be some cultural constraints unless this women worked as a partner with her husband. The women who currently act as Family Planning Association Distributors feel that they would not have adequate time to act as both a distributor and as a VBA, but there is also reluctance to take on VBA responsibilities when there are, at present, no fees for their services.

**D.2. EPI/MCH:** There are no changes in the objectives for immunization. However, in the DIP review there was some uncertainty about PCI's protocol for the follow-up of immunization defaulters. Several comments need to be made in relation to this uncertainty. Baby books will be checked by village women who have received immunization promotion training. These include VBAs and other selected women from each village. A sticker on the book identifies children who have completed their immunizations. Children who have not completed immunizations will be advised to go to the next clinic held in the area or to the outpatient clinic at the health center to receive the remaining immunizations. These women will be told by the immunization promoters, the clinic health staff, and the health center staff how many times they need to come back and when in order to complete the immunizations for that particular child. The Health Center and MCH staff are responsible to check health center vaccination records, but as yet, the health center staff are not able to provide a "list" of children who need vaccinations to the mobile clinics and foot patrols. In addition to the identification of defaulters by the immunization promoter, VBAs advise the mothers of newborns to bring them to the mobile clinic for enrollment, at which time they receive a baby book.

With high-risk births, women will be selected by the community as VBAs and they will be trained to identify high risk women and to refer them to a health facility. They, in turn, will give health education to both women and men in the villages, stressing reproductive anatomy and physiology, maternal nutrition, habits and practices for a healthy pregnancy and a safe delivery, the factors that make a woman at "high risk" and the importance of birth spacing and family planning methods. These trainings are started with focus group type sessions where current beliefs and practices are brought out and discussed. It is felt that in a country where there are many different beliefs and practices, it is imperative to conduct such sessions first to adequately focus and modify the educational sessions to make them relevant for the given audience.

Consideration has been given to villages in remote areas, and these villages are being encouraged to cooperate in the building of a bush material house

near the district health center so high risk women can come stay near the health center to wait for delivery. Mobil MCH Teams will also play an important role in these remote areas where women are far from antenatal care. These teams will examine pregnant women where possible or take thorough histories where examination is not possible.

**D.3. Diarrheal Disease Control (CDD):** The objectives for CDD have not changed. In reference to the DIP review, PCI is following the country's policy for the case management of diarrheal disease, which stresses the importance of continued breastfeeding, continued feeding with freshly cooked solid food (for older children), increased fluids and promotion of starch-based, home-available fluids.

VBA's are trained to promote early use of home-available fluids for children with diarrhea, and to refer children with severe diarrhea or diarrhea that is worse than usual to the nearest health facilities. (Please see attached CDD module.) PCI's training for VBAs stresses the importance of referring the child with severe diarrhea **before** the child exhibits symptoms of dehydration. PCI workers do not distribute ORS packets. Packets are distributed through aid posts, health centers and MCH clinics to people who live too far away from these facilities to come for a daily supply when their children are ill with diarrhea. At these distribution sites, the parents (or family members) are instructed by the health staff (nursing sisters or aid post orderlies) in the correct preparation of oral rehydration solution from the packets before they can receive the packets.

Teachers, pastors, and volunteer village health workers who know how to mix the solution also receive packets which they can distribute to or mix for villagers with children who are ill from diarrhea. In accordance with DOH policy, these distributors must request a supply of ORS packets from the health facility.

**D.4. Nutrition:** In the DIP review it was stated that the nutrition component of PCI's project needed to be better defined and elaborated upon. At the time of the DIP submission there was no Provincial Policy in relation to nutrition within the DOH and this made it very difficult for PCI to support and collaborate with the DOH. Fortunately, The Provincial Department of Health is presently in the process of developing a policy for nutrition (including recommended weaning practices) of infants, young children and mothers. All NGOs in the area have been invited to participate in the process. PCI's project director in Lae, Mr. Phillip Posarau is representing PCI in the sessions, with the objective of developing a nutrition program for the PCI project that supports the government policy.

However, it should also be noted that PCI has been stressing the importance of improved nutrition of pregnant and lactating women in its on-going VBA training sessions for both women and men. These sessions focus primarily on education to improve knowledge of good nutrition practices among women and men. Messages included in these trainings are:

- a. Colostrum is a good, protective food for the newborn, and should not be discarded.
- b. The advantages of exclusive breastfeeding until the infant is at least 4 to 6 months old include extended protection from infectious and diarrheal disease, and malnutrition.
- c. If a woman is well-nourished it increases the likelihood that she will give birth to a healthy baby.
- d. Women who are pregnant or lactating need protein in their diets. Women who do not partake of certain protein foods that are considered tabu during pregnancy should increase their intake of alternative proteins, such as beans and dried peanuts, and should eat a combination of these at each meal.
- e. Women who are pregnant or lactating need enough calories in their diets. Women and their husbands should make sure that women, who customarily eat last (often left-overs), eat often and receive enough of the best available food to stay healthy.

**D.5. ARI:** The objectives and strategies for ARI have not changed. However, the comments made in the DIP are being taken into account and ways of incorporating these changes are being addressed. It is important to realize that PCI has been introducing CS interventions in a phased fashion, EPI→CDD→ARI, in the project area Lae. After one year of project work, both EPI and CDD have been introduced but our work in ARI has been limited and at present we are still in the process of developing an ARI curriculum.

## **E. Strategies for Identifying and Providing Service to Individuals at Higher Risk**

**E.1. EPI/MC:** Identification and follow-up for immunization defaulters is the responsibility of village women who receive training in immunization promotion. These include VBAs and other selected women from each village. The immunization promoters check baby books for each child in the village. A sticker on the book identifies children who have completed vaccinations. Mothers of children with books that do not display the sticker are advised to

attend the next mobile MCH clinic held in the area, or to take their children to the outpatient clinic at the health center to receive the remaining vaccinations.

Pregnant women who have not completed their vaccinations against tetanus are similarly advised. The VBA accompanies pregnant women, mothers and their children to clinic to ensure their attendance. The health staff inform the mother how many times and when she must return to the clinic with her child to complete the vaccination series.

## **II. Human Resources Collaboration**

**A.** Since the DIP, only one new staff member was hired by PCI. The individual's name was Muwete Gatsia and she was hired as the District Health Education Coordinator. Please see the attached resume, job description and revised organizational chart and in Appendix for further information.

**B.** Technical assistance to the field project is provided by:

Dr. Stephen Robinson, MPH, PCI's Asia regional technical adviser. Dr. Robinson serves as country director for PCI's Child Survival project in Indonesia. Dr. Robinson travelled to PNG in February, 1991, to assist PCI/PNG staff with the preparation of the DIP.

Barbie Rasmussen, RN, health program officer, provides technical and administrative support from PCI's headquarters in San Diego, California. She travelled to PNG in January, 1991, to orient new staff to Child Survival and PCI administrative and management systems.

In June, Joan Brabec, PCI/PNG's Director for Health Education and Training, attended the National Council for International Health in Arlington, Virginia, where she presented a paper entitled "The Importance of Educating Men About Women's Health Issues." Joan also attended the PVO CSSP Technical Workshop for Headquarters Staff as a field representative.

Technical assistance in health information and computer systems is provided by Mr. Chua, World Health Organization/PNG.

**C.** Securing community support for the project is an essential, on-going activity. The success of the VBA and her credibility depend upon how well she is accepted in this role by the men and women in her village. Project staff spend a considerable amount of time in village recruitment, and make repetitive visits--often three or more-- in the evenings and on weekends to the community to explain the project and address concerns of the villagers. This

develops the confidence of the community that the project will do what it promises. In addition, training is conducted in a central village, where it is also possible to involve and familiarize more villagers with the concept, and to provide the courses for the village men. It is time-consuming, but our experience is that programs which neglect this process overlook the fact that the village people are the ones who will use the services of the person who they select for training. They must have a thorough understanding of the benefits of these services, and must have confidence that the person they select for training will be able to provide them. In each village, PCI will work first with the village elders or village council, comprised mainly of village men. We also work with the leaders of the Giamsao, or women's group in each village. At the district level, we work with the District Health Committee, which is composed of representatives from 22 villages in Kaiapit. The Committee supports the activities in the district health station, and serves as a link between the health station and their communities. This year PCI conducted the following activities:

- Community meeting to organize training x 18
- Community meeting to support VBAs x 2
- Health Education session for men and women in the communities x 4
- Health Education sessions at community school x 2
- District Health Committee meeting x 2

- D. In the last year, PCI has developed new linkages to other health and development organizations including the National Council of Women, and Family Planning Association/PNG. PCI serves on the national MCH Working Committee along with representatives from the PNG Department of Health, WHO, UNICEF, the national USAID/John Snow Child Survival Support Program, and Save the Children Fund.

PCI this year provided technical assistance in the development of a VBA training program to the Madang Provincial Department of Health. PCI conducted VBA training at Naeko, situated on the border of Madang and Morobe Provinces, jointly with the Madang Department of Health, at the request of the Madang Assistant Secretary for Health. Asst. Secretary Dunstan would like to introduce VBA training in Madang province and requested that PCI conduct the training jointly with his staff in order to demonstrate how the training is conducted and how the project operates.

- E. Several issues were brought up about VBAs in the DIP review that need further elaboration in the annual report.

First, VBA selection is carried out by the village people after several visits from PCI staff where selection criteria and VBA responsibilities are explained.

There is some variance from place to place, but usually there is consensus on who villages want to be trained. The woman selected must be mature and have children of their own, they must be respected in the community, and they must have the approval of their husbands to undertake this type of work.

Second, the MCH mobile team and aid post orderly are the first line of support for the VBAs. If an APO is located near to a VBA he/she will be first health worker the VBA can contact if she has a problem pregnancy or delivery and needs advice. The health center staff may be of help, but they will not be the main supporters or supervisors of VBAs because VBAs will bring pregnant mothers and mothers of newborns to the clinic sites or to the health center for assessment. VBAs will work with the MCH team in doing examinations and helping to interpret where necessary. It is hoped that this will help form a link between the VBAs in the village and the health center, will help improve the confidence of the VBAs and will make them more respectable among the villagers, as the health staff is recognizing their work.

Third, VBAs do collect and report information as well as referring mothers. A form has been created for the collection and recording of this information, but it is still in the process of being revised.

### **III. Progress in Health Information Data Collection**

#### **A. Baseline Survey**

The information on Baseline Survey has been reported in the DIP.

#### **B. Routine Data Collection**

**B.1.** The data collection system used by the district health station is primarily useful for neonates. At the clinic level, baby health books and adult health books (MCH record) and ANC (antenatal clinic) cards have been utilized. However, follow-up services usually are not provided due to the shortage and poor motivation of health department staff and a lack of transport.

**B.2.** PCI developed its own reporting system for Village Birth Attendants. The form is attached in Appendix . VBAs are requested to keep the record of mothers whom they assisted and the information on all pregnant women in the community. They provide the records to MCH mobile clinic staff or to PCI's District Health Education Coordinator at the Health Centers. The newly developed system of ANC recording will allow identification of mothers who see VBAs and attend antenatal clinic.

**B.3.** The indicator for TT booster, total high risk pregnancy identified by health center staff, attendance at antenatal clinic, and the number of clinics held have been the most difficult for our project staff to collect because of the lack of cooperation from MCH staff and the inefficient system of data collection at health centers.

**B.4.** PCI monitors the number of MCH clinics held and the number of practicing VBAs.

**B.5.** PCI/PNG does not carry out case-finding activities.

**B.6./B.7.** The District Health Education Coordinator, Sister Muwete Gatsia, and the Director for Health Education and Training, Joan Brabec, are responsible for collection, compilation and analyses of PCI's monthly corrected data. MCH team and HIS team from Morobe Provincial Department of Health collect their own data. Project Director Phillip Posanau received WHO/PNG training in the national computerized health information system. Mr. Posanau works closely with the provincial HIS team. Mr. Posanau, Ms. Brabec and the provincial HIS team are responsible for monitoring the quality of the data. In response to a comment in the DIP, PCI does provide management workshops covering data collection methods, the importance of collecting good data, the use of data for planning, etc., to health center staff in order to improve their skills in data collection. In addition, district health staff also receive training on HIS in the form of bi-annual in-service training sessions.

**B.8.** Morobe Department of Health provide monthly computer print-outs of health statistics to each district health center that are displayed as graphs in the health centers. However, this does not happen consistently because of a lack of funds to purchase computer paper and mechanical problems with the computer equipment. PCI provides quarterly reports to National and Morobe Provincial Departments of Health, Kaiapit District Health Center, and the Officer in Charge at Kaiapit District. Annual reports are provided to village leaders and VBAs in each community where project work is undertaken.

**B.9.** Approximately 1% (excluding staff time) has been spent for PCI health information system.

#### **IV. Improvements in Program Quality and Technical Effectiveness**

- A.** The increased cooperation between PCI, DOH and District Health Center staff is crucial, however, extremely difficult to accomplish. There is always a verbal agreement and cooperative gestures, but the actual implementation of cooperative activities is difficult due to lack of staff, and the lack of interest

and commitment by baseline health staff, such as health center staff and the Aid Post Orderly. Often there is a lack of incentive for health staff to work hard and to remain motivated.

Communication skills are another area to be seriously considered. In-service training for health staff should always include the development of effective communication skills. If the provision of health education and community participation is to become a reality, the improvement of the health center staff communication skills is inevitable.

So far, our ideas of the importance of providing training to VBAs and health education to the grass-roots level have been reinforced. Although the structure of health care system and health policies have been established in PNG, the implementation of services and dissemination of important health messages rarely reaches people at the grass roots level.

- B. Since the last program report, PCI has reorganized the reporting system for ante-natal clinics. Previously, a book was used to record the information, but now a card system has been introduced.

#### **V. Work Schedule**

- A. The implementation of planned activities have been hampered, on occasion, by threats and vandalism in the communities. One such example is a VBA training to be held in Yasuru that had to be postponed due to repeated break-ins at the sub-health center and threats to the center staff. We have tried to schedule our time in a flexible manner in order to avoid disruption due to such occurrences. Our strategy to overcome this has been to keep a flexible schedule and to always have alternative plans ready in case such a situation arises.
- B. See attached work plan and training schedule in appendix .

#### **VI. Changes in Project Expenditures and Justification for Budget Changes**

- A. See attached pipeline analysis in appendix .
- B. To this point, there have been no major changes in our budget.

#### **VII. Sustainability**

##### **A. Recurrent Costs**

- A.1. There are several costs that will need to be maintained after A.I.D. CS

funding ends. They are: the cost of maintaining District Health Education Coordinators who coordinate the work of VBAs and MCH staff at the health center, and the cost of training VBAs.

**A.2.** None

**A.3.** At the end of CS funding, it is unclear whether the government will be able to absorb the costs associated with staffing and VBAs. However, PCI recognizes the implication of this issue, and due to this will continue to collaborate and work closely with the department of health to promote efficiency in the department and to promote their gradual takeover of staff costs.

## **B. Strategies for Reducing Sustainability Concerns**

**B.1.** The best approach to creating sustainable programs in the PNG context is to promote the transfer of skills to local individuals, especially local village women and health center staff, and to emphasize that the programs do not belong to the Department of Health but to the communities themselves for the benefit of their people. In addition, following traditional methods of payment seem to be a good method of supporting the activities of VBAs .

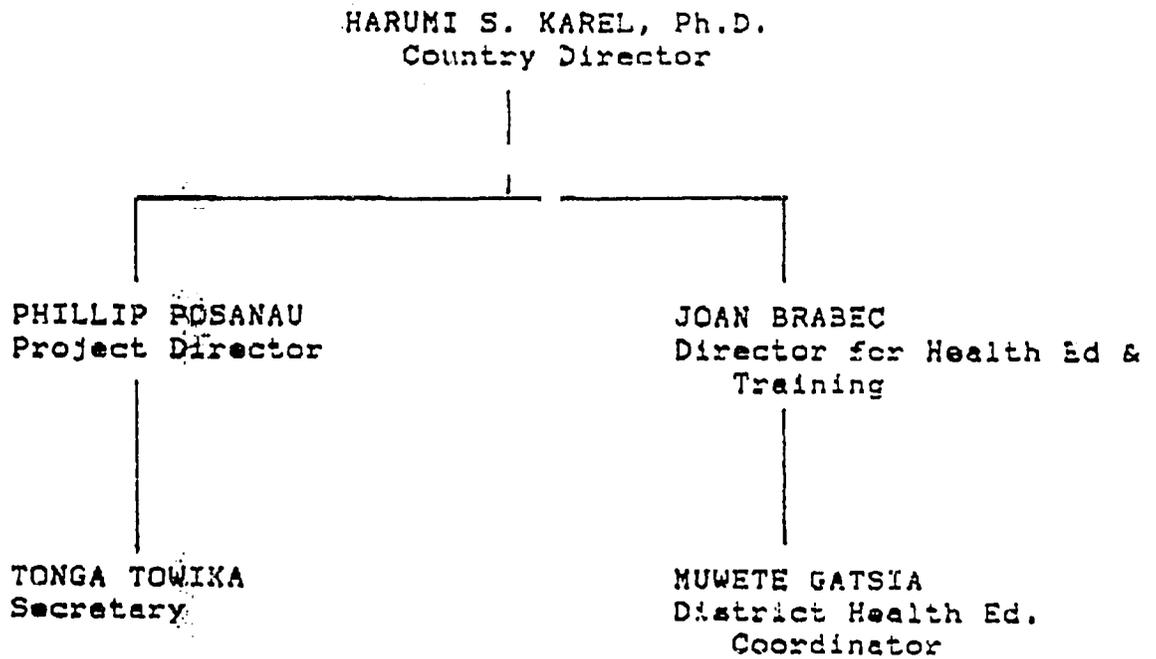
**B.2.** There was never an objective or an allocation of funds for this type of activity in either the original proposal or the DIP, and no such training has been undertaken.

## **C. Cost Recovery Activities**

At present, there are no cost recovery activities incorporated into our project. However, PCI is aware of the importance of such activities, especially in relation to the long term sustainability of such projects, and is investigating income generation opportunities within health related activities. For example, the sale of soap in villages in association with home hygiene related activities.

APPENDIX 1

FIELD ORGANIZATIONAL CHART



PAPUA NEW GUINEA

Duties and Responsibilities

This job requires a dependable female nurse/midwife or a nurse who has had experience in rural health center deliveries. She should be a good communicator and have training and/or experience in health education or be interested and capable of learning these skills.

The job includes training village women (some of whom are illiterate) in safe child-birth practices. Because of this the person for this job must be sensitive to and respectful of local customs. She must have patience, understanding and the ability to establish good rapport with village elders and with educated as well as uneducated village people.

Contacting villages and organizing training courses will mean that she will have to deal with village elders, initiate village meetings and plan, coordinate and carry out training courses. This often means her work will be done at irregular hours and on weekends when village people are available instead of during regular government working hours.

She must be available to hold 2-week-long courses in villages. Sometimes this will mean walking to the village and staying in the village until the course is completed.

She must be flexible enough to teach or learn to teach village women at their own level and to find ways to effectively communicate new ideas to village people.

She should be willing and able to contribute to development of lesson plans, training modules, and training aides etc. required for the village based courses and for in-services for health center staff.

She will be required to organize and participate in in-services for MCH, APOs and other health staff as well as health education for village women and other village groups.

She will be required to attend antenatal clinics at the health center to give on-the-job-training to health staff in examining and evaluating pregnant women and to work with the health center staff toward improving ante natal care given by the health center.

She will be required to collect data from project villages by working with the MCH clinics and training them in appropriate data collection.

APPENDIX 3

CURRICULUM VITAE

Muwete Gatsia

School: Bumayong Lutheran High School

Year: 1976 - 1977

Grade Eight

<u>Subject</u>	<u>Grade</u>
1. English	Credit
2. Maths	Credit
3. Science	Credit
4. Social Science	UP
5. Business Studies	UP
6. Home Economics	Credit

School: College of External Studies

Year: 1984 - 1986

Grade Ten

<u>Subject</u>	<u>Grade</u>
a) Science	Credit
b) English	Credit
c) Maths	Credit

WORKING HISTORY

Muwete Gatsia

<u>Year</u>	<u>Place Worked</u>	<u>Position Held</u>	<u>Reason for Leaving</u>
1982	Yageum Health Centre (Madang)	Nurse Aide/APO	Transfer
1983	Mutzing Health Centre	MCH Nurse/Nurse Aide	Further Studies
1984-86	General Nurse Training at St. Barnabus School of Nursing		
1987	To'oken Health Centre (Kainantu)	OIC	Transfer
1987 June-Dec	Gusap Health Centre	OIC	Transfer
1988 Jan-June	Private Clinic Dr. Takifuke	Nursing Officer	Resigned
1988 June-Dec	P.T.C. Clinic	Sister-in-Charge	Resigned for Studies
1989	I went to do my Post-Basic Midwifery		
1990-91	Tinsley School of Nursing	Clinical Instructor & Lecturer in Community Health Nurse Training	Rascal Activity

REKOT BILONG OL WASMERI

Nam bilong mama \_\_\_\_\_

Las sikmun \_\_\_\_\_

Nam bilong man bilong em \_\_\_\_\_

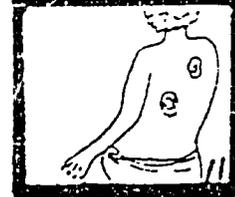
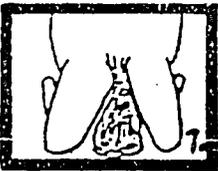
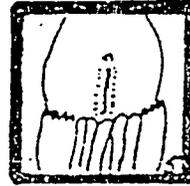
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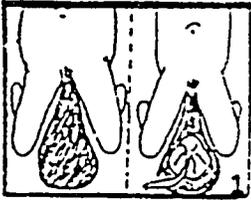
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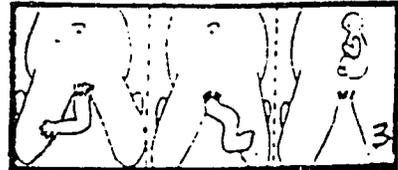
TAIM MAMA BIN KA'1 LUKIM WASMERI

Ain Tebs									
Chloroquin									
Sut long Tetanus									

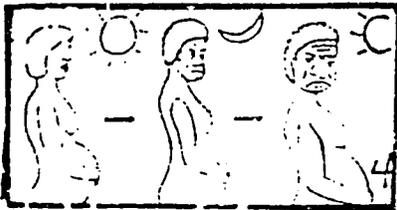
EMERGENCIES AND OTHER COMPLICATIONS



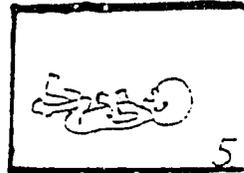
2. Bilum bilong pikinini i no inap kam ausait



3. Bebi i slip krankl / Han i kam ausait / Lek i kam ausait



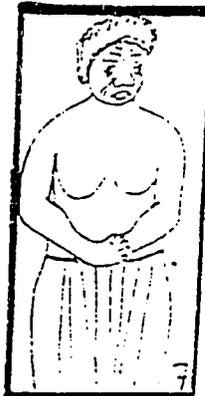
4. Muma hatwek longpela sim na i no karim



5. Pikinini i no ta'im bilong em yet



6. Skin hot



## CSVI ANNUAL REPORT: REVISED COUNTRY SCHEDULE OF ACTIVITIES

This table reflects activities completed in year one and scheduled for years 2 and 3.

PVO: <u>PROJECT CONCERN INTERNATIONAL</u>	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
Country: <u>Papau New Guinea</u>												
<b>1. Personnel in Position</b>												
a. Project Manager	X	X	X	X	X	X	X	X	X	X	X	X
b. Technical Coordinator	X	X	X	X	XZ	XZ	XZ	XZ	XZ	XZ	XZ	XZ
c. Health Information System Manager	X	X	X	X	X	XZ	XZ	XZ	XZ	XZ	XZ	XZ
d. Community/Village health workers	X	X	X	X	X	XZ	XZ	XZ	XZ	XZ	XZ	XZ
e. Other Support		X	X	X	X	XZ	XZ	XZ	XZ	XZ	XZ	XZ
<b>2. Health Information System</b>												
a. Baseline Survey											X	X
- Design/preparation	X			X								
- Data collection and analysis	X					X					X	X
- Dissemination and feedback to community and project management		X					X					X
b. Consultants/contract to design HIS												
c. Develop and test HIS	X					Z						
- Implementation	X	X	X	X	X	XZ	XZ	XZ	XZ	XZ	XZ	XZ
- Development and feedback to community and project management		X				Z						

X - Reflects activities in Kaiapit Z - Reflects expansion activities in the coastal area of Lae

CSV I ANNUAL REPORT: REVISED COUNTRY PROJECT SCHEDULE OF ACTIVITIES

PVO: PROJECT CONCERN INTERNATIONAL

Country: Papau New Guinea

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
<b>3. Training</b>												
a. Design	X											
b. Training of trainers	X				Z							
c. Training sessions		X	X	X	XZ	XZ	XZ	XZ	XZ	XZ	XZ	XZ
d. Evaluation of knowledge of skills		X	X	X	XZ	XZ	XZ	XZ	XZ	XZ	XZ	XZ

<b>4. Procurement of Supplies</b>	X	X		X	XZ			XZ	XZ			
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<b>5. Service Delivery to be initiated</b>												
a. Area 1 (Kaiapit)												
- ORT			X				X				X	
- Immunization		X				X				X		X
- Nutrition:					X				X			
Breastfeeding	X	X	X	X	X	X	X	X	X	X	X	X
Maternal Nutrition	X	X	X	X	X	X	X	X	X	X	X	X
Vitamin A												
Growth Monitoring/Promotion					X							
- ALRI/Pneumonia												
- Family Planning/Maternal Care	X	X	X	X	X	X	X	X	X	X	X	X
- Other (High Risk Births)	X	X	X	X	X	X	X	X	X	X	X	X

X - Reflects activities in Kaiapit Z - Reflects expansion activities in the coastal area of Lae



**TRAINING SCHEDULE - KAIAPT**

|| 1991 || 1992 ||

Activities	O	N	D	J	F	M	A	M	J	J	A	S	O
1. Contact new villages	X	X		X	X	X	X	X	X	X	X	X	X
2. New committed villages			8			8			9			5	
3. VBA pre-serv. training	X			X			X			X			
4. VBA in-serv. review				X	X			X			X		
5. VBA CS prom. training													
a. EPI							X						
b. CDD			X							X			
c. ARI					X								
d. Nut.							X						
6. In-serv. MCH/HC/APO													
a. Intro./Review						X							
b. Communication					X								
c. Record-keeping							X						
d. Management							X						
e. OB/High-Risk			X	X	X								
f. OB/ANC (on-the-job)				X	X	X	X	X	X	X	X	X	X
7. CS Training HC Staff													
a. EPI						X							
b. CDD			X							X			
c. ARI				X									
d. Nut.							X						
Health Staff 1 wk. in-service				X							X		

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HEADQUARTERS

Actual Expenditures to Date  
( 9 / 01 / 90 to 8 / 31 / 91 )

Projected Expenditures Against  
Remaining Obligated Funds  
( 9 / 01 / 91 to 8 / 31 / 93 )

Total Agreement Budget  
(Columns 1 & 2)  
( 9 / 01 / 90 to 8 / 31 / 93 )

COST ELEMENTS

I. PROCUREMENT

- A. Supplies
  - B. Equipment
  - \* C. Services/Consultants
    - 1. Local
    - 2. Expatriate
- SUB-TOTAL I

	AID	PVO	TOTAL
A. Supplies	0	0	0
B. Equipment	0	0	0
* C. Services/Consultants			
1. Local	0	0	0
2. Expatriate	4155	0	4155
<b>SUB-TOTAL I</b>	<b>4155</b>	<b>0</b>	<b>4155</b>

	AID	PVO	TOTAL
A. Supplies	0	0	0
B. Equipment	0	0	0
* C. Services/Consultants			
1. Local	0	0	0
2. Expatriate	73	1572	1645
<b>SUB-TOTAL I</b>	<b>73</b>	<b>1572</b>	<b>1645</b>

	AID	PVO	TOTAL
A. Supplies	0	0	0
B. Equipment	0	0	0
* C. Services/Consultants			
1. Local	0	0	0
2. Expatriate	4228	1572	5800
<b>SUB-TOTAL I</b>	<b>4228</b>	<b>1572</b>	<b>5800</b>

II. EVALUATION/SUB-TOTAL II

	1955	0	1955
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	597	948	1545
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	2552	948	3500
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III. INDIRECT COSTS

- Overhead on HQ/HO
  - (1) 34.07% approved budget
- SUB-TOTAL III

	22925	7642	30566
<b>SUB-TOTAL III</b>	<b>22925</b>	<b>7642</b>	<b>30566</b>

	(3453)	(403)	(3855)
<b>SUB-TOTAL III</b>	<b>(3453)</b>	<b>(403)</b>	<b>(3855)</b>

	19472	7239	26711
<b>SUB-TOTAL III</b>	<b>19472</b>	<b>7239</b>	<b>26711</b>

IV. OTHER PROGRAM COSTS

- A. Personnel (list each position & total person months separately)
    - 1) Technical
    - 2) Administrative
    - 3) Support
  - B. Travel/Per Diem
    - 1) In country
    - 2) International
  - C. Other Direct Costs (utilities, printing rent, maintenance, etc)
- SUB-TOTAL IV

A. Personnel	47402	0	47402
1) Technical	47402	0	47402
2) Administrative	24337	0	24337
3) Support			
B. Travel/Per Diem			
1) In country	2292	0	2292
2) International	8247	0	8247
C. Other Direct Costs	1327	0	1327
<b>SUB-TOTAL IV</b>	<b>83605</b>	<b>0</b>	<b>83605</b>

A. Personnel	(19228)	10474	(8754)
1) Technical	(12781)	4296	(8485)
2) Administrative			
3) Support			
B. Travel/Per Diem			
1) In country	(2292)	0	(2292)
2) International	2395	3958	6353
C. Other Direct Costs	(1327)	0	(1327)
<b>SUB-TOTAL IV</b>	<b>(33233)</b>	<b>18728</b>	<b>(14505)</b>

A. Personnel	28174	10474	38648
1) Technical	11556	4296	15852
2) Administrative			
3) Support			
B. Travel/Per Diem			
1) In country	0	0	0
2) International	10642	3958	14600
C. Other Direct Costs	0	0	0
<b>SUB-TOTAL IV</b>	<b>50372</b>	<b>18728</b>	<b>69100</b>

TOTAL HEADQUARTERS

	112640	7642	120281
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	(36016)	20845	(15170)
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	76624	28487	105111
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/ Excludes Evaluation Costs

NOTE: Differences in totals due to rounding.

*Handwritten initials*

ELD

Actual Expenditures to Date  
( 9/01/90 to 8/31/91 )

Projected Expenditures Against  
Remaining Obligated Funds  
( 9/01/91 to 8/31/92 )

Total Agreement Budget  
(Columns 1 & 2)  
( 9/01/90 to 8/31/93 )

ST ELEMENTS	Actual Expenditures to Date			Projected Expenditures Against			Total Agreement Budget		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
IV. PROCUREMENT									
A. Supplies	0	4285	4285	103007	34013	137020	103007	38298	141305
B. Equipment	4261	8449	12710	6091	(4601)	1490	10352	3848	14200
C. Services/Consultants									
1. Local	1954	450	2404	21301	8195	29496	23255	8645	31900
2. Expatriate	0	833	833	41844	14723	56567	41844	15556	57400
SUB-TOTAL I	6215	14017	20232	172243	52330	224573	178458	66347	244805
V. EVALUATION/SUB-TOTAL II									
A. Consultant/Contract									
B. Staff Support	1617	18	1635	(741)	306	(435)	876	324	1200
C. Other									
SUB-TOTAL I	1617	18	1635	(741)	306	(435)	876	324	1200
VI. INDIRECT COSTS									
Overhead/field offices									
(*) - 34.0% per budget	35188	11729	46917	148629	56604	205233	183817	68333	252150
SUB-TOTAL III	35188	11729	46917	148629	56604	205233	183817	68333	252150
VII. OTHER PROGRAM COSTS									
A. Personnel (list each position & total person months separately)									
1) Technical	48675	3326	52001	131588	63686	195274	180263	67012	247275
2) Administrative	25075	1108	26183	35012	21230	56242	60087	22338	82425
3) Support									
B. Travel (Short Term)									
1) In country	6890	5226	12116	14614	2770	17384	21504	7996	29500
2) International	0	2893	2893	61382	19925	81307	61382	22818	84200
C. Other Direct Costs (utilities, printing rent, maintenance, etc)	28383	591	28974	8577	13149	21726	39960	13740	50700
SUB-TOTAL IV	109023	13144	122167	251173	120760	371933	360196	133904	494100
<b>TOTAL FIELD</b>	<b>152043</b>	<b>38908</b>	<b>190952</b>	<b>571304</b>	<b>230000</b>	<b>801303</b>	<b>723347</b>	<b>268908</b>	<b>992255</b>

Excludes Evaluation Costs

NOTE: Differences in totals due to rounding.

Actual Expenditures to Date  
 ( 9 / 01 / 90 to 8 / 31 / 91 )

Projected Expenditures Against  
 Remaining Obligated Funds  
 ( 9 / 01 / 91 to 8 / 31 / 93 )

Total Agreement Budget  
 (Columns 1 & 2)  
 ( 9 / 01 / 90 to 8 / 31 / 93 )

TOTAL - FIELD & HEADQUARTERS

TOTAL HEADQUARTERS

TOTAL FIELD

TOTAL

AID	PVO	TOTAL
112640	7642	120281
152043	38908	190952
264683	46550	311233

AID	PVO	TOTAL
(36016)	20845	(15170)
571304	230000	801303
535288	250845	786133

AID	PVO	TOTAL
76624	28487	105111
723347	268908	992255
799971	297395	1097366

NOTE: Differences in totals due to rounding.

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